1997-1998

HOUSE INSURANCE

MINUTES

HOUSE COMMITTEE ON INSURANCE

1996-1997
97 98

Representative Jerry C. Dockham
Chairman

Nell R. Edwards
Joanna S. Mills
Committee Clerks

Staff Members

Linwood Jones
Lynn Marshbanks
Linda Attarian

HOUSE INSURANCE COMMITTEE

CHAIRMAN

Jerry C. Dockham

Cary D. Allred

Bobby Harold Barbee

James B. Black

C. Robert Brawley

Nelson Cole

Andrew Thomas Dedmon

W. W. (Dub) Dickson

John R. Gamble, Jr.

Charlotte A. Gardner

Thomas C. Hardaway

Edwin Mitchell Hardy

Bob Hensley

HOUSE INSURANCE COMMITTEE

RMM

George M. Holmes

John W. Hurley

William (Bill) Ives

Paul Luebke

Danny McComas

George W. Miller

David Miner

Jean R. Preston

Timothy N. Tallent

William L. Wainwright

Thomas Wright

Stephen Wood

PRO TEMPORE

N. Leo Daughtry

MAJORITY Leader

Julia Craven Howard

MAJORITY WHIP

HOUSE INSURANCE COMMITTEE

Joanne W. Bowie

Theresa H. Esposito

H. M. Michaux, Jr.

Carolyn B. Russell

1997 NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES/CLERKS

February 21, 1997

MEMBER	ROOM	PHONE	CLERK
BRUBAKER	2304	3-5431	Carey, Cindy
Adams	542	3-5902	Malone
Aldridge	640	3-5958	Gnik
Alexander	1209	3-5605	Blackmon
Allred	2223	3-5773	Allred
Arnold	535	3-5747	McNeill
Baddour	501	3-5903	Webster
Baker	632	3-5787	Hinton
Barbee	1025	3-5908	Murrey, Rosa
Beall	510	3-5868	Capps
Berry	1006	3-5861	Smith, Betty
Black	1229	3-4946	
Blue	1227	3-2528	Threatt
Bonner	617	3-9664	Johnson, Lucy
Bowie	1206	3-5853	Gaudette
B-McIntyre	507	3-5905	Aftia
Braswell	539	3-5809	Gilmore
Brawley	513	3-5931	Tillotte
Brown	1111	3-5935	Kidd
Buchanan	536	3-5825	Phillips, Shirley
Cansler	419a	3-3007	Cansler
Capps	419b	3-3005	Aftia
Carpenter	537	3-5777	McCraw
Church	1311	3-5805	Fuller
Clary	418b	3-3011	Jamison
Cole	1218	3-5779	Smith, S.
Crawford	1301	3-5824	Whitted
Creech	635	3-5829	Lennon
Culp	1010	3-5865	Lord
Culpepper	604	3-5802	Crocker
Cunningham	607	3-5735	Green
Daughtry	2301	3-0850	Bullard
Davis	419c	3-3003	Johnson, A.
Decker	2121	3-7208	Kane
Dedmon	1211	3-5654	Abu Hark
Dickson	530	3-5662	Langdon
Dockham	1106	3-5822	Edwards
Earle	602	3-4466	McClain
Easterling	606	3-5788	Willis
Eddins	1219	3-5776	Monroe

4 Digit Room Numbers-LB

MEMBER	ROOM	PHONE	CLERK
Ellis	1303	3-5821	Everett
Esposito	634	3-2530	Jackson
Fitch	1202	3-2241	Branch
Fox	1217	3-5757	Burhlmann
Gamble	416b	3-3021	Pittman
Gardner	417b	3-3017	Hewett
Goodwin	502	3-4838	Smith, Ann
Grady	402	3-3024	Murrey, Peggy
Gray	532	3-5995	Parsons
Culley	1307	3-5860	Carter
Hackney	1321	3-5752	Reynolds
Hall	637	3-5906	Stevens
Hardaway	1323	3-5775	Brooks
Hardy	417a	3-3019	Rouge
Hensley	509	3-5936	Kirby
Hiatt	1008	3-5862	Pearce, Edna
Highsmith	541	3-5778	Burleson
Hill	1309	3-5830	McCann
Holmes	631	3-5900	Jacobs
Howard	1021	3-5904	Stewart, Gail
Hunter, H.	613	3-2962	Phillips, B.
Hunter, R.	1201	3-5987	Steinbeck
Hurley	1004	3-5859	Anderson
Ingle	1319	3-5800	Baker
Ives	633	3-5784	Watson
Jarrell	1426	3-5602	Regal
Jeffus	1013	3-5191	Robinson
Justus	2204	3-5956	Justus
Kinney	527a	3-5867	Dunnigan
Kiser	1313	3-5803	Holder
Luebke	1325	3-5772	Covington, C.
McAllister	603	3-5706	Norwood
McComas	2123	3-5758	Quinn
McCombs	514	3-5881	Erskine
McCrory	601	3-5780	Berry
McMahan	2213	3-5732	Crum
Mercer	1424	3-2526	LeCount
Michaux	1409	3-5609	Scott
Miller	611	3-5878	Curtis
Minor	2219	3-5749	Mamie

3 Digit and a,b,c, Room Numbers-LOB

MEMBER	ROOM	PHONE	CLERK
Mitchell	638	3-5959	Thurmon
Moore	1019	3-5661	Call
Morgan	404	3-3028	Epps
Morris	1315	3-5741	Floyd
Mosley	2221	3-5781	Thurlow
Nesbitt	420	3-3001	Harrison
Nesbitt	1213	3-0873	Lee
Nichols	616	3-9644	Jones, Bonnie
Nye	639	3-5477	Bobbitt
Oldham	538	3-5877	Prince
Owens	608	3-0000	Sheets
Preston	403	3-3026	Falcone
Ramsey	2217	3-5606	Barber
Rayfield	418a	3-3009	George
Redwine	1204	3-4948	Shull
Reynolds	533	3-5820	Covington, T.
Rogers	414a	3-3023	Vestal
Russell	2207	3-0875	Brothers
Saunders	1017	3-5530	Fish
Sexton	506	3-5974	Turner, Debbie
Sherrill	2215	3-5601	Kelley
Shubert	2119	3-5771	Ellis
Smith	1221	3-5827	Collar
Starnes	418a	3-3012	Fleming
Sutton	1317	3-5782	Coley, Juanita
Tallent	1104	3-5934	Bullock
Thompson	1002	3-5828	Sykes
Tolson	609	3-5607	Christian
Wainwright	614	3-5898	Smith, Denise
Warner	1420	3-5806	Stancil
Warwick	1015	3-5886	Honeycutt
Watson	417c	3-3015	Watson
Weatherly	503	3-5849	Puckett
Wilkins	1220	3-5746	Pearce, Lillie
Wilson, C.	529	3-7663	Mills
Wilson, G.	1109	3-7727	Jones, Rebecca
Womble	540	3-5751	Cameron
Wood	2208	3-5807	Perkins
Wright	528	3-5754	Stewart, C.
Yongue	1305	3-5823	Umstead

House Committee Clerks' Office 733-5977 (OVER)

1997 NORTH CAROLINA GENERAL ASSEMBLY
CLERKS/HOUSE OF REPRESENTATIVES

February 21, 1997

CLERK	REPRESENTATIVE
[illegible]	[illegible]
Floyd, Monty	Morris
Fuller, Joyce	Church
Gaudette, Sharon	Bowie
George, Karen	Rayfield
Gilmore, Dianna	Braswell
Green, Sylvia	Cunningham
Groh, Susan	Aldridge
Harrison, Betty	Neely
Hinton, Jo	Baker
Hocutt, Barbara	Gardner
Holder, Marilyn	Kiser
Honeycutt, Carolyn	Warwick
Jackson, Melissa	Esposito
Jacobs, Glenda	Holmes
Jamison, Mary	Clary
Johnson, Audrey	Davis
Johnson, Lucy	Bonner
Jones, Bonnie	Nichols
Jones, Rebecca	Wilson, G.
Justus, Carolyn	Justus
Keen, Cindy	Decker
Kelley, Rosa	Sherrill
Kidd, Anna	Brown
Kirby, Margie	Hensley
Langdon, Joyce	Dickson
LeCount, Kevin	Mercer
Lee, Jan	Nesbitt
Lennon, Betty Anne	Creech
Lord, Waneta	Culp
Malone, Jo	Adams
Mansur, Stephanie	Miner
McCann, Ginny	Hill
McClain, Monica	Earle
McCraw, Kara	Carpenter
McNeill, Jean	Arnold
Mills, Joanna	Wilson, C.
Monroe, Dorie	Eddins
Murray, Peggy	Grady
Murray, Rosa	Barbee
Norwood, Annecia	McAllister
Parsons, Catherine	Gray
Pearce, Edna	Hiatt
Pearce, Lillie	Wilkins
Perkins, Sylvia	Wood
Phillips, Barbara	Hunter, H.
Phillips, Shirley	Buchanan
Pittman, Jackie	Gamble
Prince, Delia	Oldham
Puckett, Debbie	Weatherly
Quinn, Rita	McComas
Raupe, Joel	Hardy
Regal, Joan	Jarrell
Reynolds, Emily	Hackney
Robinson, Mary Lee	Jeffus
Scott, Karlene	Michaux
Sheets, Marie	Owens
Shull, Katie	Redwine
Smith, Ann	Goodwin
Smith, Betty	Berry
Smith, Denise	Wainwright
Smith, Suzanne	Cole
Stalnback, Ferebee	Hunter, R.
Stancil, Ann	Warner
Stevens, Billie	Hall
Stewart, Clarestene	Wright
Stewart, Gail	Howard
Sykes, Edna	Thompson
Thomason, Susan	Mitchell
Threatt, Lin	Blue
Thurlow, Gennie	Mosley
Trivette, Bonnie	Brawley
Turner, Debbie	Sexton
Unstead, Jenny	Yongue
Veorse, Judy	Rogers
Walton, Jayne	Ives
Watson, Ebern	Watson
Webster, Sandra	Baddour
Willis, Judy	Easterling
Winstead, Linda	Crawford
z	Black

Cindy Brooks, Finance Clerk, Room 531, Phone: 3-5863

(REPRESENTATIVES-OVER)

ATTENDANCE

1997 - 1998

HOUSE INSURANCE COMMITTEE

(Name of Committee)

DATES	2/27	3/6	3/20	4/3	4/10	4/17	4/24	4/28	5/15	6/2	7/3	7/16			
Dockham, Jerry C., Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Allred, Cary D.	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓				
Barbee, Bobby H., Sr.		✓		✓		✓	✓	✓	✓	✓	✓	✓			
Black, James B.			✓	✓			✓								
Bowie, Joanne	✓	✓	✓	✓				✓	✓			✓			
Brawley, C. Robert	✓		✓	✓	✓	✓	✓		✓	✓					
Cole, E. Nelson	✓	✓	✓	✓	✓	✓	✓		✓		✓				
Dedmon, Andrew T.	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓			
Dickson, W. W. (Dub)			✓	✓	✓	✓	✓	✓		✓	✓	✓			
Esposito, Theresa		✓						✓			✓				
Gamble, John R., Jr.	✓	✓	✓		✓		✓								
Gardner, Charlotte A.		✓	✓	✓	✓	✓		✓			✓				
Hardaway, Thomas C.		✓	✓	✓				✓	✓		✓	✓			
Hardy, Edwin M.	✓	✓	✓	✓	✓	✓	✓	A	✓						
Hensley, Robert J., Jr.				✓		✓	✓	✓	✓	✓	✓				
Holmes, George M.	✓	✓			✓				✓	✓	✓				
Hurley, John W.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Ives, William M.		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Luebke, Paul	✓	✓	✓	✓			✓		✓	✓	✓				
McComas, Daniel F.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Michaux, H. M.			✓		✓	✓	✓								
Miller, George W., Jr.		✓		✓			✓	✓			✓				
Miner, David M.		✓	✓	✓			✓			✓	✓	✓			
Preston, Jean R.		✓					✓	✓							
Russell, Carolyn B.	✓					✓		✓	✓		✓	✓			
Tallent, Timothy N.	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓				

ATTENDANCE

1997 - 1998

HOUSE INSURANCE COMMITTEE

(Name of Committee)

DATES	2/27	3/6	3/20	4/3	4/10	4/17	4/24	4/28	5/15	6/26	7/3	7/16			
Wainwright, William L.	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓				
Wright, Thomas E.		✓	✓	✓		✓	✓			✓	✓				
Pro Tem-Wood, Stephen															
Majority Leader-Leo Daughtry															
Majority Whip-Julia Howard															

NORTH CAROLINA GENERAL ASSEMBLY
1997-98 Regular Session

COMMITTEE SUMMARY REPORT
Valid Through 8-SEP-1997

HOUSE: INSURANCE

NOTES: = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL TO ANOTHER BILL.
$ AFTER BILL NUMBER INDICATES BILL AFFECTS APPROPRIATIONS.
* BEFORE ACTION INDICATES THAT TEXT OF BILL WAS ALTERED BY AN ACTION.

BILL	INTRODUCER	SHORT TITLE	IN DATE	OUT DATE
H 5	ALDRIDGE	HEALTH COVERAGE/DIABETES	01-30-97	04-30-97
	Current Status: *R -CH. SL 97-0225			
H 165=	REDWINE	LODGING ESTABLISHMENTS/SANITATION	02-13-97	04-29-97
	Current Status: *S -RE-REF COM ON CH&HUMRS			
H 184	REDWINE	EXEMPT STATE HEALTH PLAN FROM APA	02-17-97	03-20-97
	Current Status: R -CH. SL 97-0278			
H 193=	HUNTER R	NO INS. POINTS/15MPH OVER LIMIT	02-17-97	04-28-97
	Current Status: *H -CAL PURSUANT RULE 36(A)			
H 199=	CULPEPPER	STUDY MEDICAL PROVIDERS' LIENS	02-17-97	04-21-97
	Current Status: *H -RE-REF COM ON RULES			
H 276	SHERRILL	REDUCE TAX ON NONPRESCRIPTION DRUGS	02-19-97	
	Current Status: H -REPTD TO INS			
H 291	STARNES	AUTOPSY/FAMILY NOTICE	02-20-97	
	Current Status: H -REPTD TO INS			
H 312=	GOODWIN	UPDATE MORTALITY TABLES	02-24-97	04-21-97
	Current Status: *R -CH. SL 97-0133			
H 350=	DICKSON	GENETIC INFO/NO DISCRIMINATION	02-27-97	
	Current Status: H -REF TO COM ON INS			
H 358	ADAMS	OB-GYN ACCESS/MEDICAID RECIPIENTS	02-27-97	
	Current Status: H -REF TO COM ON INS			
H 405=	CUNNINGHAM	ELIMINATE MEDICAID RX LIMIT	03-05-97	
	Current Status: H -REF TO COM ON INS			
H 421	TOLSON	RESPIRATORY CARE PRACTICE ACT	05-21-97	
	Current Status: H -RE-REF COM ON INS			
H 434	DOCKHAM	FEDERAL HEALTH INSURANCE CHANGES	03-10-97	04-24-97
	Current Status: *R -CH. SL 97-0259			
H 434	DOCKHAM	FEDERAL HEALTH INSURANCE CHANGES	06-24-97	
	Current Status: *R -CH. SL 97-0259			
H 435	DOCKHAM	STATE HEALTH PLAN TECH. AMDS.	03-10-97	06-25-97
	Current Status: *H -PRES. TO GOV. 08-29			
H 435	DOCKHAM	STATE HEALTH PLAN TECH. AMDS.	06-25-97	08-18-97
	Current Status: *H -PRES. TO GOV. 08-29			
H 436	DOCKHAM	STATE HEALTH PLANS SUBSTANTIVE	03-10-97	06-25-97
	Current Status: H -RE-REF COM ON INS			
H 436	DOCKHAM	STATE HEALTH PLANS SUBSTANTIVE	06-25-97	
	Current Status: H -RE-REF COM ON INS			

H 452	REDWINE	BEACH PLAN AMENDMENTS	03-10-97	04-22-97
	Current Status:	*H -PRES. TO GOV. 08-29		
H 455=	DOCKHAM	GLAUCOMA PROGRAM REPEALED	03-10-97	04-07-97
	Current Status:	*R -CH. SL 97-0137		
H 541=	DOCKHAM	IMPROVE HMO SERVICES	03-19-97	
	Current Status:	H -REF TO COM ON INS		
H 562=	ALEXANDER	DIR. PAY/SUBS. ABUSE PROF.	03-20-97	
	Current Status:	H -REF TO COM ON INS		
H 563=	ALEXANDER	MENTAL HEALTH PARITY	03-20-97	
	Current Status:	H -REF TO COM ON INS		
H 796=	CRAWFORD	PRESCRIPTION DRUGS/COMPETITION	04-03-97	
	Current Status:	H -REF TO COM ON INS		
H 803	$GARDNER	HEALTH INS./RISK POOL	04-03-97	
	Current Status:	H -REF TO COM ON INS		
H 813	ALEXANDER	RECONSTRUCTIVE SURGERY/COVERAGE	04-07-97	04-29-97
	Current Status:	H -RE-REF COM ON APPROP		
H 891=	MITCHELL	WORKERS COMPENSATION MEDICAL CARE	04-07-97	04-24-97
	Current Status:	*S -REF TO COM ON JUDIC		
H 914	WATSON	BONE MASS MEASUREMENT/COVERAGE	04-10-97	
	Current Status:	H -REF TO COM ON INS		
H 923	WAINWRIGHT	WINDSTORM DEDUCTIBLES	04-10-97	
	Current Status:	H -REF TO COM ON INS		
H 926	BRAWLEY	PREFERRED PROVIDER CONTRACTS	04-14-97	04-24-97
	Current Status:	S -REF TO COM ON PENSIONS		
H 933	JARRELL	INCREASE PHARMACY FEES	04-14-97	04-16-97
	Current Status:	*R -CH. SL 97-0231		
H 940	REDWINE	WORKER'S COMP/REALTOR STATUS	04-24-97	04-28-97
	Current Status:	S -REF TO COM ON COMMERCE		
H 984	CULP	S&W SUPERVISOR HEALTH BENEFITS	04-17-97	04-28-97
	Current Status:	H -RE-REF COM ON APPROP		
H 987=	WILKINS	VENTURE CAPITAL INVESTMENT INCENTIVE	04-17-97	04-23-97
	Current Status:	H -RE-REF COM ON FINANCE		
H1020	HARDY	INSURANCE SETTLEMENTS	04-21-97	
	Current Status:	H -REF TO COM ON INS		
H1024=	HURLEY	FOREIGN INSURER LICENSING	04-21-97	04-24-97
	Current Status:	*R -CH. SL 97-0179		
H1052	MILLER G	EXCLUDE EXCESS COVERAGE/COVENANTS	04-21-97	04-24-97
	Current Status:	*R -CH. SL 97-0396		
H1052	MILLER G	EXCLUDE EXCESS COVERAGE/COVENANTS	07-15-97	07-17-97
	Current Status:	*R -CH. SL 97-0396		
H1058	CUNNINGHAM	HEALTH CARE FACILITY PRIVILEGES	04-21-97	
	Current Status:	H -REF TO COM ON INS		
H1115	BOYD-MCINTYRE	CHURCH INSURANCE COVERAGE	04-21-97	04-28-97
	Current Status:	*R -CH. SL 97-0438		

H1162=	WILSON C	CON MODIFICATIONS	04-28-97	
	Current Status:	H -REF TO COM ON INS		
H1223	$LUEBKE	FAMILY HEALTH-CARE PROGRAM	05-05-97	06-26-97
	Current Status:	H -RE-REF COM ON INS-HLTH		
S 234	KINCAID	INCREASE AMTS FOR INSURANCE POINTS	03-24-97	07-02-97
	Current Status:	*R -CH. SL 97-0332		
S 247	RAND	REMOVE SUNSET/HLTH CONTRACT CONFID.	04-09-97	05-12-97
	Current Status:	*R -CH. SL 97-0123		
S 254=	ODOM	GENETIC INFO/NO DISCRIMINATION	04-14-97	06-25-97
	Current Status:	*R -CH. SL 97-0350		
S 254=	ODOM	GENETIC INFO/NO DISCRIMINATION	06-25-97	07-07-97
	Current Status:	*R -CH. SL 97-0350		
S 273	FORRESTER	MASTECTOMY/HOSPITAL STAY	03-19-97	08-06-97
	Current Status:	*R -CH. SL 97-0440		
S 273	FORRESTER	MASTECTOMY/HOSPITAL STAY	08-06-97	08-07-97
	Current Status:	*R -CH. SL 97-0440		
S 299	MARTIN R	LONG-TERM CARE BENEFITS	06-26-97	08-14-97
	Current Status:	*R -CH. SL 97-0468		
S 374	ODOM	CHIROPRACTOR SUPPLEMENTS EXEMPT	06-02-97	07-02-97
	Current Status:	*R -CH. SL 97-0369		
S 400=	WINNER	MENTAL HEALTH PARITY	05-01-97	
	Current Status:	*H -ASSIGNED TO INS-HLTH		
S 455=	HOYLE	IMPROVE HMO SERVICES	05-01-97	06-25-97
	Current Status:	*R -CH. SL 97-0474		
S 455=	HOYLE	IMPROVE HMO SERVICES	06-25-97	07-07-97
	Current Status:	*R -CH. SL 97-0474		
S 515	DALTON	PRELITIGATION INS. INFO./MEDIATION	04-24-97	
	Current Status:	H -REF TO COM ON INS		
S 577	REEVES	INSURANCE PREMIUM FINANCING	05-01-97	
	Current Status:	*H -REF TO COM ON INS		
S 714	FORRESTER	RECONSTRUCTIVE SURGERY/COVERAGE-2	04-30-97	05-15-97
	Current Status:	*R -CH. SL 97-0312		
S 785	MARTIN W	DIRECT PAYMENT SUNSETS OFF	04-29-97	05-29-97
	Current Status:	R -CH. SL 97-0197		
S 843	JENKINS	INSURANCE TECHNICAL CHANGES	04-30-97	08-18-97
	Current Status:	*S -RE-REF COM ON PENSIONS		
S 914	KERR	WORKERS' COMP. HOSPITAL CHANGES	04-30-97	05-19-97
	Current Status:	*R -CH. SL 97-0145		
S 975	KINCAID	WORKERS' COMP SELF-INSURANCE	05-01-97	07-02-97
	Current Status:	*R -CH. SL 97-0362		
S1016=	MARTIN W	DIR. PAY/SUBS. ABUSE PROF.	05-01-97	
	Current Status:	H -ASSIGNED TO INS-HLTH		

MINUTES

HOUSE COMMITTEE ON INSURANCE

February 27, 1997

The House Committee on Insurance met on Thursday, February 27, 1997, at 12:00 Noon in Room 643 of the Legislative Office Building for its first meeting of the 1997-98 Session. Chairman, Rep. Jerry C. Dockham, presiding, called the meeting to order.

Members present: Representatives Dockham, Allred, Bowie, Brawley, Cole, Dedmon, Gamble, Hardy, Holmes, Hurley, Luebka, McComas, Russell, Tallent and Wainwright.

The Visitor Registration sheets are attached as a part of the record.

The main order of business was a presentation by Commissioner of Insurance, Mr. Jim Long. His comments are attached. He also provided two booklet entitled, "1995-1996 Biennial Report ,N.C. Department of Insurance and HMOs in North Carolina.

Folllowing Mr. Long's comments were questions and concerns from members of the Insurance Committee.

There being no further business, the Chairman adjourned the meeting at 12:50 p.m..

Jerry C. Dockham

Rep. Jerry C. Dockham, Chairman

Nell R. Edwards

Nell R. Edwards, Clerk

VISITOR REGISTRATION SHEET

INSURANCE — 2-27-97

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Ken Eudy	Capital Strategies
Payton Mayhew	9/2
Sheila McKenney	NC Dept. of Ins.
Roger Langley	" "
[illegible]	[illegible]
Paul Mahoney	NC HMO Association
Ballard Everett	—
Adam Searing	NC Health Access Coalition
Julian Philpott	NCFB
[illegible]	NCALH
Mo Trenberry	Doctor of the Day
Steve Keene	NCMed Society
Dave Horne	South Atlantic

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

2/27/96
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Ruffin Bailey	C I A
Alan Mueller	Bailey & Dixon LLP
Robert Pinson	Assn NC Life Disc Cos.
Eugene Hoffa	CAPIA
Rachael Bryan	NC DOI
Peter A. Kelbe	NCDOT
George N. Teague	Nowis Van Allen
DON PRESTON	ALLIANCE OF AMERICAN INSURERS
Susan Valaur	Nationwide
Robert Paschal	Young, Moore
Charles Ormer	NCATL
Lucia Zell	NC Medical Society
Evelyn Hawthorne	NC Hospital Assn.
John Bourdeau	Zeb Alley P.A.

Remarks by Insurance Commissioner Jim Long
House Insurance Committee
Raleigh, North Carolina
February 27, 1997

Good afternoon. I'd like to thank Chairman Jerry Dockham for giving me an opportunity to address this committee.

Your Department of Insurance serves the citizens of North Carolina through consumer protection and education activities, safety training and promotion, and regulation of several industries.

Our goals are:

- to assure an optimum marketplace in which consumers can readily purchase fairly-priced insurance products from financially sound and responsive companies
- to protect the lives of North Carolinians through education about loss prevention, safety awareness and by developing safety standards

- and to maintain a well-managed, fiscally-responsible organization staffed by knowledgeable, courteous and professional employees

Your Department of Insurance has continued to be a strong advocate for North Carolina consumers during the past biennium on issues ranging from auto rates to fire safety.

I am proud to say that North Carolinians currently pay the lowest auto rates of any state in the southeast and the 9th-lowest in the nation! Yet we still enjoy a thriving market of sound insurance companies eager to do business in our state.

Department staff have worked long and hard to keep auto insurance rates reasonable.

In December 1996, the North Carolina Court of Appeals issued its decision on the 1994 auto insurance rate filing—a decision which unanimously confirmed my authority to set rates and supported the department's ratemaking approach.

If the Court of Appeal's decision becomes final, I will have the distinct pleasure of ordering consumer refunds totaling millions of dollars.

As you may recall, North Carolinians received more than $110 million in auto refunds in 1993—the largest such refund in US history.

The auto insurance industry also has appealed my rate reduction decision in the 1995/96 filing to the court of appeals.

The department has continued to work to lower insurance rates through traffic safety and injury-prevention programs, such as "Click It or Ticket" and "Booze It & Lose It".

During its first two years, the "Click It or Ticket" program reduced fatalities and serious injuries by 12%, resulting in a savings of $164 million in health care costs in North Carolina.

Also, in two recent rate filings from the auto insurance industry, savings of more than $33 million in auto insurance premiums were attributed to "Click It or Ticket".

The "Booze It & Lose It" campaign is having similar success. Numbers gathered at North Carolina checkpoints indicate that we've cut late night drunk driving in half and reduced DWI-related fatalities by 20%.

Together, these programs are saving lives, preventing injuries, and helping to reduce the high medical costs of auto crashes.

The department's in-house safety programs also have been very busy during the biennium. Our Buckle Up Kids program is now active in 62 counties across the state and has distributed more than 2,100 child safety seats through local fire & rescue agencies.

Our Learn Not to Burn program provides fire safety education to more than 90,000 fourth graders annually.

And a new program was added in 1996—the North Carolina Safe Kids coalition is one of the 250 local and state groups in the country dedicated to childhood injury prevention.

Our department also has been a leader in anti-fraud efforts since we established the first investigations bureau within an insurance department in 1945.

In 1996, the Investigations Division helped to obtain a $187 million settlement in the largest criminal health care fraud case in North Carolina history.

The case against this medical laboratory was investigated jointly by state and federal law enforcement agencies and was the third-largest criminal health care fraud case in the nation.

Investigators from the Special Services Division also concluded two record-breaking cases this biennium. A $250,000 fine levied against one collection agency is the largest ever assessed by the division. An additional $233,000 in restitution was ordered in this case.

The owner of another collection agency pled guilty to 45 counts of embezzlement totaling nearly $400,000 dollars. He is currently serving a 21-year active sentence—the longest ever ordered by the courts as a result of a criminal investigation conducted by the division.

One of the division's investigators received the Governor's Award for Excellence in 1995, in part for his work on this case.

The 1995-96 biennium marked a period of great change in the health insurance industry. New federal legislation and the growth of managed care pose challenges for both regulators and consumers.

Our department has prepared legislation that brings North Carolina law into compliance with the federal Health Insurance Portability and Accountability Act of 1996, sponsored by senators Kassebaum and Kennedy, as well as new federal laws on maternity stays and mental health parity.

These acts require states to conform their statutes to the new laws or risk federal management of health insurance.

Your committee chairman, Representative Dockham, has been kind enough to sponsor this legislation this session.

Our Managed Care and Health Benefits Division has also prepared important legislation for this session.

This proposed legislation outlines some very important consumer protections on issues such as:

- coverage for services provided in emergency rooms,
- utilization review and grievance procedures, and
- making our laws on HMOs consistent with our laws on other types of insurance companies—creating a more level playing field across the industry.

The Managed Care Division has also developed a very useful status report on HMOs in North Carolina. The report provides a snapshot of the current HMO industry in the state and a detailed analysis of HMO activity in 1995.

This report is intended to give legislators, regulators, and citizens a better understanding of the health care environment in our state.

Compiling this report was quite a challenge and I'd like to recognize the efforts of the staff of the Managed Care Division.

One of the biggest challenges still facing my department remains the aftermath of Hurricane Fran.

This hurricane season was unlike any other that North Carolina has experienced. Not since Hurricane Hazel in 1954, have we suffered such a massive amount of destruction.

The one-two punch of back-to-back hurricanes dealt a major blow to North Carolina.

Hurricane Fran, a category three storm, wreaked havoc on lives and homes. Twenty-five lives were lost, and we anticipate more than $1.6 billion in insured losses.

Some 425-thousand claims have been filed so far. Yet out of that number, my department has only received some 575 complaints. And it is estimated that 97% of claims have been settled and closed.

Fifty-two North Carolina counties were declared disaster areas by the federal government, including most eastern NC counties.

These counties are home to more than 60 percent of North Carolina's citizens. An estimated 30,000 homes and 50,000 vehicles were damaged across the state.

Auto claims alone total some $70 million.

I'm sure many of you were personally affected by the storm and I'm sure you've all heard touching stories about people coming together to help each other recover.

I'm proud to say my staff has truly gone the extra mile to help folks through the recovery process.

Following both Hurricane Bertha and Hurricane Fran, our employees were immediately on the job assisting local fire and rescue personnel, helping consumers with insurance questions, and assessing damage.

Our consumer specialists took more than 3,200 phone calls in the week after Fran hit (when state employees were supposedly not working) and through the end of the year had taken a total of more than 46,000 calls.

These folks are truly dedicated to helping the people of North Carolina.

Insurance industry adjusters in the field also worked long hours.

There were some 4,500 adjusters in the field immediately after Fran. In fact, North Carolina companies put out a call for help, bringing in 3,000 reinforcements from out-of-state to help residents with their claims.

And the response time for most companies has been quite good thanks to agents' and adjusters' hard work handling claims.

The hurricanes were devastating to homeowners who found themselves in the path of destruction. However, the damage could have been much worse.

Thanks to our building codes for site built homes and to the federal standards for manufactured homes, many of North Carolina's residents suffered minimal damage.

Storms like Fran do highlight the need for insurance coverage on our coast.

Residents and business owners are still getting coverage, but increasingly they're getting it from the Beach and FAIR plans.

Your department of insurance is dedicated to helping solve the problem of coastal availability. And we've talked with coastal agents to get agent input on this issue.

We also worked closely with the Legislative Research Commission appointed by the legislature to examine this issue.

The committee met five times last year to study the issues of coastal availability and affordability. It examined ways to encourage the voluntary market to write policies in the beach area and ways to improve the Beach Plan.

What our department cannot do is force insurers to write coastal coverages.

According to a formal opinion from the Attorney General's office, companies may legally refuse to write coastal risks.

The LRC committee did ask us for our recommendations and heard the concerns of many others including agents and companies.

Based on this input, the committee proposed three bills to the General Assembly.

The first directs the Department of Insurance and the Beach Plan to develop a proposal for a reserve fund to pay catastrophic losses incurred by wind risks under plan policies.

The second proposal charges the Beach Plan with revising the participation formula for member companies to encourage companies to write more voluntary policies on the beach and to write themselves out of the losses of the Plan.

The revised participation formula will have to be approved by the department.

The final proposal on this issue recommends that the Beach Plan offer business income coverage.

These proposals were all passed by the General Assembly during the short session last summer and we're currently working with the Beach Plan on implementing them.

The Beach Plan has established a committee to carry out these directions and improve the coastal situation.

Our Assistant Commissioner, Dash Propes has served on that committee and we can report that a lot of work has been done to create an opportunity to improve the insurance availability situation in the Beach underwriting territory.

There are more than 1,500 insurance companies licensed to do business in our state and hundreds more apply each year.

This competitive environment is good for insurance rates and good for the people of North Carolina.

Most North Carolina families put a lot of their monthly income into buying auto, homeowners, life and health insurance so being able to buy the right coverages — at the right price — is critical.

Every day, the people of my department strive to make sure that the people of our state remain safe and secure in the knowledge that they are protected by stable companies at a fair price.

Thank you for having me here today. Are there any questions?

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MINUTES

HOUSE COMMITTEE ON INSURANCE

March 6, 1997

The House Committee on Insurance met on Thursday, March 6, 1997, at 12:00 Noon in Room 643 of the Legislative Office Building. Chairman, Jerry C. Dockham, presiding, called the meeting to order.

Members present: Representatives Dockham, Allred, Barbee, Bowie, Cole, Dedmon, Esposito, Gamble, Gardner, Hardaway, Hardy, Holmes, Hurley, Ives, Luebke, McComas, Miller, Miner, Preston, Tallent, Wainwright and Wright.

The Visitor Registration sheets are attached as a part of the record.

Mr. Linwood Jones, Staff Counsel, provided a summary of the Insurance Bill that was on the agenda for this meeting, which is attached.

The first order of business was House Bill 199 entitled Amend Medical Providers' Liens. Chairman Dockham recognized Representative Culpepper, sponsor of the bill, Representative Culpepper explained House Bill 199. Chairman Dockham then recognized the following members of the Insurance Committee for questions and discussions. They are as follows: McComas, Gamble, Gardner, Miller, Allred, Hardy, Wainwright and Luebke. He also recognized Anne Duvoism, an attorney from Durham.

Chairman Dockham's decision was to send House Bill 199 to a sub-sub committee. He appointed Representative Hurley to Chair this sub-sub committee and appointed Representatives Hardaway, Allred, Bowie, Miner, Barbee and Hardy to be members of the sub-sub committee. Chairman Dockham requested that they report back to the Insurance Committee on March 20th if possible.

There being no further business, the Chairman adjourned the meeting at 12:52 p.m..

Jerry C. Dockham

Rep. Jerry C. Dockham, Chairman

Nell R. Edwards

Nell R. Edwards, Clerk

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

3/6/97 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
JOE DELUCA	RULES REVIEW COM
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Bill Wilson	NCAE
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PAUL MAHONEY	NC HMO ASSOCIATION
John Jordan	ASSN. of NC Life Cos
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[illegible] Green	SEANC
Anne DuVoisin	DuVoisin Law Offices
Rita Paschal	Young, Moore
Mac Boxley	N.C. Podiatric medical society

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

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Charles Cromer	NCATL
P Bly Hall	General Statutes Commission
Tommy Worth	Carolina Health Care Systems
Sheila H. McKenney	N C Dept. of Insurance
Bill Hale	N.C. Dept. of Insurance
Susan Valauri	Nationwide
Robert Poss	Assn N.C. Life Ins. Cos
Lucius PULLEN	ATTORNEY
HUGH TILSON	NCHA
Amy Anderson	Hunton & Williams
John Rustin	H&C
Evelyn Hawthorne	NCHA
John McMillan	Manning, Fulton & Skinner
	DENR

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

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March 5, 1997

MEMORANDUM

TO: Representative Jerry Dockham, Chairman
House Insurance Committee

FROM: Linwood Jones, Committee Counsel

RE: House Bill 199 (Medical Provider Liens)

House Bill 199 rewrites the laws that govern medical providers' liens against damages recovered by their patients from third parties for the injuries for which the patients were treated. The liens help ensure that doctors, hospitals, and other medical providers are paid for the medical services they provide to these patients. The existing laws, which were put on the books earlier in the century, are repealed and replaced by the new provisions. It is my understanding from the General Statutes Commission that, with some exceptions, the new laws are designed to follow in substance the old laws and existing practice that has developed under those laws.

Under House Bill 199, the medical provider may file a lien for the amount of any unpaid bills arising from treatment for the injuries in question by doing the following:

(1) Send a written notice of the lien to the claimant's attorney. If the claimant has no attorney or the attorney is not known, send the written notice to the claimant and to the insurance company or other party responsible for paying the damages to which the claimant may be entitled. The lien notice must identify the medical provider, the injured person, the date of the injury, the date(s) of treatment, and the amount of the lien. The notice must state that the provider is asserting its lien rights. If the notice is also being sent to an insurance company, the provider must also identify the person who allegedly injured the patient.

(2) If requested by the claimant or the claimant's attorney, provide a free copy of the claimant's medical records and an itemized bill. If the medical provider is requested to prepare a special medical report on the claimant beyond the ordinary medical records, it can charge for that report.

The lien notice must be sent in one of four ways authorized by the bill: personal delivery, certified mail, overnight mail, or fax. All four methods require the provider to obtain a receipt proving delivery.

When the claimant resolves its claim for damages against the third party (through judgment in a lawsuit or settlement, including UM and UIM recoveries) and is entitled to recover damages, the insurer must pay the damages to the claimant's attorney. (By sending a copy of the medical provider's lien to the attorney before or with payment of the funds to the attorney, the insurer relieves itself of further liability to the medical providers, if the attorney actually receives the notice before or with the payment). The attorney collects his attorney fees and the reasonable expenses in the case and then uses the remainder to reimburse the medical provider for its unpaid bills that relate to the injury for which the claimant was entitled to damages. The attorney can pay no more than 50% of this remaining amount to the medical provider(s). If the claimant has no attorney, the insurer or other responsible party makes these payments.

An insurer is not required to pay a disputed medical bill under the lien law until it is resolved. The bill also provides a penalty against a medical provider who asserts a false or exaggerated lien. The penalty does not apply if the lien or the amount of the lien is filed in error and is corrected by the provider when the error is brought to its attention. The penalty is liquidated damages in the amount of $5,000 or all damages proximately resulting from the assertion of the improper lien, whichever is greater, plus attorneys' fees, court costs, and other investigative and legal expenses incurred as a result of the error.

Neither the attorney nor the insurer (or other responsible party) is liable to a medical provider under the lien law if the provider's lien is not received or perfected before the recovery is paid.

This act takes effect January 1, 1998. All valid, existing liens filed under the current lien laws (G.S. 44-49 and 44-50) as of that date are considered "perfected" under this act and will be covered by this act. If a provider has taken all steps as of January 1, 1998, to perfect a lien under the existing law expect for providing a copy of requested medical records, the provider's lien will still be considered perfected once those records are delivered.

H199-SMRN-001

ARTICLE 9.

Liens upon Recoveries for Personal Injuries to Secure Sums Due for Medical Attention, etc.

§ 44-49. Lien created; applicable to persons non sui juris.

From and after March 26, 1935, there is hereby created a lien upon any sums recovered as damages for personal injury in any civil action in this State, the said lien in favor of any person, corporation, municipal corporation or county to whom the person so recovering, or the person in whose behalf the recovery has been made, may be indebted for drugs, medical supplies, ambulance services, and medical services rendered by any physician, dentist, trained nurse, or hospitalization, or hospital attention and/or services rendered in connection with the injury in compensation for which the said damages have been recovered. Where damages are recovered for and in behalf of minors or persons non compos mentis, such liens shall attach to the sum recovered as fully as if the said person were sui juris.

Notwithstanding the provisions of paragraph one of this section, no lien therein provided for shall be valid with respect to any claims whatsoever unless the person or corporation entitled to the lien therein provided for shall file a claim with the clerk of the court in which said civil action is instituted within 30 days after the institution of such action and further provided that the physician, dentist, trained nurse, hospital or such other person as has a lien hereunder shall, without charge to the attorney as a condition precedent to the creation of such lien, furnish upon request to the attorney representing the person in whose behalf the claim for personal injury is made, an itemized statement, hospital record, or medical report for the use of such attorney in the negotiation settlement or trial of the claim arising by reason of the personal injury.

No liens of the character provided for in the first paragraph of this section shall hereafter be valid with respect to money that may be recovered in any pending civil actions in this State unless claims based on such liens are filed with the clerk of the court in which the action is pending within 90 days after April 5, 1947.

No action shall lie against any clerk of court or any surety on any clerk's bond to recover any claims based upon any lien or liens created by the first paragraph of this section when recovery has heretofore been had by the person injured, and no claims against such recovery were filed with the clerk by any person or corporation, and the clerk has otherwise disbursed according to law the money recovered in such action for personal injuries. (1935, c. 121, s. 1; 1947, c. 1027; 1959, c. 800, s. 1; 1967, c. 1204, s. 1; 1969, c. 450, s. 1.)

§ 44-50. Receiving person charged with duty of retaining funds for purpose stated; evidence; attorney's fees; charges.

Such a lien as provided for in G.S. 44-49 shall also attach upon all funds paid to any person in compensation for or settlement of the said injuries, whether in litigation or otherwise; and it shall be the duty of any person receiving the same before disbursement thereof to retain out of any recovery or any compensation so received a sufficient amount to pay the just and bona fide claims for such drugs, medical supplies, ambulance service and medical attention and/or hospital service, after having received and accepted notice thereof: Provided, that evidence as to the amount of such charges shall be competent in the trial of any such action: Provided, further, that nothing herein contained shall be construed so as to interfere with any amount due for attorney's services: Provided, further, that the lien hereinbefore provided for shall in no case, exclusive of attorneys' fees, exceed fifty percent (50%) of the amount of damages recovered. (1935, c. 121, s. 2; 1959, c. 800, s. 2; 1969, c. 450, s. 2; 1995 (Reg. Sess., 1996), c. 674, s. 3.)

§ 44-51. Disputed claims to be settled before payments.

Whenever the sum or amount or amounts demanded for medical services or hospital fees shall be in dispute, nothing in this Article shall have any effect of compelling payment thereof until the claim is fully established and determined, in the manner provided by law: Provided, however, that when any such sums are in dispute the amount of the lien shall in no case exceed the amount of the bills in dispute. (1935, c. 121, s. 3; 1943, c. 543.)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 199

Short Title: Amend Medical Providers' Liens. (Public)

Sponsors: Representative Culpepper.

Referred to: Insurance, if favorable, Judiciary II.

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW RELATING TO LIENS DUE MEDICAL PROVIDERS FOR MEDICAL SERVICES PROVIDED, AS RECOMMENDED BY THE GENERAL STATUTES COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 44-49, 44-50, and 44-51 are repealed.

Section 2. Article 9 of Chapter 44 of the General Statutes is amended by adding the following new sections to read:

"**§ 44-51.01. Definitions.**

As used in this Article:

(1) 'Claimant' means an injured person or the injured person's personal representative, collector, guardian, or parent responsible for payment for medical services.

(2) 'Injured person' means any individual who has sustained personal injuries.

(3) 'Medical provider' means all of the following:

a. Any physician, nurse, chiropractor, dentist, optometrist, podiatrist, physical therapist, psychologist, pharmacist, or other individual licensed, registered, or certified by this State or any other state to provide medical services.

b. Any employer of any individual listed in sub-subdivision a. of this subdivision, or any entity through which such an individual renders medical services, that has the right to

receive the payment due for the individual's medical services to an injured person.

c. Any hospital, health care facility, provider of ambulance services, or similar provider of medical services that is licensed or regulated under Chapter 58, 122C, 131D, or 131E of the General Statutes, former Chapter 131 of the General Statutes, or the equivalent law of any other state.

(4) 'Medical records' means all records, regardless of the form in which these records are maintained, concerning patient-provided information, observations, findings, treatment rendered, opinions, physician notes and summaries, nursing notes, laboratory and radiological reports, and any other health care records prepared by any health care professional or other person.

(5) 'Medical services' means any services or supplies furnished to an injured person for the purpose of treating the injuries.

(6) 'Person' means an individual, trust, partnership, professional association, limited liability company, corporation, federal, state, or local government, any political subdivision, agency, or institution of those governments, or any other entity.

(7) 'Recovery' means any sums recovered, or to be recovered, as compensatory damages for personal injuries in any civil action or other proceeding in this State or by settlement. Recovery includes sums recovered under uninsured and underinsured motorist coverage, but does not include proceeds from any other insurance policy when the injured person is also the insured.

(8) 'Responsible party' means an insurance company or any other person responsible for paying a recovery.

"§ 44-51.02. Creation and perfection of lien.

(a) Creation of Lien. -- Any medical provider not otherwise prohibited by law, rule, or regulation from obtaining a lien shall, upon perfection in accordance with this Article, have a lien upon any recovery for personal injuries for which the medical provider rendered medical services to the extent the amount owed for these services has not been paid. The lien attaches regardless of whether the party entitled to the recovery is the injured person or another claimant.

(b) Perfection of Lien. -- To perfect the lien, the medical provider shall comply with all of the following:

(1) Before the recovery is paid pursuant to G.S. 44-51.04(a), send a written notice of lien to:

a. The claimant's attorney.

b. If, and only if, the claimant's attorney is not known, to the responsible party and the claimant.

(2) If requested by the claimant or the claimant's attorney, furnish without charge one copy of an itemized statement and the medical records of the medical provider with respect to the medical

services rendered to the injured person by reason of the personal injury. This subdivision does not apply to charges for preparing a medical report that the medical provider does not ordinarily create if the claimant or the claimant's attorney specifically requests the medical provider to create that particular report.

(c) Contents of Notice. -- The notice of lien shall include all of the following:

(1) The name, address, and telephone number of the medical provider.

(2) The name and last known address of the injured person.

(3) The date of the injury.

(4) The date or dates during which the medical provider provided medical services.

(5) The amount for which the lien is being asserted.

(6) If sent to an insurance company, the name of its insured or other person allegedly responsible for the injury.

(7) A statement that the medical provider is claiming the lien provided for by this Article.

The information required by this subsection may be contained in the written notice of lien or any statement attached to and sent with the notice of lien.

(d) Methods of Sending Notice. -- A notice of lien and any copies of a notice of lien required by this Article to be sent to a claimant, a claimant's attorney, or a responsible party shall be sent in any one of the following ways:

(1) Personal delivery to the recipient or the recipient's business address if the recipient or other person at that address provides a receipt for the copy.

(2) Certified mail, return receipt requested.

(3) Overnight delivery service that provides proof of delivery.

(4) Transmission by facsimile machine or other form of electronic communication, if the recipient affirmatively transmits a written confirmation of receipt. A statement of receipt automatically generated by a machine shall not qualify as a confirmation under this subdivision.

(e) Additional Requirements for Notices to Insurance Companies. -- A notice of lien sent to an insurance company under subdivision (b)(1) of this section shall be sent to any office designated by the insurance company as an office authorized to receive claims, the principal office of the insurance company in this State, or the insurance company's regional office or its home office.

"§ 44-51.03. Amended liens.

A medical provider may send an amended notice of lien at any time. An amended notice of lien shall be sent by any of the methods set forth in G.S. 44-51.02(d) for a notice of lien.

"§ 44-51.04. Payment of recovery; limitations on liability for improper payment.

(a) Payment of Recovery. -- The responsible party, or the claimant's attorney acting pursuant to subsection (c) of this section, shall pay the recovery in the following order: any attorneys' fees due the claimant's attorney and the reasonable

expenses incurred by the attorney and the claimant in collecting the recovery; and any perfected liens under this Article, subject to the limitations in subsection (b) of this section; and the remainder of the recovery to the claimant.

(b) Limitations on Payment of Liens. -- The total of all payments made to medical providers under this section shall not exceed 50 percent (50%) of the recovery remaining after payment of the amounts provided in subdivision (1) of subsection (a) of this section. G.S. 28A-18-2 shall further limit payments to medical providers under this section. Multiple liens shall be paid pro rata.

(c) Payments to Claimant's Attorney. -- Notwithstanding any other provision of this Article, the responsible party shall pay the recovery to the claimant's attorney, if known, and the attorney shall pay the recovery as provided in subsections (a) and (b) of this section. The responsible party is discharged of further liability under this Article to medical providers if the responsible party sends the attorney a copy of any notice of lien previously received by the responsible party, and the attorney actually receives the copy or copies before or at the same time the attorney receives the payment. The responsible party is not liable under this Article to any medical provider whose notice of lien is received after the recovery is mailed or delivered to the claimant's attorney.

"**§ 44-51.05. Disputed liens.**

If the amount owed for medical services is in dispute, nothing in this Article shall compel a responsible party or a claimant's attorney to pay the disputed amount until it is fully established in the manner provided by law.

"**§ 44-51.06. Penalty for asserting false lien.**

Any person who asserts a lien under this Article when no amount is owed the person, or in an amount greater than the person is owed, and who refuses without justification to correct or update the lien after becoming aware of the error, is liable to the claimant for all of the following:

(1) Liquidated damages in the amount of five thousand dollars ($5,000) or all damages proximately resulting from the assertion of the improper lien, whichever is greater.

(2) Any reasonable attorneys' fees, court costs, and any other litigation and investigatory expenses incurred as a result of the error before the error is corrected.

"**§ 44-57.07. Exemptions and exclusions.**

(a) No person who pays a recovery pursuant to subsections (a) and (b) of G.S. 44-51.04 is liable under this Article to any medical provider whose notice of lien is received by that person after the recovery is paid, or whose lien is not perfected before the recovery is paid, pursuant to these subsections.

(b) This Article does not apply to injuries resulting from an accident covered by Chapter 97 of the General Statutes, the North Carolina Workers' Compensation Act.

(c) G.S. 44-48 does not apply to liens under this Article."

Section 3. A lien that was existing and valid under former G.S. 44-49 and G.S. 44-50 on the effective date of this act is a perfected lien under G.S. 44-51.01 through G.S. 44-51.07, as enacted by this act, and shall be governed by this act. A

medical provider as defined in G.S. 44-51.01, as enacted by this act, that had not received, or had received but not yet responded to, a request for medical records under former G.S. 44-49 and G.S. 44-50 before the effective date of this act, but had otherwise taken all necessary steps to obtain a valid lien under those former sections before the effective date of this act, shall provide medical records as required by G.S. 44-51.02, as enacted by this act, to have a perfected lien under this act.

Section 4. This act becomes effective January 1, 1998.

MINUTES

HOUSE COMMITTEE ON INSURANCE

March 20, 1997

The House Committee on Insurance met on Thursday, March 20, 1997, at 12:00 Noon in Room 643 of the Legislative Office Building. Chairman, Dockham, presiding, called the meeting to order.

Members present: Representatives Dockham, Allred, Black, Bowie, Brawley, Cole, Dedmon, Dickson, Gamble, Gardner, Hardaway, Hardy, Hurley, Ives, Luebke, McComas, Michaux, Miner, Tallent, Wainwright and Wright.

The Visitor Registration sheets are attached as a part of the record.

Mr. Linwood Jones, Staff Counsel, provided a summary of the Insurance Bills that were on the agenda for this meeting, which is attached.

The first order of business was House Bill 184 entitled Exempt State Health Plan From APA. Representative Redwine, sponsor of House Bill 184 explained this bill and answered questions that concerned some of the members. Representative Brawley thought this was a good bill and moved that the bill be given a favorable report. By unanimous approval of the committee, House Bill 184 was given a favorable report.

The second order of business was House Bill 455 entitled Glaucoma Program Repealed/AB. Representative Dockham, sponsor of House Bill 455, explained this bill and answered questions from the members. Representative Dockham recognized Mr. Peter Andersen, Chief, Chronic Disease Section of NC Department of Environment, Health and Natural Resources. Mr. Andersen helped in answering questions and concerns of the Insurance Committee.

After much discussion, Representative Dickson moved that House Bill 455 be sent to a sub-sub committee. Chairman Dockham appointed Representative Brawley to chair the sub-sub-committee and appointed Representatives McComas, Gardner, Bowie and Luebke to be members of this committee.

There being no further business, the Chairman adjourned the meeting at 12:52 p.m.

Jerry C. Dockham

Rep. Jerry C. Dockham, Chairman

Nell R. Edwards

Nell R. Edwards, Clerk

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

3/20/97 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Alan Miller	Bailey & Dixon LLP
John McMillan	Manning Fulton & Skinner PA
Charles Cromer	NCATL
Bill Toms	NCAHC
[illegible]	
Stan Williams	United HealthCare of NC
Floyd M. Lewis	General Statutes Commission
[illegible]	NCBA
BILLY SCOGGIN	NCBA
R Rogers	ENR
Ann Case	ENR
John Bowdish	Zeb Alley P.A.
J Craig [illegible]	PCMH
Mark A Bryant	State Farm Ins Cos
Randy W Ann	State Farm Ins. Co.

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Tammy Murphy	State Farm Insurance
Mark Sisak	OSBM
Adam Searing	NC Health Access Coalition
Portia Rochelle	DHR-DMA
ANNA TEFFT	OSBM
JOAN GEISZLER-LUDLUM	STATE FARM, WILMINGTON
Suzanne Knight	State Farm Durham
Troy Greer	SEANC
Carl Goodwin	OSP
Chuck Stone	SEANC
ROBERT A. DYER, JR	STATE FARM INS COS
Chuck BARHAM	STATE FARM INS - DURHAM
Peter Anderson	DEHNR - DAP
Larry Presnell	N.C. Retired School Personnel
A.C. Dawson	" " " " "
Evelyn B. Terry	NC State Health Plan

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Harold Wyatt	State Health Plan
DAVID C. DEVRIES	STATE HEALTH PLAN
Bob Wilson	NCAE
R. Reed Wilmoth	NCMBA
Mike Carpenter	NCMBA
Ed Brooks	State Farm
Mary Beth Cramer	State Farm
Angela Rediger	State Farm
Taylor S. [illegible]	STATE FARM
Terry Thompson	State Farm
Scott Good	State Farm

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March 6, 1997

MEMORANDUM

TO: Representative Jerry Dockham, Chairman
House Insurance Committee

FROM: Linwood Jones, Committee Counsel

RE: House Bill 184 (Exempt State Health Plan from APA)

This bill amends the Administrative Procedure Act by adding the State Employee's Health Plan to the list of agencies which are exempt from the rule making requirements of the APA.

Section 1 provides that the State Health Plan is exempt from rule making in administering the provisions of Parts 2 and 3 of Article 3 of Chapter 135 of the General Statutes. These Parts set forth the administrative structure and the benefits package of the Comprehensive Major Medical Plan.

Section 2 ensures more legislative oversight of the State Health Plan by requiring that the Employee Hospital and Medical Benefits Committee meet at least quarterly, and by directing the Executive Administrator of the Plan to report to the Committee on any administrative or medical policies issued, as well as on benefit denials which are appealed to the Board of Trustees. The Employee Hospital and Medical Benefits Committee is charged with reviewing the operation of the Plan.

Section 3 is a conforming amendment that adds a sentence to G.S. 135-39.8 to clarify that rules adopted in accordance with that section are exempt from the provisions of Article 2A of Chapter 150B. G.S. 135-39.8 grants the Executive Administrator and Board of Trustees of the Plan authority to issue rules and regulations to administer the Plan.

Section 4 makes the act effective when it becomes law.

H184-SMRN-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 184

Short Title: Exempt State Health Plan From APA. (Public)

Sponsors: Representatives Redwine, Creech, Nichols, Mitchell, and Mercer.

Referred to: Insurance.

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO EXEMPT THE NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN FROM ARTICLE 2A OF THE ADMINISTRATIVE PROCEDURE ACT AND TO REQUIRE THE EMPLOYEE HOSPITAL AND MEDICAL BENEFITS COMMITTEE TO MEET AT LEAST QUARTERLY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 150B-1(d) reads as rewritten:

"(d) Exemptions from Rule Making. -- Article 2A of this Chapter does not apply to the following:

(1) The Commission.

(2) The North Carolina Low-Level Radioactive Waste Management Authority in administering the provisions of G.S. 104G-10 and G.S. 104G-11.

(3) The North Carolina Hazardous Waste Management Commission in administering the provisions of G.S. 130B-13 and G.S. 130B-14.

(4) The Department of Revenue, with respect to the notice and hearing requirements contained in Part 2 of Article 2A.

(5) The North Carolina Global TransPark Authority with respect to the acquisition, construction, operation, or use, including fees or charges, of any portion of a cargo airport complex.

(6) The Department of Correction, with respect to matters relating solely to persons in its custody or under its supervision, including prisoners, probationers, and parolees.

(7) The North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan in administering the provisions of Parts 2 and 3 of Article 3 of Chapter 135 of the General Statutes."

Section 2. G.S. 135-38(c) reads as rewritten:

"(c) The Committee shall review programs of hospital, medical and related care provided by Part 3 of this Article as recommended by the Executive Administrator and Board of Trustees of the Plan. The Executive Administrator and the Board of Trustees shall provide the Committee with any information or assistance requested by the Committee in performing its duties under this Article. The Committee shall meet not less than once each quarter to review the actions of the Executive Administrator and Board of Trustees. At each meeting, the Executive Administrator shall report to the Committee on any administrative and medical policies which have been issued as rules and regulations in accordance with G.S. 135-39.8, and on any benefit denials, resulting from the policies, which have been appealed to the Board of Trustees."

Section 3. G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts 2 and 3 of this Article. Rules and regulations adopted in accordance with this section are exempt from the provisions of Article 2A of Chapter 150B of the General Statutes. Rules and regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other parties requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

Section 4. This act is effective when it becomes law.

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March 13, 1997

MEMORANDUM

TO: House Committee on Insurance

FROM: Linda Attarian

RE: **HB 455** – First Edition – **AN ACT TO AMEND THE GENERAL STATUTES CONCERNING THE DETECTION, PREVENTION, CARE, AND TREATMENT OF GLAUCOMA.**

Representative Dockham, sponsor.

House Bill 455 will discontinue funding for any Glaucoma services provided by local health departments. Glaucoma is an eye disease in which the normal fluid pressure inside the eyes slowly rises, leading to vision loss and even blindness. At first, there are no symptoms. Vision stays normal and there is no pain. However as the disease progresses, a person with glaucoma may notice his or her side vision gradually failing. As the disease worsens, the field of vision narrows and blindness results.

Glaucoma is detected by tests designed to measure eye pressure during an eye examination. However, this test alone cannot detect glaucoma. Glaucoma is most often found during eye examinations through dilated pupils. This allows the eye care professional to see more of the inside of the eye to check for signs of glaucoma.

Because of the appropriate technology necessary for screening and diagnosis has developed beyond what can be provided by local health departments, screening services are rarely being provided at such sites. Further, the screenings are not endorsed by the Department.

The act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 455

Short Title: Glaucoma Program Repealed/AB. (Public)

Sponsors: Representative Dockham.

Referred to: Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE GENERAL STATUTES CONCERNING THE DETECTION, PREVENTION, CARE, AND TREATMENT OF GLAUCOMA.

The General Assembly of North Carolina enacts:

Section 1. The title to Part 3 of Article 7 of Chapter 130A of the General Statutes reads as rewritten:

"Part 3. ~~Glaucoma and~~ Diabetes."

Section 2. G.S. 130A-221 reads as rewritten:

"**§ 130A-221. Department to establish program.**

(a) The Department shall establish and administer a program for the detection and prevention of ~~glaucoma and~~ diabetes and the care and treatment of persons with ~~glaucoma and~~ diabetes. The program may include:

(1) Education of patients, health care personnel and the public;

(2) Development and expansion of services to persons with ~~glaucoma and~~ diabetes; and

(3) Provision of supplies, equipment and medication for detection and control of ~~glaucoma and~~ diabetes.

(b) The Commission is authorized to adopt rules necessary to implement the program."

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

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham** for the Committee on **Insurance.**

☐ Committee Substitute for
H.B. 184 A BILL TO BE ENTITLED AN ACT TO EXEMPT THE NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN FROM ARTICLE 2A OF THE ADMINISTRATIVE PROCEDURE ACT AND TO REQUIRE THE EMPLOYEE HOSPITAL AND MEDICAL BENEFITS COMMITTEE TO MEET AT LEAST QUARTERLY.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 3, 1997

The House Committee on Insurance met on Thursday, April 3, 1997, at 12:00 Noon in Room 643 of the Legislative Office Building. Chairman Dockham, presiding, called the meeting to order.

Members present: Representatives Dockham, Allred, Barbee, Black, Bowie, Brawley, Cole, Dedmon, Dickson, Gardner, Hardaway, Hardy, Hensley, Hurley, Ives, Luebke, McComas, Miller, Miner, Tallent and Wainwright.

The Visitor Registration sheets are attached as a part of the record.

Mr. Linwood Jones, Staff Counsel, and Linda Attarian provided the attached summaries of the Insurance Bills that were on the agenda for this meeting.

The first order of business was House Bill 455 entitled Glaucoma Program Repealed/AB. Representative Brawley, Chairman of the sub-sub committee proposed a Committee Substitute for House Bill 455. This Committee Substitute was adopted and a motion by Representative Brawley was made for a favorable report as to committee substitute bill, which changes the title, unfavorable as to original bill. The motion passed.

The second order of business was House Bill 434 entitled Federal Health Insurance Changes/AB. Chairman Dockham invited Mr. Bill Hale, Chief Legislative Counsel of the Department of Insurance, to present a restatement of the main facts of House Bill 434. Mr. Hale also answered questions the committee members asked. Several members requested that Mr. Hale send all the Insurance Committee members a summary of his explanation of House Bill 434 before the next meeting since no action was taken on this House Bill at this time.

The third order of business was House Bill 563 entitled Mental Health Parity. Chairman Dockham recognized Representative Alexander, one of the sponsors of this bill. Representative Alexander explained in detail House Bill 563 and gave a handout,(which is attached) to the committee members . No action was taken on this house bill at this meeting.

There being no further business, the Chairman adjourned the meeting at 12:55 p.m.

Representative Jerry C. Dockham
Chairman

Nell R. Edwards
Clerk

VISITOR REGISTRATION SHEET

INSURANCE — 4/3/97
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Tommy Worth	CAROLINAS HEALTHCARE SYSTEM
LANE Wharton	Bode, Call & Stroupe
Beth Melcher	NC AMI
John Tate	NMIA/NC
	NASW-NC
Megan Carney	BSW Student - Meredith College
John May	NC CWA
	CAPIA
Lucius Fuller	ATTORNEY
Adam Searing	NC Health Access Coal.
	NCBA
	NCAHC

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

4/3/97 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
R. Rogers	DENR
[illegible]	Indian Pine Wildlife Magazine
Tom Schoenvogel	Assn. of non-profit Homeowners Boards
Woody Suggs	Resource Advocates for Community
[illegible]	NCBA
Willie Riddick	DPR
Ann Schwindaman	NC Council of Comm. Programs
M T Burnette	GACPD - DOA
[illegible]	[illegible]
Brenda Summers	NC Equity
[illegible]	Clerk - Rep. Locke
[illegible]	NCHSA
Alan Miles	Indy: Duke

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April 3, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 434 (Federal Health Insurance Changes)
House Bill 350 (Genetic Information)
House Bill 563 (Mental Health Parity)

Last year, Congress passed changes in health insurance laws that states will be required to enact. Most of these changes occurred in HR 3103, more popularly known as Kennedy-Kassenbaum. Congress also passed laws last year requiring the states to adopt maternity stay provisions and partial mental parity provisions. The maternity stay and mental health parity provisions were enacted separately from Kennedy-Kassenbaum.

Many of the requirements mandated by Congress are already in place in North Carolina – such as insurance portability, restrictions on medical underwriting in group plans, and maternity stay requirements. Most of these provisions will need some fine tuning to conform them to the federal law. House Bill 434 makes these conforming changes and adds other provisions necessary to meet the federal requirements. There may be some instances where our State law already exceeded the requirements of Kennedy-Kassenbaum and have been left in place in this bill: for example, our law has for the past several years included self-employed individuals under the small employer group reform provisions. Kennedy-Kassenbaum does not, but it would allow the State to continue including individual self-employeds as "small group."

The purpose of discussing the three bills (HB 434, 350, and 563) together today is to get a general overview. The three are related to each other. House Bill 350 focuses on the use of genetic information by insurers in medical underwriting, an issue that is addressed in HB 434. It also addresses the use of this information by employers. House Bill 563 involves parity for mental health insurance benefits, another issue that is addressed in HB 434. However, both HB 350 (genetic information) and HB 563 (mental parity) go beyond the minimum requirements of the federal law that are set out in HB 434. Today's overview will allow you to see the major differences.

More detailed information on the three bills will be made available next week. The major differences in the three bills are discussed in the attached memos.

SUBSTANTIVE DIFFERENCES BETWEEN HOUSE BILL 350 AND HOUSE BILL 434 (KENNEDY-KASSEBAUM)

House Bill 350 contains some of the provisions of Kennedy-Kassebaum – those relating to the use of genetic information and health coverage. However, House Bill 350 does four things that Kennedy-Kassebaum does not do:

1. It prohibits, within individual health plans, individual denials of coverage and individual rate increases on the basis of genetic information.

2. It prohibits, within group health plans, a group rate increase based on genetic information of one individual in the group.

3. It prohibits employment discrimination against a person for having requested genetic testing or counseling services or on the basis of genetic information about that person or a member of that person's family.

4. It defines "genetic information" as "information about genes, gene products, or inherited characteristics that may derive from an individual or a family member".

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MAJOR DIFFERENCES ON MENTAL PARITY

(between HB 434 and HB 563)

House Bill 434 prohibits the use of annual or lifetime benefit caps that are lower for mental health benefits than for physical illness benefits. For example, an insurer that offers a policy with $1 million in lifetime coverage could not restrict the mental health benefits in the policy to $50,000 lifetime. The same would apply to any annual limits. HB 563 would impose the same requirements.

However, HB 563 goes beyond HB 434 as follows:

* HB 563 also requires parity in coinsurance, deductibles, provider visits, etc. HB 434 does not.

* HB 563 would apply to all group health insurance policies. HB 434's provisions on mental parity apply only to group insurance sold to groups with 50 or more employees.

* HB 563 does not allow an employer to avoid the mental parity requirements because of increases in costs. HB 434 allows an insurer to avoid the requirements if it can prove to the Commissioner of Insurance that adhering to these requirements will increase plan costs by one percent or more.

*HB 563 has no expiration date. The mental parity provisions in HB 434 expire October 1, 2001.

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March 13, 1997

MEMORANDUM

TO: House Committee on Insurance

FROM: Linda Attarian

RE: **HB 455** – First Edition – **AN ACT TO AMEND THE GENERAL STATUTES CONCERNING THE DETECTION, PREVENTION, CARE, AND TREATMENT OF GLAUCOMA.**

Representative Dockham, sponsor.

House Bill 455 will discontinue funding for any Glaucoma services provided by local health departments. Glaucoma is an eye disease in which the normal fluid pressure inside the eyes slowly rises, leading to vision loss and even blindness. At first, there are no symptoms. Vision stays normal and there is no pain. However as the disease progresses, a person with glaucoma may notice his or her side vision gradually failing. As the disease worsens, the field of vision narrows and blindness results.

Glaucoma is detected by tests designed to measure eye pressure during an eye examination. However, this test alone cannot detect glaucoma. Glaucoma is most often found during eye examinations through dilated pupils. This allows the eye care professional to see more of the inside of the eye to check for signs of glaucoma.

Because of the appropriate technology necessary for screening and diagnosis has developed beyond what can be provided by local health departments, screening services are rarely being provided at such sites. Further, the screenings are not endorsed by the Department.

The act is effective when it becomes law.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham** for the Committee on **Insurance**.

☐ Committee Substitute for
H.B. 455 A BILL TO BE ENTITLED AN ACT TO AMEND THE GENERAL STATUTES CONCERNING THE DETECTION, PREVENTION, CARE, AND TREATMENT OF GLAUCOMA.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☒ With a favorable report as to committee substitute bill (#_____), ☒ which changes the title, unfavorable as to original bill ~~(Committee Substitute Bill # _____), (and recommendation that the committee substitute bill # _____) be re-referred to the Committee on _____.)~~

☐ With a favorable report as to House committee substitute bill (#_____), ☒ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 455
Proposed Committee Substitute H455-PCSA280

Short Title: Glaucoma Program Repealed/AB. (Public)

Sponsors:

Referred to:

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE GENERAL STATUTES CONCERNING THE DETECTION, PREVENTION, CARE, AND TREATMENT OF GLAUCOMA AND DIABETES.

The General Assembly of North Carolina enacts:

Section 1. The title to Part 3 of Article 7 of Chapter 130A of the General Statutes reads as rewritten:

"Part 3. Glaucoma and Diabetes."

Section 2. G.S. 130A-221 reads as rewritten:

"**§ 130A-221. Department authorized to establish program.**

(a) The Department ~~shall~~ may establish and administer a program for the detection and prevention of glaucoma and diabetes and the care and treatment of persons with glaucoma and diabetes. The program may include:

(1) Education of patients, health care personnel and the public;

(2) Development and expansion of services to persons with glaucoma and diabetes; and

(3) Provision of supplies, equipment and medication for detection and control of glaucoma and diabetes.

(b) The Commission is authorized to adopt rules necessary to implement the program."

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

Rep. Alexander

Parity *for* Mental Health *and* Substance Abuse

Bill introduced by:

Rep. Martha Alexander (H563) and
Senator Leslie Winner (S400)

Purpose:

To eliminate discrimination in health coverage for mental illness and substance abuse.

What the bill does:

Benefits for the treatment of mental illness and substance abuse would be subject to the same durational limits, dollar limits, deductibles and coinsurance factors as are benefits for physical illness. It provides that benefits for the necessary care and treatment of mental illness and substance abuse are not less favorable than benefits for physical illness.

What the bill does not do:

The bill does not prohibit insurers and HMOs from managing the care. In fact, the Coalition encourages good case management such as is provided under the State Health Plan indemnity benefit, as long as that management is not used solely to deny medically necessary treatment and clients have access to treatment.

Why is the bill needed?

Currently, insurers and HMOs do discriminate. Mental health and substance abuse care are subjected to higher deductibles, co-payments, and limits. Mental health and substance abuse care should not be treated differently than other illnesses.

What about the cost?

Currently, the State Employees Health Plan provides this full parity for mental health treatment, and has since 1992. The Plan is supporting parity for substance abuse treatment in a bill which has been introduced in the House. Since parity was established in 1992 (including a single deductible for all care) mental health payments as a portion of total health payments has decreased from 6.4% to 3.4% for the fiscal year ending June, 1996. That is a 47% **reduction** — not a rise in cost. Since 1992, hospital days paid by the Plan for mental illness have been reduced by 64%.

Independent Study Commissioned:

The NC Coalition for Mental Health Care has commissioned an independent actuarial analysis of parity for mental illness and substance abuse by Coopers and Lybrand. When this study is completed, the data will be shared with all legislators. Studies done in other states indicate a minimal cost to provide full parity for mental health and substance abuse treatment.

It's the Right Thing to Do:

Science has shown that mental illness and substance abuse are illnesses like any other. They are treatable. Treatment success rates are comparable to other major physical illnesses. Coverage of mental illness and substance abuse should be no different than for other illnesses. With parity, people's ability to access early and appropriate treatment will reduce long-term costs.

Organizations Supporting This Parity Bill

March, 1997

NC Coalition for Mental Health Care
Mental Health Association in North Carolina
NC Depressive Manic Depressive Association
NC Psychological Association
National Association of Social Workers/NC Chapter
NC Council of Community MH/DD/SA Programs
Addiction Professionals of North Carolina
Alcohol and Drug Council of North Carolina
NC Alliance for the Mentally Ill
NC Mental Health Consumers Organization
NC Association for Behavioral Health Care
NC Psychiatric Association
NC Psychological Foundation
PAIMI Committee/Governor's Advocacy Council for Persons with Disabilities

Parity *for* Mental Health *and* Substance Abuse

Bill introduced by:

Rep. Martha Alexander (H563) and
Senator Leslie Winner (S400)

Purpose:

To eliminate discrimination in health coverage for mental illness and substance abuse.

What the bill does:

Benefits for the treatment of mental illness and substance abuse would be subject to the same durational limits, dollar limits, deductibles and coinsurance factors as are benefits for physical illness. It provides that benefits for the necessary care and treatment of mental illness and substance abuse are not less favorable than benefits for physical illness.

What the bill does not do:

The bill does not prohibit insurers and HMOs from managing the care. In fact, the Coalition encourages good case management such as is provided under the State Health Plan indemnity benefit, as long as that management is not used solely to deny medically necessary treatment and clients have access to treatment.

Why is the bill needed?

Currently, insurers and HMOs do discriminate. Mental health and substance abuse care are subjected to higher deductibles, co-payments, and limits. Mental health and substance abuse care should not be treated differently than other illnesses.

What about the cost?

Currently, the State Employees Health Plan provides this full parity for mental health treatment, and has since 1992. The Plan is supporting parity for substance abuse treatment in a bill which has been introduced in the House. Since parity was established in 1992 (including a single deductible for all care) mental health payments as a portion of total health payments has decreased from 6.4% to 3.4% for the fiscal year ending June, 1996. That is a 47% **reduction** — not a rise in cost. Since 1992, hospital days paid by the Plan for mental illness have been reduced by 64%.

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It's the Right Thing to Do:

Science has shown that mental illness and substance abuse are illnesses like any other. They are treatable. Treatment success rates are comparable to other major physical illnesses. Coverage of mental illness and substance abuse should be no different than for other illnesses. With parity, people's ability to access early and appropriate treatment will reduce long-term costs.

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NC Mental Health Consumers Organization
NC Association for Behavioral Health Care
NC Psychiatric Association
NC Psychological Foundation
PAIMI Committee/Governor's Advocacy Council for Persons with Disabilities

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 563*

Short Title: Mental Health Parity. (Public)

Sponsors: Representatives Alexander; Adams, Beall, Black, Bonner, Boyd-McIntyre, Church, Crawford, Cunningham, Dedmon, Dickson, Earle, Easterling, Fox, Gamble, Goodwin, Hackney, H. Hunter, R. Hunter, Hurley, Insko, Jeffus, Luebke, Michaux, Miller, Mosley, Oldham, Smith, Wainwright, Watson, Wilkins, G. Wilson, Wright, and Yongue.

Referred to: Insurance.

March 20, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of chemical dependency and mental illness that is at least equal to the coverage required by G.S. 58-51-50 and G.S. 58-51-55, respectively."

Section 2. G.S. 58-51-50 reads as rewritten:

"**§ 58-51-50. Coverage for chemical dependency treatment.**

(a) As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1985, shall ~~offer~~ provide to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of~~

~~this section, benefits~~ Benefits for treatment of chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally.

~~(c) Every group policy or group contract of insurance that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The policy or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The policy or contract shall provide a minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for the life of the policy or contract.~~

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group policies or group contracts of insurance shall provide benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical dependency units in facilities licensed after October 1, 1984;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C.

Provided, however, that nothing in this subsection shall prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group policy holder or group contract holder who rejects the coverage in writing.~~"

Section 3. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(c) Nothing in this section prevents any insurance company from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to mental illness or chemical dependency.~~

~~(d) This section applies only to group health insurance contracts covering 20 or more employees.~~

(e) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1998, shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally."

Section 4. G.S. 58-65-75 reads as rewritten:

"**§ 58-65-75. Coverage for chemical dependency treatment.**

(a) As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Every group insurance certificate or group subscriber contract under any hospital or medical plan governed by this Article and Article 66 of this Chapter that is issued, renewed, or amended on or after January 1, 1985, shall ~~offer~~ provide to its insureds benefits for the necessary care and treatment of chemical dependency that

are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally.

~~(c) Every group insurance certificate or group subscriber contract that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The certificate or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The certificate or contract shall provide a minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for the life of the certificate or contract.~~

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group certificates or group contracts shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical dependency units in facilities licensed after October 1, 1984;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification facilities or programs; and

(3) Duly licensed physicians and duly licensed psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C. After January 1, 1995, 'duly licensed psychologists' shall be defined as licensed psychologists who hold permanent licensure and certification as health services provider psychologist issued by the North Carolina Psychology Board.

Provided, however, that nothing in this subsection shall prohibit any certificate or contract from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(c) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group certificate holder or group subscriber contract holder who rejects the coverage in writing.~~"

Section 5. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No ~~hospital, medical, dental or health service~~ corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group hospital, dental, medical or health service contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(c) Nothing in this section prevents any hospital or medical plan from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to mental illness or chemical dependency.~~

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(e) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1998, shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally."

Section 6. G.S. 58-67-70 reads as rewritten:

"**§ 58-67-70. Coverage for chemical dependency treatment.**

(a) As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) On and after January 1, 1985, every health maintenance organization that writes a health care plan on a group basis and that is subject to this Article shall ~~offer~~ provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits under the health care plan generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits under the health care plan generally.

~~(c) Every group health care plan that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:~~

~~(1) The plan shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.~~

~~(2) The plan shall provide a lifetime minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for each enrollee.~~

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group health care plans shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical dependency units in facilities licensed after October 1, 1984;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification facilities or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C.

Provided, however, that nothing in this subsection shall prohibit any plan from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

~~(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group that rejects the coverage in writing.~~

(f) Notwithstanding any other provision of this section or Article, any health maintenance organization subject to this Article that becomes a qualified health maintenance organization under Title XIII of the United States Public Health Service Act shall provide the benefits required under that federal Act, which shall be deemed to constitute compliance with the provisions of this section; and any health maintenance organization may provide that the benefits provided under this section must be obtained through providers affiliated with the health maintenance organization."

Section 7. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(c) Nothing in this section prevents any health maintenance organization from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to mental illness or chemical dependency.~~

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(e) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1998, shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally."

Section 8. G.S. 135-40.7A reads as rewritten:

"**§ 135-40.7A. Special provisions for chemical dependency.**

(a) ~~Except as otherwise provided in this section, benefits~~ Benefits for treatment of chemical dependency are covered by the Plan and shall be subject to the same

deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

~~(b) Notwithstanding any other provisions of this Part, the maximum benefit for each covered individual for treatment of chemical dependency is as follows:~~

~~Fiscal Year $ 8,000~~

~~Lifetime 25,000~~

~~Daily benefits are limited to two hundred dollars ($200.00) except for medical detoxification treatment under rules established by the Executive Administrator and Board of Trustees.~~

(c) Notwithstanding any other provision of this Part, provisions for benefits for necessary care and treatment of chemical dependency under this Part shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical dependency units in facilities licensed after October 1, 1984;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical dependency units in psychiatric hospitals;
   b. Chemical dependency hospitals;
   c. Residential chemical dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification facilities or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists, certified clinical social workers, licensed professional counselors, certified fee-based practicing pastoral counselors, certified clinical specialists in psychiatric and mental health nursing, and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency."

Section 9. G.S. 135-40.7B reads as rewritten:

"**§ 135-40.7B. Special provisions for mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of mental illness shall be covered under this section: allowable institutional and professional charges for inpatient psychiatric care, outpatient psychotherapy, intensive outpatient crisis management, partial hospitalization treatment, and residential care and treatment. The benefits provided by this section are separate and apart from those provided by G.S. 135-40.7A.

(c) Notwithstanding any other provisions of this Part, the following providers are authorized to provide necessary care and treatment for mental illness under this section:

(1) Licensed psychiatrists;

(2) Licensed or certified doctors of psychology;

(3) Certified clinical social workers;

(3a) Licensed professional counselors;

(4) Psychiatric ~~nurses;~~ nurse specialists;

~~(5) Other social workers under the direct employment and supervision of a licensed psychiatrist or licensed doctor of psychology;~~

(6) Psychological associates with a master's degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology;

(7) Licensed psychiatric hospitals and licensed general hospitals providing psychiatric treatment programs;

(8) Certified residential treatment facilities, community mental health centers, and partial hospitalization facilities; and

(9) Certified fee-based practicing pastoral counselors.

(d) Benefits provided under this section shall be subject to a managed, individualized care component consisting of (i) inpatient utilization review through preadmission and length-of-stay certification for scheduled inpatient admissions and length-of-stay reviews for unscheduled inpatient admissions, and (ii) a network of qualified, available providers of inpatient and outpatient psychiatric treatment psychotherapy. Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6."

Section 10. This act is effective when it becomes law and applies to contracts issued, delivered, or renewed on or after January 1, 1998.

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 10, 1997

The House Committee on Insurance met on Thursday, April 10, 1997, at 12:00 Noon in Room 643 of the Legislative Office Building. Chairman Dockham, presiding, called the meeting to order.

Members present: Representatives Dockham, Brawley, Cole, Dedmon, Dickson, Gardner, Hardy, Holmes, Hurley, Ives, McComas, Michaux, and Tallent.

The Visitor Registration sheets are attached as a part of the record.

Mr. Linwood Jones, Staff Counsel, provided the attached proposed committee substitute for House Bill 434.

The first order of business was recognizing Representatives Alexander who wanted to correct a statement she made at the Insurance Committee on April 3, 1997, concerning House Bill 563 entitled Mental Health Parity.

The second order of business was sending House Bill 452 entitled Beach Plan Amendments, to a sub-sub committee. He appointed Representative Brawley as Chairman of this sub-sub committee and appointed Representatives Preston, McComas, Wright and Henslely as members on this committee.

The third order of business was House Bill 434 entitled Federal Health Insurance Changes/AB. Chairman Dockham appointed Representative Brawley to preside as Chairman of the Insurance Committee while he as cosponsor of this bill explained House Bill 434.

Chairman Brawley recognized Bill Hale, Chief Legislative Counsel, of the Department of Insurance, to further explain House Bill 434 and answer any questions the members ask. Chairman Brawley recognized Representative Dickson who asked if the present revision of House Bill 434 complied with the Federal Government version of this bill. The reply was yes, it was. Representative Dickson then made a motion for a favorable report as to committee substitute, unfavorable as to original bill. The motion passed.

There being no further business, the chairman adjourned the meeting at 12:20 p.m.

Jerry C. Dockham

Representative Jerry C. Dockham
Chairman

Nell R. Edwards

Nell R. Edwards
Clerk

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

4/10/97 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Robert Brown	Assn NC Life Ins. Cos
Susan Valaw	Nationwide
Robin Huffman	Charter Behavioral Health System, NC
Sally Cameron	NC Psychological
Carolyn E. Chu	NCPA / ACABHC / NCALU
Nick Fountain	Young Moore & Henderson
Woody Sings	Alcoholism Rehabilitation Commission
Mary Morris	Methodist Retirement Communities
Tom Schoenvogel	NC non-Profit Homes for the Aging
Chris Hamlet	The Forest at Duke
Megan Carney	BSW Student - Meredith College
Elizabeth Hollon	NASW-NC
Adam Searing	NC Health Access Coalition
Robert Pasmal	Young, Moore

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Sheila H. McKenney	N.C. DOI
Bill Mak	NC DOI
Daniel Provus	N.C. DOI
Lesa Adelman	NC School of Science + Math

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April 10, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones
Committee Counsel

RE: Proposed Committee Substitute for House Bill 434
Federal Health Insurance Changes

Kennedy-Kassenbaum:

The proposed committee substitute for House Bill 434 enacts a new Article 68 in the Insurance code (Chapter 58 of the General Statutes) containing the new health insurance requirements of the Health Insurance Portability and Accountability Act of 1996, more popularly known as "Kennedy-Kassenbaum." Congress enacted and the President signed Kennedy-Kassenbaum into law last year. The law imposes many new requirements on the underwriting of health insurance.

Congress made Kennedy-Kassenbaum's requirements applicable to self-funded plans that the states are prohibited under federal ERISA law from regulating. It is estimated that about one-half of the insured population in North Carolina falls under self-funded plans. In deference to the tradition of state regulation of commercial insurance carriers (including HMOs and Blue Cross organizations), Congress has given the states until July 1, 1997, to apply the Kennedy-Kassenbaum requirements to its commercial insurers. These requirements will automatically go into effect as federal law, to be enforced by the federal government, in any state that does not enact and implement the appropriate legislation by July 1, 1997. Generally, states are allowed to exceed the minimum standards established under Kennedy-Kassenbaum.

The Kennedy-Kassenbuam legislation grew out of the failed efforts of the early 1990s in Washington and in the states to enact comprehensive health care reform. Kennedy-Kassenbaum is best characterized as "health insurance reform." Many states, including North Carolina, had already adopted some of these reforms several years ago. For example, many states already have small employer group reform laws. North Carolina has also already adopted portability requirements, limitations on the use of preexisting condition exclusions, and restrictions on medical underwriting in the group market. These existing State laws must be fine-tuned and in some cases substantially revised to meet the requirements of Kennedy-Kassenbaum. There are also some additional requirements in Kennedy-Kasenbaum, particularly in the individual insurance market (for "eligible" individuals), that are currently not in place in North Carolina.

Section 1 of the bill sets out the new Article 68 containing the health insurance requirements from Kennedy-Kassenbaum. The original bill was an attempt to restate the federal requirements in more concise terms. The proposed committee substitute more closely tracks the federal law and is in fact a verbatim copy of most of the federal law. There are a few instances in which an existing State law that exceeds the minimum requirements of Kennedy-Kassenbaum was retained. For example, Kennedy-Kassenbaum defines the "small group" market as employers with 2 to 50 employees. North Carolina law has for several years covered self-employed individuals under its "small group" laws. House Bill 434 retains the existing North Carolina law on this matter. The remaining sections of the bill, except for the provisions near the end relating to maternity stay and mental parity, conform existing insurance statutes to the changes made in Section 1 and to a few other provisions of Kennedy-Kassenbaum.

The major requirements under Kennedy-Kassenbaum with respect to health insurance underwriting are as follows:

* ***Increases portability.*** "Portability" refers to a person being able to get credit at a new job for the time he or she spent satisfying the waiting period for preexisting condition exclusions under the health insurance policy at the previous job. Without portability, the employee would likely encounter a new 12-month waiting period for coverage of preexisting conditions each time he or she changed jobs. Portability does *not* mean that the employee takes the same insurance coverage from one job to the next.

North Carolina enacted its first portability law several years ago and has liberalized its applicability in the years since. Our current state portability laws are very similar to the Kennedy-Kassenbaum requirement. The changes in Article 68 will ensure that they conform to the federal law. For example, our current law allows a lapse of up to 60 days between policies before an individual loses his or her "credit" for portability purposes. House Bill 434 increases this to the 63-day lapse period required under federal law.

* ***Limits the duration of preexisting conditions in group policies.*** North Carolina had already recently imposed limits on the duration of preexisting

condition exclusions in both the large group (G.S. 58-51-80) and small group (G.S. 58-50-130) markets. Our 12-month limit on the duration of preexisting condition exclusions matches the new federal requirement, but there are other differences: the federal law also restricts the limits on preexisting condition exclusions for late enrollees to 18 months and specifies a shorter "look-back" period. The "look-back" period, 6 months under the federal law, refers to how far back, prior to the insured's enrollment in the health benefit plan, the preexisting condition clause reaches. Under current North Carolina law, preexisting conditions are those conditions for which medical treatment was received or recommended or medical advice rendered during the 12 months prior to enrollment in the plan. The bill changes our "look-back" period to the 6-month period required under federal law.

**** Prohibits insurers from excluding someone from group coverage because of their health status.*** North Carolina already has laws prohibiting the use of evidence of individual insurability and the use of riders to exclude a person from coverage in employer group plans (G.S. 58-51-80(b)(2); G.S. 58-3-173; 58-50-125(d); G.S. 58-50-130(a)(6), (7)). Our requirements are rewritten in House Bill 434 to track the federal law exactly. The federal law, for example, lists specific types of "health status" factors that cannot be used to deny coverage in an employer group plan, including past claims experience, genetic information, and medical problems stemming from domestic violence.

**** Guaranteed renewability in the group market (both large group and small group) and the individual market.*** Federal law requires the insurer to renew the coverage if the group or individual wants to continue the coverage. The insurer is not required to renew if the premiums have not been paid, if there has been fraud, or for similar reasons that are unrelated to the health status of the group or individual. House Bill 434 makes these provisions applicable to North Carolina.

**** Guaranteed issuance of policies for eligible individuals.*** This is generally referred to as "group to individual portability." An eligible individual is a person who has at least 18 months worth of past health insurance coverage, the most recent of which was under a group plan; who is not eligible for group health insurance, Medicaid, or Medicare; who has no other insurance coverage; who did not lose coverage under the group plan for nonpayment of premium or similar reasons; and who has elected (if eligible) and exhausted COBRA coverage or State continuation coverage (Article 53 of Chapter 58 of the General Statutes). Note: The federal law does not require policies to be issued to anyone else in the individual market.

**** Guaranteed issue for the small group market.*** North Carolina's existing small group reform laws, applicable to self-employed individuals and to employers with as up to 49 employees, requires guaranteed issue of two types of plans: basic and standard (G.S. 58-50-130). The federal law appears to require all small group plans to be guaranteed-issue plans, and House BIll 434 changes North Carolina law accordingly. House Bill 434 retains self-employed individuals

under our definition of "small employer." Our reference to "49 employees" is increased to match the federal reference to "50 employees." There is no guaranteed issue requirement under the federal law for the large group market. However, the federal government will monitor access to insurance in the large group market.

* ***Allows for alternative mechansisms to satisfy the State's obligations in the individual market.*** High-risk pools, open enrollment in Blue Cross plans with no preexisting conditions, and similar mechanisms for insuring individuals are acceptable alternatives to the requirements for guaranteed renewability in the individual market and guaranteed issue to certain individuals in the individual market. North Carolina does not currently have a high-risk pool nor any other alternative market mechanism that is known to be acceptable. House Bill 434 therefore contains the federal provisions for the individual market. Kennedy-Kassenbaum does allow alternative market mechanisms to be substituted at any time in the future for the federal requirements as long as the Secretary of Health and Human Services does not disapprove of the state's proposed alternative mechanism. Failure to adopt an alternative market mechanism does not mean that the federal government will enforce the insurance laws in North Carolina with respect to individuals. However, in the absence of alternative mechanisms, failure to adopt the federal "fallback" requirements by July 1, 1997, would subject North Carolina to federal enforcement of insurance laws (just as failure to adopt all of the other Kenedy-Kassenbaum requirements by July 1, 1997, would do).

Maternity Stay and Mental Parity:

In addition to Kennedy-Kassenbaum, another federal law enacted last year requires state conforming legislation this year also. H.R. 3666, an appropriation bill for the Department of Veterans Affairs and HUD, contained two riders that were enacted as Titles VI and VII of that bill. Title VI, the Newborns' and Mothers' Health Protection Act of 1996, requires states that have not already adopted 48 hour/96 hour maternity coverage (or an acceptable alternative) to adopt the new federal maternity stay requirements. North Carolina was one of the first states to have passed maternity stay coverage legislation back in 1995. The State law has the same maternity stay period benefit coverage as is now being required by federal law (48 hours following vaginal birth and 96 hours following cesarean birth). The federal Newborns' and Mothers' Health Protection Act of 1996 appears to recognize North Carolina law as being sufficient as it now exists (HR 3166, Title VI, adding section 2704(f)(1)(A)). House Bill 434 repeals the existing maternity stay law (*see* section 20 of the bill) and substitutes a new law (*see* section 19) that more closely resembles the federal law and that contains some additional clarifying language. The additional federal restrictions include, for example, a prohibition against an insurer for (i) penalizing a doctor who advises the mother to remain in the hospital for the 48 or 96 hour period and (ii) offering rebates or other financial incentives to encourage mothers to leave earlier than the minimum coverage period.

The other rider to the federal bill, Title VII, is entitled "Parity in the Application of Certain Limits to Mental Health Benefits." Mental parity was originally debated as part of the Kennedy-Kassenbaum legislation. However, it was withdrawn from the Kennedy-Kassenbaum debate and was enacted, in a less comprehensive form, as a rider to HR 3666 weeks later. As with the health insurance requirements under Kennedy-Kassenbaum and the maternity-stay provisions, Congress has applied the mental parity law to self-funded plans and is directing the states to apply it to the commercial insurance carriers. It is important to note that the federally-mandated version of "mental parity" is substantially different than what we have generally referred to locally as "mental parity." The federal version of mental parity means parity between the coverage in physical health benefits and mental health benefits *only* with respect to the annual and lifetime limits under the health plan. For example, if a plan provides mental health benefits, it cannot impose a $50,000 lifetime limit for mental health benefits if it provides $1 million in lifetime benefits for illnesses generally. A plan providing mental health benefits cannot have a $10,000 annual cap on mental health benefits if it has no cap on benefits generally. This should not be confused with the "comprehensive mental parity" legislation that is pending before the legislature (House Bill 353 and Senate Bill 400). The federally-mandated version of mental parity, which is the version contained in House Bill 434, differs from comprehensive mental parity as follows:

(1) The federal law does not prohibit the use of different cost-sharing mechanisms for mental health benefits (such as higher deductibles, higher copayments, restrictions on the number of provider visits, etc.). Comprehensive mental parity legislation would require that these mechanisms be the same for mental health benefits and general health benefits.

(2) The federal law does not require the insurer to offer mental health benefits at all. Comprehensive mental parity requires that the benefits be provided.

(3) Small employers (2 to 50 employees) are exempt from the federal mental parity law.

(4) Parity in mental health benefits is not required under the federal law if it will increase plan costs by more than one percent.

(5) Treatment for substance abuse and chemical dependency are not covered under federal mental parity legislation.

(6) The federal mental parity requirement sunsets September 30, 2001.

The maternity stay and mental parity changes take effect January 1, 1998.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham** for the Committee on **Insurance.**

☐ Committee Substitute for
H.B. 434 A BILL TO BE ENTITLED AN ACT TO CONFORM NORTH CAROLINA HEALTH INSURANCE LAWS TO RECENTLY ENACTED FEDERAL LAWS CONCERNING HEALTH INSURANCE UNDERWRITING AND PORTABILITY, MATERNITY COVERAGE, AND COVERAGE FOR MENTAL ILLNESS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☑ With a favorable report as to committee substitute bill (#), ☐ ~~which changes the title~~, unfavorable as to original bill (~~Committee Substitute Bill #~~), (~~and recommendation that the committee substitute bill #~~) ~~be re-referred to the Committee on~~ .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 434

Short Title: Federal Health Insurance Changes/AB. (Public)

Sponsors: Representatives Dockham; and Brawley.

Referred to: Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO CONFORM NORTH CAROLINA HEALTH INSURANCE LAWS TO RECENTLY ENACTED FEDERAL LAWS CONCERNING HEALTH INSURANCE UNDERWRITING AND PORTABILITY, MATERNITY COVERAGE, AND COVERAGE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-176. Medical underwriting; portability; enrollment; termination of coverage.**

(a) Definitions. -- As used in this section:

(1) 'Creditable coverage' means coverage under one or more of the following plans, provided that the plan is not followed by a lapse of coverage longer than 63 days, excluding waiting periods:

a. A group health benefit plan.

b. A certificate or policy of individual insurance.

c. Part A or 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 of the United States Code.

f. A medical care program of the Indian Health Service or of a tribal organization.

g. A health plan offered under Chapter 89 of Title 5 of the United States Code.

h. A public health plan, as defined by federal law or regulation.

i. A health benefit plan under section 5(e) of the Peace Corps Act.

(2) 'Eligible individual' means an individual who meets all of the following at the time of application for coverage:

a. Has accumulated at least 18 months of prior creditable coverage, the most recent of which was under a health benefit plan provided by an employer, church, or government plan.

b. Has no other health insurance coverage and is not eligible for Medicare coverage.

c. Had elected and has since exhausted group health insurance continuation coverage under COBRA or Article 53 of this Chapter.

(3) 'Enrollee' means an insured or a dependent of the insured under a group health benefit plan.

(4) 'Group health benefit plan' means a plan of health care coverage provided by an insurer to an employer group, including a small employer group.

(5) 'Health status' means the physical and mental medical condition of an individual and includes prior medical history, claims experience, receipt of health care services, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and genetic information.

(6) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(7) 'Preexisting condition provision' means a policy provision excluding or limiting coverage for a condition for which medical advice diagnosis, care, or treatment was recommended or received within the six-month period immediately before enrollment.

(8) 'Small employer' means a small employer as defined in G.S. 58-50-110(22).

(b) Exceptions. -- This section does not apply to the following types of insurance benefits:

(1) Accident only, disability income coverage, coverage issued as supplemental to liability insurance, automobile and homeowners' medical payments coverages, and credit insurance.

(2) Dental, vision, long-term care, nursing home care, and Medicare supplemental insurance, if provided in a policy separate from the health benefit plan.

(c) Medical Underwriting Restricted. -- An insurer shall not refuse to enroll an individual or a dependent of the individual under a group health benefit plan because of the health status of the individual or dependent.

(d) Guaranteed Renewability. -- An insurer shall not unilaterally discontinue nor refuse to renew any of the following, except as provided in subsection (e) of this section:

(1) A group health plan.

(2) The coverage of an individual or a dependent of the individual under a group health plan.

(3) The coverage of an individual under a policy or certificate of individual insurance.

(e) Exceptions to Guaranteed Renewability. -- An insurer may unilaterally discontinue or nonrenew a health benefit plan or individual health insurance coverage under any of the following conditions:

(1) The plan sponsor or individual insured has failed to timely pay premiums.

(2) The plan sponsor, a person insured under the plan, or an individual insured has committed a fraud or made a material misrepresentation with respect to coverage under the health benefit plan.

(3) The insurer is discontinuing coverage in the market in accordance with subsection (j) of this section.

(4) With respect to group health benefit plans, the plan sponsor has not complied with the insurer's participation or contribution requirements.

(5) With respect to a health maintenance organization, the individual insured or the enrollees of the plan sponsor no longer live, reside, or work in the plan's service area.

(6) With respect to employer or individual participants in an association plan, the participant is no longer a member of the association.

(f) Premium Equity. -- An insurer shall not charge an enrollee in a group health benefit plan a higher premium than a similar enrollee in that plan solely because of the enrollee's health status.

(g) Riders; Preexisting Conditions Provisions. -- With respect to an individual or the individual's dependent under a group health benefit plan, an insurer shall not limit or exclude coverage, through a rider, endorsement, or any other means, for a specified disease or medical condition otherwise covered under that plan. An insurer may apply a preexisting condition provision under a group health benefit plan or under individual health insurance coverage only in accordance with the following criteria:

(1) The period during which coverage is limited or excluded may not exceed 12 months following the date of enrollment of an enrollee nor 18 months following the date of enrollment of a late enrollee.

(2) This period must be reduced by the waiting periods or portions thereof satisfied under all prior creditable coverage. An insurer may determine creditable coverage based on benefit categories or without regard to benefits, in accordance with rules adopted by the Commissioner.

(3) A preexisting condition provision may not be applied to any of the following:

a. Pregnancy or a pregnancy-related condition.

b. A newborn who is covered under creditable coverage no later than the thirtieth day following birth.

c. A child adopted or placed for adoption before age 18 who is covered under creditable coverage no later than the thirtieth day following adoption or placement for adoption.

d. A potential but undiagnosed condition relating to genetic information about the insured.

(h) Special Enrollment Under Group Health Benefit Plans. -- An employee or a dependent of the employee (if dependent coverage is offered) who failed to enroll during the open enrollment period in the group health benefit plan sponsored by the employer may enroll in that plan during a special enrollment period under the following conditions:

(1) The employee or dependent must have been covered under another health benefit plan at the time of open enrollment.

(2) If required by the insurer or plan sponsor at that time, the employee must have declined enrollment in writing because of the other coverage.

(3) If the other coverage was continuation coverage under COBRA or Article 53 of this Chapter, it must be exhausted.

(4) If the other coverage was not continuation coverage, the employee or dependent must have lost eligibility for the coverage or the employer stopped contributing premium.

Unless extended by the insurer, the special enrollment period begins with the loss or exhaustion of coverage under subdivision (3) or (4) of this subsection and ends 30 days later.

(i) Individual Insurance for Individuals With Prior Group Coverage. -- An insurer that provides individual health benefit plans in this State shall not deny an eligible individual coverage under an individual health benefit plan nor impose a preexisting condition limitation or exclusion under the plan. However, an insurer may limit an eligible individual to two policy forms if those forms are designed for, made generally available to, and actively marketed to, and enroll eligible and other individuals and are representative of individual health insurance coverage offered by the insurer in this State, as determined in accordance with federal law and rules adopted by the Commissioner.

An insurer may deny coverage to individuals under this subsection if the denial is applied uniformly, is not based on the health status of the individuals, and meets one of the following criteria:

(1) A health maintenance organization may limit enrollment to individuals who live, work, or reside in the plan's service area and may deny coverage to individuals within the service area if it can reasonably anticipate and demonstrate to the Commissioner that (i) it will not have the capacity within that area and among its contracted providers to deliver services adequately to these individuals because of its obligations to existing enrollees and (ii) its anticipated inability to deliver these services is not a pretext for denying coverage based on the health status of the individuals. Denial of coverage under this subdivision precludes the health maintenance organization from offering any coverage in the individual market within the affected service area for 180 days.

(2) An insurer may deny coverage in the individual market upon demonstrating to the satisfaction of the Commissioner that it lacks the financial capacity to insure additional persons, without regard to their health status.

(j) Termination of Coverage. -- An insurer may stop writing coverage in a group health benefit plan market or the individual market only in accordance with the following:

(1) If all coverage is to be discontinued in the market for small employers, as defined in G.S. 58-50-110(22), the market for other employer groups, or both, or the market for individual insureds, the insurer must do the following:

a. Notify all affected plan sponsors and plan participants or individual insureds 180 days in advance.

b. Discontinue renewal of policies in the market from which it is withdrawing.

c. Discontinue writing new policies in that market for five years.

(2) If coverage is to be discontinued only for a particular type of plan, the insurer must do the following:

a. Notify all affected plan sponsors and plan participants or individual insureds 90 days in advance.

b. Offer for purchase other coverage to affected plan sponsors or individual insureds, and if the plan sponsor is a small employer, the offer shall include all available plan coverages.

(3) Discontinuations and offers of alternative coverage shall not be based on the health status of those insured.

This subsection does not prohibit an insurer from modifying the coverage available through a particular plan in accordance with State law."

Section 2. G.S. 58-50-110 reads as rewritten:

"**§ 58-50-110. Definitions.**

As used in this Act:

(1) 'Accountable health carrier' means that as defined in G.S. 143-622(1).

(1a) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-50-130, and to the extent applicable, the provisions of G.S. 58-3-176, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(1b) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, gender, family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b).

(2) Repealed by Session Laws 1993, c. 529, s. 3.3.

(3) 'Basic health care plan' means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

(4) 'Board' means the board of directors of the Pool.

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.

(5a) 'Case characteristics' means the demographic factors age, gender, family size, and geographic location.

(6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.

(8) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-50-120.

(9) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(10) 'Eligible employee' means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a

health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

(11) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not ~~mean accident only, specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.~~ include benefits described in G.S. 58-3-176(b).

(12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

(13) Repealed by Session Laws 1993, c. 529, s. 3.3.

(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual was covered under a public or private health benefit plan that provided, at the time the individual was eligible to enroll, the same required level of benefits in the basic and standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in a basic or standard health care plan within 30 days after termination of coverage provided under another health plan; or

2. Stated, in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining coverage;

3, 4. Repealed by Session Laws 1993, c. 529, s. 3.3.

b. The individual elects a different health plan offered through the Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment for a spouse is made within 30 days after issuance of the court ~~order;~~ order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days ~~of~~ after the ~~individual~~ individual's or employee's marriage or the ~~birth or adoption~~ birth, adoption, or placement for adoption of a child.

(15) Repealed by Session Laws 1993, c. 529, s. 3.3.

(16) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) 'Preexisting-conditions provision' means a ~~policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.~~ preexisting condition provision as defined in G.S. 58-3-176.

(18) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) 'Rating period' means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) 'Risk-assuming carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) 'Reinsuring carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(21a) 'Self-employed individual' means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

(22) 'Small employer' means any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 49 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this definition. For purposes of this Act, the term small employer includes self-employed individuals.

(23) 'Small employer carrier' means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125."

Section 3. G.S. 58-50-125(c) reads as rewritten:

"(c) ~~The~~ Except as provided under G.S. 58-3-176, the plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider."

Section 4. G.S. 58-50-125(g) reads as rewritten:

"(g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is required to offer coverage or accept applications under subsection (d) of this section in the case of any of the following:

(1) To a group that is not physically located in the HMO's approved service areas;

(2) To an employee who does not reside within the HMO's approved service areas;

(3) Within an area, where the HMO can reasonably anticipate, and demonstrate, to the Commissioner's satisfaction, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers."

Section 5. G.S. 58-50-130(a) reads as rewritten:

"(a) Health benefit plans covering small employers are subject to the following provisions:

~~(1) Except in the case of a late enrollee, any preexisting conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's initial effective date of coverage and must define preexisting conditions as "those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage".~~

~~(2) In determining whether a preexisting conditions provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous health benefit plan if the previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan. As used in this subdivision with respect to previous coverage, the meaning of "health benefit plan" is not limited to the definition in G.S. 58-50-115, but includes any health benefit plan provided by a health insurer, as that term is defined in G.S. 58-51-115(a), or any government plan or program providing health benefits or health care.~~

~~(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:~~

~~a. For nonpayment of the required premiums by the policyholder or contract holder;~~

~~b. For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives;~~

~~c. For noncompliance with plan provisions that have been approved by the Commissioner;~~

~~d. When the number of enrollees covered under the plan is less than the number of insureds or percentage of enrollees required by participation requirements under the plan; or~~

~~e. When the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan.~~

~~f. When the small employer carrier stops writing new business in the small employer market, if:~~

~~1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and~~

~~2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.~~

~~A small employer carrier that stops writing new business in the small employer market in this State after January 1, 1992, shall be prohibited from writing new business in the small employer market in this State for a period of five years from the date of notice to the Commissioner. In the case of an HMO doing business in the small employer market in one service area of this State, the rules set forth in this subdivision shall apply to the HMO's operations in the service area, unless the provisions of G.S. 58-50-125(g) apply.~~

~~(4) Late enrollees may be excluded from coverage for the greater of 18 months or an 18-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of such period in the health benefit plan currently held by the small employer.~~

(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable

participation level is met. 'Qualifying existing coverage' means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. An accountable health carrier shall not enforce participation or contribution requirements on member small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.

(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary ~~or~~ of an insurer, or controlled individual of an insurance holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act.

(6) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).

~~(7) A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.~~

~~(8) In the case of an eligible employee or dependent of an eligible employee who was excluded from or denied coverage by a small employer carrier on or before August 14, 1992, the small employer carrier shall provide an opportunity for such eligible employee or dependent to enroll in the health benefit plan currently held by the small employer not later than the next plan anniversary on or after August 14, 1992.~~

(9) The health benefit plan must meet the applicable requirements of G.S. 58-3-176."

Section 6. G.S. 58-50-130(d) reads as written:

"(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales ~~materials, of.~~ materials, of the following and shall provide this information to the small employer upon request:

(1) Repealed by Session Laws 1993, c. 529, s. 3.7.

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.

(3) Provisions relating to renewability of policies and contracts.

(4) Provisions affecting any preexisting conditions provision.

(5) The benefits available and premiums charged under all health benefit plans for which the small employer is eligible."

Section 7. G.S. 58-51-15(a)(2)b reads as rewritten:

"b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions ~~must be covered no later than one year after the effective date of coverage.~~ are covered under this policy.....(insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions ~~are defined as~~ mean 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended ~~or that could be medically documented~~ within the ~~o..e year~~ six-month period immediately preceding the effective date of the person's coverage.' ~~Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period that was met under the previous plan. As used in this policy, the term "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an insured person, all health benefit plans must credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~ Credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-3-176."

Section 8. G.S. 58-51-80(b) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; <u>shall not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee); shall not make health insurance coverage through the association available other than in connection with a member of the association;</u> and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or

all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

~~e. A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject the coverage, in writing.~~

c. The policy shall make health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such member (or individuals eligible for coverage through a member).

~~(2) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more persons and for groups under subdivision (1a) of this subsection and under G.S. 58-51-81: In determining whether a preexisting condition provision applies to an eligible employee, association member, student, or to a dependent, all health benefit plans shall credit the time the~~

~~person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~"

Section 9. G.S. 58-51-80(h) reads as rewritten:

"(h) Nothing contained in this section applies to any contract issued by any corporation defined in Article 65 of this Chapter. ~~Subdivision (b)(3) of this section applies to MEWAs, as defined in G.S. 58-49-30(a).~~"

Section 10. G.S. 58-53-1 reads as rewritten:

"**§ 58-53-1. Definitions.**

As used in this Article, the following terms have the meanings specified:

(1) 'Group policy' means a group accident and health insurance policy issued by an insurance company and a group contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(2) 'Individual policy' or 'converted policy' means an individual health insurance policy issued by an insurance company or an individual ~~health services~~ contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(3) 'Insurance' and 'insured' refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided by reason of a disability extension.

(4) "Insurer" means the entity issuing a group policy or an individual or converted policy.

(5) "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(5a) 'Member' or 'employee' includes an insured spouse or dependent of a member or of an employee.

(6) 'Premium' includes any premium or other consideration payable for coverage under a group or individual policy.

(7) 'Reasonable and customary' means the most frequently used level of charge made for the supplies or for a specific service in the geographic subarea in which such supplies or services are received, of like kind or by physicians, or other practitioners, with similar qualifications."

Section 11. G.S. 58-53-5 reads as rewritten:

"**§ 58-53-5. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership.**

A group policy delivered or issued for delivery in this State ~~which~~ that insures employees or ~~members, other than the members and their dependents, if they have elected to include them, whose eligibility under the group policy does not extend to~~

~~any employee(s) the insured may have~~ members for hospital, surgical or major medical insurance on an expense incurred or service basis under ~~Articles 1 through 67 of~~ this Chapter, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose ~~insurance for these types of~~ coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible spouses and dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions ~~applicable to those forms of insurance~~ and to the conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans ~~already in force, or hereafter placed into effect,~~ that provide continuation benefits equal to or better than those required in this Part."

Section 12. G.S. 58-53-35 reads as rewritten:

"**§ 58-53-35. Termination of continuation.**

(a) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date ~~one year~~ 18 months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have terminated. The insurer that insured the group ~~prior to~~ before the date of termination shall make a converted policy available to the employee or member.

(b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the group policy with another group policy, the employee is entitled to continue under the successor group policy for any unexpired period of continuation to which the employee is entitled."

Section 13. G.S. 58-53-50 reads as rewritten:

"**§ 58-53-50. Restrictions.**

A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred because:

(1) Of termination of employment or membership and either he was not entitled to continuation of group coverage under Part 1 of this Article or failed to elect such continuation;

(2) He failed to make timely payment of any required contribution for the cost of continuation of insurance;

(3) He had not been continuously covered under the group policy or for similar benefits under any other group policy that it replaced during the period of three consecutive months immediately prior to termination of active employment ending with such termination;

(4) The group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of date of termination; or

(5) He failed to continue his insurance for the entire maximum period of ~~one year~~ 18 months following termination of active employment as provided for in Part 1 of this Article, unless that failure to continue was because of change of insurer by the employer and the change of insurer was consummated during the one year continuation period. In that event the employee or member shall be entitled to be issued a converted policy by the insurer that provided the group policy to the employer before the change of insurer."

Section 14. G.S. 58-53-55 reads as rewritten:

"**§ 58-53-55. Time limit.**

In order to be eligible for conversion, written application and the first premium payment for the converted policy must be made to the insurer not later than 31 days after the date of termination of insurance provided under Part 1 of this Article. The effective date of the converted policy shall be the day following the later of:

(1) The termination of insurance under the group policy when it is not replaced by one providing similar coverage within 31 days of the termination date of the immediately prior group plan; or

(2) The termination of the ~~one year~~ period of continued coverage under the group policy or policies."

Section 15. Article 55 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-55-31. Additional requirements.**

(a) No policy shall be used in this State unless it provides for an offer of nonforfeiture, which shall not be less than an offer of reduced paid-up insurance benefits, extended term insurance benefits, or a shortened benefit period. No policy

shall pay a cash surrender value unless the dividends or refunds are applied as a reduction of future premiums or an increase in future benefits.

(b) The Commissioner shall adopt rules to provide for annual reports by insurers of the number of claims denied, number of rescissions, and the percentage of sales involving the replacement of policies.

(c) No policy shall be used in this State unless the insurer has developed a financial or personal asset suitability test to determine whether or not issuing long-term care insurance to an applicant is appropriate. A personal long-term care worksheet and disclosure notice of issues an applicant should know before buying long-term care insurance shall be completed and provided before an application is taken. The insurer shall use the financial or suitability form and format standards as developed and adopted by the NAIC. Each applicant that does not meet the recommended financial or personal asset suitability test criteria shall receive a letter of notification and shall be given an option to waive the results of the financial suitability test and proceed with the purchase of the policy.

(d) The Commissioner shall adopt standards to handle consumer complaints about noncompliance with State requirements.

(e) Every policy shall include an offer of an alternative plan of care benefit. The alternative plan of care benefit shall not duplicate benefits provided elsewhere in the policy nor shall it substitute home health care services as defined in G.S. 131E-136(3). An alternate plan of care benefit shall allow the insured to stay home whenever medically acceptable. The alternate plan of care benefit may specify service, special treatments, and specific levels of care. The insurer shall disclose the full cost of the alternative care benefit and the method and amount of reimbursement. Alternative care benefits may include, but are not limited to, services such as the purchase of durable medical equipment, wheelchair ramps, grab bars, emergency response systems, and the payment of Meals-On-Wheels or other similar food delivery programs in the insured's area. All long-term care insurers shall offer to add the alternative plan of care benefit to any long-term care policy issued or issued for delivery in this State without additional proof of medical insurability. All benefits are subject to the following conditions:

(1) The treatment plan shall be agreed to by the insured, the treating physician, and the insurer.

(2) The treatment plan shall be developed and coordinated with the treating physician.

(f) No policy used in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

(1) 'Activities of daily living' means at least bathing, continence, dressing, eating, toileting, and transferring.

(2) 'Acute condition' means that the individual is medically unstable requiring frequent monitoring by a physician or registered nurse.

(3) 'Bathing' means washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower.

(4) 'Cognitive impairment' means a deficiency in a person's short or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(5) 'Continence' means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(6) 'Dressing' means putting on and taking of all items of clothing and any necessary braces, fasteners, or artificial limbs.

(7) 'Eating' means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

(8) 'Hands-on assistance' means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

(9) 'Mental or nervous disorder' shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(10) 'Personal care' means the provision of hands-on services to assist an individual with activities of daily living.

(11) 'Toileting' means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(12) 'Transferring' means moving into or out of a bed, chair, or wheelchair.

(13) 'Skilled nursing care', 'intermediate care', 'personal care', 'home care,' and other services shall be defined in relation to the level of skill required, and the nature of the care, the definition of which may require that the provider be appropriately licensed or certified."

Section 16. G.S. 58-65-25 reads as rewritten:

"**§ 58-65-25. Hospital, physician and dentist contracts.**

(a) Any corporation organized under ~~the provisions of~~ this Article ~~and Article 66 of this Chapter~~ may enter into contracts for the rendering of hospital service to any of its subscribers by hospitals approved by the American Medical Association and/or the North Carolina Hospital Association, and may enter into contracts for the furnishing of, or the payment in whole or in part for, medical and/or dental services rendered to any of its subscribers by duly licensed physicians and/or dentists. All obligations arising under contracts issued by such corporations to its subscribers shall be satisfied by payments made directly to the hospitals or hospitals and/or physicians and/or dentists rendering such service, or direct to the subscriber or his, her, or their legal representatives upon the receipt by the corporation from the subscriber of a statement marked paid by the hospital(s) and/or physician(s) and/or dentist(s) or both rendering such service, and all such payments heretofore made are hereby ratified. Nothing

~~herein~~ in this section shall be construed to discriminate against hospitals conducted by other schools of medical practice.

(b) ~~On and after January 1, 1956, all~~ All certificates, plans or contracts issued to subscribers or other persons by hospital and medical and/or dental service corporations operating under this Article ~~and Article 66 of this Chapter~~ shall contain in substance a provision as follows: 'After two years from the date of issue of this certificate, contract or plan no misstatements, except fraudulent misstatements made by the applicant in the application for such certificate, contract or plan, shall be used to void said certificate, contract or plan, or to deny a claim for loss incurred or disability (as therein defined) commencing after the expiration of such two-year period. ~~No claim for loss incurred or disability (as defined in the certificate, contract or plan) commencing after two years from the date of issue of this certificate, contract or plan shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specifically described, effective on the date of loss, had existed prior to the effective date of coverage of this certificate, contract or plan.~~'"

Section 17. G.S. 58-65-60(e) reads as rewritten:

"(e) A ~~hospital~~ service corporation may issue a master group contract with the approval of the Commissioner ~~of Insurance provided such~~ if the contract and the individual certificates issued to members of the ~~group, shall comply~~ group complies in substance to the other provisions of this Article and Article 66 of this Chapter. ~~Any such~~ The contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in ~~said~~ the contract, and in accordance with an adjustment schedule filed with and approved by the ~~Commissioner of Insurance.~~ Commissioner. If ~~such master group~~ the contract is issued, altered or modified, the subscribers' contracts issued ~~in pursuance thereof~~ under that contract are altered or modified accordingly, all laws and clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of subscribers thereto.

~~(1) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for coverage or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically~~

~~documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care, except that nothing in this section shall apply to a guaranteed issue product designed for uninsurables. For employer groups of 50 or more persons: In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

~~(3)~~ (e1) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

~~(1)~~ (e2) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan."

Section 18. G.S. 58-67-85 reads as rewritten:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

(a) A health maintenance organization may issue a master group contract with the approval of the Commissioner of Insurance provided the contract and the individual certificates issued to members of the group, shall comply in substance to the other

provisions of this Article. Any such contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner of Insurance. If the master group contract is issued, altered or modified, the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees' contracts to the contrary notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

~~(b) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subsection, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

(d) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(e) Whenever an employer master group contract replaces another group contract, whether the contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and

(2) Each person not covered under the succeeding corporation's plan of benefits in accordance with (e)(1) must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan."

Section 19. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-169. Required coverage for minimum hospital stay following birth.**

(a) Definitions. -- As used in this section:

(1) 'Attending providers' includes:

a. The obstetrician-gynecologists, pediatricians, family physicians, and other physicians primarily responsible for the care of a mother and newborn; and

b. The nurse midwives and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident,

b. Credit,

c. Disability income,

d. Long-term or nursing home care,

e. Medicare supplement,

f. Specified disease,

g. Dental or vision,

h. Coverage issued as a supplement to liability insurance,

i. Workers' compensation,

j. Medical payments under automobile or homeowners, and

k. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(3) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) In General. -- Except as provided in subsection (c), an insurer that provides a health benefit plan that contains maternity benefits, including benefits for childbirth, shall ensure that coverage is provided with respect to a mother who is a participant, beneficiary, or policyholder under the plan and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.

(c) Exception. -- Notwithstanding subsection (b) of this section, an insurer is not required to provide coverage for postdelivery inpatient length of stay for a mother who is a participant, beneficiary, or policyholder under the insurer's health benefit plan and her newborn child for the period referred to in subsection (b) of this section if:

(1) A decision to discharge the mother and her newborn child before the expiration of the period is made by the attending provider in consultation with the mother; and

(2) The health benefit plan provides coverage for postdelivery follow-up care as described in subsections(d) and (e) of this section.

(d) Postdelivery Follow-Up Care. -- In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the health benefit plan shall provide coverage for timely postdelivery care. This health care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

(1) The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or

(2) Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

The attending provider in consultation with the mother shall decide the most appropriate location for follow-up care.

(e) Timely Care. -- As used in subsection (d) of this section, 'timely postdelivery care' means health care that is provided:

(1) Following the discharge of a mother and her newborn child from the inpatient setting; and

(2) In a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs not later than the 72-hour period immediately following discharge.

(f) Prohibitions. -- An insurer shall not:

(1) Deny enrollment, renewal, or continued coverage with respect to its health benefit plan to a mother and her newborn child who are participants, beneficiaries, or policyholders, based on compliance with this section;

(2) Provide monetary payments or rebates to mothers to encourage the mothers to request less than the minimum coverage required under this section;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided treatment to an individual policyholder, participant, or beneficiary in accordance with this section; or

(4) Provide monetary or other incentives to an attending provider to induce the provider to provide treatment to an individual policyholder, participant, or beneficiary in a manner inconsistent with this section.

(g) Effect on Mother. -- Nothing in this section requires that a mother who is a participant, beneficiary, or policyholder covered under this section:

(1) Give birth in a hospital; or

(2) Stay in the hospital for a fixed period of time following the birth of her child.

(h) Level and Type of Reimbursements. -- Nothing in this section prevents an insurer from negotiating the level and type of reimbursement with an attending provider for care provided in accordance with this section."

Section 20. G.S. 58-3-170 reads as rewritten:

"**§ 58-3-170. Requirements for maternity coverage.**

(a) Every entity providing a health benefit plan that provides maternity coverage in this State shall provide benefits for the necessary care and treatment related to maternity that are no less favorable than benefits for physical illness generally.

~~(a1) A health benefit plan that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by caesarean section.~~

(b) As used in this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a

MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Section 21. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A policy that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the policy, without distinguishing the mental health benefits.

(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the policy contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury

benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the policy may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the policy, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the insurer offers two or more benefit package options under a policy, each package must comply with this subsection.

(6) This subsection does not apply to a policy if the insurer can demonstrate to the Commissioner that compliance will increase the cost of the policy by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental illness or chemical dependency coverage not required. -- Nothing in this section ~~prevents any insurance company from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires an insurer to offer coverage for mental illness or chemical dependency.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to group health insurance contracts covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

Section 22. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No ~~hospital, medical, dental or health~~ service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group ~~hospital, dental, medical or health service~~ subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A subscriber contract that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the subscriber contract, without distinguishing the mental health benefits.

(2) If the subscriber contract contains lifetime limits only on selected physical illness or injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the subscriber contract contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the subscriber contract, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the service corporation offers two or more benefit package options under a subscriber contract, each package must comply with this subsection.

(6) This subsection does not apply to a subscriber contract if the service corporation can demonstrate to the Commissioner that compliance will increase the cost of the subscriber contract by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any hospital or medical plan from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires a service corporation to offer coverage for mental illness or chemical dependency.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to subscriber contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 23. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A health care plan that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the plan, without distinguishing the mental health benefits.

(2) If the plan contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the plan contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the plan may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the plan, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the HMO offers two or more benefit package options under a plan, each package must comply with this subsection.

(6) This subsection does not apply to a health benefit plan if the HMO can demonstrate to the Commissioner that compliance will increase the cost of the plan by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any health maintenance organization from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires an HMO to offer coverage for mental illness or chemical dependency.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to group contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 24. Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract.

Section 25. This act is effective when it becomes law.

Minute

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 434

Short Title: Federal Health Insurance Changes/AB. (Public)

Sponsors: Representatives Dockham; and Brawley.

Referred to: Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO CONFORM NORTH CAROLINA HEALTH INSURANCE LAWS TO RECENTLY ENACTED FEDERAL LAWS CONCERNING HEALTH INSURANCE UNDERWRITING AND PORTABILITY, MATERNITY COVERAGE, AND COVERAGE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-176. Medical underwriting; portability; enrollment; termination of coverage.**

(a) Definitions. -- As used in this section:

(1) 'Creditable coverage' means coverage under one or more of the following plans, provided that the plan is not followed by a lapse of coverage longer than 63 days, excluding waiting periods:

a. A group health benefit plan.

b. A certificate or policy of individual insurance.

c. Part A or 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 of the United States Code.

f. A medical care program of the Indian Health Service or of a tribal organization.

g. A health plan offered under Chapter 89 of Title 5 of the United States Code.

h. A public health plan, as defined by federal law or regulation.

i. A health benefit plan under section 5(e) of the Peace Corps Act.

(2) 'Eligible individual' means an individual who meets all of the following at the time of application for coverage:

a. Has accumulated at least 18 months of prior creditable coverage, the most recent of which was under a health benefit plan provided by an employer, church, or government plan.

b. Has no other health insurance coverage and is not eligible for Medicare coverage.

c. Had elected and has since exhausted group health insurance continuation coverage under COBRA or Article 53 of this Chapter.

(3) 'Enrollee' means an insured or a dependent of the insured under a group health benefit plan.

(4) 'Group health benefit plan' means a plan of health care coverage provided by an insurer to an employer group, including a small employer group.

(5) 'Health status' means the physical and mental medical condition of an individual and includes prior medical history, claims experience, receipt of health care services, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and genetic information.

(6) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(7) 'Preexisting condition provision' means a policy provision excluding or limiting coverage for a condition for which medical advice diagnosis, care, or treatment was recommended or received within the six-month period immediately before enrollment.

(8) 'Small employer' means a small employer as defined in G.S. 58-50-110(22).

(b) Exceptions. -- This section does not apply to the following types of insurance benefits:

(1) Accident only, disability income coverage, coverage issued as supplemental to liability insurance, automobile and homeowners' medical payments coverages, and credit insurance.

(2) Dental, vision, long-term care, nursing home care, and Medicare supplemental insurance, if provided in a policy separate from the health benefit plan.

(c) Medical Underwriting Restricted. -- An insurer shall not refuse to enroll an individual or a dependent of the individual under a group health benefit plan because of the health status of the individual or dependent.

(d) Guaranteed Renewability. -- An insurer shall not unilaterally discontinue nor refuse to renew any of the following, except as provided in subsection (e) of this section:

(1) A group health plan.

(2) The coverage of an individual or a dependent of the individual under a group health plan.

(3) The coverage of an individual under a policy or certificate of individual insurance.

(e) Exceptions to Guaranteed Renewability. -- An insurer may unilaterally discontinue or nonrenew a health benefit plan or individual health insurance coverage under any of the following conditions:

(1) The plan sponsor or individual insured has failed to timely pay premiums.

(2) The plan sponsor, a person insured under the plan, or an individual insured has committed a fraud or made a material misrepresentation with respect to coverage under the health benefit plan.

(3) The insurer is discontinuing coverage in the market in accordance with subsection (j) of this section.

(4) With respect to group health benefit plans, the plan sponsor has not complied with the insurer's participation or contribution requirements.

(5) With respect to a health maintenance organization, the individual insured or the enrollees of the plan sponsor no longer live, reside, or work in the plan's service area.

(6) With respect to employer or individual participants in an association plan, the participant is no longer a member of the association.

(f) Premium Equity. -- An insurer shall not charge an enrollee in a group health benefit plan a higher premium than a similar enrollee in that plan solely because of the enrollee's health status.

(g) Riders; Preexisting Conditions Provisions. -- With respect to an individual or the individual's dependent under a group health benefit plan, an insurer shall not limit or exclude coverage, through a rider, endorsement, or any other means, for a specified disease or medical condition otherwise covered under that plan. An insurer may apply a preexisting condition provision under a group health benefit plan or under individual health insurance coverage only in accordance with the following criteria:

(1) The period during which coverage is limited or excluded may not exceed 12 months following the date of enrollment of an enrollee nor 18 months following the date of enrollment of a late enrollee.

(2) This period must be reduced by the waiting periods or portions thereof satisfied under all prior creditable coverage. An insurer may determine creditable coverage based on benefit categories or without regard to benefits, in accordance with rules adopted by the Commissioner.

(3) A preexisting condition provision may not be applied to any of the following:

a. Pregnancy or a pregnancy-related condition.

b. A newborn who is covered under creditable coverage no later than the thirtieth day following birth.

c. A child adopted or placed for adoption before age 18 who is covered under creditable coverage no later than the thirtieth day following adoption or placement for adoption.

d. A potential but undiagnosed condition relating to genetic information about the insured.

(h) Special Enrollment Under Group Health Benefit Plans. -- An employee or a dependent of the employee (if dependent coverage is offered) who failed to enroll during the open enrollment period in the group health benefit plan sponsored by the employer may enroll in that plan during a special enrollment period under the following conditions:

(1) The employee or dependent must have been covered under another health benefit plan at the time of open enrollment.

(2) If required by the insurer or plan sponsor at that time, the employee must have declined enrollment in writing because of the other coverage.

(3) If the other coverage was continuation coverage under COBRA or Article 53 of this Chapter, it must be exhausted.

(4) If the other coverage was not continuation coverage, the employee or dependent must have lost eligibility for the coverage or the employer stopped contributing premium.

Unless extended by the insurer, the special enrollment period begins with the loss or exhaustion of coverage under subdivision (3) or (4) of this subsection and ends 30 days later.

(i) Individual Insurance for Individuals With Prior Group Coverage. -- An insurer that provides individual health benefit plans in this State shall not deny an eligible individual coverage under an individual health benefit plan nor impose a preexisting condition limitation or exclusion under the plan. However, an insurer may limit an eligible individual to two policy forms if those forms are designed for, made generally available to, and actively marketed to, and enroll eligible and other individuals and are representative of individual health insurance coverage offered by the insurer in this State, as determined in accordance with federal law and rules adopted by the Commissioner.

An insurer may deny coverage to individuals under this subsection if the denial is applied uniformly, is not based on the health status of the individuals, and meets one of the following criteria:

(1) A health maintenance organization may limit enrollment to individuals who live, work, or reside in the plan's service area and may deny coverage to individuals within the service area if it can reasonably anticipate and demonstrate to the Commissioner that (i) it will not have the capacity within that area and among its contracted providers to deliver services adequately to these individuals because of its obligations to existing enrollees and (ii) its anticipated inability to deliver these services is not a pretext for denying coverage based on the health status of the individuals. Denial of coverage under this subdivision precludes the health maintenance organization from offering any coverage in the individual market within the affected service area for 180 days.

(2) An insurer may deny coverage in the individual market upon demonstrating to the satisfaction of the Commissioner that it lacks the financial capacity to insure additional persons, without regard to their health status.

(j) Termination of Coverage. -- An insurer may stop writing coverage in a group health benefit plan market or the individual market only in accordance with the following:

(1) If all coverage is to be discontinued in the market for small employers, as defined in G.S. 58-50-110(22), the market for other employer groups, or both, or the market for individual insureds, the insurer must do the following:

a. Notify all affected plan sponsors and plan participants or individual insureds 180 days in advance.

b. Discontinue renewal of policies in the market from which it is withdrawing.

c. Discontinue writing new policies in that market for five years.

(2) If coverage is to be discontinued only for a particular type of plan, the insurer must do the following:

a. Notify all affected plan sponsors and plan participants or individual insureds 90 days in advance.

b. Offer for purchase other coverage to affected plan sponsors or individual insureds, and if the plan sponsor is a small employer, the offer shall include all available plan coverages.

(3) Discontinuations and offers of alternative coverage shall not be based on the health status of those insured.

This subsection does not prohibit an insurer from modifying the coverage available through a particular plan in accordance with State law."

Section 2. G.S. 58-50-110 reads as rewritten:

"**§ 58-50-110. Definitions.**

As used in this Act:

(1) 'Accountable health carrier' means that as defined in G.S. 143-622(1).

(1a) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-50-130, and to the extent applicable, the provisions of G.S. 58-3-176, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(1b) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, gender, family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b).

(2) Repealed by Session Laws 1993, c. 529, s. 3.3.

(3) 'Basic health care plan' means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

(4) 'Board' means the board of directors of the Pool.

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.

(5a) 'Case characteristics' means the demographic factors age, gender, family size, and geographic location.

(6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.

(8) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-50-120.

(9) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(10) 'Eligible employee' means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a

health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

(11) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not ~~mean accident only, specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.~~ include benefits described in G.S. 58-3-176(b).

(12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

(13) Repealed by Session Laws 1993, c. 529, s. 3.3.

(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual was covered under a public or private health benefit plan that provided, at the time the individual was eligible to enroll, the same required level of benefits in the basic and standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in a basic or standard health care plan within 30 days after termination of coverage provided under another health plan; or

2. Stated, in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining coverage;

3, 4. Repealed by Session Laws 1993, c. 529, s. 3.3.

b. The individual elects a different health plan offered through the Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment for a spouse is made within 30 days after issuance of the court ~~order;~~ order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days ~~of~~ after the ~~individual~~ individual's or employee's marriage or the ~~birth or adoption~~ birth, adoption, or placement for adoption of a child.

(15) Repealed by Session Laws 1993, c. 529, s. 3.3.

(16) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) 'Preexisting-conditions provision' means a ~~policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.~~ preexisting condition provision as defined in G.S. 58-3-176.

(18) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) 'Rating period' means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) 'Risk-assuming carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) 'Reinsuring carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(21a) 'Self-employed individual' means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

(22) 'Small employer' means any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 49 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this definition. For purposes of this Act, the term small employer includes self-employed individuals.

(23) 'Small employer carrier' means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125."

Section 3. G.S. 58-50-125(c) reads as rewritten:

"(c) ~~The~~ Except as provided under G.S. 58-3-176, the plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider."

Section 4. G.S. 58-50-125(g) reads as rewritten:

"(g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is required to offer coverage or accept applications under subsection (d) of this section in the case of any of the following:

(1) To a group that is not physically located in the HMO's approved service areas;

(2) To an employee who does not reside within the HMO's approved service areas;

(3) Within an area, where the HMO can reasonably anticipate, and demonstrate, to the Commissioner's satisfaction, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers."

Section 5. G.S. 58-50-130(a) reads as rewritten:

"(a) Health benefit plans covering small employers are subject to the following provisions:

~~(1) Except in the case of a late enrollee, any preexisting conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's initial effective date of coverage and must define preexisting conditions as "those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage".~~

~~(2) In determining whether a preexisting conditions provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous health benefit plan if the previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan. As used in this subdivision with respect to previous coverage, the meaning of "health benefit plan" is not limited to the definition in G.S. 58-50-115, but includes any health benefit plan provided by a health insurer, as that term is defined in G.S. 58-51-115(a), or any government plan or program providing health benefits or health care.~~

~~(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:~~

~~a. For nonpayment of the required premiums by the policyholder or contract holder;~~

~~b. For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives;~~

~~c. For noncompliance with plan provisions that have been approved by the Commissioner;~~

~~d. When the number of enrollees covered under the plan is less than the number of insureds or percentage of enrollees required by participation requirements under the plan; or~~

~~e. When the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan.~~

~~f. When the small employer carrier stops writing new business in the small employer market, if:~~

~~1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and~~

~~2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.~~

~~A small employer carrier that stops writing new business in the small employer market in this State after January 1, 1992, shall be prohibited from writing new business in the small employer market in this State for a period of five years from the date of notice to the Commissioner. In the case of an HMO doing business in the small employer market in one service area of this State, the rules set forth in this subdivision shall apply to the HMO's operations in the service area, unless the provisions of G.S. 58-50-125(g) apply.~~

~~(4) Late enrollees may be excluded from coverage for the greater of 18 months or an 18-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of such period in the health benefit plan currently held by the small employer.~~

(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable

participation level is met. 'Qualifying existing coverage' means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. An accountable health carrier shall not enforce participation or contribution requirements on member small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.

(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary ~~or~~ of an insurer, or controlled individual of an insurance holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act.

(6) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).

~~(7) A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.~~

~~(8) In the case of an eligible employee or dependent of an eligible employee who was excluded from or denied coverage by a small employer carrier on or before August 14, 1992, the small employer carrier shall provide an opportunity for such eligible employee or dependent to enroll in the health benefit plan currently held by the small employer not later than the next plan anniversary on or after August 14, 1992.~~

(9) The health benefit plan must meet the applicable requirements of G.S. 58-3-176."

Section 6. G.S. 58-50-130(d) reads as written:

"(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales ~~materials, of:~~ materials, of the following and shall provide this information to the small employer upon request:

(1) Repealed by Session Laws 1993, c. 529, s. 3.7.

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.

(3) Provisions relating to renewability of policies and contracts.

(4) Provisions affecting any preexisting conditions provision.

(5) The benefits available and premiums charged under all health benefit plans for which the small employer is eligible."

Section 7. G.S. 58-51-15(a)(2)b reads as rewritten:

"b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions ~~must be covered no later than one year after the effective date of coverage.~~ are covered under this policy.....(insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions ~~are defined as~~ mean 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended ~~or that could be medically documented~~ within the ~~o. e-year~~ six-month period immediately preceding the effective date of the person's coverage.' ~~Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period that was met under the previous plan. As used in this policy, the term "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an insured person, all health benefit plans must credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~ Credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-3-176."

Section 8. G.S. 58-51-80(b) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; <u>shall not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee); shall not make health insurance coverage through the association available other than in connection with a member of the association;</u> and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or

all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

~~c. A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject the coverage, in writing.~~

c. The policy shall make health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such member (or individuals eligible for coverage through a member).

~~(2) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more persons and for groups under subdivision (1a) of this subsection and under G.S. 58-51-81: In determining whether a preexisting condition provision applies to an eligible employee, association member, student, or to a dependent, all health benefit plans shall credit the time the~~

~~person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~"

Section 9. G.S. 58-51-80(h) reads as rewritten:

"(h) Nothing contained in this section applies to any contract issued by any corporation defined in Article 65 of this Chapter. ~~Subdivision (b)(3) of this section applies to MEWAs, as defined in G.S. 58-49-30(a).~~"

Section 10. G.S. 58-53-1 reads as rewritten:

"**§ 58-53-1. Definitions.**

As used in this Article, the following terms have the meanings specified:

(1) 'Group policy' means a group accident and health insurance policy issued by an insurance company and a group contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(2) 'Individual policy' or 'converted policy' means an individual health insurance policy issued by an insurance company or an individual ~~health services~~ contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(3) 'Insurance' and 'insured' refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided by reason of a disability extension.

(4) "Insurer" means the entity issuing a group policy or an individual or converted policy.

(5) "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(5a) 'Member' or 'employee' includes an insured spouse or dependent of a member or of an employee.

(6) 'Premium' includes any premium or other consideration payable for coverage under a group or individual policy.

(7) 'Reasonable and customary' means the most frequently used level of charge made for the supplies or for a specific service in the geographic subarea in which such supplies or services are received, of like kind or by physicians, or other practitioners, with similar qualifications."

Section 11. G.S. 58-53-5 reads as rewritten:

"**§ 58-53-5. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership.**

A group policy delivered or issued for delivery in this State ~~which~~ that insures employees or ~~members, other than the members and their dependents, if they have elected to include them, whose eligibility under the group policy does not extend to~~

~~any employee(s) the insured may have~~ members for hospital, surgical or major medical insurance on an expense incurred or service basis under ~~Articles 1 through 67 of~~ this Chapter, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose ~~insurance for these types of~~ coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible spouses and dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions ~~applicable to those forms of insurance~~ and to the conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans ~~already in force, or hereafter placed into effect,~~ that provide continuation benefits equal to or better than those required in this Part."

Section 12. G.S. 58-53-35 reads as rewritten:

"**§ 58-53-35. Termination of continuation.**

(a) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date ~~one year~~ 18 months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have terminated. The insurer that insured the group ~~prior to~~ before the date of termination shall make a converted policy available to the employee or member.

(b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the group policy with another group policy, the employee is entitled to continue under the successor group policy for any unexpired period of continuation to which the employee is entitled."

Section 13. G.S. 58-53-50 reads as rewritten:

"**§ 58-53-50. Restrictions.**

A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred because:

(1) Of termination of employment or membership and either he was not entitled to continuation of group coverage under Part 1 of this Article or failed to elect such continuation;

(2) He failed to make timely payment of any required contribution for the cost of continuation of insurance;

(3) He had not been continuously covered under the group policy or for similar benefits under any other group policy that it replaced during the period of three consecutive months immediately prior to termination of active employment ending with such termination;

(4) The group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of date of termination; or

(5) He failed to continue his insurance for the entire maximum period of ~~one year~~ 18 months following termination of active employment as provided for in Part 1 of this Article, unless that failure to continue was because of change of insurer by the employer and the change of insurer was consummated during the one year continuation period. In that event the employee or member shall be entitled to be issued a converted policy by the insurer that provided the group policy to the employer before the change of insurer."

Section 14. G.S. 58-53-55 reads as rewritten:

"**§ 58-53-55. Time limit.**

In order to be eligible for conversion, written application and the first premium payment for the converted policy must be made to the insurer not later than 31 days after the date of termination of insurance provided under Part 1 of this Article. The effective date of the converted policy shall be the day following the later of:

(1) The termination of insurance under the group policy when it is not replaced by one providing similar coverage within 31 days of the termination date of the immediately prior group plan; or

(2) The termination of the ~~one year~~ period of continued coverage under the group policy or policies."

Section 15. Article 55 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-55-31. Additional requirements.**

(a) No policy shall be used in this State unless it provides for an offer of nonforfeiture, which shall not be less than an offer of reduced paid-up insurance benefits, extended term insurance benefits, or a shortened benefit period. No policy

shall pay a cash surrender value unless the dividends or refunds are applied as a reduction of future premiums or an increase in future benefits.

(b) The Commissioner shall adopt rules to provide for annual reports by insurers of the number of claims denied, number of rescissions, and the percentage of sales involving the replacement of policies.

(c) No policy shall be used in this State unless the insurer has developed a financial or personal asset suitability test to determine whether or not issuing long-term care insurance to an applicant is appropriate. A personal long-term care worksheet and disclosure notice of issues an applicant should know before buying long-term care insurance shall be completed and provided before an application is taken. The insurer shall use the financial or suitability form and format standards as developed and adopted by the NAIC. Each applicant that does not meet the recommended financial or personal asset suitability test criteria shall receive a letter of notification and shall be given an option to waive the results of the financial suitability test and proceed with the purchase of the policy.

(d) The Commissioner shall adopt standards to handle consumer complaints about noncompliance with State requirements.

(e) Every policy shall include an offer of an alternative plan of care benefit. The alternative plan of care benefit shall not duplicate benefits provided elsewhere in the policy nor shall it substitute home health care services as defined in G.S. 131E-136(3). An alternate plan of care benefit shall allow the insured to stay home whenever medically acceptable. The alternate plan of care benefit may specify service, special treatments, and specific levels of care. The insurer shall disclose the full cost of the alternative care benefit and the method and amount of reimbursement. Alternative care benefits may include, but are not limited to, services such as the purchase of durable medical equipment, wheelchair ramps, grab bars, emergency response systems, and the payment of Meals-On-Wheels or other similar food delivery programs in the insured's area. All long-term care insurers shall offer to add the alternative plan of care benefit to any long-term care policy issued or issued for delivery in this State without additional proof of medical insurability. All benefits are subject to the following conditions:

(1) The treatment plan shall be agreed to by the insured, the treating physician, and the insurer.

(2) The treatment plan shall be developed and coordinated with the treating physician.

(f) No policy used in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

(1) 'Activities of daily living' means at least bathing, continence, dressing, eating, toileting, and transferring.

(2) 'Acute condition' means that the individual is medically unstable requiring frequent monitoring by a physician or registered nurse.

(3) 'Bathing' means washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower.

(4) 'Cognitive impairment' means a deficiency in a person's short or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(5) 'Continence' means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(6) 'Dressing' means putting on and taking of all items of clothing and any necessary braces, fasteners, or artificial limbs.

(7) 'Eating' means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

(8) 'Hands-on assistance' means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

(9) 'Mental or nervous disorder' shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(10) 'Personal care' means the provision of hands-on services to assist an individual with activities of daily living.

(11) 'Toileting' means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(12) 'Transferring' means moving into or out of a bed, chair, or wheelchair.

(13) 'Skilled nursing care', 'intermediate care', 'personal care', 'home care,' and other services shall be defined in relation to the level of skill required, and the nature of the care, the definition of which may require that the provider be appropriately licensed or certified."

Section 16. G.S. 58-65-25 reads as rewritten:

"**§ 58-65-25. Hospital, physician and dentist contracts.**

(a) Any corporation organized under ~~the provisions of~~ this Article ~~and Article 66 of this Chapter~~ may enter into contracts for the rendering of hospital service to any of its subscribers by hospitals approved by the American Medical Association and/or the North Carolina Hospital Association, and may enter into contracts for the furnishing of, or the payment in whole or in part for, medical and/or dental services rendered to any of its subscribers by duly licensed physicians and/or dentists. All obligations arising under contracts issued by such corporations to its subscribers shall be satisfied by payments made directly to the hospitals or hospitals and/or physicians and/or dentists rendering such service, or direct to the subscriber or his, her, or their legal representatives upon the receipt by the corporation from the subscriber of a statement marked paid by the hospital(s) and/or physician(s) and/or dentist(s) or both rendering such service, and all such payments heretofore made are hereby ratified. Nothing

~~herein~~ in this section shall be construed to discriminate against hospitals conducted by other schools of medical practice.

(b) ~~On and after January 1, 1956, all~~ All certificates, plans or contracts issued to subscribers or other persons by hospital and medical and/or dental service corporations operating under this Article ~~and Article 66 of this Chapter~~ shall contain in substance a provision as follows: 'After two years from the date of issue of this certificate, contract or plan no misstatements, except fraudulent misstatements made by the applicant in the application for such certificate, contract or plan, shall be used to void said certificate, contract or plan, or to deny a claim for loss incurred or disability (as therein defined) commencing after the expiration of such two-year period. ~~No claim for loss incurred or disability (as defined in the certificate, contract or plan) commencing after two years from the date of issue of this certificate, contract or plan shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specifically described, effective on the date of loss, had existed prior to the effective date of coverage of this certificate, contract or plan.~~'"

Section 17. G.S. 58-65-60(e) reads as rewritten:

"(e) A ~~hospital~~ service corporation may issue a master group contract with the approval of the Commissioner ~~of Insurance provided such~~ if the contract and the individual certificates issued to members of the ~~group, shall comply~~ group complies in substance to the other provisions of this Article and Article 66 of this Chapter. ~~Any such~~ The contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in ~~said~~ the contract, and in accordance with an adjustment schedule filed with and approved by the ~~Commissioner of Insurance.~~ Commissioner. If ~~such master group~~ the contract is issued, altered or modified, the subscribers' contracts issued ~~in pursuance thereof~~ under that contract are altered or modified accordingly, all laws and clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of subscribers thereto.

~~(1) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for coverage or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically~~

~~documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care, except that nothing in this section shall apply to a guaranteed issue product designed for uninsurables. For employer groups of 50 or more persons: In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

~~(3)~~ (e1) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

~~(1)~~ (e2) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan."

Section 18. G.S. 58-67-85 reads as rewritten:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

(a) A health maintenance organization may issue a master group contract with the approval of the Commissioner of Insurance provided the contract and the individual certificates issued to members of the group, shall comply in substance to the other

provisions of this Article. Any such contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner of Insurance. If the master group contract is issued, altered or modified, the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees' contracts to the contrary notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

~~(b) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subsection, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

(d) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(e) Whenever an employer master group contract replaces another group contract, whether the contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and

(2) Each person not covered under the succeeding corporation's plan of benefits in accordance with (e)(1) must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan."

Section 19. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-169. Required coverage for minimum hospital stay following birth.**

(a) Definitions. -- As used in this section:

(1) 'Attending providers' includes:

a. The obstetrician-gynecologists, pediatricians, family physicians, and other physicians primarily responsible for the care of a mother and newborn; and

b. The nurse midwives and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident,

b. Credit,

c. Disability income,

d. Long-term or nursing home care,

e. Medicare supplement,

f. Specified disease,

g. Dental or vision,

h. Coverage issued as a supplement to liability insurance,

i. Workers' compensation,

j. Medical payments under automobile or homeowners, and

k. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(3) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) In General. -- Except as provided in subsection (c), an insurer that provides a health benefit plan that contains maternity benefits, including benefits for childbirth, shall ensure that coverage is provided with respect to a mother who is a participant, beneficiary, or policyholder under the plan and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.

(c) Exception. -- Notwithstanding subsection (b) of this section, an insurer is not required to provide coverage for postdelivery inpatient length of stay for a mother who is a participant, beneficiary, or policyholder under the insurer's health benefit plan and her newborn child for the period referred to in subsection (b) of this section if:

(1) A decision to discharge the mother and her newborn child before the expiration of the period is made by the attending provider in consultation with the mother; and

(2) The health benefit plan provides coverage for postdelivery follow-up care as described in subsections(d) and (e) of this section.

(d) Postdelivery Follow-Up Care. -- In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the health benefit plan shall provide coverage for timely postdelivery care. This health care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

(1) The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or

(2) Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

The attending provider in consultation with the mother shall decide the most appropriate location for follow-up care.

(e) Timely Care. -- As used in subsection (d) of this section, 'timely postdelivery care' means health care that is provided:

(1) Following the discharge of a mother and her newborn child from the inpatient setting; and

(2) In a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs not later than the 72-hour period immediately following discharge.

(f) Prohibitions. -- An insurer shall not:

(1) Deny enrollment, renewal, or continued coverage with respect to its health benefit plan to a mother and her newborn child who are participants, beneficiaries, or policyholders, based on compliance with this section;

(2) Provide monetary payments or rebates to mothers to encourage the mothers to request less than the minimum coverage required under this section;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided treatment to an individual policyholder, participant, or beneficiary in accordance with this section; or

(4) Provide monetary or other incentives to an attending provider to induce the provider to provide treatment to an individual policyholder, participant, or beneficiary in a manner inconsistent with this section.

(g) Effect on Mother. -- Nothing in this section requires that a mother who is a participant, beneficiary, or policyholder covered under this section:

(1) Give birth in a hospital; or

(2) Stay in the hospital for a fixed period of time following the birth of her child.

(h) Level and Type of Reimbursements. -- Nothing in this section prevents an insurer from negotiating the level and type of reimbursement with an attending provider for care provided in accordance with this section."

Section 20. G.S. 58-3-170 reads as rewritten:

"**§ 58-3-170. Requirements for maternity coverage.**

(a) Every entity providing a health benefit plan that provides maternity coverage in this State shall provide benefits for the necessary care and treatment related to maternity that are no less favorable than benefits for physical illness generally.

~~(a1) A health benefit plan that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by caesarean section.~~

(b) As used in this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a

MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Section 21. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A policy that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the policy, without distinguishing the mental health benefits.

(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the policy contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury

benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the policy may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the policy, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the insurer offers two or more benefit package options under a policy, each package must comply with this subsection.

(6) This subsection does not apply to a policy if the insurer can demonstrate to the Commissioner that compliance will increase the cost of the policy by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental illness or chemical dependency coverage not required. -- Nothing in this section ~~prevents any insurance company from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires an insurer to offer coverage for mental illness or chemical dependency.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to group health insurance contracts covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

Section 22. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No ~~hospital, medical, dental or health~~ service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group ~~hospital, dental, medical or health service~~ subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A subscriber contract that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the subscriber contract, without distinguishing the mental health benefits.

(2) If the subscriber contract contains lifetime limits only on selected physical illness or injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the subscriber contract contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the subscriber contract, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the service corporation offers two or more benefit package options under a subscriber contract, each package must comply with this subsection.

(6) This subsection does not apply to a subscriber contract if the service corporation can demonstrate to the Commissioner that compliance will increase the cost of the subscriber contract by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any hospital or medical plan from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires a service corporation to offer coverage for mental illness or chemical dependency.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to subscriber contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 23. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A health care plan that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the plan, without distinguishing the mental health benefits.

(2) If the plan contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the plan contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the plan may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the plan, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the HMO offers two or more benefit package options under a plan, each package must comply with this subsection.

(6) This subsection does not apply to a health benefit plan if the HMO can demonstrate to the Commissioner that compliance will increase the cost of the plan by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any health maintenance organization from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires an HMO to offer coverage for mental illness or chemical dependency.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to group contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 24. Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract.

Section 25. This act is effective when it becomes law.

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 17, 1997

The House Committee on Insurance met on Thursday, April 17, 1997, at 12:00 Noon in Room 643 of the Legislative Office Building. Chairman Dockham, presiding, called the meeting to order.

Members present: Representatives Dockham, Allred, Barbee, Brawley, Cole, Dedmon, Dickson, Gardner, Hardy, Hensley, Hurley, Ives, McComas, Michaux, Russell, Tallent, Wainwright and Wright.

Mr. Linwood Jones, Staff Counsel, provided the attached proposed committee substitute for House Bill 452 and House Bill 199.

The first order of business was House Bill 926 entitled Preferred Provider Contracts. Rep. Dockham recognized Representative Brawley, sponsor of this bill. Representative Brawley explained this bill and answered questions the members asked. Representative Brawley made a motion that House Bill 926 be sent to a sub study committee. This motion passed. Chairman Dockham appointed Representative Hurley as Chairman of the sub study committee and then appointed Representatives Michaux, Hensley and McConas to serve as members of this sub study committee.

The second order of business was House Bill 452 entitled Beach Plan Amendments/AB. Chairman Dockham recognized Representative Redwine, sponsor of this bill. Representative Redwine explained this bill and answered questions the members asked. Representative Dedmon sent forward an amendment which was adopted. This amendment was rolled into a proposed committee substitute. Representative Michaux made a motion that House Bill 452 be given a favorable report as to committee substitute which changes the title, unfavorable as to original bill. The motion passed.

The third order of business was House Bill 312 entitled Update Mortality Tables. Chairman Dockham recognized Representative Goodwin who is one of the sponsors of House Bill 312. Representative Goodwin sent forward a handout entitled Vital Statistics of the United, 1992, then he explained this bill and answered questions the members

asked. Representative Dickson made a motion that House Bill 312 be given a favorable report. The motion passed.

The fourth order of business was House Bill 199 entitled Amend Medical Providers' Liens. Chairman Dockham recognized Representative Hurley, who chaired the sub study committee which Chairman Dockham had sent House Bill 199 at a prior date. Representative Hurley recommended that this bill be sent to a Study Commission. Recommendation denied. Chairman Dockham then recognized Representative Culpepper, sponsor of this bill. Representative Culpepper explained and answered questions the members asked. Representative Dickson made a motion that House Bill 199 be given a favorable report as to committee substitute, which changes the title, unfavorable as to original bill. The motion passed.

There being no further business, the Chairman adjourned the meeting at 12:55 p.m.

Jerry C. Dockham

Representative Jerry C. Dockham
Chairman

Nell R. Edwards

Nell R. Edwards
Clerk

minutes

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **DOCKHAM** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 452 A BILL TO BE ENTITLED AN ACT TO AMEND THE BEACH PLAN PROPERTY INSURANCE STATUTES TO FURTHER CARRY OUT THE RECOMMENDATIONS THAT WERE MADE TO THE 1996 SESSION OF THE GENERAL ASSEMBLY BY THE LEGISLATIVE RESEARCH COMMISSION'S COMMITTEE ON INSURANCE ISSUES.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☒ With a favorable report as to committee substitute bill (#), ☒ which changes the title, unfavorable as to original bill. ~~(Committee Substitute Bill #); (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)~~

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

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April 17, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 452 - Proposed Committee Substitute
(Beach Plan Amendments)

The proposed committee substitute for House Bill 452 is the implementing legislation that will allow the North Carolina Insurance Underwriting Association to carry out the objectives of the legislature in encouraging insurers to write property insurance coverage for homeowners and business owners living in the "Beach area" (the barrier islands), thus keeping these policyholders out of the Beach Plan. These objectives were expressed in legislation passed in 1996 that directed the Beach Plan to revise the "participation" formula that determines the extent to which an insurer shares in the profits, losses, and expenses of the Beach Plan.

The Underwriting Association, which administers the Beach Plan program, has developed a revised formula that is designed to encourage insurers to write more business voluntarily in the Beach area. The revised formula contains a new credit system that recognizes the extent to which an insurer participates in insuring properties in the Beach area. The new credit system contains different tiers of credits, with higher participation in the Beach area earning higher credits, up to a maximum credit established by the Board. The new credit system also extends credit for all of the homeowners premium written by an insurer in the Beach area (not just a portion of that premium as in the past) and withholds credit for policies that exclude wind and hail coverage. These changes are also designed to stimulate more insurance coverage in the voluntary market in the Beach area.

There are a few other changes in the bill. Section 1 makes coverage available in the Beach Plan for travel trailers that are tied down at a fixed location. Section 4 makes clear that independent agents are not acting as the Underwriting Association's agents when insuring property through the Beach Plan. Section 5 allows short term policies to be issued in the Beach Plan. (Currently, policy periods must be 1 or 3 years).

The changes concerning the participation formula and credits take effect January 1, 1998. The remainder of the bill takes effect upon becoming law.

HOUSE BILL 452
Proposed Committee Substitute
H452-CSRN-001

Short Title: Beach Plan Amendments/AB. (Public)

Sponsors:

Referred to: Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE BEACH PLAN PARTICIPATION FORMULA AND REVISE OTHER STATUTES RELATED TO THE BEACH PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-45-5 reads as rewritten:

"**§ 58-45-5. Definition of terms.**

In this Article, unless the context otherwise requires,

(1) 'Association' means the North Carolina Insurance Underwriting Association established ~~pursuant to the provisions of~~ under this Article;

(2) 'Beach area' means all of that area of the State of North Carolina south and east of the inland waterway from the South Carolina line to Fort Macon (Beaufort Inlet); thence south and east of Core, Pamlico, Roanoke and Currituck sounds to the Virginia line, being those portions of land generally known as the Outer Banks;

(3) Repealed by Session Laws 1991, c. 720, s. 6.

(3a) 'Crime insurance' means insurance against losses resulting from robbery, burglary, larceny, and similar crimes, as more specifically defined and

limited in the various crime insurance policies, or their successor forms of coverage, approved by the Commissioner and issued by the Association. Such policies shall not be more restrictive than those issued under the Federal Crime Insurance Program authorized by Public Law 91-609.

(3b) 'Directors' means the Board of Directors of the Association.

(4) 'Essential property insurance' means insurance against direct loss to property as defined in the standard statutory fire policy and extended coverage, vandalism and malicious mischief endorsements thereon, or their successor forms of coverage, as approved by the Commissioner;

(5) 'Insurable property' means real property at fixed locations in the Beach ~~area~~ area, including travel trailers when tied down at a fixed location, or the tangible personal property located therein, but shall not include insurance on motor vehicles or farm risks; which property is determined by the Association, after inspection and under the criteria specified in the plan of operation, to be in an insurable condition. However, any one and two family dwellings built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code and any structure or building built in substantial compliance with the North Carolina Building Code, including the design-wind requirements, which is not otherwise rendered uninsurable by reason of use or occupancy, shall be an insurable risk within the meaning of this Article. However, none of the following factors shall be considered in determining insurable condition: neighborhood, area, location, environmental hazards beyond the control of the applicant or owner of the property. Also, any structure begun on or after January 1, 1970, not built in substantial compliance with the Federal Manufactured Home Construction and Safety

Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina Building Code, including the design-wind requirements therein, shall not be an insurable risk. The owner or applicant shall furnish with the application proof in the form of a certificate from a local building inspector, contractor, engineer or architect that the structure is built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina Building Code; however, an individual certificate shall not be necessary where the structure is located within a political subdivision which has certified to the Association on an annual basis that it is enforcing the North Carolina Uniform Residential Building Code or the North Carolina Building Code and has no plans to discontinue enforcing these codes during that year.

(6) Repealed by Session Laws 1995 (Regular Session, 1996), c. 592, s. 2.

(6a) 'Net direct premiums' means gross direct premiums (excluding reinsurance assumed and ceded) written on property in this State for essential property insurance, homeowners and the property portion of commercial multiple peril policies as computed by the Commissioner, less:

a. Return premiums on uncancelled contracts;

b. Dividends paid or credited to policyholders; and

c. The unused or unabsorbed portion of premium deposits.

'Net direct premiums' shall not include premiums on farm properties and manufacturing risks.

(7) 'Plan of operation' or 'plan' means the plan of operation of the Association approved or promulgated by the Commissioner, ~~pursuant to the provisions~~ under of this Article.

Section 2. G.S. 58-45-25 reads as rewritten:

"**§ 58-45-25. Each member of Association to participate in its expenses, profits, and losses.**

~~All members of the Association shall participate in its expenses, profits, and losses and shall receive credit annually for essential property insurance voluntarily written as determined by the directors of the Association, with the approval of the Commissioner. Participation of each member in the losses of the Association shall be reduced accordingly. Any insurer authorized to write and engage in writing any insurance, the writing of which requires the insurer to be a member of the Association, pursuant to G.S. 58-45-10, shall become a member of the Association on the January 1 immediately following authorization and the determination of the insurer's participation in the Association shall be made as of the date of membership in the same manner as for all other members of the Association.~~

(a) Each member of the Association shall participate in the expenses, profits, and losses of the Association in the proportion that its net direct premium written in this State during the preceding calendar year for residential and commercial properties outside of the Beach area bears to the aggregate net direct premiums written in this State during the preceding calendar year for residential and commercial properties outside of the Beach area by all members of the Association, as certified to the Association by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Association for this purpose. Any insurer that is authorized to write and that is engaged in writing any insurance, the writing of which requires the insurer to be a member of the Association under G.S. 58-45-10, shall become a member of the Association on the first day of January after authorization. The determination of the insurer's participation in the Association shall be made as of the date of membership of the insurer in the same manner as for all other members of the Association.

(b) All member companies shall receive credit each year for essential property insurance and homeowners insurance voluntarily

written in the Beach area in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. The participation of each member company in the expenses, profits, and losses of the Association shall be reduced accordingly; provided, no credit shall be given where coverage for the peril of wind has been excluded. The guidelines and procedures for granting credit shall encourage and assist each member company to voluntarily write these coverages in the Beach area for commercial and residential properties."

Section 3. G.S. 58-45-30(a) reads as rewritten:

"(a) ~~Within 90 days after April 17, 1969, the directors of the Association~~ The Directors shall submit to the Commissioner for his review and approval, a proposed plan of operation. ~~Such proposed~~ The plan shall set forth the number, qualifications, terms of office, and manner of election of the members of the board of directors, and shall grant proper credit annually to each member of the Association for essential property ~~insurance~~ insurance, homeowners insurance and the property portion of commercial multiple peril policies voluntarily written in the ~~beach~~ Beach area and shall provide for the efficient, economical, fair and nondiscriminatory administration of the Association and for the prompt and efficient provision of essential property insurance in the ~~beach areas of North Carolina so as~~ Beach area in order to promote orderly community development in ~~those areas~~ the Beach area and to provide means for the adequate maintenance and improvement of the property in ~~such areas.~~ the Beach area. ~~Such proposed~~ The plan may include ~~a preliminary assessment of all members for initial expenses necessary to the commencement of operation;~~ the establishment of necessary facilities; management of the Association; ~~plan for~~ the assessment of members to defray losses and expenses; underwriting standards; procedures for the acceptance and cession of reinsurance; procedures for determining the amounts of insurance to be provided to specific risks; time limits and procedures for processing applications for ~~insurance~~ insurance; and for such other provisions ~~as may be deemed~~ that are considered necessary by the Commissioner to carry out the purposes of this Article."

Section 4. G.S. 58-33-100 reads as rewritten:

"**§ 58-33-100. Payment of premium to agent valid; obtaining by fraud a crime.**

(a) Any agent, broker or limited representative who acts for a person other than himself negotiating a contract of insurance is, for the purpose of receiving the premium therefor, the company's agent, whatever conditions or stipulations may be contained in

the policy or contract. The subsection does not apply to the Insurance Underwriting Association established under Article 45 of this Chapter or the Joint Underwriting Association established under Article 46 of this Chapter.

(b) ~~Such~~ Any agent, broker or limited representative knowingly procuring by fraudulent representations payment, or the obligation for the payment, of a premium of insurance, shall be guilty of a Class 1 misdemeanor."

Section 5. G.S. 58-45-35(b) reads as rewritten:

"(b) If the Association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance and shall offer additional extended coverage, optional perils endorsements, business income coverage, crime insurance, separate policies of windstorm and hail insurance, or their successor forms of coverage, for a term of one year or three years. Short term policies may also be issued. Any policy issued under this section shall be renewed, upon application, as long as the property is insurable property."

Section 6. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 7. Sections 1, 3, 4, 5, and this section of this act are effective when this act becomes law. Section 2 of this act becomes effective January 1, 1998, and applies to policies issued or renewed on or after that date.

Minutes

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 452
Proposed Committee Substitute H452-PCS2295

Short Title: Beach Plan Amendments/AB. (Public)

Sponsors:

Referred to:

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE BEACH PLAN PARTICIPATION FORMULA AND REVISE OTHER STATUTES RELATED TO THE BEACH PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-45-5 reads as rewritten:

"**§ 58-45-5. Definition of terms.**

In this Article, unless the context otherwise requires,

(1) 'Association' means the North Carolina Insurance Underwriting Association established ~~pursuant to the provisions of~~ under this Article;

(2) 'Beach area' means all of that area of the State of North Carolina south and east of the inland waterway from the South Carolina line to Fort Macon (Beaufort Inlet); thence south and east of Core, Pamlico, Roanoke and Currituck sounds to the Virginia line, being those portions of land generally known as the Outer Banks;

(3) Repealed by Session Laws 1991, c. 720, s. 6.

(3a) 'Crime insurance' means insurance against losses resulting from robbery, burglary, larceny, and similar crimes, as more specifically defined and limited in the various crime insurance policies, or their successor forms of coverage, approved by the Commissioner and issued by the Association. Such policies shall not be more restrictive than those issued under the Federal Crime Insurance Program authorized by Public Law 91-609.

(3b) 'Directors' means the Board of Directors of the Association.

(4) 'Essential property insurance' means insurance against direct loss to property as defined in the standard statutory fire policy and extended coverage, vandalism and malicious mischief endorsements thereon, or their successor forms of coverage, as approved by the Commissioner;

(5) 'Insurable property' means real property at fixed locations in the Beach ~~area~~ area, including travel trailers when tied down at a fixed location, or the tangible personal property located therein, but shall not include insurance on motor vehicles or farm risks; which property is determined by the Association, after inspection and under the criteria specified in the plan of operation, to be in an insurable condition. However, any one and two family dwellings built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code and any structure or building built in substantial compliance with the North Carolina Building Code, including the design-wind requirements, which is not otherwise rendered uninsurable by reason of use or occupancy, shall be an insurable risk within the meaning of this Article. However, none of the following factors shall be considered in determining insurable condition: neighborhood, area, location, environmental hazards beyond the control of the applicant or owner of the property. Also, any structure begun on or after January 1, 1970, not built in substantial compliance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina Building Code, including the design-wind requirements therein, shall not be an insurable risk. The owner or applicant shall furnish with the application proof in the form of a certificate from a local building inspector, contractor, engineer or architect that the structure is built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina Building Code; however, an

individual certificate shall not be necessary where the structure is located within a political subdivision which has certified to the Association on an annual basis that it is enforcing the North Carolina Uniform Residential Building Code or the North Carolina Building Code and has no plans to discontinue enforcing these codes during that year.

(6) Repealed by Session Laws 1995 (Regular Session, 1996), c. 592, s. 2.

(6a) 'Net direct premiums' means gross direct premiums (excluding reinsurance assumed and ceded) written on property in this State for essential property insurance, homeowners, and the property portion of commercial multiple peril policies as computed by the Commissioner, less:

a. Return premiums on uncancelled contracts;

b. Dividends paid or credited to policyholders; and

c. The unused or unabsorbed portion of premium deposits.

'Net direct premiums' shall not include premiums on farm properties and manufacturing risks.

(7) 'Plan of operation' or 'plan' means the plan of operation of the Association approved or promulgated by the Commissioner, ~~pursuant to the provisions of~~ under this Article."

Section 2. G.S. 58-45-25 reads as rewritten:

"**§ 58-45-25. Each member of Association to participate in its expenses, profits, and losses.**

~~All members of the Association shall participate in its expenses, profits, and losses and shall receive credit annually for essential property insurance voluntarily written as determined by the directors of the Association, with the approval of the Commissioner. Participation of each member in the losses of the Association shall be reduced accordingly. Any insurer authorized to write and engage in writing any insurance, the writing of which requires the insurer to be a member of the Association, pursuant to G.S. 58-45-10, shall become a member of the Association on the January 1 immediately following authorization and the determination of the insurer's participation in the Association shall be made as of the date of membership in the same manner as for all other members of the Association.~~

(a) Each member of the Association shall participate in the expenses, profits, and losses of the Association in the proportion that its net direct premium written in this State during the preceding calendar year for residential and commercial properties outside of the Beach area bears to the aggregate net direct premiums written in this State during the preceding calendar year for residential and commercial properties outside of the Beach area by all members of the Association, as certified to the Association by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Association for this purpose. Any insurer that is

authorized to write and that is engaged in writing any insurance, the writing of which requires the insurer to be a member of the Association under G.S. 58-45-10, shall become a member of the Association on the first day of January after authorization. The determination of the insurer's participation in the Association shall be made as of the date of membership of the insurer in the same manner as for all other members of the Association.

(b) All member companies shall receive credit each year for essential property insurance, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the Beach area in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. The participation of each member company in the expenses, profits, and losses of the Association shall be reduced accordingly; provided, no credit shall be given where coverage for the peril of wind has been excluded. The guidelines and procedures for granting credit shall encourage and assist each member company to voluntarily write these coverages in the Beach area for commercial and residential properties."

Section 3. G.S. 58-45-30(a) reads as rewritten:

"(a) ~~Within 90 days after April 17, 1969, the directors of the Association~~ The Directors shall submit to the Commissioner for his review and approval, a proposed plan of operation. ~~Such proposed~~ The plan shall set forth the number, qualifications, terms of office, and manner of election of the members of the board of directors, and shall grant proper credit annually to each member of the Association for essential property ~~insurance~~ insurance, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the ~~beach~~ Beach area and shall provide for the efficient, economical, fair and nondiscriminatory administration of the Association and for the prompt and efficient provision of essential property insurance in the ~~beach areas of North Carolina so as~~ Beach area in order to promote orderly community development in ~~those areas~~ the Beach area and to provide means for the adequate maintenance and improvement of the property in ~~such areas.~~ the Beach area. ~~Such proposed~~ The plan may include ~~a preliminary assessment of all members for initial expenses necessary to the commencement of operation;~~ the establishment of necessary facilities; management of the Association; ~~plan for~~ the assessment of members to defray losses and expenses; underwriting standards; procedures for the acceptance and cession of reinsurance; procedures for determining the amounts of insurance to be provided to specific risks; time limits and procedures for processing applications for ~~insurance~~ insurance; and for such other provisions ~~as may be deemed~~ that are considered necessary by the Commissioner to carry out the purposes of this Article."

Section 4. G.S. 58-33-100 reads as rewritten:

"**§ 58-33-100. Payment of premium to agent valid; obtaining by fraud a crime.**

(a) Any agent, broker or limited representative who acts for a person other than himself negotiating a contract of insurance is, for the purpose of receiving the premium therefor, the company's agent, whatever conditions or stipulations may be contained in the policy or contract. This subsection does not apply to the Insurance

Underwriting Association established under Article 45 of this Chapter or the Joint Underwriting Association established under Article 46 of this Chapter.

(b) ~~Such~~ Any agent, broker or limited representative knowingly procuring by fraudulent representations payment, or the obligation for the payment, of a premium of insurance, shall be guilty of a Class 1 misdemeanor."

Section 5. G.S. 58-45-35(b) reads as rewritten:

"(b) If the Association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance and shall offer additional extended coverage, optional perils endorsements, business income coverage, crime insurance, separate policies of windstorm and hail insurance, or their successor forms of coverage, for a term of one year or three years. Short term policies may also be issued. Any policy issued under this section shall be renewed, upon application, as long as the property is insurable property."

Section 6. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 7. Sections 1, 3, 4, 5, and this section of this act are effective when this act becomes law. Section 2 of this act becomes effective January 1, 1998, and applies to policies issued or renewed on or after that date.

minutes

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 452

Short Title: Beach Plan Amendments/AB. (Public)

Sponsors: Representatives Redwine; Smith, Baddour, and Rayfield.

Referred to: Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE BEACH PLAN PROPERTY INSURANCE STATUTES TO FURTHER CARRY OUT THE RECOMMENDATIONS THAT WERE MADE TO THE 1996 SESSION OF THE GENERAL ASSEMBLY BY THE LEGISLATIVE RESEARCH COMMISSION'S COMMITTEE ON INSURANCE ISSUES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-45-25 reads as rewritten:

"**§ 58-45-25. Each member of Association to participate in its expenses, profits, and losses.**

All members of the Association shall participate in its expenses, profits, and losses and shall receive credit annually for ~~essential~~ property insurance voluntarily written as determined by the directors of the Association, with the approval of the Commissioner. Participation of each member in the expenses, profits, and losses of the Association shall be reduced ~~accordingly.~~ as determined by the directors of the Association, with the approval of the Commissioner. Any insurer authorized to write and engage in writing any insurance, the writing of which requires the insurer to be a member of the Association, pursuant to G.S. 58-45-10, shall become a member of the Association on the January 1 immediately following authorization and the determination of the insurer's participation in the Association shall be made as of the date of membership in the same manner as for all other members of the Association."

Section 2. This act becomes effective when it becomes law and applies to fiscal years beginning with the 1997-98 fiscal year.

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

April 17, 1997
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jimmy Work	Carolina Health Care Systems
Jan Williams	UNC & NC
Molly M. Gordon	UNCG
Beatrice S. Hayes	UNCG
[illegible]	UNCG
[illegible]	UNCG
Samantha Broomfield	UNCG
Brandi Lalond	UNCG
Dave Dimick	NCBA
John Johnson	Integon Corp
Julian Philpott	NCFB
Alan Miles	Bailey & Dixon LLP
Floyd M. Lewis	General Statutes Commission
Steve Keene	NC Medical Society
Richard Rose	Assoc of Life Cos

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Phil McHenry	NC Home ASSN
D M Dan	NWCG
J Thomas Boles	Boles Call & Stevens
Charles Cromer	NCATL
Dick Zeh	NCATA
Bob Pasch	Young, Moore
Jim Wyatt	
Gloria McKinney	NC Dept. of INS
Dorothy Propes	NC Dept. of INS
John Bowdish	Zeb Alley PA
Carol Feldman	AIDA
Ann Cave	DEHNR
Mary Jo Bain	Smith Anderson
Lucia Peel	NC Med Society

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	Manning Fulton & Skinner P.A.
Lucius Pullen	Attorney
Mark Hale	NCDOI
[illegible]	NCIUA
Jennifer Cochrane	ADA
[illegible]	[illegible]
[illegible]	BCBSNC
[illegible]	NC Dental Soc
Amanda Digby	NCATL
Ben Pratte	Alpharma
Susan Valaer	Nationwide
[illegible]	Capital Strategies
[illegible]	NCADA
[illegible]	CAPIA

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

4/12/97
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Doris Weaver	CWA
John May	NC CWA
Raleigh E. Cloud	NCALU
Jerry Henderson	Hunton & Wms.
Bill Toomey	NCMTC

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April 17, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 199 (Proposed Committee Substitute)
(Medical Liens)

The proposed committee substitute for House Bill 199 refers the related issues of medical liens and assignments of proceeds to the LRC for study for a report back to the 1998 short session. The Subcommittee that reviewed the bill was unable to reach consensus on the bill among the interested parties. House Bill 199 as introduced only addressed medical liens. In recommending the bill to the legislature, the General Statutes Commission purposefully avoided the issue of assignment of proceeds. The proposed committee substitute will require both issue to be studied.

Minutes

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **DOCKHAM** for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 312 A BILL TO BE ENTITLED AN ACT UPDATING THE STATUTORY MORTALITY TABLES USED AS EVIDENCE TO ESTABLISH THE EXPECTANCY OF CONTINUED LIFE.

☑ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

HOUSE BILL 312

Short Title: Update Mortality Tables. (Public)

Sponsors: Representatives Goodwin; Adams, Baddour, Black, Bonner, Bowie, Brawley, Buchanan, Cunningham, Dedmon, Easterling, Fitch, Fox, Grady, Hackney, Hall, Hensley, Hightower, H. Hunter, R. Hunter, Insko, Jarrell, Jeffus, Luebke, Moore, Morris, Mosley, Saunders, Smith, Sutton, Wainwright, Warwick, and Yongue.

Referred to: Insurance, if favorable, Judiciary II.

February 24, 1997

A BILL TO BE ENTITLED

AN ACT UPDATING THE STATUTORY MORTALITY TABLES USED AS EVIDENCE TO ESTABLISH THE EXPECTANCY OF CONTINUED LIFE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 8-46 reads as rewritten:

"**§ 8-46. ~~Mortuary~~ Mortality tables as evidence.**

Whenever it is necessary to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the table hereto appended shall be received in all courts and by all persons having power to determine litigation, as evidence, with other evidence as to the health, constitution and habits of ~~such~~ the person, of such expectancy represented by the figures in the columns headed by the words 'completed age' and 'expectation' respectively:

Completed Age	Expectation
0	~~68.40~~ 75.8
1	~~69.64~~ 75.4
2	~~68.78~~ 74.5
3	~~67.86~~ 73.5
4	~~66.92~~ 72.5
5	~~65.98~~ 71.6
6	~~65.02~~ 70.6
7	~~64.06~~ 69.6

1	8	~~63.09~~ 68.6
2	9	~~62.12~~ 67.6
3	10	~~61.15~~ 66.6
4	11	~~60.18~~ 65.6
5	12	~~59.20~~ 64.6
6	13	~~58.22~~ 63.7
7	14	~~57.25~~ 62.7
8	15	~~56.29~~ 61.7
9	16	~~55.34~~ 60.7
10	17	~~54.39~~ 59.8
11	18	~~53.45~~ 58.8
12	19	~~52.52~~ 57.9
13	20	~~51.58~~ 56.9
14	21	~~50.65~~ 56.0
15	22	~~49.72~~ 55.1
16	23	~~48.80~~ 54.1
17	24	~~47.87~~ 53.2
18	25	~~46.94~~ 52.2
19	26	~~46.02~~ 51.3
20	27	~~45.09~~ 50.4
21	28	~~44.17~~ 49.4
22	29	~~43.25~~ 48.5
23	30	~~42.33~~ 47.5
24	31	~~41.41~~ 46.6
25	32	~~40.49~~ 45.7
26	33	~~39.58~~ 44.7
27	34	~~38.67~~ 43.8
28	35	~~37.76~~ 42.9
29	36	~~36.85~~ 42.0
30	37	~~35.95~~ 41.0
31	38	~~35.06~~ 40.1
32	39	~~34.17~~ 39.2
33	40	~~33.29~~ 38.3
34	41	~~32.42~~ 37.4
35	42	~~31.57~~ 36.5
36	43	~~30.72~~ 35.6
37	44	~~29.87~~ 34.7
38	45	~~29.04~~ 33.8
39	46	~~28.21~~ 32.9
40	47	~~27.38~~ 32.0
41	48	~~26.56~~ 31.1
42	49	~~25.76~~ 30.2
43	50	~~24.96~~ 29.3
44	51	~~24.18~~ 28.5
45	52	~~23.40~~ 27.6
46	53	~~22.64~~ 26.8
47	54	~~21.89~~ 25.9
48	55	~~21.15~~ 25.1
49	56	~~20.42~~ 24.3
50	57	~~19.70~~ 23.5
51	58	~~18.99~~ 22.7
52	59	~~18.29~~ 21.9
53	60	~~17.61~~ 21.1

61		~~16.94~~ 20.4
62		~~16.29~~ 19.7
63		~~15.65~~ 18.9
64		~~15.02~~ 18.2
65		~~14.40~~ 17.5
66		~~13.79~~ 16.8
67		~~13.20~~ 16.1
68		~~12.61~~ 15.5
69		~~12.04~~ 14.8
70		~~11.48~~ 14.2
71		~~10.93~~ 13.5
72		~~10.39~~ 12.9
73		~~9.86~~ 12.3
74		~~9.35~~ 11.7
75		~~8.84~~ 11.2
76		~~8.35~~ 10.6
77		~~7.87~~ 10.0
78		~~7.40~~ 9.5
79		~~6.96~~ 9.0
80		~~6.53~~ 8.5
81		~~6.12~~ 8.0
82		~~5.75~~ 7.5
83		~~5.39~~ 7.1
84		~~5.05~~ 6.6
85	and over	~~4.70~~ 6.6
~~86~~		~~4.38~~ 6.2
~~87~~		~~4.08~~
~~88~~		~~3.79~~
~~89~~		~~3.54~~
~~90~~		~~3.30~~
~~91~~		~~3.08~~
~~92~~		~~2.89~~
~~93~~		~~2.72~~
~~94~~		~~2.56~~
~~95~~		~~2.43~~
~~96~~		~~2.32~~
~~97~~		~~2.21~~
~~98~~		~~2.10~~
~~99~~		~~2.01~~
~~100~~		~~1.91~~
~~101~~		~~1.83~~
~~102~~		~~1.75~~
~~103~~		~~1.67~~
~~104~~		~~1.60~~
~~105~~		~~1.53~~
~~106~~		~~1.46~~
~~107~~		~~1.40~~
~~108~~		~~1.35~~
~~109~~		~~1.29~~".

Section 2. G.S. 8-47 reads as rewritten:

"**§ 8-47. Present worth of annuities.**

Whenever it is necessary to establish the present worth or cash value of an annuity to a person, payable annually during ~~his~~ the person's life, such present worth or cash value may be ascertained by the use of the following table in connection with the ~~mortuary~~ mortality tables established by law, the first column representing the number of years the annuity is to run and the second column representing the present cash value of an annuity of one dollar for such number of years, respectively:

No. of Years Annuity is to Run	Cash Value of the Annuity of $1
1	$ 0.943
2	1.833
3	2.673
4	3.465
5	4.212
6	4.917
7	5.582
8	6.210
9	6.802
10	7.360
11	7.887
12	8.384
13	8.853
14	9.295
15	9.712
16	10.106
17	10.477
18	10.828
19	11.158
20	11.470
21	11.764
22	12.042
23	12.303
24	12.550
25	12.783
26	13.003
27	13.211
28	13.406
29	13.591
30	13.765
31	13.929
32	14.084
33	14.230
34	14.368
35	14.498
36	14.621

37	14.737
38	14.846
39	14.949
40	15.046
41	15.138
42	15.225
43	15.306
44	15.383
45	15.456
46	15.524
47	15.589
48	15.650
49	15.708
50	15.762
51	15.813
52	15.861
53	15.907
54	15.950
55	15.991
56	16.029
57	16.065
58	16.099
59	16.131
60	16.161
61	16.190
62	16.217
63	16.242
64	16.266
65	16.289
66	16.310
67	16.331

The present cash value of the annuity for a fraction of a year may be ascertained as follows: Multiply the difference between the cash value of the annuities for the preceding and succeeding full years by the fraction of the year in decimals and add the sum to the present cash value for the preceding full year. When a person is entitled to the use of a sum of money for life, or for a given time, the interest thereon for one year, computed at four and one half percent (4 1/2%), may be considered as an annuity and the present cash value be ascertained as herein provided: Provided, the interest rate in computing the present cash value of a life interest in land shall be six percent (6%).

Whenever the ~~mortuary~~ mortality tables set out in G.S. 8-46 are admissible in evidence in any action or proceeding to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the annuity tables herein set forth shall be evidence, but not

conclusive, of the loss of income during the period of life expectancy of ~~such~~ the person."

Section 3. G.S. 46-25 reads as rewritten:

"**§ 46-25. Sale of standing timber on partition; valuation of life estate.**

When two or more persons own, as tenants in common, joint tenants or copartners, a tract of land, either in possession, or in remainder or reversion, subject to a life estate, or where one or more persons own a remainder or reversionary interest in a tract of land, subject to a life estate, then in any such case in which there is standing timber upon any such land, a sale of said timber trees, separate from the land, may be had upon the petition of one or more of said owners, or the life tenant, for partition among the owners thereof, including the life tenant, upon such terms as the court may order, and under like proceedings as are now prescribed by law for the sale of land for partition: Provided, that when the land is subject to a life estate, the life tenant shall be made a party to the proceedings, and shall be entitled to receive his or her portion of the net proceeds of sales, to be ascertained under the ~~mortuary~~ mortality tables established by law: Provided further, that prior to a judgment allowing a life tenant to sell the timber there must be a finding that the cutting is in keeping with good husbandry and that no substantial injury will be done to the remainder interest."

Section 4. This act is effective when it becomes law.

HOUSE BILL 312

Short Title: Update Mortality Tables. (Public)

Sponsors: Representatives Goodwin; Adams, Baddour, Black, Bonner, Bowie, Brawley, Buchanan, Cunningham, Dedmon, Easterling, Fitch, Fox, Grady, Hackney, Hall, Hensley, Hightower, H. Hunter, R. Hunter, Insko, Jarrell, Jeffus, Luebke, Moore, Morris, Mosley, Saunders, Smith, Sutton, Wainwright, Warwick, and Yongue.

Referred to: Insurance, if favorable, Judiciary II.

February 24, 1997

A BILL TO BE ENTITLED

AN ACT UPDATING THE STATUTORY MORTALITY TABLES USED AS EVIDENCE TO ESTABLISH THE EXPECTANCY OF CONTINUED LIFE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 8-46 reads as rewritten:

"**§ 8-46. ~~Mortuary~~ Mortality tables as evidence.**

Whenever it is necessary to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the table hereto appended shall be received in all courts and by all persons having power to determine litigation, as evidence, with other evidence as to the health, constitution and habits of ~~such~~ the person, of such expectancy represented by the figures in the columns headed by the words 'completed age' and 'expectation' respectively:

Completed Age	Expectation
0	~~68.40~~ 75.8
1	~~69.64~~ 75.4
2	~~68.78~~ 74.5
3	~~67.86~~ 73.5
4	~~66.92~~ 72.5
5	~~65.98~~ 71.6
6	~~65.02~~ 70.6
7	~~64.06~~ 69.6

1	8	~~63.09~~ 68.6
2	9	~~62.12~~ 67.6
3	10	~~61.15~~ 66.6
4	11	~~60.18~~ 65.6
5	12	~~59.20~~ 64.6
6	13	~~58.22~~ 63.7
7	14	~~57.25~~ 62.7
8	15	~~56.29~~ 61.7
9	16	~~55.34~~ 60.7
10	17	~~54.39~~ 59.8
11	18	~~53.45~~ 58.8
12	19	~~52.52~~ 57.9
13	20	~~51.58~~ 56.9
14	21	~~50.65~~ 56.0
15	22	~~49.72~~ 55.1
16	23	~~48.80~~ 54.1
17	24	~~47.87~~ 53.2
18	25	~~46.94~~ 52.2
19	26	~~46.02~~ 51.3
20	27	~~45.09~~ 50.4
21	28	~~44.17~~ 49.4
22	29	~~43.25~~ 48.5
23	30	~~42.33~~ 47.5
24	31	~~41.41~~ 46.6
25	32	~~40.49~~ 45.7
26	33	~~39.58~~ 44.7
27	34	~~38.67~~ 43.8
28	35	~~37.76~~ 42.9
29	36	~~36.85~~ 42.0
30	37	~~35.95~~ 41.0
31	38	~~35.06~~ 40.1
32	39	~~34.17~~ 39.2
33	40	~~33.29~~ 38.3
34	41	~~32.42~~ 37.4
35	42	~~31.57~~ 36.5
36	43	~~30.72~~ 35.6
37	44	~~29.87~~ 34.7
38	45	~~29.04~~ 33.8
39	46	~~28.21~~ 32.9
40	47	~~27.38~~ 32.0
41	48	~~26.56~~ 31.1
42	49	~~25.76~~ 30.2
43	50	~~24.96~~ 29.3
44	51	~~24.18~~ 28.5
45	52	~~23.40~~ 27.6
46	53	~~22.64~~ 26.8
47	54	~~21.89~~ 25.9
48	55	~~21.15~~ 25.1
49	56	~~20.42~~ 24.3
50	57	~~19.70~~ 23.5
51	58	~~18.99~~ 22.7
52	59	~~18.29~~ 21.9
53	60	~~17.61~~ 21.1

61		~~16.94~~ 20.4
62		~~16.29~~ 19.7
63		~~15.65~~ 18.9
64		~~15.02~~ 18.2
65		~~14.40~~ 17.5
66		~~13.79~~ 16.8
67		~~13.20~~ 16.1
68		~~12.61~~ 15.5
69		~~12.04~~ 14.8
70		~~11.48~~ 14.2
71		~~10.93~~ 13.5
72		~~10.39~~ 12.9
73		~~9.86~~ 12.3
74		~~9.35~~ 11.7
75		~~8.84~~ 11.2
76		~~8.35~~ 10.6
77		~~7.87~~ 10.0
78		~~7.40~~ 9.5
79		~~6.96~~ 9.0
80		~~6.53~~ 8.5
81		~~6.12~~ 8.0
82		~~5.75~~ 7.5
83		~~5.39~~ 7.1
84		~~5.05~~ 6.6
85	and over	~~4.70~~ 6.6
~~86~~		~~4.38~~ 6.2
~~87~~		~~4.08~~
~~88~~		~~3.79~~
~~89~~		~~3.54~~
~~90~~		~~3.30~~
~~91~~		~~3.08~~
~~92~~		~~2.89~~
~~93~~		~~2.72~~
~~94~~		~~2.56~~
~~95~~		~~2.43~~
~~96~~		~~2.32~~
~~97~~		~~2.21~~
~~98~~		~~2.10~~
~~99~~		~~2.01~~
~~100~~		~~1.91~~
~~101~~		~~1.83~~
~~102~~		~~1.75~~
~~103~~		~~1.67~~
~~104~~		~~1.60~~
~~105~~		~~1.53~~
~~106~~		~~1.46~~
~~107~~		~~1.40~~
~~108~~		~~1.35~~
~~109~~		~~1.29~~".

Section 2. G.S. 8-47 reads as rewritten:

"**§ 8-47. Present worth of annuities.**

Whenever it is necessary to establish the present worth or cash value of an annuity to a person, payable annually during ~~his~~ the person's life, such present worth or cash value may be ascertained by the use of the following table in connection with the ~~mortuary~~ mortality tables established by law, the first column representing the number of years the annuity is to run and the second column representing the present cash value of an annuity of one dollar for such number of years, respectively:

No. of Years Annuity is to Run	Cash Value of the Annuity of $1
1	$ 0.943
2	1.833
3	2.673
4	3.465
5	4.212
6	4.917
7	5.582
8	6.210
9	6.802
10	7.360
11	7.887
12	8.384
13	8.853
14	9.295
15	9.712
16	10.106
17	10.477
18	10.828
19	11.158
20	11.470
21	11.764
22	12.042
23	12.303
24	12.550
25	12.783
26	13.003
27	13.211
28	13.406
29	13.591
30	13.765
31	13.929
32	14.084
33	14.230
34	14.368
35	14.498
36	14.621

37	14.737
38	14.846
39	14.949
40	15.046
41	15.138
42	15.225
43	15.306
44	15.383
45	15.456
46	15.524
47	15.589
48	15.650
49	15.708
50	15.762
51	15.813
52	15.861
53	15.907
54	15.950
55	15.991
56	16.029
57	16.065
58	16.099
59	16.131
60	16.161
61	16.190
62	16.217
63	16.242
64	16.266
65	16.289
66	16.310
67	16.331

The present cash value of the annuity for a fraction of a year may be ascertained as follows: Multiply the difference between the cash value of the annuities for the preceding and succeeding full years by the fraction of the year in decimals and add the sum to the present cash value for the preceding full year. When a person is entitled to the use of a sum of money for life, or for a given time, the interest thereon for one year, computed at four and one half percent (4 1/2%), may be considered as an annuity and the present cash value be ascertained as herein provided: Provided, the interest rate in computing the present cash value of a life interest in land shall be six percent (6%).

Whenever the ~~mortuary~~ mortality tables set out in G.S. 8-46 are admissible in evidence in any action or proceeding to establish the expectancy of continued life of any person from any period of ~~such~~ the person's life, whether ~~he be~~ the person is living at the time or not, the annuity tables herein set forth shall be evidence, but not

conclusive, of the loss of income during the period of life expectancy of ~~such~~ the person."

Section 3. G.S. 46-25 reads as rewritten:

"**§ 46-25. Sale of standing timber on partition; valuation of life estate.**

When two or more persons own, as tenants in common, joint tenants or copartners, a tract of land, either in possession, or in remainder or reversion, subject to a life estate, or where one or more persons own a remainder or reversionary interest in a tract of land, subject to a life estate, then in any such case in which there is standing timber upon any such land, a sale of said timber trees, separate from the land, may be had upon the petition of one or more of said owners, or the life tenant, for partition among the owners thereof, including the life tenant, upon such terms as the court may order, and under like proceedings as are now prescribed by law for the sale of land for partition: Provided, that when the land is subject to a life estate, the life tenant shall be made a party to the proceedings, and shall be entitled to receive his or her portion of the net proceeds of sales, to be ascertained under the ~~mortuary~~ mortality tables established by law: Provided further, that prior to a judgment allowing a life tenant to sell the timber there must be a finding that the cutting is in keeping with good husbandry and that no substantial injury will be done to the remainder interest."

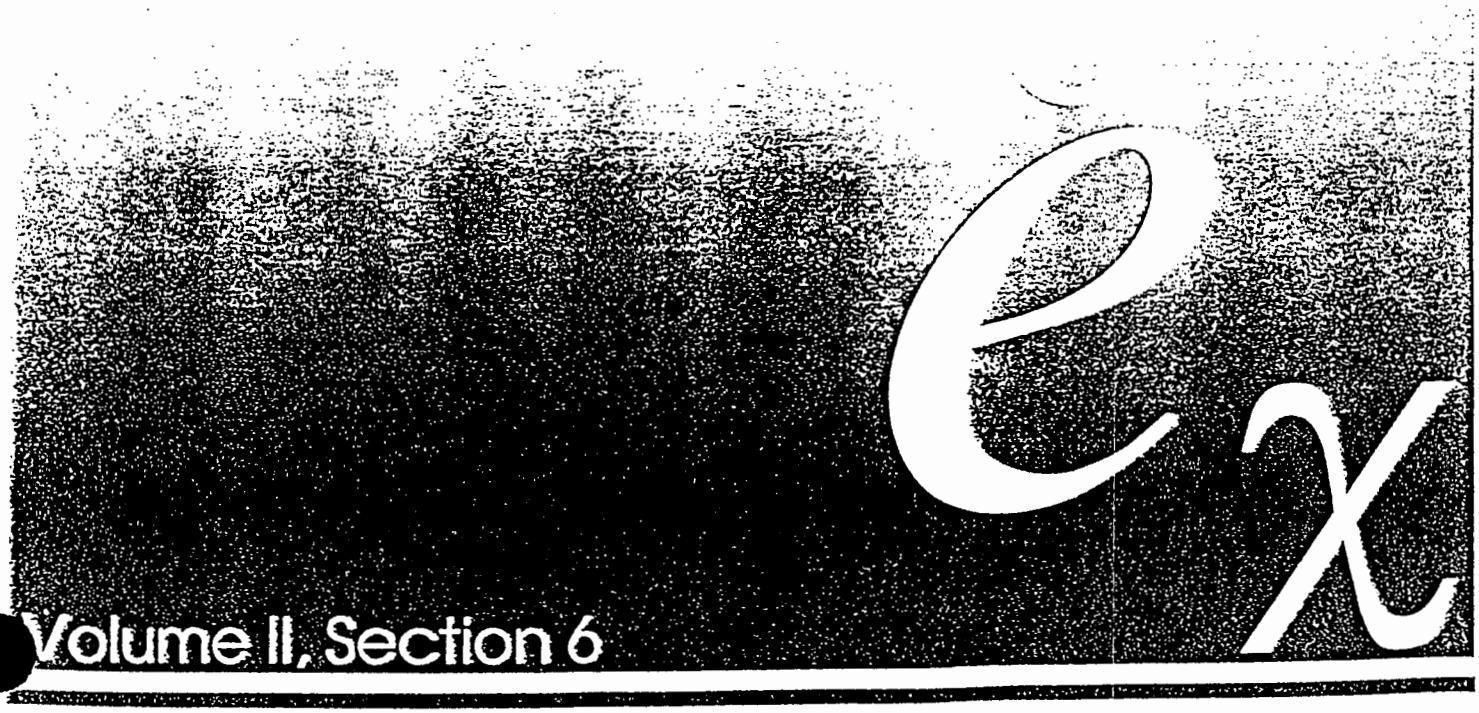
Section 4. This act is effective when it becomes law.

nchs

Vital Statistics of the United States, 1992

From the CENTERS FOR DISEASE CONTROL AND PREVENTION/National Center for Health Statistics

LIFE · TABLES



Volume II, Section 6

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for Health Statistics

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Table 6-4. Life Table Values by Race and Sex: Death-Registration States, 1900-1902 to 1919-21, and United States, 1929-31 to 1990—Con.
(Page 2 of 6)

[Alaska and Hawaii included beginning in 1958. For decennial periods prior to 1929-31, data are for groups of registration States as follows: 1900-1902 and 1909-11, 10 States and the District of Columbia; 1910-21, 34 States and the District of Columbia. Beginning 1970 excludes deaths of nonresidents of the United States; see Technical Appendix]

Age, race, and sex	Average number of years of life remaining $\mathring{e}_x$									
	1990	1979-81	1969-71	1959-61	1949-51	1939-41	1929-31	1919-21	1909-11	1900-1902
ALL RACES										
0	75.4	73.88	70.75	69.89	68.07	63.62	59.20	56.40	51.48	49.24
1	75.1	73.82	71.19	70.75	69.16	65.78	61.84	58.84	57.11	55.20
5	71.2	70.00	67.43	67.04	65.54	62.48	58.20	57.09	56.21	54.00
10	66.3	65.10	62.57	62.10	60.74	57.82	54.84	53.78	52.15	51.14
15	61.3	60.10	57.68	57.33	55.91	53.10	50.25	49.37	47.73	46.81
20	56.6	55.46	53.00	52.58	51.20	48.54	45.84	45.20	43.53	42.79
25	51.9	50.81	48.37	47.89	46.58	44.09	41.85	41.47	39.60	39.12
30	47.2	46.12	43.71	43.19	41.91	39.67	37.76	37.68	35.70	35.51
35	42.6	41.43	39.07	38.51	37.31	35.30	33.69	33.89	31.90	31.92
40	38.0	36.79	34.52	33.92	32.81	31.03	29.67	30.09	28.20	28.24
45	33.4	32.27	30.12	29.50	28.49	26.89	25.79	26.25	24.54	24.77
50	29.0	27.94	25.93	25.29	24.40	22.96	22.06	22.50	20.98	21.28
55	24.8	23.85	21.99	21.37	20.57	19.31	18.53	18.99	17.55	17.88
60	20.8	20.02	18.34	17.71	17.04	15.91	15.24	15.84	14.42	14.78
65	17.2	16.61	15.00	14.38	13.83	12.90	12.23	12.47	11.60	11.88
70	13.8	13.32	12.00	11.39	10.92	10.00	9.58	9.74	9.11	9.30
75	10.8	10.48	9.32	8.71	8.40	7.62	7.32	7.49	6.99	7.08
80	8.2	7.88	7.10	6.38	6.24	5.78	5.56	5.69	5.25	5.20
85	6.1	5.86	5.28	4.58	4.69	4.31	4.19	4.21	4.00	3.96

From "Principal Mortality Tables, Old and New"
Tillinghast Actuarial Consulting Firm
St. Louis, Missouri

minutes

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **DOCKHAM** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 199 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAW RELATING TO LIENS DUE MEDICAL PROVIDERS FOR MEDICAL SERVICES PROVIDED, AS RECOMMENDED BY THE GENERAL STATUTES COMMISSION.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (~~Committee Substitute Bill #); (and recommendation that the committee substitute bill #) be re-referred to the Committee~~ on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 199
Proposed Committee Substitute H199-PCS4101

Short Title: Study Medical Providers' Liens. (Public)

Sponsors:

Referred to:

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A STUDY OF THE LAW RELATING TO LIENS DUE MEDICAL PROVIDERS FOR MEDICAL SERVICES PROVIDED AND THE LAW RELATING TO ASSIGNMENTS OF PROCEEDS.

The General Assembly of North Carolina enacts:

Section 1. The Legislative Research Commission is authorized to study the laws related to liens due medical providers for medical services provided and the law relating to assignment of proceeds. The study shall report to the 1997 Session (1998 Regular Session) of the General Assembly.

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 199

Short Title: Amend Medical Providers' Liens. (Public)

Sponsors: Representative Culpepper.

Referred to: Insurance, if favorable, Judiciary II.

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW RELATING TO LIENS DUE MEDICAL PROVIDERS FOR MEDICAL SERVICES PROVIDED, AS RECOMMENDED BY THE GENERAL STATUTES COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 44-49, 44-50, and 44-51 are repealed.

Section 2. Article 9 of Chapter 44 of the General Statutes is amended by adding the following new sections to read:

"**§ 44-51.01. Definitions.**

As used in this Article:

(1) 'Claimant' means an injured person or the injured person's personal representative, collector, guardian, or parent responsible for payment for medical services.

(2) 'Injured person' means any individual who has sustained personal injuries.

(3) 'Medical provider' means all of the following:

a. Any physician, nurse, chiropractor, dentist, optometrist, podiatrist, physical therapist, psychologist, pharmacist, or other individual licensed, registered, or certified by this State or any other state to provide medical services.

b. Any employer of any individual listed in sub-subdivision a. of this subdivision, or any entity through which such an individual renders medical services, that has the right to

receive the payment due for the individual's medical services to an injured person.

c. Any hospital, health care facility, provider of ambulance services, or similar provider of medical services that is licensed or regulated under Chapter 58, 122C, 131D, or 131E of the General Statutes, former Chapter 131 of the General Statutes, or the equivalent law of any other state.

(4) 'Medical records' means all records, regardless of the form in which these records are maintained, concerning patient-provided information, observations, findings, treatment rendered, opinions, physician notes and summaries, nursing notes, laboratory and radiological reports, and any other health care records prepared by any health care professional or other person.

(5) 'Medical services' means any services or supplies furnished to an injured person for the purpose of treating the injuries.

(6) 'Person' means an individual, trust, partnership, professional association, limited liability company, corporation, federal, state, or local government, any political subdivision, agency, or institution of those governments, or any other entity.

(7) 'Recovery' means any sums recovered, or to be recovered, as compensatory damages for personal injuries in any civil action or other proceeding in this State or by settlement. Recovery includes sums recovered under uninsured and underinsured motorist coverage, but does not include proceeds from any other insurance policy when the injured person is also the insured.

(8) 'Responsible party' means an insurance company or any other person responsible for paying a recovery.

"**§ 44-51.02. Creation and perfection of lien.**

(a) Creation of Lien. -- Any medical provider not otherwise prohibited by law, rule, or regulation from obtaining a lien shall, upon perfection in accordance with this Article, have a lien upon any recovery for personal injuries for which the medical provider rendered medical services to the extent the amount owed for these services has not been paid. The lien attaches regardless of whether the party entitled to the recovery is the injured person or another claimant.

(b) Perfection of Lien. -- To perfect the lien, the medical provider shall comply with all of the following:

(1) Before the recovery is paid pursuant to G.S. 44-51.04(a), send a written notice of lien to:

a. The claimant's attorney.

b. If, and only if, the claimant's attorney is not known, to the responsible party and the claimant.

(2) If requested by the claimant or the claimant's attorney, furnish without charge one copy of an itemized statement and the medical records of the medical provider with respect to the medical

services rendered to the injured person by reason of the personal injury. This subdivision does not apply to charges for preparing a medical report that the medical provider does not ordinarily create if the claimant or the claimant's attorney specifically requests the medical provider to create that particular report.

(c) Contents of Notice. -- The notice of lien shall include all of the following:

(1) The name, address, and telephone number of the medical provider.
(2) The name and last known address of the injured person.
(3) The date of the injury.
(4) The date or dates during which the medical provider provided medical services.
(5) The amount for which the lien is being asserted.
(6) If sent to an insurance company, the name of its insured or other person allegedly responsible for the injury.
(7) A statement that the medical provider is claiming the lien provided for by this Article.

The information required by this subsection may be contained in the written notice of lien or any statement attached to and sent with the notice of lien.

(d) Methods of Sending Notice. -- A notice of lien and any copies of a notice of lien required by this Article to be sent to a claimant, a claimant's attorney, or a responsible party shall be sent in any one of the following ways:

(1) Personal delivery to the recipient or the recipient's business address if the recipient or other person at that address provides a receipt for the copy.
(2) Certified mail, return receipt requested.
(3) Overnight delivery service that provides proof of delivery.
(4) Transmission by facsimile machine or other form of electronic communication, if the recipient affirmatively transmits a written confirmation of receipt. A statement of receipt automatically generated by a machine shall not qualify as a confirmation under this subdivision.

(e) Additional Requirements for Notices to Insurance Companies. -- A notice of lien sent to an insurance company under subdivision (b)(1) of this section shall be sent to any office designated by the insurance company as an office authorized to receive claims, the principal office of the insurance company in this State, or the insurance company's regional office or its home office.

"§ 44-51.03. Amended liens.

A medical provider may send an amended notice of lien at any time. An amended notice of lien shall be sent by any of the methods set forth in G.S. 44-51.02(d) for a notice of lien.

"§ 44-51.04. Payment of recovery; limitations on liability for improper payment.

(a) Payment of Recovery. -- The responsible party, or the claimant's attorney acting pursuant to subsection (c) of this section, shall pay the recovery in the following order: any attorneys' fees due the claimant's attorney and the reasonable

expenses incurred by the attorney and the claimant in collecting the recovery; and any perfected liens under this Article, subject to the limitations in subsection (b) of this section; and the remainder of the recovery to the claimant.

(b) Limitations on Payment of Liens. -- The total of all payments made to medical providers under this section shall not exceed 50 percent (50%) of the recovery remaining after payment of the amounts provided in subdivision (1) of subsection (a) of this section. G.S. 28A-18-2 shall further limit payments to medical providers under this section. Multiple liens shall be paid pro rata.

(c) Payments to Claimant's Attorney. -- Notwithstanding any other provision of this Article, the responsible party shall pay the recovery to the claimant's attorney, if known, and the attorney shall pay the recovery as provided in subsections (a) and (b) of this section. The responsible party is discharged of further liability under this Article to medical providers if the responsible party sends the attorney a copy of any notice of lien previously received by the responsible party, and the attorney actually receives the copy or copies before or at the same time the attorney receives the payment. The responsible party is not liable under this Article to any medical provider whose notice of lien is received after the recovery is mailed or delivered to the claimant's attorney.

"**§ 44-51.05. Disputed liens.**

If the amount owed for medical services is in dispute, nothing in this Article shall compel a responsible party or a claimant's attorney to pay the disputed amount until it is fully established in the manner provided by law.

"**§ 44-51.06. Penalty for asserting false lien.**

Any person who asserts a lien under this Article when no amount is owed the person, or in an amount greater than the person is owed, and who refuses without justification to correct or update the lien after becoming aware of the error, is liable to the claimant for all of the following:

(1) Liquidated damages in the amount of five thousand dollars ($5,000) or all damages proximately resulting from the assertion of the improper lien, whichever is greater.

(2) Any reasonable attorneys' fees, court costs, and any other litigation and investigatory expenses incurred as a result of the error before the error is corrected.

"**§ 44-57.07. Exemptions and exclusions.**

(a) No person who pays a recovery pursuant to subsections (a) and (b) of G.S. 44-51.04 is liable under this Article to any medical provider whose notice of lien is received by that person after the recovery is paid, or whose lien is not perfected before the recovery is paid, pursuant to these subsections.

(b) This Article does not apply to injuries resulting from an accident covered by Chapter 97 of the General Statutes, the North Carolina Workers' Compensation Act.

(c) G.S. 44-48 does not apply to liens under this Article."

Section 3. A lien that was existing and valid under former G.S. 44-49 and G.S. 44-50 on the effective date of this act is a perfected lien under G.S. 44-51.01 through G.S. 44-51.07, as enacted by this act, and shall be governed by this act. A

medical provider as defined in G.S. 44-51.01, as enacted by this act, that had not received, or had received but not yet responded to, a request for medical records under former G.S. 44-49 and G.S. 44-50 before the effective date of this act, but had otherwise taken all necessary steps to obtain a valid lien under those former sections before the effective date of this act, shall provide medical records as required by G.S. 44-51.02, as enacted by this act, to have a perfected lien under this act.

Section 4. This act becomes effective January 1, 1998.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 199

Short Title: Amend Medical Providers' Liens. (Public)

Sponsors: Representative Culpepper.

Referred to: Insurance, if favorable, Judiciary II.

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW RELATING TO LIENS DUE MEDICAL PROVIDERS FOR MEDICAL SERVICES PROVIDED, AS RECOMMENDED BY THE GENERAL STATUTES COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 44-49, 44-50, and 44-51 are repealed.

Section 2. Article 9 of Chapter 44 of the General Statutes is amended by adding the following new sections to read:

"**§ 44-51.01. Definitions.**

As used in this Article:

(1) 'Claimant' means an injured person or the injured person's personal representative, collector, guardian, or parent responsible for payment for medical services.

(2) 'Injured person' means any individual who has sustained personal injuries.

(3) 'Medical provider' means all of the following:

a. Any physician, nurse, chiropractor, dentist, optometrist, podiatrist, physical therapist, psychologist, pharmacist, or other individual licensed, registered, or certified by this State or any other state to provide medical services.

b. Any employer of any individual listed in sub-subdivision a. of this subdivision, or any entity through which such an individual renders medical services, that has the right to

receive the payment due for the individual's medical services to an injured person.

c. Any hospital, health care facility, provider of ambulance services, or similar provider of medical services that is licensed or regulated under Chapter 58, 122C, 131D, or 131E of the General Statutes, former Chapter 131 of the General Statutes, or the equivalent law of any other state.

(4) 'Medical records' means all records, regardless of the form in which these records are maintained, concerning patient-provided information, observations, findings, treatment rendered, opinions, physician notes and summaries, nursing notes, laboratory and radiological reports, and any other health care records prepared by any health care professional or other person.

(5) 'Medical services' means any services or supplies furnished to an injured person for the purpose of treating the injuries.

(6) 'Person' means an individual, trust, partnership, professional association, limited liability company, corporation, federal, state, or local government, any political subdivision, agency, or institution of those governments, or any other entity.

(7) 'Recovery' means any sums recovered, or to be recovered, as compensatory damages for personal injuries in any civil action or other proceeding in this State or by settlement. Recovery includes sums recovered under uninsured and underinsured motorist coverage, but does not include proceeds from any other insurance policy when the injured person is also the insured.

(8) 'Responsible party' means an insurance company or any other person responsible for paying a recovery.

"**§ 44-51.02. Creation and perfection of lien.**

(a) Creation of Lien. -- Any medical provider not otherwise prohibited by law, rule, or regulation from obtaining a lien shall, upon perfection in accordance with this Article, have a lien upon any recovery for personal injuries for which the medical provider rendered medical services to the extent the amount owed for these services has not been paid. The lien attaches regardless of whether the party entitled to the recovery is the injured person or another claimant.

(b) Perfection of Lien. -- To perfect the lien, the medical provider shall comply with all of the following:

(1) Before the recovery is paid pursuant to G.S. 44-51.04(a), send a written notice of lien to:

a. The claimant's attorney.

b. If, and only if, the claimant's attorney is not known, to the responsible party and the claimant.

(2) If requested by the claimant or the claimant's attorney, furnish without charge one copy of an itemized statement and the medical records of the medical provider with respect to the medical

services rendered to the injured person by reason of the personal injury. This subdivision does not apply to charges for preparing a medical report that the medical provider does not ordinarily create if the claimant or the claimant's attorney specifically requests the medical provider to create that particular report.

(c) Contents of Notice. -- The notice of lien shall include all of the following:

(1) The name, address, and telephone number of the medical provider.

(2) The name and last known address of the injured person.

(3) The date of the injury.

(4) The date or dates during which the medical provider provided medical services.

(5) The amount for which the lien is being asserted.

(6) If sent to an insurance company, the name of its insured or other person allegedly responsible for the injury.

(7) A statement that the medical provider is claiming the lien provided for by this Article.

The information required by this subsection may be contained in the written notice of lien or any statement attached to and sent with the notice of lien.

(d) Methods of Sending Notice. -- A notice of lien and any copies of a notice of lien required by this Article to be sent to a claimant, a claimant's attorney, or a responsible party shall be sent in any one of the following ways:

(1) Personal delivery to the recipient or the recipient's business address if the recipient or other person at that address provides a receipt for the copy.

(2) Certified mail, return receipt requested.

(3) Overnight delivery service that provides proof of delivery.

(4) Transmission by facsimile machine or other form of electronic communication, if the recipient affirmatively transmits a written confirmation of receipt. A statement of receipt automatically generated by a machine shall not qualify as a confirmation under this subdivision.

(e) Additional Requirements for Notices to Insurance Companies. -- A notice of lien sent to an insurance company under subdivision (b)(1) of this section shall be sent to any office designated by the insurance company as an office authorized to receive claims, the principal office of the insurance company in this State, or the insurance company's regional office or its home office.

"§ 44-51.03. Amended liens.

A medical provider may send an amended notice of lien at any time. An amended notice of lien shall be sent by any of the methods set forth in G.S. 44-51.02(d) for a notice of lien.

"§ 44-51.04. Payment of recovery; limitations on liability for improper payment.

(a) Payment of Recovery. -- The responsible party, or the claimant's attorney acting pursuant to subsection (c) of this section, shall pay the recovery in the following order: any attorneys' fees due the claimant's attorney and the reasonable

expenses incurred by the attorney and the claimant in collecting the recovery; and any perfected liens under this Article, subject to the limitations in subsection (b) of this section; and the remainder of the recovery to the claimant.

(b) Limitations on Payment of Liens. -- The total of all payments made to medical providers under this section shall not exceed 50 percent (50%) of the recovery remaining after payment of the amounts provided in subdivision (1) of subsection (a) of this section. G.S. 28A-18-2 shall further limit payments to medical providers under this section. Multiple liens shall be paid pro rata.

(c) Payments to Claimant's Attorney. -- Notwithstanding any other provision of this Article, the responsible party shall pay the recovery to the claimant's attorney, if known, and the attorney shall pay the recovery as provided in subsections (a) and (b) of this section. The responsible party is discharged of further liability under this Article to medical providers if the responsible party sends the attorney a copy of any notice of lien previously received by the responsible party, and the attorney actually receives the copy or copies before or at the same time the attorney receives the payment. The responsible party is not liable under this Article to any medical provider whose notice of lien is received after the recovery is mailed or delivered to the claimant's attorney.

"**§ 44-51.05. Disputed liens.**

If the amount owed for medical services is in dispute, nothing in this Article shall compel a responsible party or a claimant's attorney to pay the disputed amount until it is fully established in the manner provided by law.

"**§ 44-51.06. Penalty for asserting false lien.**

Any person who asserts a lien under this Article when no amount is owed the person, or in an amount greater than the person is owed, and who refuses without justification to correct or update the lien after becoming aware of the error, is liable to the claimant for all of the following:

(1) Liquidated damages in the amount of five thousand dollars ($5,000) or all damages proximately resulting from the assertion of the improper lien, whichever is greater.

(2) Any reasonable attorneys' fees, court costs, and any other litigation and investigatory expenses incurred as a result of the error before the error is corrected.

"**§ 44-57.07. Exemptions and exclusions.**

(a) No person who pays a recovery pursuant to subsections (a) and (b) of G.S. 44-51.04 is liable under this Article to any medical provider whose notice of lien is received by that person after the recovery is paid, or whose lien is not perfected before the recovery is paid, pursuant to these subsections.

(b) This Article does not apply to injuries resulting from an accident covered by Chapter 97 of the General Statutes, the North Carolina Workers' Compensation Act.

(c) G.S. 44-48 does not apply to liens under this Article."

Section 3. A lien that was existing and valid under former G.S. 44-49 and G.S. 44-50 on the effective date of this act is a perfected lien under G.S. 44-51.01 through G.S. 44-51.07, as enacted by this act, and shall be governed by this act. A

medical provider as defined in G.S. 44-51.01, as enacted by this act, that had not received, or had received but not yet responded to, a request for medical records under former G.S. 44-49 and G.S. 44-50 before the effective date of this act, but had otherwise taken all necessary steps to obtain a valid lien under those former sections before the effective date of this act, shall provide medical records as required by G.S. 44-51.02, as enacted by this act, to have a perfected lien under this act.

Section 4. This act becomes effective January 1, 1998.

INSURANCE SUBCOMMITTEE MEMBERS:

REPRESENTATIVES: HURLEY, CHAIRMAN
ALLRED
BARBEE
BOWIE
HARDAWAY
HARDY
MINER

PERSONS TO CONTACT FOR INSURANCE SUBCOMMITTEE MEETING:

1. Becky Blankenship-NC Bar Assoc. 677-0561 ext. 341 ✓
2. Chas. Cromer-NC Academy of Trial Lawyers-832-1413 ✓
3. Bill Pully-NC Hospital Assoc. 677-2400 ✓
4. Susan Valuari-Nationwide Insurance Enterprise 571-3747 ✓
5. Ann Winner - NC Bar Assoc.-834-5500 ✓

North Carolina General Assembly
HISTORY OF HOUSE BILL H 199 (= S 156)
STUDY MEDICAL PROVIDERS' LIENS
by: CULPEPPER

Date: 5/21/97
Time: 4:01 p.m.

Leg. day:H-065/S-065

Introduced 2-17-97 by: CULPEPPER
GS Chapters: S

Date		Action
2-17-97	H	REF TO COM ON INS
4-21-97	HA	REPTD FAV COM SUBSTITUTE
4-21-97	H	CAL PURSUANT RULE 36(A)
4-22-97	H	WITHDRAWN FROM CAL
4-22-97	H	RE-REF COM ON RULES

Dot Anderson (Rep. Hurley)

From: Linwood Jones (Research)
Sent: Wednesday, April 02, 1997 3:31 PM
To: Rep. Bill Hurley
Subject: HB 199

I'm not sure we're going to get the "assignment of proceeds" issue resolved in HB 199. The State Bar Ethics Committee and some plaintiffs' attorneys want us to declare assignments void, the hospitals and medical providers want to retain them, and the insurance companies want to make sure that they get proper notice of the assignments.

One suggestion I have is that we (1) do the amendments that were brought up at the subcommittee meeting that specifically relate to the statutory liens and (2) require a study of the issue of assignment of proceeds that will report back to the 1998 short session. This would allow HB 199 to move on, while assuring everyone that the assignment issue will be addressed next session. It's my feeling that the assignment of proceeds issue is going to take a great deal of time to work through and probably needs the more deliberate pace of an interim study committee. The study committee could be (but doesn't have to be) the General Statutes Commission.

Let me know what you think.

IN SUPPORT OF

AN ACT TO PROVIDE IMPROVEMENTS IN THE LAWS GOVERNING PREFERRED PROVIDER ORGANIZATIONS

Managed care organizations in North Carolina include both health maintenance organizations (HMO's) and preferred provider organizations (PPO's). Both HMOs and PPOs seek to coordinate the financing and provision of high quality health care at the lowest possible cost.

Health care providers who participate in an HMO or PPO managed care network augment the reduction of the cost of health care by agreeing to a fee schedule or other basis for reducing costs. However, in a PPO, and in an HMO which provides its members with a "Point of Service" option, members can choose to obtain health care services from a provider who is not a member of the managed care network.

By administrative rule, the Department of Insurance allows an HMO to provide benefits for a nonparticipating provider at a differential up to thirty percent below the level of services rendered by participating providers. This is a provision which allows the HMO to encourage its members to utilize the services of its network of participating providers, enabling it to (1) reduce costs, (2) hold premium charges down, and (3) actively and consistently work through its managed care network to improve the health of its members.

PPOs, rather than being governed in this respect by an administrative rule, are governed by G.S. 58-50-55, a statute enacted in 1985, which provides that the reduction in benefits for nonparticipating provider charges can be no more than twenty percent of payments that would be made to participating providers. This is a restriction on the operation of PPOs which hinders the provision of this form of managed care to North Carolinians.

Since the time this statute was enacted, thirty percent has become a more commonly used maximum differential in other states and is the maximum differential already applied to HMOs in this State. In addition, HMOs are allowed to exclude certain services provided by non-network providers. The purpose of the proposed revision to the PPO statute, G.S. 58-50-55, is to remove the statutory twenty percent differential limit, and add a reference to PPO "product limitations" as an appropriate subject of the Department of Insurance rulemaking, so that the Department can adopt appropriate rules for PPOs as it already does for HMOs, and ensure a "level playing field" for the provision of managed health care to the public.

STATE OF NORTH CAROLINA
GENERAL STATUTES COMMISSION
P.O. BOX 629
RALEIGH, NORTH CAROLINA 27602
(919) 733-6026

MEMORANDUM:

TO: House Insurance Committee

FROM: General Statutes Commission

DATE: March 4, 1997

RE: House Bill 199 (Amend Medical Providers' Liens)

General Comments

This bill updates the statutes on medical providers' liens, found in Article 9 of Chapter 48 of the General Statutes, G.S. 44-49 et seq. Under current law, medical providers may obtain a lien on sums recovered as damages for personal injury. The lien is for unpaid medical bills incurred by the injured person for treatment of the injury. The current statutes were first enacted in 1935 and have not been significantly changed since that time. In response to suggestions for revision from attorneys in general practice, the General Statutes Commission (Commission) reviewed Article 9 and concluded that it should be overhauled to update the language and to "fill in the gaps" that have arisen as a result of changes in practice over the last 60 years. During the updating process, the Commission attempted to keep substantive changes to a minimum, making them only where necessary to resolve actual problems. In "filling in the gaps" in the current law, the Commission codified existing practice as reported to the Commission where it seemed to work well.

Consistent with the Commission's usual process, it circulated a draft of proposed revisions to its mailing list for comments. The Commission received extensive comments and circulated a revised draft as a result, in addition to furnishing drafts on request at any time. This second circulation produced additional comments. The Commission received more comments and suggestions on this legislative proposal than it has received for any other legislative proposal in the last several years. As is its usual practice, the Commission considered all of the comments it received and made several changes in response to them. It should be noted, however, that some commentators requested diametrically opposite revisions. The bill as introduced represents the best consensus the Commission could obtain.

Under the current law, a medical provider must do at least two things to have a valid lien.

The medical provider must (i) file a claim in the office of the clerk of court in the county in which a lawsuit to recover money for personal injury is filed and (ii) as a condition precedent to the creation of a lien, furnish on request free copies of medical records to the injured person's attorney. Failure to make the filing in the clerk's office within 30 days after the lawsuit is filed causes loss of the chance to obtain a lien. In cases where no lawsuit was filed and the parties settle out of court, the medical provider must give notice of the lien to the person, usually an attorney, who distributes the money received in settlement. The attorney then distributes the settlement money according to current G.S. 44-50 (after payment of attorney fees, half to medical providers with liens and half to the injured person).

This bill makes few changes in these procedures. The biggest change is the elimination of the requirement of filing a claim with the clerk of court. These claims are not indexed and therefore are not particularly effective as a means of public notice. In addition, a medical provider may not be aware that a lawsuit has been filed and may lose the opportunity to assert a lien without ever receiving any notice that the opportunity existed. The bill substitutes a requirement that a notice of lien be given to the attorney or other person who will actually be responsible for distributing the money. The bill requires this notice to be given in a way that the sender will have proof that the notice was actually received.

The largest "gap" in the current law arose as a result of a 1995 North Carolina Supreme Court opinion. The opinion makes it clear that the current law allows a notice of lien to be sent to the liability insurance company of the person who wrongfully caused the injury (the "tortfeasor") and to be paid directly by the insurance company, at least in cases where the injured person does not have an attorney. This opinion caused some confusion over the insurance company's duties when the injured person does have an attorney. It is also not clear what constitutes adequate notice to insurance companies. The bill contains requirements for the content of a notice of lien, specifies the procedure for sending such a notice to a tortfeasor's insurance company, and codifies current practice by specifying that the insurance company sends the money to the injured person's attorney, if there is one, along with any notices of lien received by the insurance company, for the attorney to distribute the money.

One new feature in this bill is the inclusion of a provision for recovery of liquidated damages if a medical provider aserts a lien when no money is due, or claims a larger amount than is actually due, and refuses without justification to correct the lien after becoming aware of the error. The Commission decided to recommend this provision after reports that incorrect claims by medical providers are becoming more frequent.

Specific Comments

Section 1 of the bill repeals the existing provisions on medical providers' liens, which are being replaced.

Section 2 of the bill contains the replacement provisions for medical providers' liens.

The first new statutory section, proposed G.S. 44-51.01, contains definitions. The current law does not have any defined terms, and in attempting to update it and make it more precise, it rapidly became apparent that some defined terms were needed to avoid constant repetition of particular phrases. The definitions are based either on the descriptive phrases in the current law or on definitions generally accepted elsewhere (for instance, "person"). One key definition is "claimant": simply speaking, a claimant is the person who brings, or is entitled to bring, the personal injury action. The claimant will normally be the injured person but could also be, for example, the executor or administrator of a decedent's estate (if the injured person died), a guardian of an injured person who is incompetent, or a parent responsible for paying medical expenses if the injured person is a minor. A second key definition is "responsible party," which is defined as the insurance company or other person responsible for paying the money owed to the claimiant by the person who wrongfully caused the injury (the "tortfeasor"). The responsible party will normally be a liability insurance company.

Please note that the second sentence in the definition of "recovery" is intended to codify current practice. Generally speaking, the description in the current statute, "sums recovered as damages for personal injury" would not normally include an insurance benefit paid by the injured person's own insurance company. "Damages" are paid by (or on behalf of) the tortfeasor. An insurance benefit payable to an injured person under the person's own insurance is not paid by or on behalf of the tortfeasor. Nevertheless, practice, at least in some areas of the State, has made an exception for uninsured and underinsured motorist coverage and has, rightly or wrongly, treated this type of insurance as money to which the lien under the current statutes will attach. After some reflection, the General Statutes Commission (Commission) decided that this practice was logically sound and should be codified, because this type of insurance is actually a substitute for payment from or on behalf of a tortfeasor and is only payable if the tortfeasor is at fault and is not insured, is inadequately insured, or fails to pay from the tortfeasor's own resources, unlike other types of first party insurance.

Proposed G.S. 44-51.02 contains the provisions for perfecting a medical provider's lien. This section replaces the requirement for filing a claim with the clerk of court in the county in which a lawsuit is filed with a requirement for sending a notice of lien, as described under General Comments. A notice of lien must be sent to the claimant's attorney, if known; otherwise, the notice can be sent to the responsible party. The subsection on contents of the notice is new and was added by the Commission in response to comments on the Commission's drafts. The subsection on methods of sending notice was added in order that there be some record of receipt of a notice of lien, since there will no longer be any filing on the public record. The special provisions for notices of lien sent to insurance companies were added by the Commission as a result of comments from insurance companies and are designed primarily to enable more efficient processing of notices of lien, which in turn should increase the likelihood that the notice will be associated with the proper claim in a timely fashion.

Proposed G.S. 44-51.03 has no explicit counterpart section in current law. It was added at the suggestion of several commentators to make it explicit that a medical provider can amend a

notice of lien.

Proposed G.S. 44-51.04 preserves the order of payment set out in current G.S. 44-50. Proposed G.S. 44-51.04 explicitly states that multiple liens are paid pro rata, which is the current practice. It also explicitly recognizes the limits on payments in wrongful death actions imposed by G.S. 28A-18-2. Subsection (c) codifies current practice by requiring a responsible party to pay a judgment or settlement to the claimiant's attorney so that the attorney can distribute the funds. The responsible party is required to transmit any notices of lien it receives before it sends the funds to the attorney and is relieved of further liability if it complies.

Proposed G.S. 44-51.05 brings forward in more modern language the gist of current G.S. 44-51.

Proposed G.S. 44-51.06 contains the new provision allowing liquidated damages for wilfully continuing to assert a false lien as described under General Comments.

Proposed G.S. 44-51.07 contains a list of exemptions and exclusions. There is no explicit counterpart section in current law. Subsection (a) protects a person from liability for notices of lien received after the person distributes money paid in judgment or settlement and follows logically from the entire concept of claiming a lien. Subsection (b) excludes injuries covered by the Workers' Compensation Act, because medical payments are already covered under that Act. Subection (c) provides that G.S. 44-48, which deals with discharge of liens filed with the clerk of court, does not apply to medical providers' liens.

Section 3 of the bill contains transition provisions, essentially designed to "grandfather" valid liens under the current law.

Section 4 of the bill provides for an effective date of January 1, 1998.

Amend proposed committee substitute to House Bill 199 to read as follows:

"58-3-174(a) No assignment of proceeds of a claim for personal injury shall be enforceable against a payor of any sums paid as damages for personal injury unless the assignment is signed by the injured person or individual authorized to make the assignment and is served upon the payor by certified mail, return receipt requested, prior to payment of the claim."

"(b) In the event of a recovery of damages for personal injury that is less than the amount of valid assignments of proceeds of a claim for personal injury that have been properly served on payors under the procedure described in subsection (a), all parties entitled to assignment of proceeds under this section shall share the funds held by the payor on a pro rata basis."

MINUTES

INSURANCE SUBCOMMITTEE ON HB 199

March 11, 1997

The first meeting of the Insurance Subcommittee to study House Bill 199-Amend Medical Providers' Liens-was called to order by the chairman, Representative Bill Hurley, on Tuesday, March 11, 1997, at 4:00P.M. in Room 605 L.O.B. Members present were Representatives Allred, Hardaway, Hardy and Miner. Members absent were Representatives Barbee and Bowie. Representative Culpepper, sponsor of the bill, was unable to attend. Linwood Jones, Committee Counsel, Legislative Research Staff, was present.

Visitors registration sheet is attached. (ATTACHMENT 1).

Each member received a copy of the bill and an explanation of House Bill 199, prepared by Linwood Jones, Committee Counsel. Copies were also available for visitors. (ATTACHMENT 2).

Chairman Hurley stated that the committee was appointed by House Insurance Committee Chairman Representative Dockham to study House Bill 199, and to report its recommendations back to the full Insurance Committee. He added that in fairness to Representative Culpepper, who could not be present today, that this meeting serve only as a forum for discussion and that no final recommendations be made. Another meeting will be called.

Chairman Hurley called on Mr. Jones, Committee Counsel, to review the bill, and asked members and visitors to address their questions to Mr. Jones.

Mr. Jones explained that a number of questions which came up in the Insurance Committee regarding this bill necessitated the formation of this special committee. He added that the bill originated with the General Statutes Commission. The Commission made a recommendation to the General Assembly, and Representative Culpepper introduced this bill. This law has been on the books for many years. The commission wants to codify existing law and practice and bring it up to date. He continued by stating there were questions that came up in the Insurance Committee that may go beyond what the General Statutes Commission was trying to do.

Representative Hardy raised the first question, concerning assignment of proceeds. P. Bly Hall, Counsel for the General Statutes Commission, responded that "the General Statutes Commission was neutral on this".

MINUTES
Insurance Subcommittee on HB 199
March 11, 1997

Further questions and discussion followed both from committee members and visitors.

Chairman Hurley recommended that counsel incorporate questions and recommendations into an amendment draft form to be presented at the next meeting of this subcommittee. Mr. Jones asked that all visitors give him their changes to the bill by Friday, March 13, or Monday, March 16, at the latest.

With no further questions or discussion, the meeting was adjourned at 5:00p.m., to meet next week after Session, at the call of the chairman.

Respectfully submitted,

Hurley
Chairman

Dot Anderson
Committee Clerk

VISITOR REGISTRATION SHEET

Subcommittee for HB 199 — Name of Committee

3-11-97 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Anne Dubois	Dubois Law Offices 2700 Old Sugar Rd Durham NC 27705
Floyd M. Lewis	General Statutes Commission
P. Bay Heald	General Statutes Commission
Bill Scoggin	NCBA
Doug Winner	NCBA
Charles Cromer	NCATL
Steve Keene	NCMed Society
Hugh Tilson	NCHA
Susan Valauri	Nationwide
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Raleigh, NC 2760
(919) 733-2578

March 5, 1997

MEMORANDUM

TO: Representative Jerry Dockham, Chairman
House Insurance Committee

FROM: Linwood Jones, Committee Counsel

RE: House Bill 199 (Medical Provider Liens)

House Bill 199 rewrites the laws that govern medical providers' liens against damages recovered by their patients from third parties for the injuries for which the patients were treated. The liens help ensure that doctors, hospitals, and other medical providers are paid for the medical services they provide to these patients. The existing laws, which were put on the books earlier in the century, are repealed and replaced by the new provisions. It is my understanding from the General Statutes Commission that, with some exceptions, the new laws are designed to follow in substance the old laws and existing practice that has developed under those laws.

Under House Bill 199, the medical provider may file a lien for the amount of any unpaid bills arising from treatment for the injuries in question by doing the following:

(1) Send a written notice of the lien to the claimant's attorney. If the claimant has no attorney or the attorney is not known, send the written notice to the claimant and to the insurance company or other party responsible for paying the damages to which the claimant may be entitled. The lien notice must identify the medical provider, the injured person, the date of the injury, the date(s) of treatment, and the amount of the lien. The notice must state that the provider is asserting its lien rights. If the notice is also being sent to an insurance company, the provider must also identify the person who allegedly injured the patient.

(2) If requested by the claimant or the claimant's attorney, provide a free copy of the claimant's medical records and an itemized bill. If the medical provider is requested to prepare a special medical report on the claimant beyond the ordinary medical records, it can charge for that report.

The lien notice must be sent in one of four ways authorized by the bill: personal delivery, certified mail, overnight mail, or fax. All four methods require the provider to obtain a receipt proving delivery.

When the claimant resolves its claim for damages against the third party (through judgment in a lawsuit or settlement, including UM and UIM recoveries) and is entitled to recover damages, the insurer must pay the damages to the claimant's attorney. (By sending a copy of the medical provider's lien to the attorney before or with payment of the funds to the attorney, the insurer relieves itself of further liability to the medical providers, if the attorney actually receives the notice before or with the payment). The attorney collects his attorney fees and the reasonable expenses in the case and then uses the remainder to reimburse the medical provider for its unpaid bills that relate to the injury for which the claimant was entitled to damages. The attorney can pay no more than 50% of this remaining amount to the medical provider(s). If the claimant has no attorney, the insurer or other responsible party makes these payments.

An insurer is not required to pay a disputed medical bill under the lien law until it is resolved. The bill also provides a penalty against a medical provider who asserts a false or exaggerated lien. The penalty does not apply if the lien or the amount of the lien is filed in error and is corrected by the provider when the error is brought to its attention. The penalty is liquidated damages in the amount of $5,000 or all damages proximately resulting from the assertion of the improper lien, whichever is greater, plus attorneys' fees, court costs, and other investigative and legal expenses incurred as a result of the error.

Neither the attorney nor the insurer (or other responsible party) is liable to a medical provider under the lien law if the provider's lien is not received or perfected before the recovery is paid.

This act takes effect January 1, 1998. All valid, existing liens filed under the current lien laws (G.S. 44-49 and 44-50) as of that date are considered "perfected" under this act and will be covered by this act. If a provider has taken all steps as of January 1, 1998, to perfect a lien under the existing law expect for providing a copy of requested medical records, the provider's lien will still be considered perfected once those records are delivered.

H199-SMRN-001

ARTICLE 9.

Liens upon Recoveries for Personal Injuries to Secure Sums Due for Medical Attention, etc.

§ 44-49. Lien created; applicable to persons non sui juris.

From and after March 26, 1935, there is hereby created a lien upon any sums recovered as damages for personal injury in any civil action in this State, the said lien in favor of any person, corporation, municipal corporation or county to whom the person so recovering, or the person in whose behalf the recovery has been made, may be indebted for drugs, medical supplies, ambulance services, and medical services rendered by any physician, dentist, trained nurse, or hospitalization, or hospital attention and/or services rendered in connection with the injury in compensation for which the said damages have been recovered. Where damages are recovered for and in behalf of minors or persons non compos mentis, such liens shall attach to the sum recovered as fully as if the said person were sui juris.

Notwithstanding the provisions of paragraph one of this section, no lien therein provided for shall be valid with respect to any claims whatsoever unless the person or corporation entitled to the lien therein provided for shall file a claim with the clerk of the court in which said civil action is instituted within 30 days after the institution of such action and further provided that the physician, dentist, trained nurse, hospital or such other person as has a lien hereunder shall, without charge to the attorney as a condition precedent to the creation of such lien, furnish upon request to the attorney representing the person in whose behalf the claim for personal injury is made, an itemized statement, hospital record, or medical report for the use of such attorney in the negotiation settlement or trial of the claim arising by reason of the personal injury.

No liens of the character provided for in the first paragraph of this section shall hereafter be valid with respect to money that may be recovered in any pending civil actions in this State unless claims based on such liens are filed with the clerk of the court in which the action is pending within 90 days after April 5, 1947.

No action shall lie against any clerk of court or any surety on any clerk's bond to recover any claims based upon any lien or liens created by the first paragraph of this section when recovery has heretofore been had by the person injured, and no claims against such recovery were filed with the clerk by any person or corporation, and the clerk has otherwise disbursed according to law the money recovered in such action for personal injuries. (1935, c. 121, s. 1; 1947, c. 1027; 1959, c. 800, s. 1; 1967, c. 1204, s. 1; 1969, c. 450, s. 1.)

§ 44-50. Receiving person charged with duty of retaining funds for purpose stated; evidence; attorney's fees; charges.

Such a lien as provided for in G.S. 44-49 shall also attach upon all funds paid to any person in compensation for or settlement of the said injuries, whether in litigation or otherwise; and it shall be the duty of any person receiving the same before disbursement thereof to retain out of any recovery or any compensation so received a sufficient amount to pay the just and bona fide claims for such drugs, medical supplies, ambulance service and medical attention and/or hospital service, after having received and accepted notice thereof: Provided, that evidence as to the amount of such charges shall be competent in the trial of any such action: Provided, further, that nothing herein contained shall be construed so as to interfere with any amount due for attorney's services: Provided, further, that the lien hereinbefore provided for shall in no case, exclusive of attorneys' fees, exceed fifty percent (50%) of the amount of damages recovered. (1935, c. 121, s. 2; 1959, c. 800, s. 2; 1969, c. 450, s. 2; 1995 (Reg. Sess., 1996), c. 674, s. 3.)

§ 44-51. Disputed claims to be settled before payments.

Whenever the sum or amount or amounts demanded for medical services or hospital fees shall be in dispute, nothing in this Article shall have any effect of compelling payment thereof until the claim is fully established and determined, in the manner provided by law: Provided, however, that when any such sums are in dispute the amount of the lien shall in no case exceed the amount of the bills in dispute. (1935, c. 121, s. 3; 1943, c. 543.)

MINUTES

INSURANCE SUBCOMMITTEE ON HB 199

March 26, 1997

The **second** meeting of the Insurance Subcommittee to study House Bill 199- Amend Medical Providers' Liens- was called to order by the chairman, Representative Bill Hurley, on Tuesday, March 26, 1997, at 4:00 p.m. in Room 605 L.O.B. Members present were Representatives Cary Allred, Bobby Barbee, and Edwin Hardy. Members absent were Representatives Joanne Bowie, Thomas Hardaway and David Miner. Representative Bill Culpepper, bill sponsor, was unable to attend. Linda Attarain, Legislative Research Staff, attended for Linwood Jones, Committee Counsel.

Visitors registration sheet is attached. (ATTACHMENT 1)

Chairman Hurley recognized and introduced Linda Attarain; Mr. & Mrs. Jay Gothard, visitors from Fayetteville; and the page, Charles Trivet from Cary.

The chairman called the members attention to the draft prepared by Linwood Jones, Committee Counsel, incorporating recommendations made by the members and visitors during and following the first meeting of this committee. He called on P. Bly Hall, General Statutes Commission, to explain the Subcommittee Draft Substitute. (ATTACHMENT 2)

Representative Barbee called on William Pully, NC Hospital Association, to explain why the hospitals wanted the changes on top of page 3, lines 1-6. Mr. Pully deferred to Hugh Tilson, Director of Legal Affairs, Hospital Association, to explain.

Representative Hardy questioned lines 5&6, page 3, beginning with "medical payment coverage".

Ms. Hall pointed out numbered items on top of page 5. These clauses were not numbered in the original bill. The second thing Mr. Jones changed here was, in response to comment from our last meeting, to move the "reasonable expense incurred " clause from item (1) and make it a separate item (3).

Ms. Hall continued to the bottom of page 5, lines 41 & 42. A change was made here at the suggestion of the State Bar Ethics Subcommittee.

She continued that the big change was on page 6, Section 3. This is intended to address what kind of notice an insurance company needs to have in assigning proceeds. "Arguably, this section should not be in this bill."

Ms. Bly added that Linwood Jones attached to this draft a copy of a memorandum that was sent by the Ethics Committee of the N.C. Bar Association asking the General Statutes Commission to include a provision that would essentially clear assignments of proceeds as void and against public policy. She continued that "this particular memo was not turned over by the General Statutes Commission to this committee, but was sent independently of us".

Representative Barbee asked if an assignment was no good unless the person who is injured made the assignment to the hospital?

Susan Valuari answered that "according to the Mecklenburg vs. First of Georgia case, yes. We are concerned about this assignment issue, which is why we simply ask (for notification that it can't be pocketed)."

Mr. Pully reiterated that in the process of payment, "if we (hospitals) don't get in early, we (hospitals) are very unlikely to get paid. Without these types of assignments, people who are injured are, basically, allowed to pocket the money they owe the medical provider."

Representative Hardy asked if this would only apply if (the injured party) settled the case themselves, or when an attorney was involved also?

Mr. Pully replied that this is when an attorney is involved also. "The attorney would more than likely get a notice of assignment and this would allow the hospital to notify the insurance company that an assignment is due."

Representative Hardy asked if this would still be limited by the fifty percent rule.

Mr. Pully responded that these assignments are not limited by the fifty percent rule.

Discussion continued on how and when assignments are made.

Chairman Hurley asks for further suggestions from committee members on how to proceed with this bill.

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Representative Hardy suggested that it would be nice if all the parties involved would give us some memos of specific examples of how things flow with various settlements so that it would make it easier for the members to understand the process.

Representative Allred questioned the memo from the N.C. Bar Association.

The meeting adjourned at 5:00p.m. Another meeting will be scheduled at the call of the chairman.

_____
Chairman

Dot Anderson
Committee Clerk

ATTACHMENT 1

VISITOR REGISTRATION SHEET

INSURANCE SUBCOMMITTEE-HB 199 — Name of Committee

MARCH 26, 1997 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
P. Bay Hall	General Statutes Commission
Charles Cromer	NCATL
William J. Gothard	224 Hillside Ave Fayetteville NC
Jan M. Gothard	224 Hillside Ave. Fayetteville
Susan Valauri	Nationwide
Anne Dinnen	NCBA
[illegible]	NCGA

North Carolina General Assembly
Legislative Services Office

George R. (919) 733-

ATTACHMENT 2

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March 26, 1997

MEMORANDUM

TO: HB 199 Subcommittee

FROM: Linwood Jones

RE: House Bill 199

Attached are proposed changes to House Bill 199. Also attached is a letter from the counsel to the General Statutes Commission recommending changes. These changes have been incorporated into the draft. Finally, a provision recommended last fall by a State Bar Ethics Subcommittee and provided by Mr. Cromer is attached for consideration. I did not include it in the bill at this point but submit it for your consideration as requested. If other parties have suggested changes that were not included in this draft, I'm sure we'll hear from them.

The changes from the original bill are shown with underlining and strike-through.

The changes on page 1, line 12, part of the changes on page 5, lines 1-11, the change on page 5, lines 41-42, and the change on page 6, line 9 are technical amendments from the General Statutes Commission staff, some of which originated with the Bar Association.

The change on page 2, line 35 is a change I suggested to the General Statutes Commission staff. My concern was that "treating" does not clearly include "diagnosing." A significant portion of the medical services provided by a hospital or other provider may consist of diagnostic tests. By including "diagnosing" in the definition, we ensure that the medical provider's lien also extends to these services.

I suggested the change on page 3, line 23 (eliminating "and only if") because the phrase is redundant. The "and only if" language was apparently placed there for more emphasis, but it is still redundant and unnecessary in my opinion. It means no more than beginning the sentence simply with "If".

On page 5, lines 1-10, I moved the legal expenses so that they come after the medical provider's lien. Attorneys fees' would still have priority over the medical provider's lien, but the other legal expenses would come under subdivision (3) – after the medical lien.

On page 6, lines 21-30, I added language suggested by Nationwide Insurance concerning assignment of proceeds. This language describes how a medical provider who has obtained an assignment of proceeds from a potential personal injury action from its patient is to notify the insurance company of the assignment. I placed this language in the insurance laws, not the lien laws.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H

HOUSE BILL 199
SUBCOMMITTEE DRAFT SUBSTITUTE

Short Title: Amend Medical Providers' Liens. (Public)

Sponsors:

Referred to: Insurance, if favorable, Judiciary II.

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW RELATING TO LIENS DUE MEDICAL PROVIDERS FOR MEDICAL SERVICES ~~PROVIDED, AS RECOMMENDED BY THE GENERAL STATUTES COMMISSION.~~ PROVIDED.

The General Assembly of North Carolina enacts:

Section 1. G.S. 44-49, 44-50, and 44-51 are repealed.

Section 2. Article 9 of Chapter 44 of the General Statutes is amended by adding the following new sections to read:

(THE FOLLOWING UNDERLINING AND STRIKE-THROUGH SHOWS PROPOSED CHANGES TO THE BILL):

"§ 44-51.01. Definitions.

As used in this Article:

(1) 'Claimant' means an injured person or the injured person's personal representative, collector, guardian, or parent responsible for payment for medical services.

(2) 'Injured person' means any individual who has sustained personal injuries.

(3) 'Medical provider' means all of the following:

a. Any physician, nurse, chiropractor, dentist, optometrist, podiatrist, physical therapist, psychologist, pharmacist, or other individual licensed, registered, or certified by this State or any other state to provide medical services.

b. Any employer of any individual listed in sub-subdivision a. of this subdivision, or any ~~entity~~ partnership or limited liability company through which such an individual renders medical services, that has the right to receive the payment due for the individual's medical services to an injured person.

c. Any hospital, health care facility, provider of ambulance services, or similar provider of medical services that is licensed or regulated under Chapter 58, 122C, 131D, or 131E of the General Statutes, former Chapter 131 of the General Statutes, or the equivalent law of any other state.

(4) 'Medical records' means all records, regardless of the form in which these records are maintained, concerning patient-provided information, observations, findings, treatment rendered, opinions, physician notes and summaries, nursing notes, laboratory and radiological reports, and any other health care records prepared by any health care professional or other person.

(5) 'Medical services' means any services or supplies furnished to an injured person for the purpose of diagnosing or treating the injuries.

(6) 'Person' means an individual, trust, partnership, professional association, limited liability company, corporation, federal, state, or local government, any political subdivision, agency, or institution of those governments, or any other entity.

(7) 'Recovery' means any sums recovered, or to be recovered, as compensatory damages for personal injuries in any civil action or other proceeding in

this State or by settlement. Recovery includes sums recovered under uninsured and underinsured motorist coverage, but does not include proceeds from ~~any other insurance policy when the injured person is also the insured.~~ medical payments coverage under an insurance policy.

(8) 'Responsible party' means an insurance company or any other person responsible for paying a recovery.

"§ 44-51.02. Creation and perfection of lien.

(a) Creation of Lien. -- Any medical provider not otherwise prohibited by law, rule, or regulation from obtaining a lien shall, upon perfection in accordance with this Article, have a lien upon any recovery for personal injuries for which the medical provider rendered medical services to the extent the amount owed for these services has not been paid. The lien attaches regardless of whether the party entitled to the recovery is the injured person or another claimant.

(b) Perfection of Lien. -- To perfect the lien, the medical provider shall comply with all of the following:

(1) Before the recovery is paid pursuant to G.S. 44-51.04(a), send a written notice of lien to:

a. The claimant's attorney.

b. If~~, and only if,~~ the claimant's attorney is not known, to the responsible party and the claimant.

(2) If requested by the claimant or the claimant's attorney, furnish without charge one copy of an itemized statement and the medical records of the medical provider with respect to the medical services rendered to the injured person by reason of the personal injury. This subdivision does not apply to charges for preparing a medical report that the medical provider does not ordinarily create if the claimant or the claimant's attorney specifically requests the medical provider to create that particular report.

(c) Contents of Notice. -- The notice of lien shall include all of the following:

(1) The name, address, and telephone number of the medical provider.

(2) The name and last known address of the injured person.

(3) The date of the injury.

(4) The date or dates during which the medical provider provided medical services.
(5) The amount for which the lien is being asserted.
(6) If sent to an insurance company, the name of its insured or other person allegedly responsible for the injury.
(7) A statement that the medical provider is claiming the lien provided for by this Article.

The information required by this subsection may be contained in the written notice of lien or any statement attached to and sent with the notice of lien.

(d) Methods of Sending Notice. -- A notice of lien and any copies of a notice of lien required by this Article to be sent to a claimant, a claimant's attorney, or a responsible party shall be sent in any one of the following ways:

(1) Personal delivery to the recipient or the recipient's business address if the recipient or other person at that address provides a receipt for the copy.
(2) Certified mail, return receipt requested.
(3) Overnight delivery service that provides proof of delivery.
(4) Transmission by facsimile machine or other form of electronic communication, if the recipient affirmatively transmits a written confirmation of receipt. A statement of receipt automatically generated by a machine shall not qualify as a confirmation under this subdivision.

(e) Additional Requirements for Notices to Insurance Companies. -- A notice of lien sent to an insurance company under subdivision (b)(1) of this section shall be sent to any office designated by the insurance company as an office authorized to receive claims, the principal office of the insurance company in this State, or the insurance company's regional office or its home office.

"§ 44-51.03. Amended liens.

A medical provider may send an amended notice of lien at any time. An amended notice of lien shall be sent by any of the methods set forth in G.S. 44-51.02(d) for a notice of lien.

"§ 44-51.04. Payment of recovery; limitations on liability for improper payment.

(a) Payment of Recovery. -- The responsible party, or the claimant's attorney acting pursuant to subsection (c) of this section, shall pay the recovery in the following order:

(1) ~~any~~ Any attorneys' fees due the claimant's ~~attorney~~ attorney. ~~and the reasonable expenses incurred by the attorney and the claimant in collecting the recovery;~~

(2) ~~and any~~ Any perfected liens under this Article, subject to the limitations in subsection (b) of this section;

(3) The reasonable expenses incurred by the attorney and the claimant in collecting the recovery;

(4) ~~and the~~ The remainder of the recovery to the claimant.

(b) Limitations on Payment of Liens. -- The total of all payments made to medical providers under this section shall not exceed 50 percent (50%) of the recovery remaining after payment of the amounts provided in subdivision (1) of subsection (a) of this section. G.S. 28A-18-2 shall further limit payments to medical providers under this section. Multiple liens shall be paid pro rata.

(c) Payments to Claimant's Attorney. -- Notwithstanding any other provision of this Article, the responsible party shall pay the recovery to the claimant's attorney, if known, and the attorney shall pay the recovery as provided in subsections (a) and (b) of this section. The responsible party is discharged of further liability under this Article to medical providers if the responsible party sends the attorney a copy of any notice of lien previously received by the responsible party, and the attorney actually receives the copy or copies before or at the same time the attorney receives the payment. The responsible party is not liable under this Article to any medical provider whose notice of lien is received after the recovery is mailed or delivered to the claimant's attorney.

"§ 44-51.05. Disputed liens.

If the amount owed for medical services is in dispute, nothing in this Article shall compel a responsible party or a claimant's attorney to pay the disputed amount until it is fully established in the manner provided by law.

"§ 44-51.06. Penalty for asserting false lien.

Any person who asserts a lien under this Article when no amount is owed the person, or in an amount greater than the person is owed, and who refuses without justification to correct or update the lien after ~~becoming aware~~ discovering or receiving written notice of the error, is liable to the claimant for all of the following:

(1) Liquidated damages in the amount of five thousand dollars ($5,000) or all damages proximately resulting from the assertion of the improper lien, whichever is greater.

(2) Any reasonable attorneys' fees, court costs, and any other litigation and investigatory expenses incurred as a result of the error before the error is corrected.

Typo

"§ ~~44-57.07.~~ 44-51.07. Exemptions and exclusions.

(a) No person who pays a recovery pursuant to subsections (a) and (b) of G.S. 44-51.04 is liable under this Article to any medical provider whose notice of lien is received by that person after the recovery is paid, or whose lien is not perfected before the recovery is paid, pursuant to these subsections.

(b) This Article does not apply to injuries resulting from an accident covered by Chapter 97 of the General Statutes, the North Carolina Workers' Compensation Act.

(c) G.S. 44-48 does not apply to liens under this Article."

PART II. ASSIGNMENT OF PROCEEDS

~~X~~Section 3. Chapter 58 of the General Statutes is amended by adding the following new section to read:

per suggestions from visitors (Valerie)

"58-3-174. No assignment of proceeds of a claim for personal injury shall be enforceable against a payor of any sums paid as damages for personal injury unless the assignment is signed by the injured person or individual authorized to make the assignment and is served upon the payor by certified mail, return receipt requested, prior to payment of the claim."

Section 4. A lien that was existing and valid under former G.S. 44-49 and G.S. 44-50 on the effective date of this act is a perfected lien under G.S. 44-51.01 through G.S. 44-51.07, as enacted by this act, and shall be governed by this act. A medical provider as defined in G.S. 44-51.01, as enacted by this act, that had not received, or had received but not yet responded to, a request for medical records under former G.S. 44-49 and G.S. 44-50 before the effective date of this act, but had otherwise taken all necessary steps to obtain a valid lien under those former sections before the effective date of this act, shall provide medical records as required by G.S. 44-51.02, as enacted by this act, to have a perfected lien under this act.

Section 4. This act becomes effective January 1, 1998.

The North Carolina State Bar

ALICE NEECE MOSELEY
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December 5, 1996

Memorandum

To: Floyd M. Lewis, Ex Officio Secretary, General Statutes Commission

From: Ethics Committee of the North Carolina State Bar

Re: Tenth Draft, DN 90-7, Medical Providers' Liens
November 6, 1996

A subcommittee appointed by the chair of the Ethics committee of the North Carolina State Bar previously commented on the Sixth Draft of the Medical Providers' Lien Act. See the revised memorandum to you of August 15, 1996.

The subcommittee reviewed the Tenth Draft of the proposed Act and is gratified that, with one exception, all of its previous suggestions were incorporated into the Tenth Draft in some form.

The exception is the recommendation by the subcommittee that assignments of settlement proceeds to third party medical providers should be prohibited as a matter of public policy and the liens permitted under the Act should be the sole remedy available to medical providers. The subcommittee feels strongly that if the claim of a medical provider against any recovery for personal injury is not controlled by the proposed Act, then medical providers will routinely require assignments of proceeds to circumvent the Act. This will defeat the purpose of the Act. The proceeds from uninsured and underinsured motorist insurance coverage should also be protected from assignment. A good, viable lien act should provide more than adequate protection for medical providers. The subcommittee proposes the inclusion of the following provision in the proposed Act:

> **§ 44-51.08. Exclusive remedy.**
>
> **This Act shall be the sole remedy for the establishment and enforcement by any medical provider of a lien, right or other claim to attach the proceeds of a claimant's recovery of compensatory damages for personal injuries. Assignments of a claimant's recovery of compensatory damages and assignments of the proceeds from insurance coverages issued pursuant to G. S. 20-279.21(b)(3)-(4) are void. Nothing in the Act shall prohibit the enforcement of a judgment lien against a recovery.**

MINUTES

INSURANCE SUBCOMMITTEE ON HB 199

April 15, 1997

The **third** meeting of the Insurance Subcommittee to study House Bill 199-Amend Medical Provider Liens-was called to order by the chairman, Representative Bill Hurley, Tuesday, April 15, 1997 at 8:20 a.m. in Room 1425 L.B. Members **present** were Representatives Bobby Barbee, Joanne Bowie and Edwin Hardy. Members **absent** were Representatives Cary Allred, Thomas Hardaway and David Miner.

Visitors Registration Sheet is attached.

Chairman Hurley recognized Representative Bill Culpepper, bill sponsor, to explain the bill.

Representative Culpepper apologized for not being able to attend past meetings. He explained that The General Statutes Commission has gone through twelve (12) rewrites trying to update the statutes. This committee has sent it for its 13th and 14th rewrite. This legislation was discussed at length in the full Insurance Committee, which precipitated the appointment of this special subcommittee. He continued that the General Statutes Commission sought to address *solely* the issue of medical provider liens (and *not* assignment of proceeds). Representative Carpenter continued to explain the difference in " medical provider liens" and "assignment of proceeds". Interested parties want to see assignment of proceeds addressed in this bill. The question before the committee is "do we want to leave the bill in the narrow scope—only medical provider liens, or go on to address assignment of proceeds?"

Representative Bowie asked if there is time before the bill crossover date to address broader legislation.

Representative Carpenter says it could be addressed if committee could arrive at a consensus. He continued "this is a great vehicle to address the issue (assignment of benefits), because the appellate courts have left it up to us to settle this before another case is called."

Chairman Hurley called on Staff Council, Linwood Jones, for suggestions.

Mr. Jones reiterated Representative Carpenter's remarks.

Chairman Hurley called on visitors to voice their comments.

William Pully, NC Hospital Association, stated that a lien is often not for the full amount of the assignment and medical and legal services should be equal (50% rule).

MINUTES
Insurance Subcommittee on HB 199
April 15, 1997

Doug Maynard, attorney, member of Well, Jenkins, _____, Attorneys-at-Law in Winston-Salem, NC, stated that he was responsible for draft from the Academy of Trial Lawyers and NC Bar Association which was brought to the March 22 meeting of this subcommittee.

Representative Barbee asked for further illustration of how settlement proceeds are assigned under present law.

Doug Maynard explained, using the Charlotte-Mecklenburg vs.First of Georgia case as an example. (See March 26 Minutes.)

Steve Keen, NC Medical Society, spoke for his association, stating that discussion should continue; liens and assignments should be treated the same.

Chairman Hurley called on Representative Carpenter to state his final recommendation on the future of this legislation after hearing from interested parties present.

Representative Carpenter: It sounds like it needs to go to a study commission. He recommended that the committee council draft a study bill to take before the full Insurance Committee.

Representative Hardy stated that he would like to see the matter resolved in this subcommittee, but that he would not object to a study commission pursuing it.

Chairman Hurley called for a motion.

Representative Bowie moved for a study bill to go to the full Insurance Committee.

The members voted unanimously **in favor** of the motion.

Having no further business, the meeting adjourned at 9:50a.m.

Respectfully submitted,

_____
Chairman

Dot Anderson
Committee Clerk

VISITOR REGISTRATION SHEET

INSURANCE SUBCOMMITTEE ON HB 199 — April 15, 1997

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daphne Lyon	DMA - DHR
Doug Maynard	Wells Jenkins Lucas & Jenkins PLLC - W-S NC
Dick [illegible]	NCATL
Charles Cromer	NCATL
Anne I. Dixon	NCBA
Steve Keene	NC Med. Soc.
Tommy Watts	Carolina HealthCare System
[illegible]	NCNA
Floyd M. Lewis	General Statutes Commission
P. Bly Hall	(ditto)
Lyman Cowper	CSX Corp.

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 24, 1997

The House Committee on Insurance met in Room 643 of the Legislative Office Building on April 24, 1997 at 12:00 noon. Representative Dockham, Chairman, presided. Members present were: Representatives Allred, Barbee, Black, Bowie, Brawley, Cole, Dedmon, Dickson, Gamble, Hardy, Hensley, Hurley, Ives, Luebke, McComas, Michaux, Miller, Miner, Preston, Tallent, Wainwright, and Wright. A list of visitors attending is attached.

Chairman Dockman called the meeting to order and the following bills were considered:

House Bill 926, entitled, An Act Pertaining to Preferred Provider Contracts was before the committee for consideration (bill summary attached). Representative Brawley, sponsor, gave a report from the subcommittee that considered this bill. The recommendation of the subcommittee was that this bill needed further work but that it be passed out of the full committee in order to meet the crossover deadline. Further work would need to be done on the bill when it reaches the Senate. Mr. William Potter, a representative from the Dental Society spoke against the bill stating that the bill is inappropriate. Representative Michaex moved that House Bill 926 be given a favorable report. The motion passed.

House Bill 1024, entitled An Act to Allow for the Licensing of Certain Subsidiaries of Insurers Owned or Controlled by Foreign Governments was considered (bill summary attached) .Bill sponsor, Representative Hurley stated that this legislation was requested by the Department of Insurance and that the Department has no objections to the bill. Representative Tallent moved that House Bill 1024 be given a favorable report. The motion carried.

House Bill 891, entitled, An Act to Allow an Employer and its Representatives to Contact an Employee's Right to Direct Medical Treatment and to Obtain Information Regarding Medical Treatment was considered (bill summary attached). Representative Mitchell, sponsor, presented a committee substitute for the bill. Representative Dickson moved that the committee substitute be before the committee for consideration. The motion passed. Chairman Dockham ruled that the bill be temporarily displaced until an adequate number of the correct committee substitute could be handed out to the members. When all members received copies, the bill was back before the committee and Representative Mitchell explained that this bill substitute gives an employer the right to a employee's medical record if the employee is drawing workers compensation. Representative Barbee

moved that the committee substitute be given a favorable report and the original bill be given an unfavorable report. The motion carried.

House Bill 923, entitled, An Act to Require Insurers Writing Home Owners Insurance to Offer Coverage Without Separate Deductibles for Windstorm and Hail, was before the committee for consideration (bill summary attached). Representative Wainwright, sponsor, stated that coastal counties were experiencing difficulties because windstorm and hail deductibles were being placed on homeowners policies. The bill prohibits insurance companies from requiring that policy holders accept windstorm deductible on home owners' policies but does not limit insurance companies from offering home owners windstorm and hail deductible. Questions from the members were answered by Bill Hale of the Department of Insurance. Representative Brawley expressed concern that the bill might hinder insurance companies from providing adequate benefits. Susan Valerie, Nationwide Insurance representative, expressed concern about problems resulting from passage of this bill. After committee discussion and questions, Chairman Dockham determined that House Bill 923 needed further study by a sub-committee, to be appointed, and perhaps a more in-depth study by a legislative interim study committee.

House bill 1052, entitled, An Act to Allow Insurers to Limit or Exclude Excess Liability Coverage for Uninsured and Underinsured Motorists as Provided by Law (bill summary attached), was presented for consideration. Bill sponsor, Representative Miller, discussed the bill and moved for a favorable report. The motion carried.

The meeting adjourned at 3:15 p.m.

Jerry C. Dockham, Chairman

Mary H. Moore, Acting Clerk

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

HOUSE BILL 926

Short Title: Preferred Provider Contracts. (Public)

Sponsors: Representatives Brawley; Carpenter, Clary, Dockham, Eddins, Hurley, McAllister, McMahan, and Tallent.

Referred to: Insurance.

April 14, 1997

A BILL TO BE ENTITLED

AN ACT PERTAINING TO PREFERRED PROVIDER CONTRACTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-55 reads as rewritten:

"**§ 58-50-55. Preferred provider contracts.**

(a) Notwithstanding any other provisions of law, except the second and third paragraphs of G.S. 58-50-30, corporations organized pursuant to Articles 1 through 64 of this Chapter are authorized to enter into preferred provider contracts in addition to all other contracts authorized by Articles 1 through 64 of this Chapter, or to enter other cost containment arrangements approved by the Commissioner, with persons, entities or organizations for the purpose of reducing the cost of providing health care services. Such preferred provider contracts may be entered into with licensed institutions and practitioners of all types without regard to specialty of services or limitation to a specific type of practice.

(b) The Department shall have authority to make rules applicable to persons offering preferred provider plans, policies, or contracts pursuant to this section. These rules shall be designed to provide for (i) accessibility of preferred provider services to individuals comprising the insured or contracted group, (ii) the adequacy of the number and locations of institutions and practitioners, (iii) the availability of services at reasonable times, ~~and~~ (iv) financial ~~solvency.~~ solvency, and (v) product limitations. Rules adopted for product limitations shall be similar in substance to rules governing HMO point-of-service products.

(c) The Department shall require each preferred provider plan to provide summary data regarding the financial reimbursement offered to providers of health care. All such plans shall disclose annually the following information:

(1) The name by which the preferred provider plan policy or arrangement is known, and its business address;

(2) The name, address and nature of any separate organization which administers the plan, policy or arrangement on behalf of the preferred provider; and

(3) The names and addresses of all providers of health care designated by the preferred provider and the terms of the agreements entered into with those providers.

~~(d) A person enrolled in a preferred provider plan may obtain covered health care services from a provider not participating in the plan. The preferred provider plan may, however, limit the coverage for health care services obtained from a provider not participating in the plan, except that payments for services rendered by such non-participating providers may not be reduced by more than twenty percent (20%) of payments that would be made to participating providers under coverage for the same services. This percentage limitation shall not require any waiver of copayments or waiver of deductibles in determining payments for services rendered by non-participating providers. Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by non-participating providers. Except as provided in this subsection, such payment may differ from that provided to participating providers in the discretion of the corporation. Non-participating providers may participate in other arrangements with the preferred provider, but will be subject to the provider's approved reimbursement mechanisms including, but not limited to, direct payment of health insurance benefits to the subscriber without right of assignment to the provider of health care services.~~

(e) Upon the initial offering of a preferred provider plan to the public, any potential provider institutions and practitioners shall be allowed the opportunity to submit a proposal for participation in accordance with the terms of the plan. The health care providers shall have at least thirty (30) days to submit a proposal for participation. Subsequent to the initial offering of a preferred provider plan, any provider seeking to submit a proposal may be permitted to do so, and the plan shall consider all pending applications for participation and give reasons for any rejections on at least an annual basis. Any provider seeking to participate in the plan, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the preferred provider plan. The second and third paragraphs of G.S. 58-50-30 are specifically made applicable to preferred provider plans.

(f) Any provision of a contract between a preferred provider plan and a health care provider restricting the health care provider's right to enter into preferred provider arrangements with other parties is prohibited. Any such restriction in a preferred provider contract between a preferred provider plan and a provider of health care services is null and void and shall not be enforceable. The existence of

any such unenforceable restriction shall not invalidate any other provision of the preferred provider contract.

(g) A list of the current participating health care providers in the geographic area in which a substantial portion of health care services will be available shall be provided to enrollees and contracting parties.

(h) Publications or advertisements of preferred providers plans or arrangements shall not refer to the quality or efficiency of the services of non-participating providers."

Section 2. G.S. 58-65-140 reads as rewritten:

"**§ 58-65-140. Preferred provider contracts.**

(a) Notwithstanding any other provisions of law, except the second and third paragraphs of G.S. 58-50-30, corporations organized for the purposes of this Article and Article 66 of this Chapter are authorized to enter into preferred provider contracts in addition to all other contracts authorized by this Article and Article 66 of this Chapter, or to enter other cost containment arrangements approved by the Commissioner of Insurance, with persons, entities or organizations for the purpose of reducing the costs of providing health care services. Such preferred provider contracts may be entered into with licensed institutions and practitioners of all types without regard to speciality of services or limitation to a specific type of practice.

(b) The Department of Insurance shall have authority to make rules applicable to corporations offering preferred provider plans, policies, or contracts pursuant to this section. These rules shall be designed to provide for (i) accessibility of preferred provider services to individuals comprising the insured or contracted group, (ii) the adequacy of the number and locations of institutions and practitioners, (iii) the availability of services at reasonable times, ~~and~~ (iv) financial ~~solveney.~~ solvency, and (v) product limitations. Rules adopted for product limitations shall be similar in substance to rules governing HMO point-of-service products.

(c) The Department of Insurance shall require each corporation developing preferred provider plans, policies or contracts under this section to provide summary data regarding the financial reimbursement offered to providers. Any corporation which proposes to offer preferred provider plans, contracts or policies authorized by this section shall furnish annually to the Department of Insurance the following information:

(1) The name by which the preferred provider plan, policy or contract will be known, and its business address;

(2) The name, address and nature of any separate organization which administers the plan, policy or contract on behalf of the insured; and

(3) The names and addresses of all providers designated by the corporation and the terms of the agreements with these providers.

~~(d) A person enrolled in a preferred provider plan may obtain covered health care services from a provider not participating in the plan. The preferred provider plan may, however, limit the coverage for health care services obtained from a provider not participating in the plan, except that payments for services rendered by such~~

~~non-participating providers may not be reduced by more than twenty percent (20%) of payments that would be made to participating providers under coverage for the same services. This percentage limitation shall not require any waiver of copayments or waiver of deductibles in determining payments for services rendered by nonparticipating providers. Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by nonparticipating providers. Except as provided in this subsection, such payment may differ from that provided to participating providers in the discretion of the corporation. Nonparticipating providers may participate in other arrangements with the corporation, but will be subject to reimbursement mechanisms approved by the corporation including, but not limited to, direct payment of health insurance benefits to the subscriber without right of assignment to the provider of health care services.~~

(e) Upon the initial offering of a preferred provider plan to the public, any potential provider institutions and practitioners shall be allowed the opportunity to submit a proposal for participation in accordance with the terms of the plan. The health care providers shall have at least thirty (30) days to submit a proposal for participation. Subsequent to the initial offering of a preferred provider plan, any provider seeking to submit a proposal may be permitted to do so, and the plan shall consider all pending applications for participation and give reasons for any rejections on at least an annual basis. The second and third paragraphs of G.S. 58-50-30 are specifically made applicable to preferred provider plans.

(f) Any provision of a contract between a corporation and a provider restricting the provider's right to enter into preferred provider arrangements with other parties is prohibited. Any such restriction in a preferred provider contract between a corporation and a provider of health care services is null and void and shall not be enforceable; however, the existence of any such unenforceable restriction shall not invalidate any other provision of the preferred provider contract.

(g) Any corporation marketing a preferred provider plan to subscribers or contracting parties must provide to the same a written list of the then current participating institutions and practitioners in the geographic area in which it is anticipated that the substantial portion of health care services will be provided prior to entering into a preferred provider plan contract with the actual or potential subscriber or contracting party.

(h) Publications or advertisements of preferred providers shall not refer to the quality or efficiency of the health care services of nonparticipating providers."

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

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April 24, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 926 (Preferred Provider Contracts)

House Bill 926 authorizes the Department of Insurance to adopt rules imposing "product limitations" on preferred provider organization (PPO) products. These rules must be similar to those adopted for HMO point-of-service products.

The bill also repeals the existing statutory limitation on how much the insurer can reduce its reimbursement to an insured who participates in a PPO when that insured obtains medical care and treatment from a provider who is not a member of that PPO. The statutes currently allow the reimbursement to be reduced twenty percent (20%) for these out-of-network visits. Presumably, the allowable reduction would be addressed in rules adopted by the Department if this bill passes. As mentioned above, the rules must be substantially the same as the rules for HMOs. By rule, the HMO point-of-service plans can currently reduce reimbursement 30% for out-of-network visits.

This bill would take effect upon becoming law.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Rep. Dockham for the Committee on Insurance

( ) **Committee Substitute for**
H.B. 926 , S.B. _____ A BILL TO BE ENTITLED AN ACT
H.J.R. _____ , S.J.R. _____ A JOINT RESOLUTION
H.R. _____ A HOUSE RESOLUTION

PERTAINING TO PREFERRED PROVIDER CONTRACTS.

X With a favorable report.

___ With a favorable report and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

___ With a favorable report, as amended.

___ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

___ With a favorable report as to committee substitute bill (# ____), ( ) which changes the title, unfavorable as to original bill (Committee Substitute Bill # ____). (and recommendation that the committee substitute bill (# ____) be re-referred to the Committee on _____.)

___ With a favorable report as to House committee substitute bill (# ____), ( ) which changes the title, unfavorable as to Senate committee substitute bill.

___ And having received a unanimous vote in committee, is placed on the Consent Calendar.

___ With an unfavorable report.

___ With recommendation that the House concur.

___ With recommendation that the House do not concur.

___ With recommendation that the House do not concur; request conferees.

___ With recommendation that the House concur; committee believes bill to be material.

___ With an unfavorable report, with a Minority Report attached.

___ Without prejudice.

___ With an indefinite postponement report.

___ With an indefinite postponement report, with a Minority Report attached.

___ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

1/15/97

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 1024*

Short Title: Foreign Insurer Licensing. (Public)

Sponsors: Representatives Hurley; Barbee, Boyd-McIntyre, Brawley, Gamble, Holmes, McCrary, Morris, and Warner.

Referred to: Insurance, if favorable, Judiciary I.

April 21, 1997

A BILL TO BE ENTITLED

AN ACT TO ALLOW FOR THE LICENSING OF CERTAIN SUBSIDIARIES OF INSURERS OWNED OR CONTROLLED BY FOREIGN GOVERNMENTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-16-20 reads as rewritten:

"**§ 58-16-20. Company owned or controlled by ~~alien~~ foreign government prohibited from doing business.**

(a) Any insurance company or other insurance entity ~~which~~ that is financially owned or financially controlled by any alien or foreign government outside the continental limits of the United States or the territories of the United States is ~~hereby~~ prohibited from doing any kind of insurance business in the State of North Carolina. For the purposes of this section, ~~the term~~ 'alien or foreign government' ~~is defined to mean~~ means any foreign government or any state, province, municipality, or political subdivision of any foreign government, and shall not be construed to apply to any insurance company organized under the laws of a foreign nation ~~which~~ that is financially owned or financially controlled by the private citizens or private business interest of such foreign nation.

(b) The Commissioner ~~is hereby forbidden to grant a~~ shall not license ~~to~~ any insurance company or other insurance entity ~~which~~ that is financially owned or financially controlled by any alien or foreign government outside the continental limits of the United States or the territories of the United States, ~~or to~~ nor shall the Commissioner authorize any such company or entity to transact any kind of insurance business in the State of North Carolina.

(c) Any insurance company or other insurance entity ~~which~~ that is financially owned or financially controlled by any alien or foreign government outside the continental limits of the United States or the territories of the United States, or any representative or agent of any such company or entity ~~which~~ that violates the provisions of this section, ~~shall be~~ is guilty of a Class 3 misdemeanor.

(d) This section does not apply to the operating subsidiary of any insurance company or other insurance entity, which company or entity is financially owned or financially controlled by any alien or foreign government outside the continental limits of the United States or the territories of the United States, as long as the operating subsidiary is domesticated in and licensed by a state of the United States as an insurer or reinsurer and as a separate subsidiary."

Section 2. This act becomes effective October 1, 1997, and applies to acts committed and applications for licensure submitted on or after that date.

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2.

April 24, 1997

MEMORANDUM

To: House Insurance Committee

From: M. Lynn Marshbanks, Committee Counsel

Re: House Bill 1024: Foreign Insurer Licensing - Hurley

House Bill 1024 would allow some subsidiaries of foreign insurance companies to be licensed in North Carolina. Currently, no insurance entity that is financially owned or controlled by a foreign government may do business in this state. This bill would allow an operating subsidiary of such an insurance company to be licensed in North Carolina if the subsidiary is domesticated in and licensed by another state as an insurer or reinsurer and as a separate subsidiary.

Effective date: October 1, 1997, applying to acts committed and applications for licenseure submitted on or after that date.

H1024-SMRS-001

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Rep. Dockham for the Committee on Insurance

( ) **Committee Substitute for**
H.B. 1024, S.B. _____ A BILL TO BE ENTITLED AN ACT
H.J.R. _____, S.J.R. _____ A JOINT RESOLUTION
H.R. _____ A HOUSE RESOLUTION

TO ALLOW FOR THE LICENSING OF CERTAIN SUBSIDIARIES OF INSURERS OWNED OR CONTROLLED BY FOREIGN GOVERNMENTS.

X With a favorable report.

____ With a favorable report and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report, as amended.

____ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report as to committee substitute bill (# ____), ( ) which changes the title, unfavorable as to original bill (Committee Substitute Bill # ____). (and recommendation that the committee substitute bill (# ____) be re-referred to the Committee on _____.)

____ With a favorable report as to House committee substitute bill (# ____), ( ) which changes the title, unfavorable as to Senate committee substitute bill.

____ And having received a unanimous vote in committee, is placed on the Consent Calendar.

____ With an unfavorable report.

____ With recommendation that the House concur.

____ With recommendation that the House do not concur.

____ With recommendation that the House do not concur; request conferees.

____ With recommendation that the House concur; committee believes bill to be material.

____ With an unfavorable report, with a Minority Report attached.

____ Without prejudice.

____ With an indefinite postponement report.

____ With an indefinite postponement report, with a Minority Report attached.

____ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

1/15/97

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

Proposed Comm

HOUSE BILL 891*

Short Title: Workers Compensation Medical Care. (Public)

Sponsors: Representatives Mitchell; Cole, Creech, Hardy, McComas, McMahan, Miner, Morris, Nichols, Owens, Weatherly, and Wilkins.

Referred to: Insurance, if favorable, Judiciary I.

April 7, 1997

A BILL TO BE ENTITLED

AN ACT TO ALLOW AN EMPLOYER AND ITS REPRESENTATIVES TO CONTACT AN EMPLOYEE'S TREATING PHYSICIAN AS NECESSARY TO EXERCISE THE EMPLOYER'S RIGHT TO DIRECT MEDICAL TREATMENT AND TO OBTAIN INFORMATION REGARDING MEDICAL TREATMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 97-25 reads as rewritten:

"**§ 97-25. Medical treatment and supplies.**

Medical compensation shall be provided by the employer. Notwithstanding the provisions of G.S. 8-53 and the prohibition against ex parte contacts at common law, the employer, its insurer, representatives, attorneys, or claims adjusters may directly communicate in person, orally, or in writing with any medical provider rendering treatment for any injury claimed by the employee to be compensable under this Chapter and may obtain copies of records of the treatment. The employee, or the employee's attorney, if he or she is represented, shall be notified of the substance of the conversation promptly thereafter. In case of a controversy arising between the employer and employee relative to the continuance of medical, surgical, hospital, or other treatment, the Industrial Commission may order such further treatments as may in the discretion of the Commission be necessary.

The Commission may at any time upon the request of an employee order a change of treatment and designate other treatment suggested by the injured employee subject to the approval of the Commission, and in such a case the expense thereof shall be

borne by the employer upon the same terms and conditions as hereinbefore provided in this section for medical and surgical treatment and attendance.

The refusal of the employee to accept any medical, hospital, surgical or other treatment or rehabilitative procedure when ordered by the Industrial Commission shall bar said employee from further compensation until such refusal ceases, and no compensation shall at any time be paid for the period of suspension unless in the opinion of the Industrial Commission the circumstances justified the refusal, in which case, the Industrial Commission may order a change in the medical or hospital service.

If in an emergency on account of the employer's failure to provide the medical or other care as herein specified a physician other than provided by the employer is called to treat the injured employee, the reasonable cost of such service shall be paid by the employer if so ordered by the Industrial Commission.

Provided, however, if he so desires, an injured employee may select a physician of his own choosing to attend, prescribe and assume the care and charge of his case, subject to the approval of the Industrial Commission."

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

fav - report

H

D

HOUSE BILL 891*
Proposed Committee Substitute H891-CSLD-004
WARNING: LINE NUMBERS MAY CHANGE AFTER ADOPTION

Short Title: Workers Compensation Medical Care. (Public)

Sponsors:

Referred to: Insurance, if favorable, Judiciary I.

April 7, 1997

A BILL TO BE ENTITLED

AN ACT TO ALLOW AN EMPLOYER AND ITS REPRESENTATIVES TO CONTACT AN EMPLOYEE'S TREATING PHYSICIAN AS NECESSARY TO EXERCISE THE EMPLOYER'S RIGHT TO DIRECT MEDICAL TREATMENT AND TO OBTAIN INFORMATION REGARDING MEDICAL TREATMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 97-25 reads as rewritten:

"§ 97-25. Medical treatment and supplies.

Medical compensation shall be provided by the employer. Notwithstanding the provisions of G.S. 8-53, any law relating to the privacy of medical records or information, and the prohibition against ex parte communications at common law, an employer paying medical compensation to a provider rendering treatment under this Chapter may obtain records of the treatment without the express authorization of the employee. The Commission shall adopt rules that govern additional methods of oral and written communications between an employer paying compensation under this Chapter and medical care providers. These rules shall protect the employee's right to a confidential physician-patient relationship, while facilitating the release of information necessary to the administration of the employee's claim. In case of a controversy arising between the employer and

employee relative to the continuance of medical, surgical, hospital, or other treatment, the Industrial Commission may order such further treatments as may in the discretion of the Commission be necessary.

The Commission may at any time upon the request of an employee order a change of treatment and designate other treatment suggested by the injured employee subject to the approval of the Commission, and in such a case the expense thereof shall be borne by the employer upon the same terms and conditions as hereinbefore provided in this section for medical and surgical treatment and attendance.

The refusal of the employee to accept any medical, hospital, surgical or other treatment or rehabilitative procedure when ordered by the Industrial Commission shall bar said employee from further compensation until such refusal ceases, and no compensation shall at any time be paid for the period of suspension unless in the opinion of the Industrial Commission the circumstances justified the refusal, in which case, the Industrial Commission may order a change in the medical or hospital service.

If in an emergency on account of the employer's failure to provide the medical or other care as herein specified a physician other than provided by the employer is called to treat the injured employee, the reasonable cost of such service shall be paid by the employer if so ordered by the Industrial Commission.

Provided, however, if he so desires, an injured employee may select a physician of his own choosing to attend, prescribe and assume the care and charge of his case, subject to the approval of the Industrial Commission."

Section 2. This act is effective when it becomes law.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

Minutes

The following report(s) from standing committee(s) is/are presented:

By Rep. Dockham for the Committee on Insurance

( ) **Committee Substitute for**
H.B. 891 , S.B. _____ A BILL TO BE ENTITLED AN ACT
H.J.R. _____ , S.J.R. _____ A JOINT RESOLUTION
H.R. _____ A HOUSE RESOLUTION

TO ALLOW AN EMPLOYER AND ITS REPRESENTATIVES TO CONTACT AN EMPLOYEE'S TREATING PHYSICIAN AS NECESSARY TO EXERCISE THE EMPLOYER'S RIGHT TO DIRECT MEDICAL TREATMENT AND TO OBTAIN INFORMATION REGARDING MEDICAL TREATMENT.

____ With a favorable report.

____ With a favorable report and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report, as amended.

____ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

With a favorable report as to committee substitute bill ~~(# ____), ( ) which changes the title,~~ unfavorable as to original bill ~~(Committee Substitute Bill # ____). (and recommendation that the committee substitute bill (# ____) be re-referred to the Committee on~~ _____.)

____ With a favorable report as to House committee substitute bill (# ____), ( ) which changes the title, unfavorable as to Senate committee substitute bill.

____ And having received a unanimous vote in committee, is placed on the Consent Calendar.

____ With an unfavorable report.

____ With recommendation that the House concur.

____ With recommendation that the House do not concur.

____ With recommendation that the House do not concur; request conferees.

____ With recommendation that the House concur; committee believes bill to be material.

____ With an unfavorable report, with a Minority Report attached.

____ Without prejudice.

____ With an indefinite postponement report.

____ With an indefinite postponement report, with a Minority Report attached.

With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

1/15/97

North Carolina General Assembly
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April 24, 1997

3.

P.C.S. 891 Dubon moved for adoption ✓ McComas moved for favorable rpt

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 891 (Workers' Compensation Medical Care)

House Bill 891 provides that an employer or its insurance company (or the attorney, adjuster, or other representative of either) may directly contact the medical provider that treats an injured employee (under Workers' Compensation) and may obtain copies of the medical records relating to that treatment. The nature of the contact with the provider and what was communicated must be promptly revealed afterwards to the employee, or if the employee is represented by counsel, to the employee's attorney.

The bill addresses a recent Court of Appeals decision (*Salaam v. N.C. Department of Transportation)* in which the Court ruled that the employer could not have *ex parte* contact with the medical provider who treated or is treating the employee for a workers' compensation injury. In its ruling, the Court indicated that it was bound by a prior decision of the Supreme Court (*Crist v. Moffattt*) prohibiting ex parte contacts between a party and a medical provider in the context of a medical malpractice action. A copy of the Salaam decision is attached.

This bill would take effect upon becoming law.

KENZIE SALAAM, Plaintiff-Appellant
vs.
NORTH CAROLINA DEPARTMENT OF TRANSPORTATION, Defendant-Appellee

No. COA95-425
COURT OF APPEALS OF NORTH CAROLINA
468 S.E.2d 536, 122 N.C. App. 83
March 19, 1996, Filed

From the North Carolina Industrial Commission I.C. No. 840436. Appeal by plaintiff from Opinion and Award of the North Carolina Industrial Commission filed 3 November 1994.

COUNSEL

Donaldson & Horsley, P.A., by Kathleen G. Sumner, Greensboro, NC, for plaintiff-appellant.
Attorney General Michael F. Easley, by Special Deputy Attorney General Elisha H. Bunting, Jr., for defendant-appellee.

JUDGES

MARTIN, Mark D., Judge, Judges EAGLES and MARTIN, John C., concur.
AUTHOR: MARTIN

OPINION

*{*84}* MARTIN, Mark D., Judge.

Plaintiff Kenzie Salaam (Salaam) appeals from Opinion and Award entered by the North Carolina Industrial Commission (Commission) denying Salaam's claim for additional compensation based on an alleged change of condition.

On 30 June 1988 Salaam, while employed with defendant North Carolina Department of Transportation (NCDOT), suffered an injury *{*85}* to his back arising out of, and in the course of, his employment. On 24 August 1988 the Commission approved I.C. Form 21, Agreement for Compensation for Disability, submitted by NCDOT and Salaam.

On 30 January 1989 Salaam underwent surgery on his back. After surgery Dr. William L. Pritchard, Salaam's surgeon, rated Salaam with a ten percent permanent partial disability of the back. On 25 July 1989 the Commission approved I.C. Form 26, Supplemental Memorandum of Agreement as to Payment of Compensation, submitted by the parties. Under the terms of I.C. Form 26, Salaam received thirty weeks of ten percent permanent partial disability compensation pursuant to N.C. Gen. Stat. § 97-31.

Salaam subsequently requested a hearing for additional benefits under N.C. Gen. Stat. § 97-47. In the course of the attendant discovery process, the parties deposed Dr. Pritchard. Prior to the deposition, NCDOT's counsel engaged in an **ex parte** conversation with Dr. Pritchard. At the deposition, Salaam's counsel objected to the entire proceeding based on, among other things, the alleged inappropriate nature of the **ex parte** conversation.

On 15 December 1993 Deputy Commissioner Scott M. Taylor, after considering all the evidence, including Dr. Pritchard's deposition testimony, concluded Salaam had not sustained a change of condition. Salaam appealed to the Full Commission which also admitted Dr. Pritchard's deposition testimony. On 3 November 1994 the Full Commission filed an Opinion and Award finding "on September 19, 1991 plaintiff returned to Dr. Pritchard complaining of pain. Plaintiff's physical condition, however, has not significantly changed since plaintiff agreed to accept ten percent permanent partial disability compensation as a result of his compensable injury on June 30, 1988." The Commission therefore concluded Salaam, since receiving a permanent partial disability rating of ten percent, "has not undergone a change of condition, and is not, therefore, entitled to additional compensation under N.C.G.S. § 97-47."

On appeal Salaam contends the Commission erred by: (1) approving I.C. Form 26 in light of the standard enunciated by the Supreme Court in **Vernon v. Steven L. Mabe Builders,** 336 N.C. 425, 444 S.E.2d 191 (1994); (2) overruling Salaam's objection to the **ex parte** communication between Dr. Pritchard and NCDOT; (3) concluding Salaam has not sustained a change of condition; (4) finding NCDOT established, assuming **arguendo** I.C. Form 26 is set aside, that Salaam is employable; (5) failing to set forth sufficient findings of fact to allow *{*86}* this Court to determine the rights of the parties; and (6) finding there was "no good ground to reconsider" the previous Order and Award.

I.

We first consider Salaam's allegation the Commission should not have approved I.C. Form 26 because it was fundamentally unfair.

Our Supreme Court recently held the Commission, prior to approving any I.C. Form 26, must exercise its judicial authority by determining "the fairness of the agreement." **Vernon,** 336 N.C. at 434, 444 S.E.2d at 196. In **Vernon,** the parties submitted, and the Commission subsequently approved, I.C. Form 26, under which plaintiff received compensation for his injury pursuant to section 97-31. The medical report attached to I.C. Form 26 assigned plaintiff a fifteen percent permanent partial disability of the back, but also stated plaintiff would probably not be able to return to work. **Id.** at 434, 444 S.E.2d at 195.

The Supreme Court, relying on the attending physician's assertion plaintiff would be unable to work in the future, noted "plaintiff may have been entitled to permanent total disability benefits under section 97-29, as well as permanent partial disability benefits based on the fifteen percent rating under section 97-31." **Id.** The Court also found the approving authority assumed, rather than determined, that plaintiff understood his right to elect the most beneficial method of compensation under the Workers' Compensation Act. 336 N.C. at 434, 444 S.E.2d at 195-196. The Court therefore concluded the Commission failed to "act in a judicial capacity [by determining] the fairness of the agreement." **Id.** at 434, 444 S.E.2d at 196.

In contrast, although the present record establishes Salaam was assigned a ten percent permanent partial disability of his back, we find no evidence in the medical records submitted to the Commission with I.C. Form 26 which supports awarding permanent total disability benefits

under section 97-29. **See** N.C. Gen. Stat. § 97-29 (1991). In fact, Dr. Pritchard, in his letter assigning Salaam a ten percent permanent impairment, "**encouraged** [Salaam] . . . **to seek some gainful employment** within his capabilities." (emphasis added). Therefore, the present case is distinguishable from **Vernon** because Salaam, unlike the plaintiff in **Vernon,** was not entitled to benefits under section 97-29. Accordingly, we conclude the Commission appropriately exercised its judicial authority by approving I.C. Form 26 submitted by NCDOT and Salaam.

*[*87]* Finally, we note the Commission may set aside a previously approved I.C. Form 26 if plaintiff can establish "that there has been error due to fraud, misrepresentation, undue influence or mutual mistake . . . ." N.C. Gen. Stat. § 97-17 (1991). We believe, after careful review of the present record, that Salaam cannot establish the existence of any of these factors. **See Brookover v. Borden, Inc.,** 100 N.C. App. 754, 755-756, 398 S.E.2d 604, 605-606 (1990), **disc. review denied,** 328 N.C. 270, 400 S.E.2d 450 (1991). Accordingly, this assignment of error must fail.

II.

We next consider Salaam's contention the Commission erred by overruling his objection to the **ex parte** communication between Dr. Pritchard and NCDOT.

N.C. Gen. Stat. § 97-27(b) (1991) provides, in pertinent part: "No fact communicated to or otherwise learned by any physician . . . who may have . . . examined the employee, or . . . been present at any examination, shall be privileged, either in hearings provided for by this Article or any action at law." **Id.** This proviso is considered an exception to the statutory physician-patient privilege created by N.C. Gen. Stat. § 8-53. LEONARD T. JERNIGAN, JR., NORTH CAROLINA WORKERS' COMPENSATION § 17-6 (2d Ed. 1995).

Nevertheless, "the statutory physician-patient privilege is distinct from the rule prohibiting unauthorized **ex parte** contacts" and, therefore, information actually discoverable because the statutory privilege is inapplicable may be improperly acquired if done so through **ex parte** communications. **Crist v. Moffatt,** 326 N.C. 326, 332-333, 389 S.E.2d 41, 45 (1990). Clearly, "the gravamen of [allowing **ex parte** contacts] is not whether evidence of plaintiff's medical condition is subject to discovery, but by what methods the evidence may be discovered." **Id.** at 336, 389 S.E.2d at 47.

In **Crist,** a medical malpractice case, the Court held "defense counsel may not interview plaintiff's nonparty treating physician privately without plaintiff's express consent" because "considerations of patient privacy, the confidential relationship between doctor and patient, the adequacy of formal discovery devices, and the untenable position in which **ex parte** contacts place the nonparty treating physician supersede defendant's interest in a less expensive and more convenient method of discovery." **Id.** In so holding, the Court assumed the **statutory** physician-patient privilege was waived by plaintiff. *[*88]* Therefore, the **Crist** rule precludes non-consensual **ex parte** communications during adversarial proceedings.

Although we recognize "the Commission is not required to strictly apply the rules of evidence applicable to a court of law," **Tucker v. City of Clinton,** 120 N.C. App. 776, 777, 463 S.E.2d 806, 810 (1995), we likewise note the rationale of the **Crist** Court did not turn on the

existence or nonexistence of an evidentiary privilege. Moreover, after careful review of the bases for the **Crist** holding -- patient privacy, the confidential relationship between doctor and patient, and the adequacy of formal discovery devices -- we cannot discern why these policy considerations would not be equally applicable to adversarial proceedings before the Commission. Therefore, notwithstanding the relaxed evidentiary rules applicable to the Commission, **Id.,** and the fact defendant's arguments would carry great force were we writing on a clean slate, we nonetheless are bound by **Crist.** Consequently, we must conclude the Commission erred by admitting Dr. Pritchard's deposition testimony in light of the non-consensual **ex parte** contact between NCDOT and Dr. Pritchard. **See Crist,** 326 N.C. at 336, 389 S.E.2d at 47.

Finally, we also note NCDOT, in its brief, argues Salaam suffered no prejudice by admitting Dr. Pritchard's deposition over his objection because "Salaam was allowed to question the physician about the [**ex parte**] communication and show any possible taint or bias." Although the opportunity to cure any prejudice resulting from **ex parte** communications prior to deposition is theoretically available in every adversarial proceeding, we note the **Crist** Court appears to have established a prophylactic protection against **non-consensual ex parte** communications. S **ee Id.** Therefore, we must reject this contention.

Accordingly, we reverse the Opinion and Award filed 3 November 1994 and remand this case to the Commission with directions to strike the deposition testimony of Dr. Pritchard and reconsider Salaam's request for additional benefits under N.C. Gen. Stat. § 97-47.

Reversed and remanded.

Judges EAGLES and MARTIN, John C., concur.

DISPOSITION

Reversed and remanded.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 923

Short Title: Windstorm Deductibles. (Public)

Sponsors: Representatives Wainwright, Nichols; and Smith.

Referred to: Insurance.

April 10, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURERS WRITING HOMEOWNERS' INSURANCE TO OFFER COVERAGE WITHOUT SEPARATE DEDUCTIBLES FOR WINDSTORM AND HAIL.

The General Assembly of North Carolina enacts:

Section 1. Article 36 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-36-105. Windstorm and hail deductibles in homeowners' insurance.**

(a) An insurer that writes coverage against loss to residential real property under this Article shall offer coverage without separate deductibles (from the all perils deductibles) for losses arising from windstorm and hail. An insurer may not refuse to issue or renew coverage against loss to residential real property under this Article solely on grounds that the insured or prospective insured declines to accept coverage with a separate deductible for windstorm and hail.

(b) This section does not prohibit an insurer from doing the following:

(1) Offering coverage with separate windstorm and hail deductibles if the insured or prospective insured is informed of the right to select:

a. Any windstorm and hail deductible generally offered by the insurer for that product, and

b. Coverage without the separate windstorm and hail deductibles.

(2) Offering or using lower premiums for separate windstorm and hail deductibles.

(3) Offering or using different levels of deductibles for all perils or offering or using separate deductibles for other named perils.

(4) Offering to write or writing coverage that excludes the perils of windstorm and hail."

Section 2. G.S. 58-45-35 reads as rewritten:

"**§ 58-45-35. Persons eligible to apply to Association for coverage; contents of application.**

(a) Any person having an insurable interest in insurable property, may, on or after the effective date of the plan of operation, be entitled to apply to the Association for such coverage and for an inspection of the property. A broker or agent authorized by the applicant may apply on the applicant's behalf. Each application shall contain a statement as to whether or not there are any unpaid premiums due from the applicant for essential property insurance on the property.

The term 'insurable interest' as used in this subsection shall include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

(b) If the Association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance and shall offer additional extended coverage, optional perils endorsements, business income coverage, crime insurance, separate policies of windstorm and hail insurance, or their successor forms of coverage, for a term of one year or three years. Any policy issued under this section shall be renewed, upon application, as long as the property is insurable property.

(c) If the Association, for any reason, denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant or takes no action on an application within the time prescribed in the plan of operation, the applicant may appeal to the Commissioner and the Commissioner, or the Commissioner's designee from the Commissioner's staff, after reviewing the facts, may direct the Association to issue or cause to be issued an insurance policy to the applicant. In carrying out the Commissioner's duties under this section, the Commissioner may request, and the Association shall provide, any information the Commissioner deems necessary to a determination concerning the reason for the denial or delay of the application.

(d) An agent who is licensed under Article 33 of this Chapter as an agent of a company which is a member of the Association established under this Article shall not be deemed an agent of the Association.

(e) Policies of windstorm and hail insurance provided for in subsection (b) of this section are available only for risks for which essential property insurance has been written by licensed insurers. Whenever such other essential property insurance written by licensed insurers includes replacement cost coverage, the Association shall also offer replacement cost coverage. In order to be eligible for a policy of windstorm and hail insurance, the applicant shall provide the Association, along with the

premium payment for the windstorm and hail insurance, a certificate that the essential property insurance is in force. The policy forms for windstorm and hail insurance shall be filed by the Association with the Commissioner for his approval before they may be used.

(f) Policies other than those providing only windstorm and hail insurance under subsection (b) of this section must comply with the provisions of G.S. 58-36-105."

Section 3. This act becomes effective September 1, 1997, and applies to policies issued or renewed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 1052

Short Title: Permit Exclusion of Excess Coverage. (Public)

Sponsors: Representative Miller.

Referred to: Insurance.

April 21, 1997

A BILL TO BE ENTITLED

AN ACT TO ALLOW INSURERS TO LIMIT OR EXCLUDE EXCESS LIABILITY COVERAGE FOR UNINSURED AND UNDERINSURED MOTORISTS AS PROVIDED BY LAW.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-152. Excess liability policies; uninsured and underinsured motorist coverages.**

With respect to policy forms that provide excess liability coverage, an insurer may limit or exclude coverage for uninsured motorists as provided in G.S. 20-279.21(b)(3) and for underinsured motorists as provided in G.S. 20-279.21(b)(4)."

Section 2. This act is effective when it becomes law.

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April 24, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 1052 (Permit Exclusion of Excess Coverage)

House Bill 1052 allows an insurer to limit or exclude uninsured (UI) and underinsured (UIM) coverage from policies that provide excess liability coverage. The bill does not prohibit an insurer and the policyholder from agreeing to UI or UIM coverage in an excess liability policy (for which the insurer will charge additional premium).

The bill addresses a 1995 Supreme Court decision, *Isenhour v. Universal Writers Insurance Company.* In *Isenhour*, the Court ruled that the statutory requirement that an insurer must provide its policyholder UI/UIM coverage in the same amount as the liability limits under the policy unless rejected in writing by the policyholder applied to excess liability insurance policies. In Isenhour, the excess liability policy provided $2 million in coverage. Because there was no official evidence on record of the UI/UIM coverage having been rejected, the Court ruled that the policyholder in effect had $2 million in UI/UIM coverage.

The LRC Study Committee on Insurance and Insurance-Related Issues first recommended this legislation during the short session last year.

The bill would take effect upon becoming law.

DALLAS L. ISENHOUR, and wife, SANDRA K. ISENHOUR
vs.
UNIVERSAL UNDERWRITERS INSURANCE COMPANY, and UNIVERSAL UNDERWRITERS GROUP

No. 47PA94 - Catawba
SUPREME COURT OF NORTH CAROLINA
461 S.E.2d 317, 341 N.C. 597
September 8, 1995, Filed

On discretionary review pursuant to N.C.G.S. § 7A-31 of a unanimous decision of the Court of Appeals, 113 N.C. App. 152, 437 S.E.2d 702 (1993), affirming an order granting summary judgment for defendants entered 10 November 1992 by Burroughs, J., in Superior Court, Catawba County.

COUNSEL

Pritchett, Cooke & Burch, by David J. Irvine, Jr., for plaintiff-appellants.
Hutchins, Tyndall, Doughton & Moore, by Kent L. Hamrick, for defendant-appellees.

JUDGES

FRYE, Justice.
AUTHOR: FRYE

OPINION

FRYE, Justice.

On 29 April 1989, plaintiff Dallas Isenhour was injured when the vehicle he was operating collided with a vehicle driven by Willie Kate Clark. The vehicle Mr. Isenhour was operating was owned by his employer, Far East Motors, Inc. [hereinafter Far East Motors], and was a covered automobile under a multiple-coverage fleet insurance policy purchased by Far East Motors. The fleet policy was issued by defendants, Universal Underwriters Insurance Company and Universal Underwriters Group [hereinafter Universal].

On 12 March 1990, Dallas and Sandra Isenhour instituted an action against Willie Kate Clark for damages for personal injuries sustained in the accident. In the complaint, the Isenhours alleged, among other things, negligence in failing to keep a proper lookout and driving in a reckless manner. Mr. Isenhour asserted a claim for serious, painful, and permanent bodily injuries causing medical and other expenses and decreased earning capacity. Mrs. Isenhour asserted a claim for loss of consortium. At the time of the accident, both Clark and the Isenhours were insured by Nationwide Mutual Insurance Company [hereinafter Nationwide] under nonfleet personal automobile insurance policies.

The Isenhours' policy with Nationwide insured three vehicles and carried underinsured motorists (UIM) coverage limits of $ 100,000 per person/$ 300,000 per accident with a separate premium being paid for each vehicle. Ms. Clark's policy with Nationwide provided liability coverage limits of $ 50,000 per person/$ 100,000 per accident. On 11 July 1991, Nationwide paid

to the Isenhours $ 50,000, the per-person liability limit under the Clark policy. Additionally, the Isenhours settled for $ 25,000 under the UIM portion of their Nationwide policy.

Thereafter, plaintiffs' attorney notified Universal of the Isenhours' intent to seek "additional compensation" under the UIM coverage in Far East Motors' policy with Universal. In a 17 July 1991 letter, plaintiffs' attorney informed Universal of his clients' demand for settlement of $ 1,200,000 and sent Universal copies of the complaint and other pertinent documents.

On 1 October 1991, plaintiffs' attorney notified Universal that the case was set on the 14 October 1991 trial calendar. Universal did not appear for trial. Universal sent plaintiffs' attorney a letter dated 31 January 1992 in which it denied it was a party to the suit and produced its insurance policy for review.

The trial court entered judgment in the underlying action against Ms. Clark on 10 March 1992 in the amount of $ 750,000 for Mr. Isenhour and $ 150,000 for Mrs. Isenhour. The judgment stated that the parties had waived trial by jury and specific findings of fact and conclusions of law and provided that the plaintiffs could recover from Ms. Clark to "the extent of underinsured motorist's [sic] coverage provided by an underinsured motorist carrier other than Nationwide Mutual Insurance Company," as per a partial release negotiated by the parties. This partial release limited Nationwide's total liability under the Clark and Isenhour policies to $ 75,000, the total amount of the settlement.

In a letter dated 12 May 1992, Universal notified plaintiffs' attorney that the maximum that might be available to the Isenhours under the Far East Motors fleet policy was $ 60,000 and that an umbrella provision in the policy did not apply to the Isenhours' claim. Universal explained that the coverage parts for the underlying policy and the umbrella policy were separate and distinct forms of coverage, adding that UIM coverage is added to the umbrella policy only by specific endorsement. Universal stated that only $ 60,000 in UIM coverage existed via specific endorsement and that no UIM coverage had been endorsed onto the umbrella provision. Accordingly, Universal tendered $ 60,000 in settlement of the UIM claim under its fleet policy.

On 8 June 1992, the Isenhours filed suit against Universal alleging (1) gross negligence, (2) unfair and deceptive acts or practices in violation of N.C.G.S. § 58-63-15(11) and N.C.G.S. § 75-16, and (3) liability by virtue of N.C.G.S. § 20-279.21(b)(4). Universal filed its answer on 23 July 1992, denying liability and defending on the basis that (1) the policy is a fleet policy under N.C.G.S. § 20-279.21(b)(4) and cannot be stacked onto a nonfleet policy; (2) plaintiffs are not insureds under the policy; and (3) Universal was not a party to the underlying action against Clark, did not participate in the settlement agreement, and cannot be bound by that agreement.

Universal moved for summary judgment on 25 August 1992. Universal submitted two affidavits in support of its motion for summary judgment. In the first affidavit, Universal's underwriting manager stated that Universal's policy issued to Far East Motors was a fleet policy that insured a multiple and changing number of motor vehicles used in Far East Motors' business. In the second affidavit, Nationwide, which had issued policies to both Clark (the tort-feasor) and the Isenhours, stated that both policies were nonfleet personal automobile insurance policies.

On the basis of these two affidavits and the Court of Appeals' decision in **Watson v. American Nat'l Fire Ins. Co.**, 106 N.C. App. 681, 417 S.E.2d 814 (1992), **aff'd on other grounds,** 333 N.C. 338, 425 S.E.2d 696 (1993), the trial court granted summary judgment in favor of Universal and dismissed the Isenhours' claims on 10 November 1992. From the entry of summary judgment, plaintiffs appealed to the Court of Appeals.

The Court of Appeals held that its decision in **Watson** "barred the coverage sought in this case and [that] the trial court correctly granted summary judgment." **Isenhour v. Universal Underwriters Ins. Co.,** 113 N.C. App. 152, 155, 437 S.E.2d 702, 704 (1993). We allowed plaintiffs' petition for discretionary review, and we now reverse the decision of the Court of Appeals which affirmed the trial court's entry of summary judgment in favor of defendants.

Defendants contend that the Court of Appeals properly affirmed the trial court's entry of summary judgment because the trial court and the Court of Appeals correctly applied the Court of Appeals' decision in **Watson.** We disagree.

In **Watson,** the Court of Appeals held that "fleet policies may not be stacked onto nonfleet policies" under N.C.G.S. § 20-279.21(b)(4). **Watson,** 106 N.C. App. at 686, 417 S.E.2d at 818. The Court of Appeals stated that

> the appellee's policy is a fleet policy under **Sutton [v. Aetna Casualty & Surety Co.,** 325 N.C. 259, 382 S.E.2d 759, **reh'g denied,** 325 N.C. 437, 384 S.E.2d 546 (1989)] and excluded from inter-policy stacking, since the stacking provisions of N.C.G.S. § 20-279.21(b)(4) cover only nonfleet private passenger motor vehicle insurance. **Aetna Casualty and Sur. Co. v. Fields,** 105 N.C. App. 563, 414 S.E.2d 69 [, **disc. rev. denied,** 331 N.C. 383, 417 S.E.2d 788] (1992). We recognize that inter-policy stacking is permitted so as to provide the innocent victim of an inadequately insured driver with an additional source of recovery; however, to allow stacking of a victim's fleet policy onto the nonfleet policy of the insured-tortfeasor is a result contemplated neither by the insurer when it wrote the fleet policy nor the legislature when it wrote the statute. We therefore hold that under N.C.G.S. § 20-279.21(b)(4) fleet policies may not be stacked onto nonfleet policies.
>
> **Watson,** 106 N.C. App. at 686, 417 S.E.2d at 818.

This Court granted discretionary review of **Watson** and affirmed the Court of Appeals' decision on grounds different from those articulated by the Court of Appeals. **Watson v. American Nat'l Fire Ins. Co.,** 333 N.C. 338, 425 S.E.2d 696 (1993). We determined that the insurance policy at issue was exempt, via N.C.G.S. § 20-279.32, from the requirements of the Financial Responsibility Act, since the vehicle involved was operating under a certificate of convenience and necessity issued by the Interstate Commerce Commission. Accordingly, the plaintiff was entitled to "only such coverage as is provided in the policy." **Id.** at 340, 425 S.E.2d at 697. We noted that "by its plain words N.C.G.S. § 20-279.32 says that N.C.G.S. §

20-279.21(b)(4) does not apply in this case." **Id.** The present case differs from **Watson** because N.C.G.S. § 20-279.21(b)(4) is applicable.

This Court stated clearly in **Sutton v. Aetna Casualty & Surety Co.,** 325 N.C. 259, 382 S.E.2d 759, **reh'g denied,** 325 N.C. 437, 384 S.E.2d 546 (1989), that no reason exists to distinguish between fleet and nonfleet policies under interpolicy stacking. Accordingly, we disavow the language of the Court of Appeals in **Watson** that the stacking provisions of N.C.G.S. § 20-279.21(b)(4) cover only nonfleet vehicle insurance. Under **Sutton,** the interpolicy stacking of fleet and nonfleet policies is permissible. Therefore, the Court of Appeals erred by relying on its holding in **Watson** in holding that the coverage sought by the Isenhours was barred.

We now proceed to the second issue, which is a matter of first impression for this Court. The issue is whether a multiple-coverage fleet insurance policy which includes umbrella coverage must offer UIM coverage equal to the liability limits under its umbrella coverage section.

We begin by looking at the nature and purpose of umbrella coverage. It is a form of insurance protection against losses in excess of the amount covered by other liability insurance policies. It provides coverage above basic or normal limits of liability. **Black's Law Dictionary** 808 (6th ed. 1990). The umbrella portion of the policy in this case, for example, provides in the insuring agreement that the insurer will pay for loss in excess of coverage provided in any underlying insurance; coverage provided in any other insurance available to an insured; and in the absence of such coverage, the retention shown in the declarations in the policy. As noted by John A. and Jean Appleman:

> Umbrella policies serve an important function in the industry. In this day of uncommon, but possible, enormous verdicts, they pick up this exceptional hazard at a small premium. Assuming one's automobile . . . policy [has] liability limits of $ 100,000 or even $ 500,000, the umbrella policy may pick up at that point and cover for an additional million, five million, or ten million.

8C Appleman, **Insurance Law and Practice** § 5071.65 (1981).

Our analysis in this case is aided by a very recent decision of the New Jersey Supreme Court, which noted a split of authority among courts considering the issue. **See Doto v. Russo,** 140 N.J. 544, 659 A.2d 1371 (1995). States with statutes requiring insurers to write UM/UIM coverage only to the statutory minimum of liability coverage have held that such statutes do not apply to umbrella provisions. **See Continental Ins. Co. v. Howe,** 488 So. 2d 917 (Fla. Dist. Ct. App.) (construing Rhode Island law), **disc. rev. denied,** 494 So. 2d 1151 (Fla. 1986); **Moser v. Liberty Mut. Ins. Co.,** 731 P.2d 406 (Okla. 1986). The Kansas Supreme Court has noted that the rationale behind this position is that the amount of liability coverage is irrelevant if UM/UIM coverage is only required in a minimum amount and that minimum is met. **See Bartee v. R.T.C. Transp., Inc.,** 245 Kan. 499, 511, 781 P.2d 1084, 1092 (1989).

On the other hand, states with statutes requiring UM/UIM coverage limits equal to those of liability coverage have held that such statutes are applicable to umbrella provisions. **See St. Paul Fire and Marine Ins. Co. v. Gilmore,** 168 Ariz. 159, 812 P.2d 977 (1991); **Chicago Ins. Co. v. Dominguez,** 420 So. 2d 882 (Fla. Dist. Ct. App. 1982), **disc. rev. denied,** 430 So. 2d 450 (Fla. 1983); **First State Ins. Co. v. Stubbs,** 418 So. 2d 1114 (Fla. Dist. Ct. App. 1982), **disc. rev. denied,** 426 So. 2d 26 (Fla.) **and disc. rev. denied,** 426 So. 2d 29 (Fla. 1983); **Cohen v. American Home Assur. Co.,** 367 So. 2d 677 (Fla. Dist. Ct. App.), **cert. denied,** 378 So. 2d 342 (Fla. 1979); **Bartee v. R.T.C. Transp., Inc.,** 245 Kan. 499, 781 P.2d 1084; **Southern Am. Ins. Co. v. Dobson,** 441 So. 2d 1185 (La. 1983); **Doto v. Russo,** 140 N.J. 544, 659 A.2d 1371; **House v. State Auto. Mut. Ins. Co.,** 44 Ohio App. 3d 12, 540 N.E.2d 738, **appeal dismissed,** 37 Ohio St. 3d 704, 531 N.E.2d 1316 (1988); **Cincinnati Ins. Co. v. Siemens,** 16 Ohio App. 3d 129, 474 N.E.2d 655 (1984) (Table No. 88-659).

Our analysis is further aided by a decision of the United States District Court for the Northern District of Ohio which construed North Carolina law with regard to the issue of whether an excess liability umbrella policy must offer UM/UIM coverage. In **Krstich v. United Services Auto. Ass'n,** 776 F. Supp. 1225 (N.D. Ohio 1991), the court found that the umbrella policy at issue "would be required to provide uninsured coverage under [North Carolina] law," since the policy was "a 'policy of bodily injury liability insurance' which covers 'liability arising out of the ownership, maintenance, or use' of a motor vehicle." **Id.** at 1234 (quoting N.C.G.S. § 20-279.21(b)(3) (Supp. 1988)). The court concluded that "by operation of § 20-279.21(b)(3), it must, therefore, provide uninsured motorist coverage." **Id.** The court further concluded that the defendant was obligated to "provide underinsured motorist coverage 'in an amount equal to the policy limits for automobile bodily injury liability as specified in the owner's policy,'" since the umbrella policy therein "exceeded the limits of subsection (b)(2) and . . . contained uninsured coverage as required by subsection (b)(3)." **Id.** (quoting N.C.G.S. § 20-279.21(b)(4)). The court found that "underinsured coverage is, therefore, mandatory in the amount of the liability policy's limit, here $ 1,000,000, pursuant to subsection (b)(4)." **Id.**

Under our statute, the policyholder is entitled to UM/UIM coverage only if the policyholder elects liability coverage above the statutory minimum. See N.C.G.S. § 20-279.21(b)(3), (b)(4). In **Sutton,** we said that "an owner's policy of liability insurance must, subject to rejection by the insured, provide UIM coverage 'only with policies that are written at limits that exceed' minimum statutory limits and that afford uninsured motorist coverage." **Sutton,** 325 N.C. at 268, 382 S.E.2d at 765 (quoting N.C.G.S. § 20-279.21(b)(4) (Supp. 1988)). Under the version of our statute applicable to this case, if these statutory prerequisites for UIM coverage are met, the policyholder is entitled to UIM coverage "in an amount equal to the policy limits for automobile bodily injury liability as specified in the owner's policy."[1] N.C.G.S. § 20-279.21(b)(4) (Supp. 1988). Because the statute links the amount of UIM coverage to the amount of liability coverage, the increase of liability coverage through umbrella coverage provisions will naturally cause an insurer to offer UIM coverage in a higher amount. This result is in accord with the manifest purpose of the Financial Responsibility Act in North Carolina, which is to protect innocent victims who have been injured by financially irresponsible motorists. **Nationwide Mut. Ins. Co.**

v. Chantos, 293 N.C. 431, 238 S.E.2d 597 (1977).

Accordingly, we hold that Universal was required to offer Far East Motors UIM coverage in the umbrella section of the fleet policy. The umbrella coverage section of the policy provided automobile bodily injury liability coverage in the amount of $ 2,000,000. Therefore, Universal was required to offer Far East Motors $ 2,000,000 in UIM coverage.

When a statute is applicable to the terms of an insurance policy, the provisions of the statute become a part of the policy, as if written into it. If the terms of the statute and the policy conflict, the statute prevails. **Sutton,** 325 N.C. 259, 382 S.E.2d 759; **Chantos,** 293 N.C. 431, 238 S.E.2d 597.

Under N.C.G.S. § 20-279.21(b)(4), the UIM coverage is the same as the policy limits for automobile liability unless the insured has rejected such insurance or selected a different limit, and this rejection or selection must be in writing. **Proctor v. N.C. Farm Bureau Mut. Ins. Co.,** 324 N.C. 221, 376 S.E.2d 761 (1989).

In the present case, there is no evidence in the record[2] that Far East Motors either rejected in writing UM or UIM coverage for the umbrella section of the policy or selected a different limit. Therefore, the umbrella section of the policy provides UIM coverage of $ 2,000,000, "an amount equal to the policy limits for automobile bodily injury liability as specified in the owner's [umbrella coverage section of the] policy," N.C.G.S. § 20-279.21(b)(4); **accord Proctor,** 324 N.C. 221, 376 S.E.2d 761.

Under N.C.G.S. § 20-279.21(b)(3) and (b)(4), there are two classes of "persons insured":

> (1) the named insured and, while resident of the same household, the spouse of the named insured and relatives of either and (2) any person who uses with the consent, express or implied, of the named insured, the insured vehicle, and a guest in such vehicle.

Smith v. Nationwide Mut. Ins. Co., 328 N.C. 139, 143, 400 S.E.2d 44, 47, **reh'g denied,** 328 N.C. 577, 403 S.E.2d 514 (1991). Members of the first class are "persons insured" for purposes of UM/UIM coverage regardless of whether the insured vehicle is involved in their injuries. **Id.** Members of the second class are "persons insured" only when the insured vehicle is involved in the insured's injuries. **Id.**

Turning to the present case, there is no contention that the Isenhours are persons insured of the first class under the Universal policy. The question becomes whether the Isenhours are "persons insured" of the second class under the UIM provisions of the Far East Motors fleet policy with Universal. It is undisputed that Mr. Isenhour was occupying a covered automobile owned by Far East Motors, the insured, and that Mr. Isenhour was using the automobile with the permission of Far East Motors when he was struck by the automobile driven by Ms. Clark. Thus, Mr. Isenhour is a person insured of the second class for UIM purposes and, accordingly, is entitled to coverage under the umbrella section of the fleet policy pursuant to N.C.G.S. §

20-279.21(b)(3) and (b)(4).

However, Mrs. Isenhour was not a person insured of the second class under the Universal policy. She was neither using the insured vehicle nor a guest in the vehicle at the time of the accident. Therefore, she is not entitled to UIM coverage under the Universal policy.

The final issue on this appeal is whether Mr. Isenhour's failure to exhaust the UIM limits of his Nationwide policy precludes his claim against Universal. The Universal fleet policy providing UIM coverage contained the following clause in its endorsement:

MOST WE WILL PAY

> We will pay under this endorsement only after the limits of any other applicable insurance policies or bonds have been exhausted by payment of judgments or settlements.

Universal contends that because Mr. Isenhour failed to claim all of the available UIM coverage under the Nationwide policy, he should be precluded from recovery under the Far East Motors policy. The Isenhours entered into a settlement agreement for $ 50,000 of liability coverage under the tort-feasor's Nationwide policy and $ 25,000 of UIM coverage under their personal Nationwide policy. The agreement purported to release the tort-feasor from any and all liability and further released Nationwide from any UIM claims by the Isenhours. Defendants here contend that because the Isenhours did not exhaust the limits of their UIM coverage under their Nationwide policy in the settlement agreement, Mr. Isenhour should not be allowed any recovery pursuant to the above endorsement.

We do not agree with Universal's contentions. The exhaustion requirement in Universal's "Most We Will Pay" clause relates to "applicable" insurance policies or bonds, such as liability insurance or UIM coverage of a lower tier than the insurance in question. Universal's obligation to pay under its UIM coverage does not arise until all sums available under any liability policies or bonds and any other UIM coverage which is of a lower tier has been exhausted. Universal does not argue that any liability policies and bonds have not been exhausted, but contends that the competing Nationwide UIM limits have not been exhausted. We agree, but this does not decide the issue before us.

In deciding this issue, we must first determine which policy provides primary coverage. If one policy provides primary coverage while the other provides excess coverage, then we must determine whether the primary policy is sufficient to satisfy Mr. Isenhour's $ 750,000 judgment. If the primary policy limits are sufficient to fully satisfy the judgment, no stacking issue arises in this case. On the other hand, if the policy providing primary coverage is not sufficient to satisfy the judgment, the fact that one policy is fleet and the other nonfleet would not prohibit stacking the primary and excess coverage under the two policies so as to provide full payment of the judgment. See Sutton, 325 N.C. 259, 382 S.E.2d 759.

Here, we have two policies providing UIM coverage issued by different companies to different policyholders. "The liability of each company must be determined by the terms of its

own policy, subject to such modification as may be imposed by statute or by authorized administrative regulation or order." **Insurance Co. v. Insurance Co.,** 269 N.C. 341, 346, 152 S.E.2d 436, 440 (1967). To determine who is the primary carrier and who is the excess carrier, if any, we must examine the "Other Insurance" clauses in the competing policies. **Id.**

The Universal policy issued to Far East Motors provides in pertinent part:

OTHER INSURANCE

The insurance afforded by the endorsement is primary, except it is excess for any COVERED AUTO not owned by the INSURED or any trailer attached to it.

Based on the plain language of the Far East Motors Universal policy, it provides primary coverage because the automobile that Mr. Isenhour was driving at the time of the accident was a covered automobile owned by Universal's insured, Far East Motors. The Nationwide policy issued to the Isenhours provides in pertinent part:

OTHER INSURANCE

. . . .

Any insurance we provide with respect to a vehicle you do not own shall be excess over any other collectible insurance.

Based on the plain language of the Isenhours' Nationwide policy, it provides excess coverage in this case, since the automobile Mr. Isenhour was driving at the time of the accident was not owned by him.

Accordingly, we hold that Far East Motors' Universal policy provides primary coverage and the Isenhours' Nationwide policy provides secondary coverage. Therefore, the liability of Nationwide, the excess insurer, does not arise until the limits of the Universal policy, the primary coverage policy, have been exceeded. **See Insurance Co. v. Insurance Co.,** 269 N.C. 341, 152 S.E.2d 436.

In support of its contention that Mr. Isenhour is precluded from recovery, Universal here cites **Eaves v. Universal Underwriters Group,** 107 N.C. App. 595, 421 S.E.2d 191, **disc. rev. denied,** 333 N.C. 167, 424 S.E.2d 908 (1992). In **Eaves,** Universal's garage liability policy contained a "Most We Will Pay" clause limiting its coverage to the minimum limits of the Financial Responsibility Act and an "Other Insurance" clause purporting to make its coverage excess over any other collectible insurance, while the competing policy issued by Amica Mutual Insurance Company also contained an "Other Insurance" clause purporting to make its coverage excess for any vehicle the insured did not own where other insurance was available. Because

Universal's policy effectively defined its policy limits to exclude liability in the event there was other collectible insurance which met the minimum standards set by the Financial Responsibility Act, the Court of Appeals held that Universal did not provide any coverage to the plaintiffs in that case.

In **Eaves,** the Court of Appeals relied on **United Services Auto. Ass'n v. Universal Underwriters Ins. Co.,** 332 N.C. 333, 420 S.E.2d 155 (1992). In **United Services,** this Court examined two policies to determine which of them provided liability coverage for the accident in question. In that case, it was "apparent that in defining the limits for which it would be liable for an occurrence involving a person required by law to be insured, Universal agreed to cover only what was needed to comply with the financial responsibility law." **Id.** at 336, 420 S.E.2d at 157. This Court concluded that because United Services provided the coverage required to comply with the Financial Responsibility Act, the Universal policy did not provide any coverage in that case.

The present case is distinguishable from both **Eaves** and **United Services.** In the present case, both Universal and Nationwide contracted to provide coverage under the circumstances of this case, notwithstanding the fact that one is primary and the other secondary. Further, unlike **United Services** and **Eaves,** Universal here did not define its policy limits to exclude liability in the event there was other collectible insurance which met the minimum standards set by the Financial Responsibility Act. Accordingly, neither **United Services** nor **Eaves** is dispositive in this case. Therefore, we reject Universal's contention that it was not required to pay until the Nationwide UIM policy limits were exhausted.

Since the policy limits available in the Universal policy are sufficient to satisfy Mr. Isenhour's portion of the judgment, this is not a stacking case. This case involves a question of coverage. The primary coverage under the Universal policy exceeds the judgment of $ 750,000 in Mr. Isenhour's favor. Therefore, Mr. Isenhour could satisfy his entire judgment without resorting to the Nationwide policy.

Thus, Universal is not absolved of liability simply because the Isenhours settled with Nationwide for less than the UIM policy limits. Accordingly, we hold that Mr. Isenhour is entitled to satisfy his portion of the judgment from the Universal policy.

For the foregoing reasons, the decision of the Court of Appeals is reversed, and the case is remanded to the Court of Appeals for further remand to the trial court for further proceedings consistent with this opinion.

REVERSED AND REMANDED.

DISPOSITION

REVERSED AND REMANDED.

OPINION FOOTNOTES

1 This statute has been amended, and now requires an insurer to offer UIM coverage in an amount "equal to the highest limit of bodily injury liability coverage for any one vehicle in the policy." N.C.G.S. § 20-279.21(b)(4) (1992).

2 This Court denied defendants' motion, made for the first time in this Court, to amend the record on appeal by introducing evidence of a purported rejection of such coverage by Far East Motors.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham** for the Committee on **Insurance.**

☐ Committee Substitute for
H.B. 1052 A BILL TO BE ENTITLED AN ACT TO ALLOW INSURERS TO LIMIT OR EXCLUDE EXCESS LIABILITY COVERAGE FOR UNINSURED AND UNDERINSURED MOTORISTS AS PROVIDED BY LAW

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
John Jordan	ASSN. of NC Life Cos - Box 2021 Raleigh 27602
Robert Price	Assn NC Life Ins Cos.
Susan Valauri	Nationwide
John McMillan	Manning Fulton & Skinner PA.
Ruth Farab	atty
Charlene Stabley	OSP
Valerie Johnson	atty
Rob Schofield	NCJCIDC
Henry W. Patterson, Jr.	atty
Bob Sloan	NC Forestry Association
Lucia Deel	NC Med Society
Evelyn Hawes Rivers	NC P-84
Steve Keen	NCMed Soc.
Amy Jo Brim	Smith Anderson
Kasemir Prop	NC DOT

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

4-24-97 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Andy Ellen	NC Farm Bureau
Julian T Pulfo[illegible]	NC FB
Lucius PULLEN	ATTORNEY
PERRI MORGAN	NFIB
Michelle Cook	Weyerhaeuser
Nancy Bradley	NCCPSA
Don McConquodale	NCRMA
[illegible]	Poyner & Spruill
W A Pully	NCHA
[illegible]	[illegible]
Walker Weaver	CWA
[illegible]	NC CWA
Amanda Mox	Edwards Best School
James E. Lee	IP
Robert PASchal	Young, Moore & Henderson

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Phillip Bailey	BIA Bailey & Dixon
David Fiveall	Hafer, McNamara, Caldwell, McCoy
[signature]	NCSSA
James Hooker Bond	Carolinas Health Care System
Tommy West	Carolinas HealthCare System
Alan Miles	Bailey & Dixon LLP
Eugene Hafer	CAPIA
[signature illegible]	NC Assoc of Realtors
Starla H. McKenney	NC DOI
Barbara Nicholls Burke	NC DOI
Oscar Smith	AARP
Charles Cromer	NCATL
Kathleen G. Sumner	Greensboro Law Offices of Kathleen G Sumner
[signature]	NCAT
John P. Mooney	IIANC
[signature]	IIANC

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
KEITH HUNDLEY	WEYERHAEUSER
Nola Clements	ACHSA
Jerry Hardesty	NC Pork Council
John Bowdish	zeb Alley PA
ADAM SEARING	NC Health Access

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

Rep. DOCKHAM for the Committee on INSURANCE

( ) **Committee Substitute for**
H.B. 984 , S.B. _____ A BILL TO BE ENTITLED AN ACT
H.J.R. _____ , S.J.R. _____ A JOINT RESOLUTION
H.R. _____ A HOUSE RESOLUTION

AN ACT TO PROVIDE HEALTH BENEFITS FOR SOIL AND WATER CONSERVATION DISTRICT SUPERVISORS AND THEIR ELIGIBLE DEPENDENTS WHO DO NOT HAVE ACCESS TO COMPREHENSIVE GROUP HEALTH BENEFITS BY ALLOWING VOLUNTARY PARTICIPATION IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

____ With a favorable report.

__X__ With a favorable report and recommendation that the bill be re-referred to the Committee on (X) Appropriations ( ) Finance ( ) _____.

____ With a favorable report, as amended.

____ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report as to committee substitute bill (# ____), ( ) which changes the title, unfavorable as to original bill (Committee Substitute Bill # ____). (and recommendation that the committee substitute bill (# ____) be re-referred to the Committee on _____.)

____ With a favorable report as to House committee substitute bill (# ____), ( ) which changes the title, unfavorable as to Senate committee substitute bill.

____ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

____ With an unfavorable report.

____ With recommendation that the House concur.

____ With recommendation that the House do not concur.

____ With recommendation that the House do not concur; request conferees.

____ With recommendation that the House concur; committee believes bill to be material.

____ With an unfavorable report, with a Minority Report attached.

____ Without prejudice.

____ With an indefinite postponement report.

____ With an indefinite postponement report, with a Minority Report attached.

____ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 193

Short Title: No Ins. Points for Infractions. (Public)

Sponsors: Representatives R. Hunter, Culpepper, Hensley, McCrary; Bonner, Capps, Goodwin, Hall, Hightower, Moore, Rayfield, and Starnes.

Referred to: Insurance, if favorable, Judiciary I.

February 17, 1997

A BILL TO BE ENTITLED

AN ACT TO ELIMINATE INFRACTIONS FROM CONSIDERATION IN THE SAFE DRIVER INCENTIVE PLAN, TO PROVIDE FOR A GRADUATED INSURANCE POINT AND SURCHARGE SCHEDULE FOR BODILY INJURY CAUSED IN AUTOMOBILE ACCIDENTS, AND TO PROHIBIT INSURANCE POINTS AND SURCHARGES IF BODILY INJURY DOES NOT OCCUR.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-36-65(b) reads as rewritten:

"(b) The Bureau shall file, subject to review, modification, and promulgation by the Commissioner, a Safe Driver Incentive Plan ('Plan') that adequately and factually distinguishes among various classes of drivers that have safe driving records and various classes of drivers that have a record of at-fault accidents; a record of convictions of ~~major~~ moving traffic violations; ~~a record of convictions of minor moving traffic violations;~~ or a combination thereof; and that provides for premium differentials among those classes of drivers. Subsequently, the Commissioner may require the Bureau to file modifications of the Plan. If the Bureau does not file the modifications within a reasonable time, the Commissioner may promulgate the modifications. The Commissioner is authorized to structure the Plan to provide for surcharges above and discounts below the rate otherwise charged."

Section 2. G.S. 58-36-65(i) reads as rewritten:

"(i) As used in this section, 'conviction' ~~means a conviction as defined in G.S. 20-279.1 and means~~ does not include an infraction as defined in G.S. 14-3.1."

Section 3. G.S. 58-36-75(a) reads as rewritten:

"(a) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) may provide for separate surcharges for major, intermediate, and minor accidents. A 'major accident' is an at-fault accident that results in either (i) bodily injury or death or (ii) only property damage of two thousand dollars ($2,000) or more. An 'intermediate accident' is an at-fault accident that results in only property damage of more than one thousand dollars ($1,000) but less than two thousand dollars ($2,000). A 'minor accident' is an at-fault accident that results in only property damage of one thousand dollars ($1,000) or less. The subclassification plan may also exempt certain minor accidents from the Facility recoupment surcharge. The Bureau shall assign varying Safe Driver Incentive Plan point values and surcharges for bodily injury in at-fault accidents that are commensurate with the severity of the injury. There shall be no points or insurance premium surcharge under the Safe Driver Incentive Plan or increase in insurance premium on account of payment of medical costs associated with obtaining a diagnosis when the diagnosis indicates that an accident did not result in bodily injury."

Section 4. G.S. 58-36-75(g) reads as rewritten:

"(g) As used in this section 'conviction' ~~means a conviction as defined in G.S. 20-279.1 and means~~ does not include an infraction as defined in G.S. 14-3.1."

Section 5. The North Carolina Rate Bureau shall develop an amendment to the subclassification plan consistent with the provisions of this act. The Bureau shall file the amendment with the Commissioner no later than October 1, 1997, and the amendment shall become effective January 1, 1998.

Section 6. Sections 5 and 6 of this act are effective when it becomes law. The remainder of this act becomes effective January 1, 1998, and applies to accidents occurring on or after January 1, 1998.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **DOCKHAM** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 193 A BILL TO BE ENTITLED AN ACT TO ELIMINATE INFRACTIONS FROM CONSIDERATION IN THE SAFE DRIVER INCENTIVE PLAN, TO PROVIDE FOR A GRADUATED INSURANCE POINT AND SURCHARGE SCHEDULE FOR BODILY INJURY CAUSED IN AUTOMOBILE ACCIDENTS, AND TO PROHIBIT INSURANCE POINTS AND SURCHARGES IF BODILY INJURY DOES NOT OCCUR.

☐ With a favorable report.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on ~~☐ Appropriations ☐ Finance ☐~~ Judiciary 1. (This was reported on House floor P.M. 4-24-97)

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(a), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The (committee substitute) bill/resolution (, as amended,) is placed on the Consent Calendar of _____. The original bill/resolution is placed on the Unfavorable Calendar.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(a), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 28, 1997

The House Committee on Insurance met in Room 643 of the Legislative Office Building on April 28, 1997 at 12:00 Noon. Chairman, Representative Dockham, presided and the following members were present: Allred, Barbee, Bowie, Dedmon, Dickson, Esposito, Gardner, Hardaway, Hensley, Hurley, Ives, McComas, Miller, Preston, and Russell. A list of visitors attending is attached.

Chairman Dockham called the meeting to order and the following bills were considered:

House Bill 165, entitled An Act Pertaining to the Sanitation of Cooking Utensils Provided by Lodging Establishments, as Recommended by The Joint Legislative Administrative Procedure Oversight Committee was sponsored by Representative Redwine. Chairman Dockham stated that this bill was given an unfavorable report and the committee substitute was given a favorable report in the subcommittee chaired by Representative McComas. Through an error, the bill was never reported out. With no objections from the committee, the bill was passed out as recommended by the subcommittee.

House Bill 813, entitled, An Act to Require Health and Accident Insurance Policies, Hospital or Medical Service Plans, HMO Plans, and the Teachers' and State Employees' Comprehensive Major Medical Plan to Provide Coverage for Reconstructive Breast Surgery Resulting from Mastectomy was considered by the committee. In the absence of bill sponsor Representative Alexander, Cosponsor Representative Bowie explained the bill (bill summary and actuarial note attached). Sam Byrd of the Research Division of the General Assembly was recognized and spoke regarding the cost which would be between three and four million dollars. Representative Russell spoke in support of the bill and made a motion that the bill be given a favorable report and re-referred to the Appropriations Committee. The motion passed.

House Bill 940, entitled, An Act to Clarify that a Real Estate Broker and Real Estate Salesperson are not Employees Within the Meaning of the Workers' Compensation Act was explained by bill sponsor, Representative Redwine (bill summary attached). Mr. Tim Minton, Director of Governmental Affairs of the N.C. Association of Realtors spoke in support of the bill. Representative Barbee made a motion that the bill be given a favorable report. The motion carried.

House Bill 1115, entitled, An Act to Prohibit the Cancellation of Insurance Policies that Provide Coverage for Churches for Losses Resulting From a Fire was explained by bill sponsor, Representative Boyd-McIntyre (bill summary attached). Information regarding

arson attacks in America against churches was passed out (attached). Representative Bowie moved that the bill be given a favorable report. The motion passed.

At the request of Representative Culp, sponsor of House Bill 984, Chairman Dockham ruled that, with no objections from the committee, this bill be found favorable and re-referred to the Appropriations Committee. There were no objections.

House Bill 193, entitled, An Act to Eliminate Infractions From Consideration in the Safe Driver Incentive Plan, to Provide for a 'Graduated Insurance Point and Surcharge Schedule for Bodily Injury Caused in Automobile Accidents, and to Prohibit Insurance Points and Surcharges if Bodily Injury Does Not Occur is sponsored by Representative R. Hunter. With no objections from the committee, the bill was given a favorable report and re-referred to the Judiciary I Committee.

The meeting adjourned at 3:30 p.m.

Representative Jerry Dockham, Chairman

Mary Moore, Acting Clerk

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

4-28-97
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Steve Wyne	NC Med Soc.
[illegible] Hale	NC DOI
Harry Taylor	
Dennis Scott	DEHNR SEW
David Ferrell	Hofler, McNamara, Caldwell McElroy & Cutler
Eddie Caldwell	" "
Sam Byrd	Leg. Fiscal Research
Ken Wright	BCBSNC
Alan Mills	Bailey & Dixon LLP
Susan Valaani	Nationwide

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

4-28-97
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Charles Cromer	NCATL
Robert Paschal	Young, Moore & Henderson
Jim Minton	NC Assoc of Realtors
Emanuel Hafer	CAPIA
[illegible]	[illegible]
John Burdick	Zebulon Alley PA
Stan Williams	UHC of NC
Robert Rose	Assn NC Life Ins Cos
EVELYN TERRY	N.C. STATE HEALTH PLAN
DAVID G. DEVRIES	N. STATE HEALTH PLAN
BART Campbell	NC DEHNR
PAUL MAHONEY	NC Hmo Assn
Michelle Garber RN	HealthWise Educational Services
Laura Deal	NC Med Society
[illegible]	[illegible]

AGENDA

HOUSE COMMITTEE ON INSURANCE

April 28, 1997
Room 643 LOB
12:00 Noon

OPENING REMARKS

Representative Dockham, Chairman
Insurance Committee

BILL TO BE CONSIDERED

unfav to Sub fav. to Com. sub **HB 165** - LODGING ESTABLISHMENTS/SANITATION
SPONSOR - Representative Redwine

fav — referred to Approp. **HB 813** - RECONSTRUCTIVE SURGERY/COVERAGE
SPONSOR - Representative Alexander

fav — **HB 940** - WORKER'S COMPENSATION/REALTOR STATUS
SPONSOR - Representative Redwine

re-refer to Approp **HB 984** - SOIL & WATER SUPERVISOR HEALTH BENEFITS
SPONSOR - Representative Culp

fav — **HB 1115** - CHURCH INSURANCE COVERAGE
SPONSOR - Representative Boyd-McIntyre

H.B. 193 — re-refer to J1

ADJOURNMENT

H.B. 193 — Handled on floor Monday Night

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 165*

Unfavorable Report for to Com. Sub

Short Title: Lodging Establishments/Sanitation. (Public)

Sponsors: Representatives Redwine, Creech, Mercer, Mitchell, Nichols; Smith and Wainwright.

Referred to: Insurance.

February 13, 1997

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE SANITIZATION OF COOKING UTENSILS PROVIDED BY LODGING ESTABLISHMENTS, AS RECOMMENDED BY THE JOINT LEGISLATIVE ADMINISTRATIVE PROCEDURE OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 130A-248(a3) reads as rewritten:

"(a3) The rules adopted by the Commission pursuant to subsections (a), (a1), and (a2) of this section shall address, but not be limited to, the following:

(1) Sanitation requirements for cleanliness of floors, walls, ceilings, storage spaces, utensils, ventilation equipment, and other areas and items;

(2) Requirements for:

a. Lighting and water supply;

b. Wastewater collection, treatment, and disposal facilities; and

c. Lavatory and toilet facilities, food protection, and waste disposal;

(3) The cleaning and bactericidal treatment of eating and drinking utensils and other food-contact ~~surfaces;~~ surfaces. A requirement imposed under this subdivision to sanitize eating and drinking utensils and other food-contact surfaces does not apply to utensils and surfaces in a lodging unit that provides reusable utensils for guests to prepare food while staying in the lodging unit.

(3a) The appropriate and reasonable use of gloves or utensils by employees who handle unwrapped food;

(4) The methods of food preparation, transportation, catering, storage, and serving;

(5) The health of employees;

(6) Animal and vermin control; and

(7) The prohibition against the offering of unwrapped food samples to the general public unless the offering and acceptance of the samples are continuously supervised by an agent of the entity preparing or offering the samples or by an agent of the entity on whose premises the samples are made available. As used in this subdivision, 'food samples' means unwrapped food prepared and made available for sampling by and without charge to the general public for the purpose of promoting the food made available for sampling. This subdivision does not apply to unwrapped food prepared and offered in buffet, cafeteria, or other style in exchange for payment by the general public or by the person or entity arranging for the preparation and offering of such unwrapped food. This subdivision shall not apply to open air produce markets nor to farmer market facilities operated on land owned or leased by the State of North Carolina or any local government.

The rules shall contain a system for grading establishments, such as Grade A, Grade B, and Grade C. The rules shall be written in a manner that promotes consistency in both the interpretation and application of the grading system."

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 165*
Proposed Committee Substitute H165-PCS1214

Short Title: Lodging Establishments/Sanitation. (Public)

Sponsors:

Referred to:

February 13, 1997

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE SANITIZATION OF COOKING UTENSILS PROVIDED BY LODGING ESTABLISHMENTS, AS RECOMMENDED BY THE JOINT LEGISLATIVE ADMINISTRATIVE PROCEDURE OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 130A-248(a3) reads as rewritten:

"(a3) The rules adopted by the Commission pursuant to subsections (a), (a1), and (a2) of this section shall address, but not be limited to, the following:

(1) Sanitation requirements for cleanliness of floors, walls, ceilings, storage spaces, utensils, ventilation equipment, and other areas and items;

(2) Requirements for:

a. Lighting and water supply;

b. Wastewater collection, treatment, and disposal facilities; and

c. Lavatory and toilet facilities, food protection, and waste disposal;

(3) The cleaning and bactericidal treatment of eating and drinking utensils and other food-contact ~~surfaces;~~ surfaces. A requirement imposed under this subdivision to sanitize multiuse eating and drinking utensils and other food-contact surfaces does not apply to utensils and surfaces provided in the guest room of a lodging unit for guests to prepare food while staying in the guest room.

(3a) The appropriate and reasonable use of gloves or utensils by employees who handle unwrapped food;

(4) The methods of food preparation, transportation, catering, storage, and serving;

(5) The health of employees;

(6) Animal and vermin control; and

(7) The prohibition against the offering of unwrapped food samples to the general public unless the offering and acceptance of the samples are continuously supervised by an agent of the entity preparing or offering the samples or by an agent of the entity on whose premises the samples are made available. As used in this subdivision, 'food samples' means unwrapped food prepared and made available for sampling by and without charge to the general public for the purpose of promoting the food made available for sampling. This subdivision does not apply to unwrapped food prepared and offered in buffet, cafeteria, or other style in exchange for payment by the general public or by the person or entity arranging for the preparation and offering of such unwrapped food. This subdivision shall not apply to open air produce markets nor to farmer market facilities operated on land owned or leased by the State of North Carolina or any local government.

The rules shall contain a system for grading establishments, such as Grade A, Grade B, and Grade C. The rules shall be written in a manner that promotes consistency in both the interpretation and application of the grading system."

Section 2. This act is effective when it becomes law.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **DOCKHAM** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 165 A BILL TO BE ENTITLED AN ACT PERTAINING TO THE SANITIZATION OF COOKING UTENSILS PROVIDED BY LODGING ESTABLISHMENTS, AS RECOMMENDED BY THE JOINT LEGISLATIVE ADMINISTRATIVE PROCEDURE OVERSIGHT COMMITTEE.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☒ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #:), (and recommendation that the committee substitute bill #) be re-referred to the Committee on)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 813

Re - Honorable Com on Approp.

Short Title: Reconstructive Surgery/Coverage. (Public)

Sponsors: Representatives Alexander, Bowie, Neely; Allred, Arnold, Baddour, Baker, Barbee, Beall, Berry, Black, Blue, Bonner, Boyd-McIntyre, Brawley, Brown, Buchanan, Cansler, Capps, Church, Clary, Cole, Creech, Culpepper, Daughtry, Dedmon, Dickson, Earle, Easterling, Esposito, Fitch, Fox, Gardner, Goodwin, Grady, Gray, Gulley, Hiatt, Hill, Howard, H. Hunter, R. Hunter, Hurley, Insko, Ives, Jarrell, Jeffus, Justus, Kinney, Kiser, Luebke, McAllister, McComas, McCrary, Mercer, Michaux, Miller, Miner, Mosley, Nesbitt, Nichols, Nye, Oldham, Owens, Preston, Ramsey, Rayfield, Redwine, Reynolds, Rogers, Russell, Saunders, Sexton, Sherrill, Shubert, Smith, Tallent, Tolson, Wainwright, Warwick, Watson, Weatherly, Wilkins, and G. Wilson.

Referred to: Insurance.

April 7, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICE PLANS, HMO PLANS, AND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM MASTECTOMY.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-61. Coverage for reconstructive breast surgery resulting from mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from mastectomy. The coverage shall include coverage for all

stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive surgery on the diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. 'Reconstructive breast surgery' includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 2. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-96. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive surgery on the diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. 'Reconstructive breast surgery' includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 3. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-79. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1998, that is subject to this Article and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive surgery on the diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. 'Reconstructive breast surgery' includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;
(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;
(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;
(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or
(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 4. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy to the same extent as required under G.S. 58-51-61.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. This section shall be effective after July 10, 1991."

Section 5. Effective January 1, 1998, G.S. 135-40.6(5) is amended by adding the following new sub-subdivision to read:

"h. Reconstructive Breast Surgery: Reconstructive breast surgery resulting from a mastectomy. The coverage shall include all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. As used in this sub-subdivision, (i) 'mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer; (ii) 'reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. 'Reconstructive

breast surgery' includes augmentation mammoplasty, reduction mammoplasty, and mastopexy. Coverage described in this sub-subdivision shall not be denied on the basis that the coverage is for cosmetic surgery."

Section 6. Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies.

Section 7. For purposes of this act, renewal of a health benefit plan, policy, or contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan, policy, or contract.

Section 8. This act is effective when it becomes law.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **DOCKHAM** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 813 A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICE PLANS, HMO PLANS, AND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM MASTECTOMY.

☐ With a favorable report.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on ☒ Appropriations ☐ Finance ☐

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

North Carolina General Assembly
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April 28, 1997

MEMORANDUM

To: House Insurance Committee

From: M. Lynn Marshbanks, Committee Counsel

Re: House Bill 813: Reconstructive Surgery/Coverage

House Bill 813 requires insurers, HMOs, and hospital and medical service corporations (Blue Cross) to provide coverage for breast reconstruction resulting from a mastectomy if they cover the mastectomy. The standard health plan offered in the small employer group market must also include this coverage if it covers mastectomies. In addition, there cannot be different deductibles or coinsurance amounts for breast reconstruction than for similar services; a health plan cannot deny coverage on the basis that the surgery is cosmetic; and the plan cannot provide incentives to the woman or incentives or disincentives to her health care provider to avoid following the coverage requirements.

"Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. The term also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

The bill also requires the State Health Plan to cover reconstructive breast surgery that results from a mastectomy.

The coverage is required in all insurance policies that are issued or renewed on or after January 1, 1998. The coverage in the State Health Plan would also begin January 1, 1998.

H813-SMRS-001

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 813, Section 5

SHORT TITLE: Coverage for Reconstructive Breast Surgery

SPONSOR(S): Rep. Martha Alexander

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, Other State Employer Receipts, Premium Payments for Dependents by Active and Retired Teachers and State Employees, and Premium Payments for Coverages Selected by Eligible Former Teachers and State Employees.

BILL SUMMARY: Section 5 of the bill provides surgical benefits under the Plan for reconstructive breast surgery to nondiseased breasts following a mastectomy resulting from breast cancer. Reconstructive surgery on nondiseased breasts is for the purpose of establishing body symmetry when reconstructive surgery on diseased breasts is performed. Reconstruction includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of nondiseased breasts.

The Plan's self-insured indemnity program has for some time covered medically necessary mammoplasties for diseased breasts following mastectomies. However, prior approval from the program's claims processor, Blue Cross and Blue Shield of North Carolina, has been required to determine medical necessity before the procedure is performed. The program's medical policies have furthermore considered reconstruction of a nondiseased breast to be cosmetic and not covered by the program.

The Plan's twelve health maintenance organization (HMO) alternatives to the indemnity program are required to have the same coverage for reconstructive breast surgery under Section 3 of the bill as the Plan's indemnity program.

EFFECTIVE DATE: January 1, 1998

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical Plan, the consulting actuary for the Plan, Aon Consulting, estimates that mammoplasty coverage for nondiseased breasts following a mastectomy would increase the indemnity program's claim costs by 0.20% to 0.34%. However, using a midpoint value of 0.27%, the Plan's consulting actuary projects the cost to the Plan's indemnity program to be $1,296,000 for 1997-98 and $1,866,000 for 1998-99. The consulting actuary for the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, estimates the cost for covering mammoplasties for nondiseased breasts to be $750,000 for 1997-98 and $3,245,000 for 1998-99. Using the estimate from the consulting actuary of the Fiscal research Division as an upper limit based upon the mastectomy and mammoplasty experience of the Plan's indemnity program, a combined estimate from the two actuarial projections results in a cost of $1,023,000 for 1997-98 and $2,556,000 for 1998-99. Further using these combined projections,

additional costs to the Plan's indemnity program for mammoplasty coverage of nondiseased breasts following a mastectomy for outlying years are expected to be $2,760,000 for 1999-2000, $2,980,000 for 2000-01, and $3,218,000 for 2001-02. Although Section 5 of the bill is expected to produce additional claim costs for the Plan's indemnity program, the program's anticipated reserves for 1997-99 are sufficient to cover the additional costs of the bill without requiring an additional General or Highway Fund appropriation for the 1997-99 biennium.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of servi credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with twelve HMOs currently covering about 25% of the Plan's total population in about 85 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1996, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	186,400	70,400	256,800
Active Employee Dependents	104,700	51,800	156,500
Retired Employees	84,400	5,400	89,800
Retired Employee Dependents	14,400	1,200	15,600
Former Employees & Dependents with Continued Coverage	2,700	800	3,50
Total Enrollments	392,600	129,600	522,20

Number of Contracts			
Employee Only	206,300	51,800	258,100
Employee & Child(ren)	29,900	14,500	44,400
Employee & Family	36,600	10,100	46,700
Total Contracts	272,800	76,400	349,200
Percentage of Enrollment by Age			
29 & Under	27.3%	44.7%	31.6%
30-44	21.6	28.0	23.2
45-54	20.0	17.8	19.5
55-64	13.8	7.1	12.1
65 & Over	17.3	2.4	13.6
Percentage of Enrollment by Sex			
Male	39.8%	40.0%	39.8%
Female	60.2	60.0	60.2

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1996, the self-insured program started its operations with a beginning cash balance of $368.3 million. Receipts for the year are estimated to be $580 million from premium collections, $25 million from investment earnings, and $12 million in risk adjustment and administrative fees from HMOs, for a total of $617 million in receipts for the year. Disbursements from the self-insured program are expected to be $595 million in claim payments and $18 million in administration and claims processing expenses for a total of $613 million for the year beginning July 1, 1996. For the fiscal year beginning July 1, 1997, the self-insured indemnity program is expected to have an operating cash balance of over $372 million with a net operating loss of $54 million for the 1997-98 fiscal year. For the fiscal year beginning July 1, 1998, the self-insured indemnity program is expected to have an operating cash balance of $318 million with a net operating loss of $118 million for the 1998-99 fiscal year. The estimated cash balance for the self-insured indemnity program is expected to be $200 million at the end of the 1997-99 biennium. The self-insured indemnity program is consequently assumed to be able to carry out its operations without any increases in its current premium rates or a reduction in existing benefits until the 1999-2000 fiscal year. This assumption is predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $110.08 monthly for employees whose primary payer of health benefits is Medicare and $144.60 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $68.50 monthly for children whose primary payer of health benefits is Medicare and $90.12 monthly for other covered children, and $164.30 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $216.18 per month for other family contract dependents. Claim cost trends are expected to increase 8-10% annually. Total enrollment in the program is expected to decrease about one percent (1.0%) annually due to

competition from alternative HMOs. The number of enrolled active employees is expected to show a 1-2% loss annually, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to lose about 3-4% of its number of active employee dependents each year, whereas the number of enrolled retiree dependents is assumed to show no appreciable change from year to year. Investment earnings are based upon a 6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Asssumptions for the Self-Insured Indemnity Program's Mastectomies and Mammoplasties: For the last three calendar years, the indemnity program has averaged covering 466 mastectomies annually. In addition, the program has covered an average of 208 mammoplasties annually for the last three years. Average professional and institutional charges for mammmoplasties were $13,705 in 1996 of which an average of $10,735 was covered by the program. Claim payments by the program for mammoplasties average $9,689 in 1996. The indemnity program has some 236,000 female members, of which 125,000 fall between the ages of 20 and 55. This age band represents the ages at which most mammoplasties are expected to be performed and amounts to some 53% of all of the program's female members.

SOURCES OF DATA:

-Actuarial Note, Dilts, Umstead & Dunn, House Bill 813, Section 5, April 22, 1997, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 813, Section 5, April 24, 1997, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: Sam Byrd
APPROVED BY: Tom L. Covington
DATE: April 24, 1997.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 940

Short Title: Worker's Compensation/Realtor Status. (Public)

Sponsors: Representatives Redwine; Boyd-McIntyre, Clary, Decker, Dedmon, Hill, Howard, McComas, McMahan, Sherrill, Smith, Thompson, and Wainwright.

Referred to: Commerce, if favorable, Insurance.

April 14, 1997

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT A REAL ESTATE BROKER AND REAL ESTATE SALESPERSON ARE NOT EMPLOYEES WITHIN THE MEANING OF THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 97-2(2) reads as rewritten:

"(2) Employee. -- The term 'employee' means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term 'employee' shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term 'employee' shall include all officers and employees thereof, including such as are elected by the people. The term 'employee' shall include members of the North Carolina national guard, except when called into the

service of the United States, and members of the North Carolina State guard, and members of these organizations shall be entitled to compensation for injuries arising out of and in the course of the performance of their duties at drill, in camp, or on special duty under orders of the Governor. The term 'employee' shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving on a fee basis or on a salary basis, or whether deputy sheriffs serving upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment, and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been injured shall, when the employee is dead, include also his legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee as herein defined of a municipality, county, or of the State of North Carolina while engaged in the discharge of his official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of his employer.

Every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation specifically excluding such executive officer in such contract of insurance and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty

members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term employee shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-491(a) when performing duties in the course and scope of a State approved mission pursuant to Article 11 of Chapter 143B.

Employee shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

Employee shall not include any person who satisfies both of the following conditions:

a. The person is a real estate broker or real estate salesman within the meaning of G.S. 93A-2.

b. The person is an independent contractor within the meaning of section 3508 of the Internal Revenue Code, as defined in G.S. 105-228.90.

Any sole proprietor or partner of a business or any member of a limited liability company may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article."

Section 2. This act is effective when it becomes law.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

Rep. DOCKHAM for the Committee on INSURANCE

( ) **Committee Substitute for**
H.B. 940 , S.B. _____ A BILL TO BE ENTITLED AN ACT
H.J.R._____, S.J.R._____ A JOINT RESOLUTION
H.R._____ A HOUSE RESOLUTION

TO CLARIFY THAT A REAL ESTATE BROKER AND REAL ESTATE SALESPERSON ARE NOT EMPLOYEES WITHIN THE MEANING OF THE WORKERS' COMPENSATION ACT.

_X_ With a favorable report.

____ With a favorable report and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report, as amended.

____ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report as to committee substitute bill (# ____), ( ) which changes the title, unfavorable as to original bill (Committee Substitute Bill # ____). (and recommendation that the committee substitute bill (# ____) be re-referred to the Committee on _____.)

____ With a favorable report as to House committee substitute bill (# ____), ( ) which changes the title, unfavorable as to Senate committee substitute bill.

____ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

____ With an unfavorable report.

____ With recommendation that the House concur.

____ With recommendation that the House do not concur.

____ With recommendation that the House do not concur; request conferees.

____ With recommendation that the House concur; committee believes bill to be material.

____ With an unfavorable report, with a Minority Report attached.

____ Without prejudice.

____ With an indefinite postponement report.

____ With an indefinite postponement report, with a Minority Report attached.

____ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

W. Robinson, Director
Administrative Division
Room 5, Legislative Building
16 W. Jones Street
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April 28, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 940 (Workers Comp/Realtors)

House Bill 940 provides that real estate salespersons and brokers (hereinafter "agents") are not, for workers' compensation purposes, employees of the brokers with whom they contract if they are salespersons or brokers as defined in the real estate laws and independent contractors as defined in the Internal Revenue Code (for withholding purposes). As a result, the broker would not be *required* to carry workers' compensation coverage on those agents.

The Workers' Compensation Act requires businesses with three or more employees to carry workers' compensation coverage, but it does not require coverage of independent contractors. Whether a person is an independent contractor for workers' compensation purposes is often difficult to determine. Many factors are considered in determining whether the employer has sufficient control over the work of the person to render that person an employee. The answer often comes only after the issue is litigated. Many employers in this situation are often advised to obtain workers' compensation coverage as a precaution. In the case of real estate agents, the statutory requirement that they practice "under the supervision" of brokers (G.S. 93A-2(b) may be one of the biggest factors that would lead the Commission or a court to determine that the real estate agent is an employee in a given case.

The Internal Revenue Code recognizes real estate agents as independent contractors for tax withholding purposes (assuming certain criteria are met). However, recognition as an independent contractor for federal tax purposes does not mean that the same individual will be recognized as an independent contractor for State workers' compensation purposes.

House Bill 940 still preserves the right of the broker to *elect* to carry workers' compensation coverage on the agents. Many brokers may make this election because it limits an agent injured

on the job exclusively to recovery under the Workers' Compensation Act. A broker that decides to carry workers' compensation coverage can, with the consent of the salesperson, pass the costs of coverage on to the salespersons. This is authorized in G.S. 93A-11, enacted in 1995.

The requirement for workers' compensation coverage will continue to apply to actual employees in the real estate office (for example, secretaries) if the business has three or more employees.

This bill take effect when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 1115

Short Title: Church Insurance Coverage. (Public)

Sponsors: Representatives Boyd-McIntyre, Grady (Cosponsors); Adams, Aldridge, Alexander, Baddour, Black, Blue, Bonner, Bowie, Braswell, Cansler, Carpenter, Clary, Crawford, Culp, Culpepper, Cunningham, Davis, Dedmon, Dickson, Earle, Easterling, Esposito, Fitch, Fox, Gamble, Gardner, Hackney, Hall, Hardaway, Hensley, Hightower, Hill, Howard, H. Hunter, Hurley, Insko, Jarrell, Jeffus, Kinney, Luebke, McAllister, McCrary, Mercer, Michaux, Miller, Miner, Mitchell, Moore, Morris, Mosley, Nichols, Oldham, Owens, Preston, Reynolds, Russell, Saunders, Sexton, Sherrill, Smith, Starnes, Sutton, Tolson, Wainwright, Warner, Warwick, Watson, Wilkins, Womble, Wright, and Yongue.

Referred to: Insurance.

April 21, 1997

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE CANCELLATION OF INSURANCE POLICIES THAT PROVIDE COVERAGE FOR CHURCHES FOR LOSSES RESULTING FROM A FIRE.

The General Assembly of North Carolina enacts:

Section 1. Article 43 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-43-40. Cancellation of fire insurance for buildings owned by religious organizations prohibited in certain circumstances.**

(a) An insurer shall not cancel or decline to renew an insurance policy providing coverage for losses resulting from fire for a building owned by a religious organization solely because of:

(1) A previous occurrence of arson, unless the occurrence of arson was the act of an official of the religious organization that owns the building; or

(2) An oral or written statement directed to the religious organization or an official of the religious organization and threatening an act of arson against the religious organization.

(b) As used in this section, 'religious organization' means any church, ecclesiastical, or denominational organization, or any established physical place for worship in this State at which nonprofit religious services and activities are regularly conducted.

(c) The Commissioner may revoke, suspend, or refuse to renew the license of any insurer that violates this section pursuant to G.S. 58-3-100."

Section 2. This act becomes effective October 1, 1997, and applies to insurance policies issued or renewed on or after January 1, 1998.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

Rep. DOCKHAM for the Committee on INSURANCE

( ) **Committee Substitute for**
H.B. 1115, S.B. _____ A BILL TO BE ENTITLED AN ACT
H.J.R. _____, S.J.R. _____ A JOINT RESOLUTION
H.R. _____ A HOUSE RESOLUTION

TO PROHIBIT THE CANCELLATION OF INSURANCE POLICIES THAT PROVIDE COVERAGE FOR CHURCHES FOR LOSSES RESULTING FROM A FIRE.

_X_ With a favorable report.

____ With a favorable report and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report, as amended.

____ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report as to committee substitute bill (# ____), ( ) which changes the title, unfavorable as to original bill (Committee Substitute Bill # ____). (and recommendation that the committee substitute bill (# ____) be re-referred to the Committee on _____.)

____ With a favorable report as to House committee substitute bill (# ____), ( ) which changes the title, unfavorable as to Senate committee substitute bill.

____ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

____ With an unfavorable report.

____ With recommendation that the House concur.

____ With recommendation that the House do not concur.

____ With recommendation that the House do not concur; request conferees.

____ With recommendation that the House concur; committee believes bill to be material.

____ With an unfavorable report, with a Minority Report attached.

____ Without prejudice.

____ With an indefinite postponement report.

____ With an indefinite postponement report, with a Minority Report attached.

____ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

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April 28, 1997

MEMORANDUM

TO: Representative Jerry Dockham, Chair
House Insurance Committee

FROM: Linwood Jones, Staff Counsel

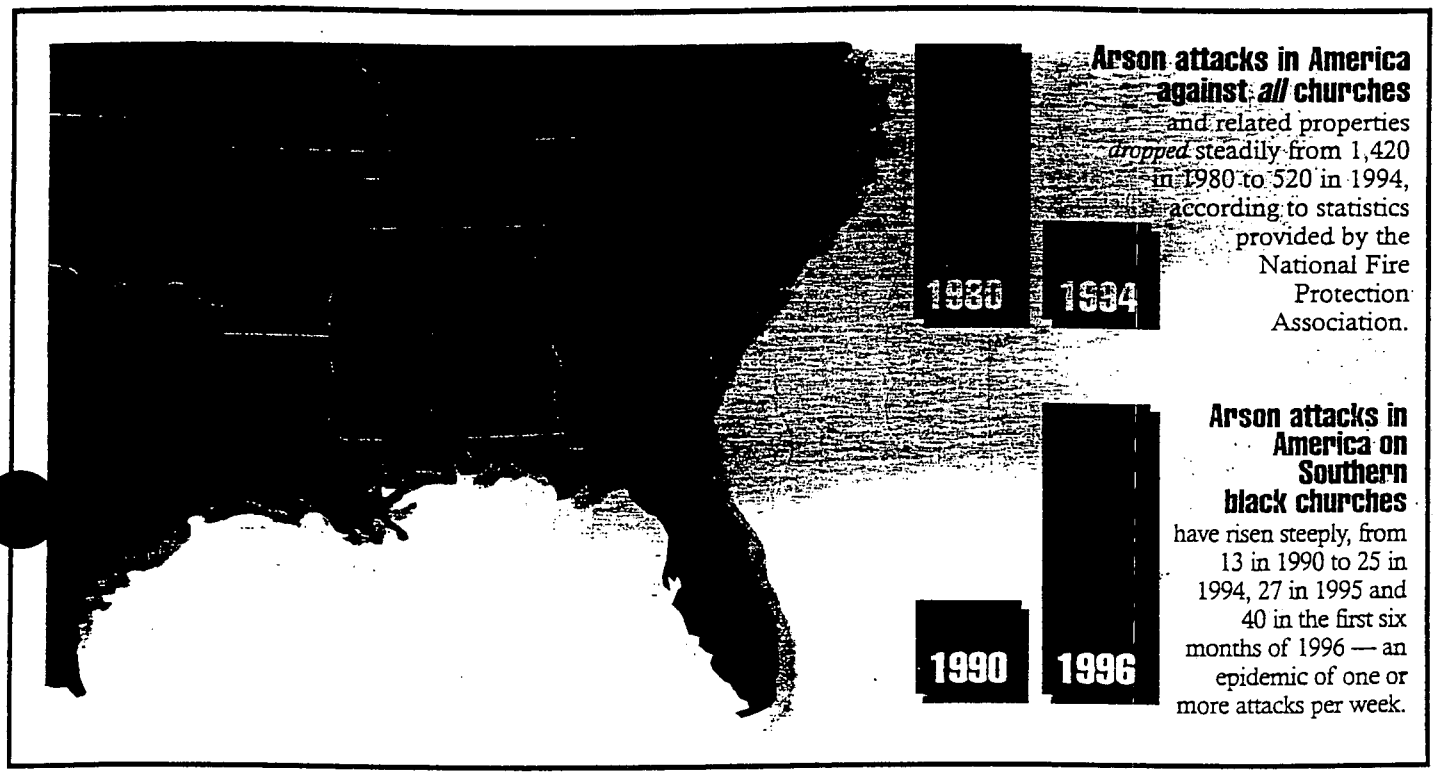
RE: House Bill 1115 (Church Insurance Coverage)

House Bill 1115 prohibits an insurer from canceling or refusing to renew fire insurance coverage or a multiple-peril policy that insures against fire loss of a building owned by a religious organization solely because of a past occurrence of arson or a threat of arson. The Commissioner may suspend, revoke, or refuse to renew the license of an insurer that violates this law. This prohibition does not apply if an official of the religious organization committed the arson in the past.

A religious organization is defined as a church, ecclesiastical, or denominational organization or any established place regularly used for worship.

The bill takes effect October 1, 1997, and applies to policies issued or renewed on or after January 1, 1998.

S1115-SMRN-001



Arson attacks in America against *all* churches and related properties *dropped* steadily from 1,420 in 1980 to 520 in 1994, according to statistics provided by the National Fire Protection Association.

Arson attacks in America on Southern black churches have risen steeply, from 13 in 1990 to 25 in 1994, 27 in 1995 and 40 in the first six months of 1996 — an epidemic of one or more attacks per week.

From:
"Fire on the Cross" printed in *Freedom* magazine
Vol.20, Issue 1
1996

According to the Center for Democratic Renewal, a clearinghouse for information about hate crimes, insurance fails to come close to covering the costs incurred in rebuilding a church that has burned. And that has been the goal of virtually all congregations — to rebuild. Any whisper of "insurance fraud" thus becomes another red herring.

The heavy-handed manner in which ATF agents pursue pastors and parishioners for alleged fraud is not warranted, according to information from insurance firms. The vice president of Southern Mutual Church Insurance Company, Robert Bedell, whose firm insures a large number of churches in South Carolina, one of the states most heavily hit by arson, said that of the black churches they insure, not a single burning had been an "inside job." Church Mutual Insurance Company reported that among all churches they insure, both black and white, in which arson is involved, the percentage attributed to "inside jobs" is so small that it is of no concern to them.

Freedom also learned that insurance policies of certain Southern black churches have been canceled in light of the waves of firebombings — yet another form of punishment of the innocent.

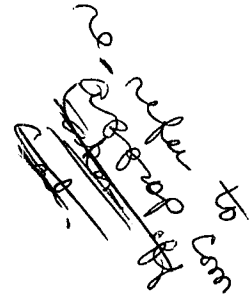
IN

From:
"Fire on the Cross" printed in *Freedom* magazine
Vol.20, Issue 1
1996

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1



HOUSE BILL 984

Short Title: Soil & Water Supervisor Health Benefits. (Public)

Sponsors: Representatives Culp; Brown, Kiser, McCombs, Mitchell, Mosley, Weatherly, and G. Wilson.

Referred to: Insurance.

April 17, 1997

A BILL TO BE ENTITLED

AN ACT TO PROVIDE HEALTH BENEFITS FOR SOIL AND WATER CONSERVATION DISTRICT SUPERVISORS AND THEIR ELIGIBLE DEPENDENTS WHO DO NOT HAVE ACCESS TO COMPREHENSIVE GROUP HEALTH BENEFITS BY ALLOWING VOLUNTARY PARTICIPATION IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40 is amended by adding a new subsection to read:

"(a1) The State of North Carolina deems it to be in the public interest for North Carolina soil and water conservation district supervisors and certain of their dependents who are not eligible for any other type of comprehensive group health insurance or other comprehensive group health benefits to be given the opportunity to participate in the benefits provided by the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan. Coverage under the Plan shall be voluntary for eligible soil and water conservation district supervisors who elect participation in the Plan for themselves and their eligible dependents."

Section 2. G.S. 135-40.1(3) reads as rewritten:

"(3) Dependent Child. -- A natural, legally adopted, or foster child of the employee and/or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent

child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday.

A foster child is covered (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the Claims Processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of, the child(ren), are not eligible participants.

Coverage may be extended beyond the 19th birthday under the following conditions:

a. If the dependent is a full-time student, between the ages of 19 and 26, who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction.

b. The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-40.1(3)a.

Dependent children of soil and water conservation district supervisors are subject to the same terms and conditions as are other dependent children covered by this subdivision."

Section 3. G.S. 135-40.1(6) reads as rewritten:

"(6) Employing Unit. -- A North Carolina School System; Community College; State Department, Agency or Institution; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in a State-Supported Retirement System. An employing unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the General Statutes whose employees are deemed to be public employees and members of a State-Supported Retirement System. North Carolina

soil and water conservation districts are deemed to be employing units for the purpose of providing benefits under this Article."

Section 4. G.S. 135-40.1(7) reads as rewritten:

"(7) Enrollment. -- New employees must enroll themselves and their dependents within 30 days from the date of employment. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional prepaid hospital and medical benefit plans. Children born to covered employees having coverage type (2), or (3), as outlined in G.S. 135-40.3(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the Claims Processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2), or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born. Soil and water conservation district supervisors and their eligible dependents are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

Section 5. G.S. 135-40.1 is amended by adding a new subdivision to read:

"(18a) Soil and Water Conservation District Supervisors. -- Elected and appointed soil and water conservation district supervisors pursuant to Article 1 of Chapter 139 of the General Statutes who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage. Soil and water conservation district supervisors include those who are actively serving as district supervisors as well as former soil and water conservation district supervisors, and former county supervisors and county committeemen covered by G.S. 139-15, who served their respective soil and water conservation districts for 10 or more years. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services,

prescription drugs, and medical supplies and equipment that are generally available in the health insurance market. Comprehensive group health insurance and other benefit coverage includes Medicare benefits. North Carolina soil and water conservation districts shall certify the eligibility of their supervisors and former supervisors and committeemen to the Plan for their participation in its benefits prior to enrollment. In situations where soil and water conservation districts cannot certify the eligibility of former supervisors or committeemen, the North Carolina Soil and Water Conservation Commission may certify the eligibility to the Plan."

Section 6. G.S. 135-40.2(b) is amended by adding a new subdivision to read:

"(13) Soil and water conservation district supervisors, their eligible spouses, and eligible dependent children."

Section 7. G.S. 135-40.3 is amended by adding a new subsection to read:

"(f) Soil and water conservation district supervisors are subject to the same terms and conditions of this section as are employees. Eligible dependents of soil and water conservation district supervisors are subject to the same terms and conditions of this section as are dependents of employees."

Section 8. G.S. 135-39.6A reads as rewritten:

"**§ 135-39.6A. Premiums set.**

The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Comprehensive Major Medical Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish regulations for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits.

In setting premiums for soil and water conservation district supervisors and their eligible dependents, the Executive Administrator and Board of Trustees shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents."

Section 9. This act is effective July 1, 1998.

MINUTES

HOUSE COMMITTEE ON INSURANCE

May 15, 1997

The House Committee on Insurance met in Room 643 of the Legislative Office Building on May 15, 1997 at 12:00 noon. Representative Dockham, presided. Members present were: Allred, Barbee, Bowie, Brawley, Cole, Hardaway, Hardy, Hensley, Holmes, Hurley, Ives, Luebke, McComas, Russell,Tallent and Wainwright. A list of visitors attending is attached. Attachment I

Chairman Dockham called the meeting to order at 12:02; introduced the pages and the following bills were considered:

Senate Bill 714, entitled, AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICE PLANS, HMO PLANS, AND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN, TO PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM MASTECTOMY was before the committee for consideration (bill summary attached). Senator Forrester, sponsor, explained the bill. Senate Bill 714 requires insurers, HMOs, and hospital and medical service corporations (Blue Cross) to provide coverage for breast reconstruction resulting from a mastectomy if they cover the mastectomy. "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to re-establish symmetry between the two breasts, including reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. Coverage must also be provided for surgery on the nondiseased breast when necessary to establish symmetry with the reconstructed diseased breast. Representative Bowie moved that Senate Bill 714 be given a favorable report. After some discussion, the motion carried. (Attachment II- Explanation of HB-714, Attachment III- Proposed House Committee Substitute)

Senate Bill 914, entitled, AN ACT TO REVISE THE REIMBURSEMENT METHODOLOGY FOR HOSPITAL CHARGES UNDER WORKERS' COMPENSATION was explained by the introducer, Senator Kerr and an explanation of this bill was given to each committee member. (Attachment IV, by Linwood Jones) Senator Kerr explained that Senate Bill 914 revises the method by which hospitals are reimbursed for treatment and care rendered to workers' compensation patients. The bill addresses a problem that arose a little over a year ago with self-insured employers and the impact of the hospital reimbursement methodology on those employers. A temporary solution was enacted last year but expires June 30th of this year. This bill extends and modifies that solution. Senate Bill 914 re-establishes this 90/100 risk corridor for the remainder of this year. The corridor would be adjusted in future years by the Industrial Commission to produce a discount for the payors (insurers and self-insured employers) that is equal to the discount received under the State Health Plan. In modifying the risk corridor, the Industrial Commission would follow more formal requirements by giving notice of its proposed modification. The Commissions' modification would be subject to judicial review. The proposed committee substitute (Attachment V) makes a couple of technical changes: it makes clear in subdivision (3) that the 100% limitation continues to apply after January 1, 1999, and it makes clear that the purpose of deeming the Industrial Commission's determination of a payment rate a final agency rule is to ensure that judicial review of that determination is available. This bill takes effect June 30, 1997. Chairman Dockham called for questions from the committee members and from the audience. Representative Bowie ask about the cost to the State and after some discussion, Representative Wainwright made a motion that the bill pass with a favorable report as to House Committee substitute bill, unfavorable as to original bill. The motion carried.

Chairman Dockham adjoined the meeting at 12:50 p.m.

Jerry Dockham, Chairman

Joanna Mills, Clerk

VISITOR REGISTRATION SHEET

Insurance — 5-15-97
Name of Committee — Date

Attachment I

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Robert Pinion	Jordan Price Wall
Jan Kost	OSP
EVELYN B. TERRY	N.C. STATE HEALTH PLAN
L. Watson	Both Cain & Royce
Kwin Huff	QualChoice
Kristi Bunn	
Joan Danieley	QualChoice
Harold Wright	State Health Plan
David M. DeVane	State Health Plan.
Alan Miles	Bailey & Dixon LLP
Evelyn Armstrong	NCHA
HUGH TILSON	NCHA
MICHAEL CRONELL	NC NURSES ASSN
Sandy Barker	NC Nurses Assoc.

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

MAY 15, 1997 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Hale	NC Ins Dept
Dascheil Propes	"
Marie McMillan	citizen
Tommy Watts	Carolina Kaiser Health Care System
[illegible]	
[illegible]	BCBSNC
[illegible]	[illegible], PA
R. Paul Wilms	NCHSA
John Bowdish	Zebulon, PA
Harry Kaplan	
Nancy Bradley	NCIBS

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Attachment II

May 15, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: Senate Bill 714 (Reconstructive Surgery/Coverage)
Proposed Committee Substitute

Senate Bill 714 requires insurers, HMOs, and hospital and medical service corporations (Blue Cross) to provide coverage for breast reconstruction resulting from a mastectomy if they cover the mastectomy. The standard health plan offered in the small employer group market must also include this coverage. In addition, there cannot be different deductibles or coinsurance amounts for breast reconstruction than for similar services. Sections 1, 2, and 3 apply to commercial insurers, hospital and medical service corporations, and HMOs, respectively. Section 4 applies to the standard health plan in the small employer group market.

"Reconstructive breast surgery" means surgery performed as a result of a mastectomy to re-establish symmetry between the two breasts, including reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. The term also includes reduction mammoplasty, augmentation mammoplasty, and mastopexy of the nondiseased breast. Coverage must also be provided for surgery on the nondiseased breast when necessary to establish symmetry with the reconstructed diseased breast. In addition, coverage for the nipple reconstruction following the mastectomy is to be performed without regard to the lapse in time between the mastectomy and the nipple reconstruction.

The proposed committee substitute adds other limitations to ensure that this coverage is provided. The insurer cannot do any of the following: (1) deny coverage for reconstruction after mastectomy on grounds that it is cosmetic surgery, (2) discontinue or deny coverage for the purpose of avoiding these requirements, (3) provide rebates or other financial incentives that encourage a woman to accept less coverage than is

required, (4) penalize a provider, financially or otherwise, for providing care under this law, and (5) provide incentives to the provider to induce the provider to provide care inconsistent with this law. These prohibitions are identical to those contained in the House version of this bill (HB 813) that was passed by this Committee a few weeks ago. They are also similar to the new restrictions on maternity stay that are contained in the federal Health Insurance Portability and Accountability Act of 1996 (Kennedy-Kassenbaum) and North Carolina's proposed conforming amendments to that Act (HB 434).

The bill (*see Section 5*) also requires the State Health Plan to cover reconstructive breast surgery that results from a mastectomy. Coverage extends to the nondiseased breast to the extent necessary to establish symmetry with the reconstructed diseased breast.

The coverage is required in all insurance policies that are issued or renewed on or after January 1, 1998. The coverage in the State Health Plan also would begin January 1, 1998.

Attachment III

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 714
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97

Proposed House Committee Substitute
S714-CSRN-001

Short Title: Coverage for Reconstr. Surgery. (Public)

Sponsors:

Referred to:

April 7, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICE PLANS, HMO PLANS, AND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN, TO PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM MASTECTOMY.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"§ 58-51-61. Coverage for reconstructive breast surgery resulting from mastectomy.

(a) Every policy or contract of accident and health insurance, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast

to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or

beneficiary in a manner inconsistent with this section."

Section 2. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-96. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 3. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-79. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1998, that is subject to this Article and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to

reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 4. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a

mastectomy at least equal to the coverage required by G.S. 58-51-61.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. This section shall be effective after July 10, 1991."

Section 5. Effective January 1, 1998, G.S. 135-40.6(5) is amended by adding the following new sub-subdivision to read:

"h. Reconstructive Breast Surgery: Reconstructive breast surgery resulting from a mastectomy. The coverage shall include all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. As used in this sub-subdivision, (i) 'mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease; (ii) 'reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast. Coverage described under this sub-subdivision shall not be denied on the basis that the coverage is for cosmetic surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician."

Section 6. Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 714
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97
Proposed House Committee Substitute S714-PCSA753

Short Title: Coverage for Reconstr. Surgery. (Public)

Sponsors:

Referred to:

April 7, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICE PLANS, HMO PLANS, AND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM MASTECTOMY.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-61. Coverage for reconstructive breast surgery resulting from mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 2. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-96. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55, that is issued, renewed, or amended on or after January 1, 1998, that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the

reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 3. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-67-79. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1998, that is subject to this Article and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) 'Mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) 'Reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section."

Section 4. Effective January 1, 1998, G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-61.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. This section shall be effective after July 10, 1991."

Section 5. Effective January 1, 1998, G.S. 135-40.6(5) is amended by adding the following new sub-subdivision to read:

"h. Reconstructive Breast Surgery: Reconstructive breast surgery resulting from a mastectomy. The coverage shall include all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. As used in this sub-subdivision, (i) 'mastectomy' means the surgical removal of all or part of a breast as a result of breast cancer or breast disease; (ii) 'reconstructive breast surgery' means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. 'Reconstructive breast surgery' also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast. Coverage described under this sub-subdivision shall not be denied on the basis that the coverage is for cosmetic surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician."

Section 6. Nothing in this act shall apply to specified accident, specified disease, hospital indemnity, or long-term care health insurance policies.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 914

PROPOSED COMMITTEE SUBSTITUTE
S914-CSRN-001

Short Title: Workers' Comp. Hospital Charges. (Public)

Sponsors:

Referred to: Commerce.

April 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REVISE THE REIMBURSEMENT METHODOLOGY FOR HOSPITAL CHARGES UNDER WORKERS' COMPENSATION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 97-26(b) reads as rewritten:

"(b) (Effective June 30, 1997 -- see editor's note) Hospital Fees. -- ~~Payment for medical compensation rendered by a hospital participating in the State Plan shall be equal to the payment the hospital receives for the same treatment and services under the State Plan. Payment for a particular type of medical compensation that is not covered under the State Plan shall be based on the allowable charge under the State Plan for comparable services or treatment, as determined by the Commission.~~ Each hospital subject to the provisions of this subsection shall be reimbursed the amount provided for in this subsection unless it has agreed under contract with the ~~insurer or managed care organization~~ insurer, managed care organization, employer (or other payor obligated to reimburse for inpatient hospital services rendered under this Chapter) to accept a different amount or reimbursement methodology.

Except as otherwise provided herein, payment for medical treatment and services rendered to workers' compensation patients by a hospital shall be equal to the payment the hospital is authorized to receive for the same treatment or service under the State Plan, provided that:

(1) Payment for inpatient hospital inpatient services provided on or after July 1, 1997, and on or before December 31, 1997, shall not be less than a minimum of ninety percent (90%) nor more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form.

(2) Payment for inpatient hospital services provided on or after January 1, 1998, through and including December 31, 1998, shall be not more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form nor less than a minimum percentage of such charges that the Commission determines would have been required to have produced an average payment rate equal to ninety-three and one-tenth percent (93.1%) of aggregate charges for all inpatient claims processed by the Commission during the fiscal year ending June 30, 1997.

(3) Payment for inpatient hospital services provided on or after January 1, 1999, shall be not more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form nor less than the minimum percentage established annually by the Commission as follows:

a. Beginning in the third quarter (July, August, and September) of 1998, and annually thereafter, the Commission shall review data from the State Plan to ascertain the aggregate hospital itemized charges and aggregate amounts authorized for payment by the State Plan (including payments actually made by the State Plan and deductible, coinsurance, or other amounts for which the patient/insured may have been liable) for inpatient hospital claims paid to participating hospitals by the State Plan during the immediately preceding fiscal year ending June 30. The Commission shall then utilize the data described in the preceding sentence to calculate the extent, if any, to

which aggregate State Plan authorized payments were less than aggregate charges on inpatient hospital claims paid by the State Plan during the preceding fiscal year.

b. Beginning in the third quarter (July, August, and September) of 1998, and annually thereafter, the Commission shall calculate aggregate hospital itemized charges and aggregate payments authorized by the Commission on all inpatient hospital workers' compensation claims approved for payment by the Commission during the preceding fiscal year ending June 30.

c. Based on the data described in sub-subdivisions a. and b. of this subdivision, the Commission shall on or before December 1, 1998, and December 1 of each subsequent year establish a minimum percentage that will result in a payment rate for inpatient workers' compensation cases that in the aggregate bears a percentage relationship to hospital itemized charges that is equal to the State Plan relationship between aggregate payments authorized and aggregate itemized charges for claims paid by the State Plan during the preceding fiscal year ending June 30. The percentage rate established shall be effective for the next succeeding calendar year beginning January 1 of that year.

Notwithstanding any other provisions of law, the Commission's determination of payment rates under this subsection shall:

(1) Comply with the procedures for adoption of a fee schedule established in G.S. 97-26(a);

(2) Include publication on or before October 1 of each year of the proposed payment rate, and a summary of the data and calculations on which the rate is based;

(3) Be subject to the declaratory ruling provisions of G.S. 150B-4; and

(4) Be deemed to constitute a final permanent rule under Article 2A of Chapter 150B for purposes of judicial review under Article 4 of that Chapter.

Payment for a particular type of medical compensation that is not covered under the State Plan shall be based on the allowable

charge under the State Plan for comparable services or treatment, as determined by the Commission.

A hospital's itemized charges on the UB-92 claim form for workers' compensation services shall be the same as itemized charges for like services for all other payers."

Section 2. This act becomes effective June 30, 1997.

North Carolina General Assembly
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Attachment V

May 15, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel LJ

RE: Senate Bill 914 (Workers Comp. Hospital Charges)
Proposed Committee Substitute

Senate Bill 914 revises the method by which hospitals are reimbursed for treatment and care rendered to workers' compensation patients. The bill addresses a problem that arose a little over a year ago with self-insured employers and the impact of the hospital reimbursement methodology on those employers. A temporary solution was enacted last year but expires June 30th of this year. This bill extends and modifies that solution.

When the Workers' Compensation Reform Act of 1994 (SB 906) was enacted, it tied hospital reimbursement for workers' compensation payments to the same reimbursement those hospitals received under the State Health Plan. When the State Health Plan went to a diagnostic related grouping (DRG) reimbursement system for hospital reimbursement over a year ago, the workers' compensation reimbursement system was also switched to a DRG system. Under the DRG system, a hospital is reimbursed primarily on the basis of the diagnosis of the patient, not the actual itemized charges that are calculated based on how long the patient stays in the hospital. The reimbursement is reduced some for each unusually short inpatient stay, and it is increased some for each unusually long inpatient stay. Most insurers have a large enough mix of cases so that the DRG system does not adversely effect them. However, self-insured employers who must pay their injured employees' medical bills under workers' compensation may not have this type of case mix and may end up with bills that exceed the hospital's actual itemized charges.

Legislation enacted last year addressed this by creating a "risk corridor" under which the self-insured employers would not pay more under the DRG system than the actual charges and the hospitals would not be reimbursed less than 90% of those

charges. However, this legislation expires June 30, 1997. Senate Bill 914 re-establishes this 90/100 risk corridor for the remainder of this year. The corridor would be adjusted in future years by the Industrial Commission to produce a discount for the payors (insurers and self-insured employers) that is equal to the discount received under the State Health Plan. In modifying the risk corridor, the Industrial Commission would follow more formal requirements for giving notice of its proposed modification. The Commissions' modification would be subject to judicial review.

The proposed committee substitute makes a couple of technical changes: it makes clear in subdivision (3) that the 100% limitation continues to apply after January 1, 1999, and it makes clear that the purpose of deeming the Industrial Commission's determination of a payment rate a final agency rule is to ensure that judicial review of that determination is available.

This bill takes effect June 30, 1997.

S914-SMRN-002

Attachment V

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S **D**

SENATE BILL 914
Proposed House Committee Substitute S914-PCS8701

Short Title: Workers' Comp. Hospital Charges. (Public)

Sponsors:

Referred to:

April 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REVISE THE REIMBURSEMENT METHODOLOGY FOR HOSPITAL CHARGES UNDER WORKERS' COMPENSATION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 97-26(b) reads as rewritten:

"(b) **(Effective June 30, 1997 -- see editor's note)** Hospital Fees. -- ~~Payment for medical compensation rendered by a hospital participating in the State Plan shall be equal to the payment the hospital receives for the same treatment and services under the State Plan. Payment for a particular type of medical compensation that is not covered under the State Plan shall be based on the allowable charge under the State Plan for comparable services or treatment, as determined by the Commission.~~ Each hospital subject to the provisions of this subsection shall be reimbursed the amount provided for in this subsection unless it has agreed under contract with the ~~insurer or managed care organization~~ insurer, managed care organization, employer (or other payor obligated to reimburse for inpatient hospital services rendered under this Chapter) to accept a different amount or reimbursement methodology.

Except as otherwise provided herein, payment for medical treatment and services rendered to workers' compensation patients by a hospital shall be equal to the payment the hospital is authorized to receive for the same treatment or service under the State Plan, provided that:

(1) Payment for inpatient hospital inpatient services provided on or after July 1, 1997, and on or before December 31, 1997, shall not be less than a minimum of ninety percent (90%) nor more than a

maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form.

(2) Payment for inpatient hospital services provided on or after January 1, 1998, through and including December 31, 1998, shall be not more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form nor less than a minimum percentage of such charges that the Commission determines would have been required to have produced an average payment rate equal to ninety-three and one-tenth percent (93.1%) of aggregate charges for all inpatient claims processed by the Commission during the fiscal year ending June 30, 1997.

(3) Payment for inpatient hospital services provided on or after January 1, 1999, shall be not more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form nor less than the minimum percentage established annually by the Commission as follows:

a. Beginning in the third quarter (July, August, and September) of 1998, and annually thereafter, the Commission shall review data from the State Plan to ascertain the aggregate hospital itemized charges and aggregate amounts authorized for payment by the State Plan (including payments actually made by the State Plan and deductible, coinsurance, or other amounts for which the patient/insured may have been liable) for inpatient hospital claims paid to participating hospitals by the State Plan during the immediately preceding fiscal year ending June 30. The Commission shall then utilize the data described in the preceding sentence to calculate the extent, if any, to which aggregate State Plan authorized payments were less than aggregate charges on inpatient hospital claims paid by the State Plan during the preceding fiscal year.

b. Beginning in the third quarter (July, August, and September) of 1998, and annually thereafter, the Commission shall calculate aggregate hospital itemized charges and aggregate payments authorized by the Commission on all inpatient hospital workers' compensation claims approved for payment by the Commission during the preceding fiscal year ending June 30.

c. Based on the data described in sub-subdivisions a. and b. of this subdivision, the Commission shall on or before December 1, 1998, and December 1 of each subsequent year establish a minimum percentage that will result in a payment rate for inpatient workers' compensation cases that in the aggregate bears a percentage relationship to hospital itemized charges

that is equal to the State Plan relationship between aggregate payments authorized and aggregate itemized charges for claims paid by the State Plan during the preceding fiscal year ending June 30. The percentage rate established shall be effective for the next succeeding calendar year beginning January 1 of that year.

Notwithstanding any other provisions of law, the Commission's determination of payment rates under this subsection shall:

(1) Comply with the procedures for adoption of a fee schedule established in G.S. 97-26(a);

(2) Include publication on or before October 1 of each year of the proposed payment rate, and a summary of the data and calculations on which the rate is based;

(3) Be subject to the declaratory ruling provisions of G.S. 150B-4; and

(4) Be deemed to constitute a final permanent rule under Article 2A of Chapter 150B for purposes of judicial review under Article 4 of that Chapter.

Payment for a particular type of medical compensation that is not covered under the State Plan shall be based on the allowable charge under the State Plan for comparable services or treatment, as determined by the Commission.

A hospital's itemized charges on the UB-92 claim form for workers' compensation services shall be the same as itemized charges for like services for all other payers."

Section 2. This act becomes effective June 30, 1997.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

Following report(s) from standing committee(s) is/are presented:

By Rep. Jerry C. Dockham for the Committee on INSTRUCTION

(X) **Committee Substitute for**
H.B._____, S.B. 714 A BILL TO BE ENTITLED AN ACT
H.J.R._____, S.J.R._____ A JOINT RESOLUTION
H.R._____ A HOUSE RESOLUTION

TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICE PLANS, HMO PLANS, AND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN, TO PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM MASTECTOMY.

____ With a favorable report.

____ With a favorable report and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

____ With a favorable report, as amended.

____ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ( ) Appropriations ( ) Finance ( ) _____.

With a favorable report as to committee substitute bill (# ____), ( ) which changes the title, unfavorable as to original bill (Committee Substitute Bill # ____). (and recommendation that the committee substitute bill (# ____) be re-referred to the Committee on _____.)

_X_ With a favorable report as to House committee substitute bill ~~(# ____)~~, (X) which changes the title, unfavorable as to Senate committee substitute bill, (and recommendation that the House committee substitute bill be re-referred to the Committee on Appropriations).

____ And having received a unanimous vote in committee, is placed on the Consent Calendar.

____ With an unfavorable report.

____ With recommendation that the House concur.

____ With recommendation that the House do not concur.

____ With recommendation that the House do not concur; request conferees.

____ With recommendation that the House concur; committee believes bill to be material.

____ With an unfavorable report, with a Minority Report attached.

____ Without prejudice.

____ With an indefinite postponement report.

With an indefinite postponement report, with a Minority Report attached.

____ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

1/15/97

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham** for the Committee on **Insurance**.

☐ Committee Substitute for
S.B. 914 A BILL TO BE ENTITLED AN ACT TO REVISE THE REIMBURSEMENT METHODOLOGY FOR HOSPITAL CHARGES UNDER WORKERS' COMPENSATION.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☒ With a favorable report as to House committee substitute bill ~~(#); ☐ which changes the title~~, unfavorable as to original bill ~~(Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on~~ .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

AGENDA

HOUSE COMMITTEE ON INSURANCE

MAY 15, 1997

OPENING REMARKS

Representative Dockham, Chairman

BILLS TO BE CONSIDERED

SB-714- Reconstructive Surgery/Coverage-2
Senator Forrester

referred to Comm. & Appr

SB-914- Workers' Comp. Hospital Changes
Senator Kerr

– With favorable report – as to House Comm. Sub. unfavorable as to original Bill

ADJOURNMENT

MINUTES

HOUSE COMMITTEE ON INSURANCE

JUNE 16, 1997

The House Committee on Insurance met in Room 643 of the Legislature Office Building on June 26, 1997 at 12:00 Noon. Chairman Dockham, presiding, called the meeting to order and welcomed the visitors. (Visitor Registration sheets-Attachment I)

Members present: Representative Dockham, Allred, Barbee, Brawley, Dedmon, Dickson, Hensley, Holmes, Hurley, Ives, Luebke, McComas, Miner, Tallent, Wainwright, and Wright.

Chairman Dockham announced that the agenda would have to be revised due to the time constraints that we have and because of the time sensitive nature of the bill, we will have to hear House Bill 434-Federal Health Insurance Changes first. Representative Barbee made the motion that the proposed committee substitute be before us for consideration. The motion passed and was presented to the Committee. Mr. Bill Hale was introduced by Chairman Dockham to explain the bill and Linwood Jones, Counsel for the Insurance Committee, gave all of the members an explanation of the changes made by the Senate to House Bill 434. Mr. Bill Hale referred to Jones' explanation and explained these are only technical changes. He went over the changes made to Cobra and the changes made in the language which are shown in the attached explanation. (See Attachment II)

Representative Luebke asked what the "look back" period was. Mr. Hale explained that the "look back" period for determining whether a person on an individual policy of insurance has a preexisting condition is retained at l year. Although the federal law shortens the look-back period for group policies to 6 months, it does not require a 6 month look-back period on individual health insurance policies unless the individual is an "eligible individual" as defined in the law. A. provision is added to make clear that the 1-year look back period only applies to those individuals who are not "elegible" individuals.

Representative Brawley made the motion that the bill be given a favorable report and that the Committee concurs with the Senate. Representative Wright made the second and the motion was passed.

The second Bill for discussion was Senate Bill 975. Chairman Dockham welcomed Senator Kincaid to the floor and asked him to please explain his bill. Senator Kincaid explained that the changes made in the Substitute Bill were technical and should not present any reasons for the substitute not to pass. Senator Kincaid explained the bill and welcomed questions from the committee members and the audience. He stated that this is a non-controversial bill with no opposition; the Insurance Industry favors the bill; and the Self-Insured Workman's compensation Guaranty Fund favors the bill. Rep. Tallent made a motion that it be voted favorable for Committee Substitute and not favorable for the original bill. The motion carried.

Chairman Dockham called on Senator Kincaid to explain Senate Bill 234-Increase Amts. For Insurance Points. The point system in North Carolina has not been up-dated in ten years and this bill is to bring the system in line and more current. Under the current law, if one car runs into the rear of another car and an ambulance is called the person in the rear car gets an automatic 3 points. This will change the law from automatic to being able to make a choice in the points given to that driver. Senator Kincaid said he wished we would do away with the point system but since it is in place this bill would allow the point system to be based upon the severity of the accident.

Representative Allred asked who establishes the amount of damages done in an accident and Senator Kincaid replied that it was not the police officer (who was almost always wrong) but that it is based on the amount of claims paid by the Insurance Company.

Representative Hurley made the motion that the Bill be given a favorable report and the motion was carried and passed.

Chairman Dockham pointed out the time was short; however, Senator Odom said his bill was straight forward and very simple. This bill refers to sales tax on vitamin supplements given by Chiropractors. Representative Allred said that Physicians had to pay sales tax on injectibles and he would like to do an amendment to the bill. After further discussion, it was determined that this Bill was going to the Finance Committee and that in the essence of time, Rep. Allred would add the amendment to the bill when it is in the Committee on Finance. Representative Dixon made a motion that the bill be given a favorable report. The Bill passed and was referred to the Finance Committee.

Chairman Dockham, adjourned the meeting at 12:56 p.m.

Chairman Jerry C. Dockham

Clerk Joanna S. Mills

VISITOR REGISTRATION SHEET

Attachment I

INSURANCE

Name of Committee

June 26, 1997

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
D. D. Propes	NC DOI
Susan Valeani	Nationwide
[illegible]	Mouras Van Allen
[illegible]	WCSR
David M. Adkins	NC State Health Plan
Harold Vaughn	State Health Plan
Evelyn B. Terry	State Health Plan
Marion White	DEHNR - Adv. Comm on Cancer
Brenda Summers	NC Equity
Lynn Dressler	UNC Lineberger Ca Ctr
Jack Hawke	
Verne Kinlaw	NC Chiropractic Assoc.
C M Caron	"
John Bowdish	Zeb Alley P.A.

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

June 26, 1997 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Lance Wrenn	Bode, Call + Stroupe - Raleigh
Mike James	NCRPA
Leighton Roper	ZDA, PA
Davis Bradshaw	SHPDA
[signature]	SEANC
Wendy Mills	SEANC
Dawn Arnall	SEANC
[signature]	
David Ferrell	Hafer, McNamara et al
[signature]	Jordan Price Wall Gray Jones
Henry Jones	" " "
T. Mullhan	UHC
Ken Mitchell	NCSIGA
Jim Stuart	NCSIGA
B.K. Whitehouse	NCCF

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

June 26, 1997

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Clifford Baker	CGSIF
Neill Cox	NCFA-SIF
Keith Biggs	NCFA-SIF
~~Bob~~ Sloan	NC Forestry Association
Robert PASchal	Young, Moore & Henderson
	WCSR
Becky P. Hunt	PPAB
Amy Jo Bain	Smith Anderson
Marie Lewis	Burch, Porter & Johnson
Sheila H. McKinney	NCDOI
Ken Wright	BCBSNC

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

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16 W. Jones Street
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Donald W. Fulford, Director
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Terrence D. Sullivan, Director
Research Division
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(919) 733-2578

Attachment I

June 26, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Counsel

RE: Senate Changes to House Bill 434 (Federal Health Insurance)

The following are the changes made by the Senate to House Bill 434. In my opinion, these are all technical changes:

- "COBRA continuation provision" is defined to also include coverage under a State continuation law (see sub-subdivision d.)

- The reference to "service corporation" in the definition of "health insurer" is changed to "hospital or medical" service corporation, making clear that a dental service corporation is not considered a "health insurer" (see subdivision (6)).

- The reference to "providers" in the definition of "network plan" is changed to "health care providers" for clarification (see subdivision 13).

- Language is added (see sub-subdivision c.) to provide that the time an individual spends on short-term limited duration health insurance (less than 12 months) does not count in determining creditable coverage under the portability law.

- Language is added to exempt self-employed individuals, who currently come under our Small Employer Group laws, from the requirement for guaranteed issuance of a health insurance policy. The federal law does not require guaranteed availability of coverage to self-employed individuals.

- Unnecessary language concerning high risk health insurance pools is eliminated from the bill. North Carolina does not have a high-risk pool.

- Definition of "late enrollee" in the existing small group law is amended in three places to make clarifications.

- The "look-back" period for determining whether a person on an individual policy of insurance has a pre-existing condition is retained at 1 year. Although the federal law shortens the look-back period for *group* policies to 6 months, it does not require a 6-month look-back period on *individual* health insurance policies unless the individual is an "eligible individual" as defined in the law. A provision is added to make clear that the 1-year look back period only applies to those individual who are not "eligible" individuals.

- Language is added to clarify that the limits on preexisting conditions in individual health insurance policies do not apply to certain types of "excepted benefits" defined under federal law (such as specified disease policies, etc.)

- A provision is added repealing GS 58-3-173. This statute is no longer necessary because it is being replaced by the new conforming provisions in the bill.

- Provisions were added to make clear that the bill does not override existing State law on chemical dependency coverage.

- Language was added to clarify that individual health insurance coverage does not include short-term coverage.

- Provisions relating to the existing law on preexisting conditions in individual health insurance policies and its inapplicability to "eligible individuals" (to whom pre-ex clauses do not apply) was relocated in the bill.

- Grammar and erroneous cross-references were corrected

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) Dockham for the Committee on **Insurance.**

x Committee Substitute for
H.B. 434 A BILL TO BE ENTITLED AN ACT TO CONFORM NORTH CAROLINA HEALTH INSURANCE LAWS TO RECENTLY ENACTED FEDERAL LAWS CONCERNING HEALTH INSURANCE UNDERWRITING AND PORTABILITY, MATERNITY COVERAGE, AND COVERAGE FOR MENTAL ILLNESS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

X With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 4

HOUSE BILL 434
Committee Substitute Favorable 4/24/97
Senate Pensions & Retirement and Insurance Committee Substitute Adopted 6/12/97
Fourth Edition Engrossed 6/19/97

Short Title: Federal Health Insurance Changes/AB. (Public)

Sponsors:

Referred to:

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO CONFORM NORTH CAROLINA HEALTH INSURANCE LAWS TO RECENTLY ENACTED FEDERAL LAWS CONCERNING HEALTH INSURANCE UNDERWRITING AND PORTABILITY, MATERNITY COVERAGE, AND COVERAGE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. Article 68 of Chapter 58 of the General Statutes is amended as follows:

(a) By repealing G.S. 58-68-1, 58-68-5, 58-68-10, 58-68-15, and 58-68-20.

(b) By rewriting the Article heading to read:

"~~North Carolina Health Insurance Trust Commission.~~
Health Insurance Portability and Accountability."

(c) By adding the following Part A and Part B:

"Part A. Group Market Reforms.

"Subpart 1. Portability, Access, and Renewability Requirements.

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. -- In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

(1) 'Bona fide association'. -- With respect to health insurance coverage offered in this State, an association that:

a. Has been actively in existence for at least five years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee).

d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

f. Meets the additional requirements as may be imposed under State law.

(2) 'COBRA continuation provision'. -- Any of the following:

a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.

b. Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of the Act.

c. Title XXII of the Public Health Service Act (42 U.S.C.S. § 300bb, et seq.,) as requirements for certain group health plans for certain State and local employees.

d. Article 53 of this Chapter or the health insurance continuation law of another state.

(3) 'Employee'. -- The meaning given the term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) 'Employer'. -- The meaning given the term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of two or more employees.

(5) 'Health insurance coverage' or 'coverage' or 'health insurance plan' or 'plan'. -- Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer.

(6) 'Health insurer'. -- An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement

subject to Article 49 of this Chapter, that offers and issues health insurance coverage.

(7) 'Health status-related factor'. -- Any of the factors described in G.S. 58-68-35(a)(1).

(8) 'Individual health insurance coverage'. -- Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.

(9) 'Individual market'. -- The market for health insurance coverage offered to individuals.

(10) 'Large employer'. -- An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the health insurance plan year.

(11) 'Large group market'. -- The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.

(12) 'Medical care'. -- 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. Amounts paid for transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision.

c. Amounts paid for insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(13) 'Network plan'. -- Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.

(14) 'Participant'. -- The meaning given the term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(15) 'Placed for adoption'. -- The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

(16) 'Small employer'. -- The meaning given to the term in G.S. 58-50-110(22).

(17) 'Small group market'. -- The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents

through a group health insurance plan maintained by a small employer.

(b) Excepted Benefits. -- For the purposes of this Article, 'excepted benefits' means benefits under one or more or any combination of the following:

(1) Benefits not subject to requirements. --

a. Coverage only for accident or disability income insurance or any combination of these.

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, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately. --

a. Limited scope dental or vision benefits.

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

c. The other similar, limited benefits as are specified in federal regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits. --

a. Coverage only for a specified disease or illness.

b. Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy. -- Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health insurance plan.

(c) Application of certain rules in determination of employer size. -- For the purposes of this Article:

(1) Application of aggregation rule for employers. -- All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(2) Employers not in existence in preceding year. -- In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of

employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(3) Predecessors. -- Any reference in this subsection to an employer shall include a reference to any predecessor of the employer.

"§ 58-68-30. Increased portability through limitation on preexisting condition exclusions.

(a) Limitation on Preexisting Condition Exclusion Period; Crediting for Periods of Previous Coverage. -- Subject to subsection (d) of this section, a group health insurer may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.

(2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.

(3) The period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions. -- For the purposes of this Part:

(1) Preexisting condition exclusion. --

a. In general. -- 'Preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date.

b. Treatment of genetic information. -- Genetic information shall not be treated as a condition described in subdivision (a)(1) of this subsection in the absence of a diagnosis of the condition related to the information.

(2) Enrollment date. -- With respect to an individual covered under a group health insurance plan, the date of enrollment of the individual in the coverage or, if earlier, the first day of the waiting period for the enrollment.

(3) Late enrollee. -- With respect to coverage under a group health insurance plan, a participant or beneficiary who enrolls under the plan other than during:

a. The first period in which the individual is eligible to enroll under the plan, or

b. A special enrollment period under subsection (f) of this section.

(4) Waiting period. -- With respect to a group health insurance plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules Relating to Crediting Previous Coverage. --

(1) Creditable coverage defined. -- For the purposes of this Article, 'creditable coverage' means, with respect to an individual, coverage of the individual under any of the following:

a. A self-funded employer group health plan under the Employee Retirement Income Security Act of 1974.
b. Group or individual 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)).

'Creditable coverage' does not include coverage consisting solely of coverage of excepted benefits.

(2) Not counting periods before significant breaks in coverage. --

a. In general. -- A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health insurance plan, if, after the period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.
b. Waiting period not treated as a break in coverage. -- For the purposes of sub-subdivision a. of this subdivision and subdivision (d)(4) of this subsection, any period that an individual is in a waiting period for any coverage under a group health insurance plan or is in an affiliation period shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.
c. Time spent on short term limited duration health insurance not treated as a break in coverage. -- For the purposes of sub-subdivision a. of this subdivision, any period that an

individual is enrolled on a short term limited duration health insurance policy shall not be taken into account in determining the continuous period under sub-subdivision. a. of this subdivision so long as the period of time spent on the short term limited duration health insurance policy or policies does not exceed 12 months.

(3) Method of crediting coverage. --

a. Standard method. -- Except as otherwise provided under sub-subdivision b. of this subdivision for the purposes of applying subdivision (a)(3) of this subsection, a group health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.

b. Election of alternative method. -- A group health insurer may elect to apply subdivision (a)(3) of this subsection based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations rather than as provided under sub-subdivision a. of this subdivision. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election a group health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

c. Health insurer notice. -- In the case of an election under sub-subdivision b. of this subdivision with respect to health insurance coverage in the small or large group market, the health insurer: (i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made the election, and (ii) shall include in the statements a description of the effect of the election.

(4) Establishment of period. -- Periods of creditable coverage for an individual shall be established through presentation of certifications described in subsection (e) of this section or in another manner that is specified in federal regulations.

(d) Exceptions. --

(1) Exclusion not applicable to certain newborns. -- Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. -- Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child

who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. -- A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. -- Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and Disclosure of Coverage. --

(1) Requirement for certification of period of creditable coverage. --

a. In general. -- A group health insurer shall provide the certification described in sub-subdivision b. of this subdivision: (i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, (ii) in the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision, and (iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii) of this sub-subdivision, whichever is later.

The certification under clause (i) of this sub-subdivision may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

b. Certification. -- The certification described in this sub-subdivision is a written certification of: (i) the period of creditable coverage of the individual under the plan and any coverage under the COBRA continuation provision, and (ii) any waiting period and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) Disclosure of information on previous benefits. -- In the case of an election described in sub-subdivision (c)(3)b. of this subsection by a group health insurer, if the health insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (1) of this subsection:

a. Upon request of the health insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or health insurer information on coverage of classes and categories of health benefits available under the entity's coverage.

b. The entity may charge the requesting plan or health insurer for the reasonable cost of disclosing the information.

(f) Special Enrollment Periods. --

(1) Individuals losing other coverage. -- A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

a. The employee or dependent was covered under an ERISA group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

b. The employee stated in writing at the time that coverage under the group health plan or health insurance coverage was the reason for declining enrollment, but only if the health insurer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

c. The employee's or dependent's coverage described in sub-subdivision a.: (i) was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) was not under that provision and either the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; or (iii) employer contributions toward the coverage were terminated.

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the date of exhaustion of coverage described in sub-subdivision c.(i) of this subdivision or termination of coverage or employer contribution described in sub-subdivision c.(ii) of this subdivision.

(2) For dependent beneficiaries. --

a. In general. -- If: (i) a group health insurance plan makes coverage available with respect to a dependent of an individual, (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a

participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and (iii) a person becomes the dependent of the individual through marriage, birth, or adoption or placement for adoption.

The plan shall provide for a dependent special enrollment period described in sub-subdivision b. of this subdivision during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

b. Dependent special enrollment period. -- A dependent special enrollment period under this sub-subdivision shall be a period of not less than 30 days and shall begin on the later of: (i) the date dependent coverage is made available, or (ii) the date of the marriage, birth, or adoption or placement for adoption described in sub-subdivision a.(iii) of this subdivision.

c. No waiting period. -- If an individual seeks to enroll a dependent during the first 30 days of the dependent's special enrollment period, the coverage of the dependent shall become effective: (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received; (ii) in the case of a dependent's birth, as of the date of the birth; or (iii) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(g) Use of Affiliation Period by HMO as Alternative to Preexisting Condition Exclusion. --

(1) In general. -- A health maintenance organization that does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for the coverage option, but only if:

a. The period is applied uniformly without regard to any health status-related factors.

b. The period does not exceed two months (or three months in the case of a late enrollee).

(2) Affiliation period. --

a. Defined. -- For the purposes of this Subpart, 'affiliation period' means a period that, under the terms of the health insurance coverage offered by the health maintenance

organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

b. Beginning. -- The period shall begin on the enrollment date.

c. Runs concurrently with waiting periods. -- An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods. -- A health maintenance organization described in subdivision (1) of this subsection may use alternative methods, as approved by the Commissioner, from those described in that subdivision, to address adverse selection.

"§ 58-68-35. Prohibiting discrimination against individual participants and beneficiaries based on health status.

(a) In Eligibility To Enroll. --

(1) In general. -- Subject to subdivision (2) of this subsection, a group health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the health insurer's plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status.

b. Medical condition (including both physical and mental illnesses).

c. Claims experience.

d. Receipt of health care.

e. Medical history.

f. Genetic information.

g. Evidence of insurability (including conditions arising out of acts of domestic violence).

h. Disability.

(2) No application to benefits or exclusions. -- To the extent consistent with G.S. 58-68-30, subdivision (1) of this subsection shall not be construed:

a. To require a group health insurance plan to provide particular benefits other than those provided under the terms of the plan, or

b. To prevent the plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan.

(3) Construction. -- For the purposes of subdivision (1) of this subsection, rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for the enrollment.

(b) In Premium Contributions. --

(1) In general. -- A group health insurance plan shall not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of individual.

(2) Construction. -- Nothing in subdivision (1) of this subsection shall be construed:

a. To restrict the amount that an employer may be charged for coverage under a group health insurance plan; or

b. To prevent a group health insurer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

"Subpart 2. Health Insurance Availability and Renewability.

"§ 58-68-40. Guaranteed availability of coverage for employers in the small group market.

(a) Issuance of Coverage in the Small Group Market. --

(1) In general. -- Subject to subsections (c) through (f) of this section, each health insurer that offers health insurance coverage in the small group market in this State:

a. Must accept every small employer that applies for the coverage; and

b. Must accept for enrollment under the coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health insurance plan and shall not place any restriction that is inconsistent with G.S. 58-68-35 on an eligible individual being a participant or beneficiary.

(2) Eligible individual defined. -- For the purposes of this section, 'eligible individual' means, with respect to a health insurer that offers health insurance coverage to a small employer in the small group market, such an individual in relation to the employer as shall be determined:

a. In accordance with the terms of the plan,

b. As provided by the health insurer under rules of the health insurer that are uniformly applicable in this State to small employers in the small group market, and

c. In accordance with all applicable State laws governing the health insurer and the market.

(b) Special Rules for Network Plans. --

(1) In general. -- In the case of a health insurer that offers health insurance coverage in the small group market through a network plan, the health insurer may:

a. Limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; and

b. Within the service area of the network plan, deny coverage to the employers if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and (ii) it is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.

(2) 180-day suspension upon denial of coverage. -- A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subsection, shall not offer coverage in the small group market within the service area for a period of 180 days after the date the coverage is denied.

(c) Application of Financial Capacity Limits. --

(1) In general. -- A health insurer may deny health insurance coverage in the small group market if the health insurer has demonstrated to the Commissioner that:

a. It does not have the financial reserves necessary to underwrite additional coverage; and

b. It is applying this subdivision uniformly to all employers in the small group market in the State consistent with this Chapter and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.

(2) 180-day suspension upon denial of coverage. -- A health insurer upon denying health insurance coverage in accordance with subdivision (1) of this subsection shall not offer coverage in the small group market in the State for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage,

whichever is later. The Commissioner may apply this subsection on a service-area-specific basis.

(d) Exception to Requirement for Failure to Meet Certain Minimum Participation or Contribution Rules. --

(1) In general. -- Subsection (a) of this section does not preclude a health insurer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health insurance plan in the small group market, as allowed under this Chapter.

(2) Rules defined. -- For the purposes of subdivision (1) of this subsection:

a. 'Employer contribution rule' means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

b. 'Group participation rule' means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(e) Exception for Coverage Offered Only to Bona Fide Association Members. -- Subsection (a) of this section does not apply to:

(1) Health insurance coverage offered by a health insurer if the coverage is made available in the small group market only through one or more bona fide associations.

(2) A self-employed individual as defined in G.S. 58-50-110(21a).

"§ 58-68-45. Guaranteed renewability of coverage for employers in the group market.

(a) In General. -- Except as provided in this section, if a health insurer offers health insurance coverage in the small or large group market, the health insurer must renew or continue in force the coverage at the option of the employer.

(b) General Exceptions. -- A health insurer may nonrenew or discontinue health insurance coverage in the small or large group market based only on one or more of the following:

(1) Nonpayment of premiums. -- The policyholder has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.

(2) Fraud. -- The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rules. -- The policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under G.S. 58-68-40(e) in the case of the small group market or pursuant to this Chapter in the case of the large group market.

(4) Termination of coverage. -- The health insurer is ceasing to offer coverage in the market in accordance with subsection (c) of this section and this Chapter.

(5) Movement outside service area. -- In the case of a health insurer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with the network plan who lives, resides, or works in the service area of the health insurer or in the area for which the health insurer is authorized to do business and, in the case of the small group market, the health insurer would deny enrollment with respect to the network plan under G.S. 58-68-40(c)(1)a.

(6) Association membership ceases. -- In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for Uniform Termination of Coverage. --

(1) Particular type of coverage not offered. -- In any case in which a health insurer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of the type may be discontinued by the health insurer in accordance with this Chapter in the market only if:

a. The health insurer provides notice to each policyholder provided coverage of this type in the market and to the participants and beneficiaries covered under the coverage of the discontinuation at least 90 days before the date of the discontinuation of the coverage;

b. The health insurer offers to each policyholder provided coverage of this type in the market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the health insurer to a group health insurance plan in the market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

(2) Discontinuance of all coverage. --

a. In general. -- In any case in which a health insurer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in this State, health insurance coverage may be discontinued by the health insurer only in accordance with this Chapter and if: (i) the health insurer provides notice to the Commissioner and to each policyholder and to the participants and beneficiaries covered under the coverage of the discontinuation at least 180 days before the date of the discontinuation of the coverage; and (ii) all health insurance issued or delivered for issuance in this State in the market or markets are discontinued and coverage under the health insurance coverage in the market or markets is not renewed.

b. Prohibition on market reentry. -- In the case of a discontinuation under sub-subdivision a. of this subdivision in a market, the health insurer shall not provide for the issuance of any health insurance coverage in that market in this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. -- At the time of coverage renewal, a health insurer may modify the health insurance coverage for a product offered to a group health insurance plan:

(1) In the large group market; or

(2) In the small group market if, for coverage that is available in the market other than only through one or more bona fide associations, the modification is consistent with this Chapter and effective on a uniform basis among group health insurance plans with that product.

(e) Application to Coverage Offered Only Through Associations. -- In applying this section in the case of health insurance coverage that is made available by a health insurer in the small or large group market to employers only through one or more associations, a reference to 'policyholder' is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer.

"§ 58-68-50. Disclosure of information.

(a) Disclosure of Information by Health Insurers. -- In connection with the offering of any health insurance coverage to a small employer, a health insurer:

(1) Shall make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b) of this section, and

(2) Shall upon request of the small employer, provide the information.

(b) Information Described. --

(1) In general. -- Subject to subdivision (3) of this subsection, with respect to a health insurer offering health insurance coverage to a small employer, information described in this subsection is information concerning:

a. The provisions of the coverage concerning the health insurer's right to change premium rates and the factors that may affect changes in premium rates;

b. The provisions of the coverage relating to renewability of coverage;

c. The provisions of the coverage relating to any preexisting condition exclusion; and

d. The benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) Form of information. -- Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

(3) Exception. -- A health insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

"Subpart 3. Exclusion of Plans.

"§ 58-68-55. Exclusion of certain plans.

(a) Exception for Certain Benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(1).

(b) Exception for Certain Benefits if Certain Conditions Met. --

(1) Limited, excepted benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(2) if the benefits:

a. Are provided under a separate policy, certificate, or contract of insurance; or

b. Are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(3) if all of the following conditions are met:

a. The benefits are provided under a separate policy, certificate, or contract of insurance.

b. There is no coordination between the provision of the benefits and any exclusion of benefits under any group health insurance plan maintained by the same policyholder.

c. The benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health insurance plan maintained by the same policyholder.

(3) Supplemental, excepted benefits. -- The requirements of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

"Part B -- Individual Market Reforms.

"§ 58-68-60. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

(a) Guaranteed Availability. --

(1) In general. -- Subject to the succeeding subsections of this section, each health insurer that offers health insurance coverage in the individual market in this State shall not, with respect to an eligible individual desiring to enroll in individual health insurance coverage:

a. Decline to offer the coverage to, or deny enrollment of, the individual; or

b. Impose any preexisting condition exclusion with respect to the coverage.

(b) Eligible Individual Defined. -- In this Part, 'eligible individual' means an individual:

(1)(i) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under an ERISA group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) Who is not eligible for coverage under (i) an ERISA group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of the Act (or any successor program), and does not have other health insurance coverage;

(3) With respect to whom the most recent coverage within the coverage period described in subdivision (1)(i) was not terminated based on a factor described in G.S. 58-68-45(b)(1) or (b)(2);

(4) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under Article 53 of this Chapter, who elected the coverage; and

(5) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program.

(c) Alternative Coverage Permitted. --

(1) In general. -- In the case of health insurance coverage offered in this State, a health insurer may elect to limit the coverage offered under subsection (a) of this section as long as it offers at least two different policy forms of health insurance coverage both of which:

a. Are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the health insurer; and

b. Meet the requirement of subdivision (2) or (3) of this subsection, as elected by the health insurer.

For the purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) Choice of most popular policy forms. -- The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all the policy forms offered by the health insurer in this State or applicable marketing or service area (as may be prescribed by rules or regulations) by the health insurer in the individual market in the period involved.

(3) Choice of two policy forms with representative coverage. --

a. In general. -- The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers a lower-level coverage policy form (as described in sub-subdivision b. of this subdivision) and a higher-level coverage policy form (as described in sub-subdivision c. of this subdivision) each of which includes benefits substantially similar to other individual health insurance coverage offered by the health insurer in this State.

b. Lower-level of coverage described. -- A policy form is described in this sub-subdivision if the actuarial value of the benefits under the coverage is at least eighty-five percent (85%) but not greater than one hundred percent (100%) of a weighted average (described in sub-subdivision d. of this subdivision).

c. Higher-level of coverage described. -- A policy form is described in this sub-subdivision if: (i) the actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of the coverage described in sub-subdivision b. of this subdivision offered by the health insurer in the area involved; and (ii) the actuarial value of the benefits under the coverage is at least one hundred percent (100%) but not greater than one hundred

twenty percent (120%) of a weighted average (described in sub-subdivision d. of this subdivision).

d. Weighted average. -- For the purposes of this subdivision, the weighted average described in this sub-subdivision is the average actuarial value of the benefits provided by all the health insurance coverage issued, as elected by the health insurer, either by that health insurer or by all health insurers in this State in the individual market during the previous year, not including coverage issued under this section, weighted by enrollment for the different coverage.

(4) Election. -- The health insurer elections under this subsection shall apply uniformly to all eligible individuals in this State for that health insurer. The election shall be effective for policies offered during a period of not less than two years.

(5) Assumptions. -- For the purposes of subdivision (3) of this subsection, the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(d) Special Rules for Network Plans. --

(1) In general. -- In the case of a health insurer that offers health insurance coverage in the individual market through a network plan, the health insurer may:

a. Limit the individuals who may be enrolled under the coverage to those who live, reside, or work within the service area for the network plan; and

b. Within the service area of the plan, deny the coverage to the individuals if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and (ii) it is applying this subdivision uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(2) 180-day suspension upon denial of coverage. -- A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subdivision, shall not offer coverage in the individual market within the service area for a period of 180 days after the coverage is denied.

(e) Application of Financial Capacity Limits. --

(1) In general. -- A health insurer may deny health insurance coverage in the individual market to an eligible individual if the health insurer has demonstrated to the Commissioner that:

a. It does not have the financial reserves necessary to underwrite additional coverage; and

b. It is applying this subdivision uniformly to all individuals in the individual market in this State consistent with this Chapter and without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(2) 180-day suspension upon denial of coverage. -- A health insurer, upon denying individual health insurance coverage in any service area in accordance with subdivision (1) of this subsection, shall not offer the coverage in the individual market within the service area for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(f) Market Requirements. --

(1) In general. -- Subsection (a) of this section does not require that a health insurer offering health insurance coverage only in connection with ERISA group health plans or through one or more bona fide associations, or both, offer the health insurance coverage in the individual market.

(2) Conversion policies. -- A health insurer offering health insurance coverage in connection with group health plans under title XXVII of the federal Public Health Service Act shall not be deemed to be a health insurer offering individual health insurance coverage solely because the health insurer offers a conversion policy.

(g) Construction. -- Nothing in this section shall be construed:

(1) To restrict the amount of the premium rates that a health insurer may charge an individual for health insurance coverage provided in the individual market under this Chapter; or

(2) To prevent a health insurer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(h) Other Definitions. -- As used in this section:

(1) 'Church plan'. -- The meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(2) 'Governmental plan'. --

a. The meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

b. Federal governmental plan. -- A governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government.

c. Nonfederal governmental plan. -- A governmental plan that is not a federal governmental plan.

"**§ 58-68-65. Guaranteed renewability of individual health insurance coverage.**

(a) In General. -- Except as provided in this section, a health insurer that provides individual health insurance coverage to an individual shall renew or continue in force the coverage at the option of the individual.

(b) General Exceptions. -- A health insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) Nonpayment of premiums. -- The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.

(2) Fraud. -- The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Termination of plan. -- The health insurer is ceasing to offer coverage in the individual market in accordance with subsection (c) of this section and this Chapter.

(4) Movement outside service area. -- In the case of a health insurer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the health insurer is authorized to do business) but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(5) Association membership ceases. -- In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(c) Requirements for Uniform Termination of Coverage. --

(1) Particular type of coverage not offered. -- In any case in which a health insurer decides to discontinue offering a particular type of health insurance coverage offered in the individual market,

coverage of the type may be discontinued by the health insurer only if:

a. The health insurer provides notice, notwithstanding G.S. 58-51-20 or G.S. 58-65-60(c)(3)b., to each covered individual provided coverage of this type in the market of the discontinuation at least 90 days before the date of the discontinuation of the coverage;

b. The health insurer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the health insurer for individuals in the market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(2) Discontinuance of all coverage. --

a. In general. -- Subject to sub-subdivision c. of this subdivision, in any case in which a health insurer elects to discontinue offering all health insurance coverage in the individual market in this State, health insurance coverage may be discontinued by the health insurer only if: (i) the health insurer provides notice to the Commissioner and to each individual of the discontinuation at least 180 days before the date of the expiration of the coverage, and (ii) all health insurance coverage issued or delivered for issuance in this State in the market is discontinued and the health insurance coverage in the market is not renewed.

b. Prohibition on market reentry. -- In the case of a discontinuation under sub-subdivision a. of this subdivision in the individual market, the health insurer shall not provide for the issuance of any health insurance coverage in the market and this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. -- At the time of coverage renewal, a health insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market as long as the modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

(e) Application to Coverage Offered Only Through Associations. -- In applying this section in the case of health insurance coverage that is made available by a

health insurer in the individual market to individuals only through one or more associations, a reference to an 'individual' is deemed to include a reference to the association of which the individual is a member.

"**§ 58-68-70. Certification of coverage.**

G.S. 58-68-30(e) applies to health insurance coverage offered by a health insurer in the individual market in the same manner that it applies to health insurance coverage offered by a health insurer in the small or large group market.

"**§ 58-68-75. General exceptions.**

(a) Exception for Certain Benefits. -- This Part does not apply to any health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(1).

(b) Exception for Certain Benefits if Certain Conditions Met. -- This Part does not apply to any health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(2), (3), or (4) if the benefits are provided under a separate policy, certificate, or contract of insurance."

Section 2. G.S. 58-50-110 reads as rewritten:

"**§ 58-50-110. Definitions.**

As used in this Act:

(1) 'Accountable health carrier' means that as defined in G.S. 143-622(1).

(1a) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-50-130, and to the extent applicable, the provisions of Article 68 of this Chapter, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(1b) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, gender, family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b).

(2) Repealed by Session Laws 1993, c. 529, s. 3.3.

(3) 'Basic health care plan' means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

(4) 'Board' means the board of directors of the Pool.

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance

organization (HMO), and a multiple employer welfare arrangement.

(5a) 'Case characteristics' means the demographic factors age, gender, family size, and geographic location.

(6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.

(8) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-50-120.

(9) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(10) 'Eligible employee' means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

(11) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not ~~mean accident only, specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.~~ include benefits described in G.S. 58-68-25(b).

(12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

(13) Repealed by Session Laws 1993, c. 529, s. 3.3.

(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual was covered under a public or private health benefit plan that provided, at the time the individual was eligible to enroll, benefits equal to or exceeding the same required level of benefits in the basic ~~and~~ or standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in a ~~basic or standard health care plan~~ health benefit plan within 30 days after termination of coverage provided under another health plan; or
2. Stated, in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining coverage;

3, 4. Repealed by Session Laws 1993, c. 529, s. 3.3.

b. The individual elects a different health plan offered through the Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment for a spouse is made within 30 days after issuance of the court ~~order;~~ order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days ~~of~~ after the ~~individual~~ individual's or employee's marriage or the ~~birth or adoption~~ birth, adoption, or placement for adoption of a child.

(15) Repealed by Session Laws 1993, c. 529, s. 3.3.

(16) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) 'Preexisting-conditions provision' means a ~~policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to pregnancy existing on the effective~~

~~date of coverage.~~ preexisting-condition provision as defined in G.S. 58-68-30.

(18) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) 'Rating period' means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) 'Risk-assuming carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) 'Reinsuring carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(21a) 'Self-employed individual' means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

(22) 'Small employer' means any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than ~~49~~ 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this definition. For purposes of this Act, the term small employer includes self-employed individuals.

(23) 'Small employer carrier' means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125."

Section 3. G.S. 58-50-125(c) reads as rewritten:

"(c) ~~The~~ Except as provided under Article 68 of this Chapter, the plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider."

Section 4. G.S. 58-50-125(g) reads as rewritten:

"(g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is required to offer coverage or accept applications under subsection (d) of this section in the case of any of the following:

(1) To a group that is not physically located in the HMO's approved service areas;

(2) To an employee who does not reside within the HMO's approved service areas;

(3) Within an area, where the HMO can reasonably anticipate, and demonstrate, to the Commissioner's satisfaction, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers."

Section 5. G.S. 58-50-130(a) reads as rewritten:

"(a) Health benefit plans covering small employers are subject to the following provisions:

~~(1) Except in the case of a late enrollee, any preexisting conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's initial effective date of coverage and must define preexisting conditions as "those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage".~~

~~(2) In determining whether a preexisting conditions provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous health benefit plan if the previous coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan. As used in this subdivision with respect to previous coverage, the meaning of "health benefit plan" is not limited to the definition in G.S. 58-50-115, but includes any health benefit plan provided by a health insurer, as that term is defined in G.S. 58-51-115(a), or~~

~~any government plan or program providing health benefits or health care.~~

~~(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:~~

~~a. For nonpayment of the required premiums by the policyholder or contract holder;~~

~~b. For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives;~~

~~c. For noncompliance with plan provisions that have been approved by the Commissioner;~~

~~d. When the number of enrollees covered under the plan is less than the number of insureds or percentage of enrollees required by participation requirements under the plan; or~~

~~e. When the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan.~~

~~f. When the small employer carrier stops writing new business in the small employer market, if:~~

~~1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and~~

~~2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.~~

~~A small employer carrier that stops writing new business in the small employer market in this State after January 1, 1992, shall be prohibited from writing new business in the small employer market in this State for a period of five years from the date of notice to the Commissioner. In the case of an HMO doing business in the small employer market in one service area of this State, the rules set forth in this subdivision shall apply to the HMO's operations in the service area, unless the provisions of G.S. 58-50-125(g) apply.~~

~~(4) Late enrollees may be excluded from coverage for the greater of 18 months or an 18-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled~~

~~at the end of such period in the health benefit plan currently held by the small employer.~~

(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. 'Qualifying existing coverage' means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. An accountable health carrier shall not enforce participation or contribution requirements on member small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.

(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary ~~or~~ of an insurer, or controlled individual of an insurance holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act.

(6) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).

~~(7) A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.~~

~~(8) In the case of an eligible employee or dependent of an eligible employee who was excluded from or denied coverage by a small~~

~~employer carrier on or before August 14, 1992, the small employer carrier shall provide an opportunity for such eligible employee or dependent to enroll in the health benefit plan currently held by the small employer not later than the next plan anniversary on or after August 14, 1992.~~

(9) The health benefit plan must meet the applicable requirements of Article 68 of this Chapter."

Section 6. G.S. 58-50-130(d) reads as written:

"(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales ~~materials, of.~~ materials, of the following and shall provide this information to the small employer upon request:

(1) Repealed by Session Laws 1993, c. 529, s. 3.7.

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.

(3) Provisions relating to renewability of policies and contracts.

(4) Provisions affecting any preexisting conditions provision.

(5) The benefits available and premiums charged under all health benefit plans for which the small employer is eligible."

Section 7. G.S. 58-51-15(a)(2)b. reads as rewritten:

"b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions ~~must be covered no later than one year after the effective date of coverage.~~ are covered under this policy.....(insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions ~~are defined as~~ mean 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended ~~or that could be medically documented~~ within the one-year period immediately preceding the effective date of the person's coverage.' ~~Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period that was met under the previous plan. As used in this policy, the term "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an insured person, all health benefit plans must credit the time the person was covered under a previous~~

~~plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~ Credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G. S. 58-68-30."

Section 7.1. G.S. 58-51-15 is amended by adding a new subsection to read:

"(h) Preexisting Condition Exclusion Clarification. -- Sub-subdivision (a)(2)b. of this section does not apply to:

(1) Policies issued to eligible individuals under G.S. 58-68-60.

(2) Excepted benefits as described in G.S. 58-68-25(b)."

Section 8. G.S. 58-51-80(b) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further

purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the ~~members~~ members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

~~c. A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject the coverage, in writing.~~

~~(2) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more persons and for groups~~

~~under subdivision (1a) of this subsection and under G.S. 58-51-81. In determining whether a preexisting condition provision applies to an eligible employee, association member, student, or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~"

Section 9. G.S. 58-51-80(h) reads as rewritten:

"(h) Nothing contained in this section applies to any contract issued by any corporation defined in Article 65 of this Chapter. ~~Subdivision (b)(3) of this section applies to MEWAs, as defined in G.S. 58-49-30(a).~~"

Section 10. G.S. 58-53-1 reads as rewritten:

"**§ 58-53-1. Definitions.**

As used in this Article, the following terms have the meanings specified:

(1) 'Group policy' means a group accident and health insurance policy issued by an insurance company and a group contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(2) 'Individual policy' or 'converted policy' means an individual health insurance policy issued by an insurance company or an individual ~~health services~~ contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(3) 'Insurance' and 'insured' refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided by reason of a disability extension.

(4) "Insurer" means the entity issuing a group policy or an individual or converted policy.

(5) "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(5a) 'Member' or 'employee' includes an insured spouse or dependent of a member or of an employee.

(6) 'Premium' includes any premium or other consideration payable for coverage under a group or individual policy.

(7) 'Reasonable and customary' means the most frequently used level of charge made for the supplies or for a specific service in the geographic subarea in which such supplies or services are received, of like kind or by physicians, or other practitioners, with similar qualifications."

Section 11. G.S. 58-53-5 reads as rewritten:

"**§ 58-53-5. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership.**

A group policy delivered or issued for delivery in this State ~~which~~ that insures employees or ~~members, other than the members and their dependents, if they have elected to include them, whose eligibility under the group policy does not extend to any employee(s) the insured may have~~ members for hospital, surgical or major medical insurance on an expense incurred or service basis under ~~Articles 1 through 67 of~~ this Chapter, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose ~~insurance for these types of~~ coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible spouses and dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions ~~applicable to those forms of insurance~~ and to the conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans ~~already in force, or hereafter placed into effect,~~ that provide continuation benefits equal to or better than those required in this Part."

Section 12. G.S. 58-53-35 reads as rewritten:

"**§ 58-53-35. Termination of continuation.**

(a) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date ~~one year~~ 18 months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have terminated. The insurer that insured the group ~~prior to~~ before the date of termination shall make a converted policy available to the employee or member.

(b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the group policy with another group policy, the employee is entitled to continue under the successor group policy for any unexpired period of continuation to which the employee is entitled."

Section 13. G.S. 58-53-50 reads as rewritten:

"**§ 58-53-50. Restrictions.**

A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred because:

(1) Of termination of employment or membership and either he was not entitled to continuation of group coverage under Part 1 of this Article or failed to elect such continuation;

(2) He failed to make timely payment of any required contribution for the cost of continuation of insurance;

(3) He had not been continuously covered under the group policy or for similar benefits under any other group policy that it replaced during the period of three consecutive months immediately prior to termination of active employment ending with such termination;

(4) The group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of date of termination; or

(5) He failed to continue his insurance for the entire maximum period of ~~one year~~ 18 months following termination of active employment as provided for in Part 1 of this Article, unless that failure to continue was because of change of insurer by the employer and the change of insurer was consummated during the one year continuation period. In that event the employee or member shall be entitled to be issued a converted policy by the insurer that provided the group policy to the employer before the change of insurer."

Section 14. G.S. 58-53-55 reads as rewritten:

"**§ 58-53-55. Time limit.**

In order to be eligible for conversion, written application and the first premium payment for the converted policy must be made to the insurer not later than 31 days after the date of termination of insurance provided under Part 1 of this Article. The effective date of the converted policy shall be the day following the later of:

(1) The termination of insurance under the group policy when it is not replaced by one providing similar coverage within 31 days of the termination date of the immediately prior group plan; or

(2) The termination of the ~~one year~~ period of continued coverage under the group policy or policies."

Section 15. Article 55 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-55-31. Additional requirements.**

(a) No policy shall be used in this State unless it provides for an offer of nonforfeiture, which shall not be less than an offer of reduced paid-up insurance benefits, extended term insurance benefits, or a shortened benefit period. No policy shall pay a cash surrender value unless the dividends or refunds are applied as a reduction of future premiums or an increase in future benefits.

(b) The Commissioner shall adopt rules to provide for annual reports by insurers of the number of claims denied, number of rescissions, and the percentage of sales involving the replacement of policies.

(c) No policy shall be used in this State unless the insurer has developed a financial or personal asset suitability test to determine whether or not issuing long-term care insurance to an applicant is appropriate. For purposes of this section:

(1) All insurers except those issuing life insurance that accelerates the death benefit for long-term care shall use the financial or suitability form and format standards as developed and adopted by the NAIC. A personal long-term care worksheet and disclosure notice of issues an applicant should know before buying long-term care insurance shall be completed and provided before an application is taken.

(2) Each applicant that does not meet the recommended financial or personal asset suitability test criteria shall receive a letter of notification and shall be given an option to waive the results of the financial suitability test and proceed with the purchase of the policy.

(d) The Commissioner shall adopt standards to handle consumer complaints about noncompliance with State requirements."

Section 16. G.S. 58-65-25 reads as rewritten:

"**§ 58-65-25. Hospital, physician and dentist contracts.**

(a) Any corporation organized under ~~the provisions of~~ this Article ~~and Article 66 of this Chapter~~ may enter into contracts for the rendering of hospital service to any of its subscribers by hospitals approved by the American Medical Association and/or the North Carolina Hospital Association, and may enter into contracts for the furnishing of, or the payment in whole or in part for, medical and/or dental services rendered to any of its subscribers by duly licensed physicians and/or dentists. All obligations arising under contracts issued by such corporations to its subscribers shall be satisfied by payments made directly to the hospitals or hospitals and/or physicians and/or dentists rendering such service, or direct to the subscriber or his, her, or their legal representatives upon the receipt by the corporation from the subscriber of a statement marked paid by the hospital(s) and/or physician(s) and/or dentist(s) or both rendering such service, and all such payments heretofore made are hereby ratified. Nothing ~~herein~~ in this section shall be construed to discriminate against hospitals conducted by other schools of medical practice.

(b) ~~On and after January 1, 1956, all~~ All certificates, plans or contracts issued to subscribers or other persons by hospital and medical and/or dental service corporations operating under this Article ~~and Article 66 of this Chapter~~ shall contain

in substance a provision as follows: 'After two years from the date of issue of this certificate, contract or plan no misstatements, except fraudulent misstatements made by the applicant in the application for such certificate, contract or plan, shall be used to void said certificate, contract or plan, or to deny a claim for loss incurred or disability (as therein defined) commencing after the expiration of such two-year period. ~~No claim for loss incurred or disability (as defined in the certificate, contract or plan) commencing after two years from the date of issue of this certificate, contract or plan shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specifically described, effective on the date of loss, had existed prior to the effective date of coverage of this certificate, contract or plan.~~'"

Section 17. G.S. 58-65-60(e) reads as rewritten:

"(e) A ~~hospital~~ service corporation may issue a master group contract with the approval of the Commissioner ~~of Insurance provided such~~ if the contract and the individual certificates issued to members of the ~~group, shall comply~~ group comply in substance to the other provisions of this Article and Article 66 of this Chapter. ~~Any such~~ The contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in ~~said~~ the contract, and in accordance with an adjustment schedule filed with and approved by the ~~Commissioner of Insurance.~~ Commissioner. If ~~such master group~~ the contract is issued, altered or modified, the subscribers' contracts issued ~~in pursuance thereof~~ under that contract are altered or modified accordingly, all laws and clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of subscribers thereto.

~~(1) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for coverage or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of~~

~~the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care, except that nothing in this section shall apply to a guaranteed issue product designed for uninsurables. For employer groups of 50 or more persons: In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

~~(3)~~ (e1) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

~~(4)~~ (e2) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan."

Section 18. G.S. 58-67-85 reads as rewritten:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

(a) A health maintenance organization may issue a master group contract with the approval of the Commissioner of Insurance provided the contract and the individual certificates issued to members of the group, shall comply in substance to the other provisions of this Article. Any such contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner of Insurance. If the master group contract is issued, altered or modified, the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees' contracts to the contrary

notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

~~(b) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage." Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subsection, a "previous plan" includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

(d) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(e) Whenever an employer master group contract replaces another group contract, whether the contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and

(2) Each person not covered under the succeeding corporation's plan of benefits in accordance with (e)(1) must nevertheless be covered

by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan."

Section 19. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-169. Required coverage for minimum hospital stay following birth.**

(a) Definitions. -- As used in this section:

(1) 'Attending providers' includes:

a. The obstetrician-gynecologists, pediatricians, family physicians, and other physicians primarily responsible for the care of a mother and newborn; and

b. The nurse midwives and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident,

b. Credit,

c. Disability income,

d. Long-term or nursing home care,

e. Medicare supplement,

f. Specified disease,

g. Dental or vision,

h. Coverage issued as a supplement to liability insurance,

i. Workers' compensation,

j. Medical payments under automobile or homeowners, and

k. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

l. Hospital income or indemnity.

(3) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this

Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) In General. -- Except as provided in subsection (c) of this section, an insurer that provides a health benefit plan that contains maternity benefits, including benefits for childbirth, shall ensure that coverage is provided with respect to a mother who is a participant, beneficiary, or policyholder under the plan and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.

(c) Exception. -- Notwithstanding subsection (b) of this section, an insurer is not required to provide coverage for postdelivery inpatient length of stay for a mother who is a participant, beneficiary, or policyholder under the insurer's health benefit plan and her newborn child for the period referred to in subsection (b) of this section if:

(1) A decision to discharge the mother and her newborn child before the expiration of the period is made by the attending provider in consultation with the mother; and

(2) The health benefit plan provides coverage for postdelivery follow-up care as described in subsections(d) and (e) of this section.

(d) Postdelivery Follow-Up Care. -- In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the health benefit plan shall provide coverage for timely postdelivery care. This health care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

(1) The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or

(2) Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

The attending provider in consultation with the mother shall decide the most appropriate location for follow-up care.

(e) Timely Care. -- As used in subsection (d) of this section, 'timely postdelivery care' means health care that is provided:

(1) Following the discharge of a mother and her newborn child from the inpatient setting; and

(2) In a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs not later than the 72-hour period immediately following discharge.

(f) Prohibitions. -- An insurer shall not:

(1) Deny enrollment, renewal, or continued coverage with respect to its health benefit plan to a mother and her newborn child who are participants, beneficiaries, or policyholders, based on compliance with this section;

(2) Provide monetary payments or rebates to mothers to encourage the mothers to request less than the minimum coverage required under this section;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided treatment to an individual policyholder, participant, or beneficiary in accordance with this section; or

(4) Provide monetary or other incentives to an attending provider to induce the provider to provide treatment to an individual policyholder, participant, or beneficiary in a manner inconsistent with this section.

(g) Effect on Mother. -- Nothing in this section requires that a mother who is a participant, beneficiary, or policyholder covered under this section:

(1) Give birth in a hospital; or

(2) Stay in the hospital for a fixed period of time following the birth of her child.

(h) Level and Type of Reimbursements. -- Nothing in this section prevents an insurer from negotiating the level and type of reimbursement with an attending provider for care provided in accordance with this section."

Section 20. G.S. 58-3-170 reads as rewritten:

"**§ 58-3-170. Requirements for maternity coverage.**

(a) Every entity providing a health benefit plan that provides maternity coverage in this State shall provide benefits for the necessary care and treatment related to maternity that are no less favorable than benefits for physical illness generally.

~~(a1) A health benefit plan that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by caesarean section.~~

(b) As used in this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Section 21. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A policy that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the policy, without distinguishing the mental health benefits.

(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the policy contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the policy may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the policy, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the insurer offers two or more benefit package options under a policy, each package must comply with this subsection.

(6) This subsection does not apply to a policy if the insurer can demonstrate to the Commissioner that compliance will increase the cost of the policy by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any insurance company from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires an insurer to offer coverage for mental illness or chemical ~~dependency.~~ dependency, except as provided in G.S. 58-51-50.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to group health insurance contracts covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

Section 22. G.S. 58-65-90 reads as rewritten:

"§ 58-65-90. No discrimination against the mentally ill and chemically dependent.

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No ~~hospital, medical, dental or health~~ service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group ~~hospital, dental, medical or health service~~ subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A subscriber contract that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar

limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the subscriber contract, without distinguishing the mental health benefits.

(2) If the subscriber contract contains lifetime limits only on selected physical illness or injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the subscriber contract contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the subscriber contract, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the service corporation offers two or more benefit package options under a subscriber contract, each package must comply with this subsection.

(6) This subsection does not apply to a subscriber contract if the service corporation can demonstrate to the Commissioner that compliance will increase the cost of the subscriber contract by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any hospital or medical plan from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires a service corporation to offer coverage for mental illness or chemical ~~dependency.~~ dependency, except as provided in G.S. 58-65-75.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to subscriber contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 23. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. -- As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. -- No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. -- A health care plan that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the plan, without distinguishing the mental health benefits.

(2) If the plan contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the plan contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits.

The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(4) Except as otherwise provided in this section, the plan may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the plan, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.

(5) If the HMO offers two or more benefit package options under a plan, each package must comply with this subsection.

(6) This subsection does not apply to a health benefit plan if the HMO can demonstrate to the Commissioner that compliance will increase the cost of the plan by one percent (1%) or more.

(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.

(c) Mental Illness or Chemical Dependency Coverage Not Required. -- Nothing in this section ~~prevents any health maintenance organization from excluding from coverage any physical illness or injury or mental illness or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to~~ requires an HMO to offer coverage for mental illness or chemical ~~dependency.~~ dependency, except as provided in G.S. 58-67-70.

(d) Applicability. -- ~~This~~ Subsection (b1) of this section applies only to group contracts covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 24. G. S. 58-3-173 is repealed.

Section 25. Sections 1 through 18 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20, 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the contract.

Section 26. This act is effective when it becomes law.

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attachment I

June 26, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Counsel

RE: Senate Changes to House Bill 434 (Federal Health Insurance)

The following are the changes made by the Senate to House Bill 434. In my opinion, these are all technical changes:

- "COBRA continuation provision" is defined to also include coverage under a State continuation law (see sub-subdivision d.)
- The reference to "service corporation" in the definition of "health insurer" is changed to "hospital or medical" service corporation, making clear that a dental service corporation is not considered a "health insurer" (see subdivision (6)).
- The reference to "providers" in the definition of "network plan" is changed to "health care providers" for clarification (see subdivision 13).
- Language is added (see sub-subdivision c.) to provide that the time an individual spends on short-term limited duration health insurance (less than 12 months) does not count in determining creditable coverage under the portability law.
- Language is added to exempt self-employed individuals, who currently come under our Small Employer Group laws, from the requirement for guaranteed issuance of a health insurance policy. The federal law does not require guaranteed availability of coverage to self-employed individuals.
- Unnecessary language concerning high risk health insurance pools is eliminated from the bill. North Carolina does not have a high-risk pool.

- Definition of "late enrollee" in the existing small group law is amended in three places to make clarifications.

- The "look-back" period for determining whether a person on an individual policy of insurance has a pre-existing condition is retained at 1 year. Although the federal law shortens the look-back period for *group* policies to 6 months, it does not require a 6-month look-back period on *individual* health insurance policies unless the individual is an "eligible individual" as defined in the law. A provision is added to make clear that the 1-year look back period only applies to those individual who are not "eligible" individuals.

- Language is added to clarify that the limits on preexisting conditions in individual health insurance policies do not apply to certain types of "excepted benefits" defined under federal law (such as specified disease policies, etc.)

- A provision is added repealing GS 58-3-173. This statute is no longer necessary because it is being replaced by the new conforming provisions in the bill.

- Provisions were added to make clear that the bill does not override existing State law on chemical dependency coverage.

- Language was added to clarify that individual health insurance coverage does not include short-term coverage.

- Provisions relating to the existing law on preexisting conditions in individual health insurance policies and its inapplicability to "eligible individuals" (to whom pre-ex clauses do not apply) was relocated in the bill.

- Grammar and erroneous cross-references were corrected

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 975
Proposed House Committee Substitute S975-PCS1844

Short Title: Workers' Compensation Self-Insurance. (Public)

Sponsors:

Referred to:

April 21, 1997

A BILL TO BE ENTITLED

AN ACT TO REWRITE THE LAWS CONCERNING EMPLOYER AND EMPLOYER GROUP WORKERS' COMPENSATION SELF-INSURANCE AND CODIFY RELATED ADMINISTRATIVE RULES AND TO PROVIDE FOR GUIDELINES FOR PERSONS AND ENTITIES THAT ADMINISTER OR SERVICE WORKERS' COMPENSATION BUSINESS FOR SELF-INSURED EMPLOYERS AND EMPLOYER GROUPS.

The General Assembly of North Carolina enacts:

Section 1. The heading of Article 47 of Chapter 58 of the General Statutes reads as rewritten:

"~~North Carolina Health Care Excess Liability Fund.~~
Workers' Compensation Self-Insurance."

Section 2. G.S. 58-47-1, 58-47-5, 58-47-10, 58-47-15, 58-47-20, 58-47-25, 58-47-30, 58-47-35, 58-47-40, 58-47-45, and 58-47-50 are repealed.

Section 3. Article 47 of Chapter 58 of the General Statutes is amended by adding the following:

"Part 1. Employer Groups.

"**§ 58-47-60. Definitions.**

As used in this Part:

(1) 'Act' means the Workers' Compensation Act in Article 1 of Chapter 97 of the General Statutes, as amended.

(2) 'Affiliate' has the same meaning as in G.S. 58-19-5(1).

(3) 'Annual statement filing' means the most recent annual filing made with the Commissioner under G.S. 58-2-165.

(4) 'Board' means the board of trustees or other governing body of a group.

(5) 'Books and records' means all files, documents, and databases in a paper form, electronic medium, or both.

(6) 'Control' means "control" as defined in G.S. 58-19-5(2).

(7) 'GAAP financial statement' means a financial statement as defined by generally accepted accounting principles.

(8) 'Group' means two or more employers who agree to pool their workers' compensation liabilities under the Act and are licensed under this Part.

(9) 'Hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a person is insolvent or, although not financially impaired or insolvent, is unlikely to be able to meet obligations for known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.

(10) 'Member' means an employer that participates in a group.

(11) 'Qualified actuary' means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries, who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries, and is in compliance with G.S. 58-2-171.

(12) 'Rate' means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and variations in loss experience, before any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

(13) 'Service company' means an entity that has contracted with an employer or group for the purpose of providing any services related to claims adjustment, loss control, or both.

(14) 'Third-party administrator' or 'TPA' means a person engaged by a board to execute the policies established by the board and to provide day-to-day management of the group. 'Third-party administrator' or 'TPA' does not mean:

a. An employer acting on behalf of its employees or the employees of one or more of its affiliates.

b. An insurer that is licensed under this Chapter or that is acting as an insurer with respect to a policy lawfully issued and delivered by it and under the laws of a state in which the insurer is licensed to write insurance.

c. An agent or broker who is licensed by the Commissioner under Article 33 of this Chapter whose activities are limited exclusively to the sale of insurance.

d. An adjuster licensed by the Commissioner under Article 33 of this Chapter whose activities are limited to adjustment of claims.

e. An individual who is an officer, a member, or an employee of a board.

(15) 'Underwriting' means the process of selecting risks and classifying them according to their degrees of insurability so that the appropriate rates may be assigned. The process also includes rejection of those risks that do not qualify.

"**§ 58-47-65. Licensing; qualification for approval.**

(a) No group shall self-insure its workers' compensation liabilities under the Act unless it is licensed by the Commissioner under this Part.

(b) An applicant for a license shall file with the Commissioner the information required by subsection (f) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. The applicant shall furnish to the Commissioner satisfactory proof of the proposed group's financial ability, through its members, to comply with the Act. No application is complete until the Commissioner has received all required information.

(c) The group shall comprise two or more employers who are members of and are sponsored by a single bona fide trade or professional association. The association shall (i) comprise members engaged in the same or substantially similar business or profession within the State, (ii) have been incorporated in North Carolina, (iii) have been in existence for at least five years before the date of application to the Commissioner to form a group, and (iv) submit a written determination from the Internal Revenue Service that it is exempt from taxation under 26 U.S.C. § 501(c). This subsection does not apply to a group that was organized and approved under North Carolina law before July 1, 1995.

(d) Only an applicant whose members' employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk may apply for a license. The Commissioner shall consider (i) the financial strength and liquidity of the applicant relative to its ability to comply with the Act, (ii) the applicant's criteria and procedures regarding the review and monitoring of members' financial strength, (iii) reliability of the financial information, (iv) workers' compensation loss history, (v) underwriting guidelines, (vi) claims administration, (vii) excess insurance or reinsurance, and (viii) access to excess insurance or reinsurance.

(e) Before issuing a license to any applicant, the Commissioner shall require, in addition to the other requirements provided by law, that the applicant file an affidavit signed by the association's board members that it has not violated any of the applicable provisions of this Part or the Act during the last 12 months, and that it accepts the provisions of this Part and the Act in return for the license.

(f) The license application shall comprise the following information:

(1) Biographical affidavits providing the education, prior occupation, business experience, and other supplementary information submitted for each promoter, incorporator, director, trustee, proposed management personnel, and other persons similarly situated.

(2) A forecast for a five-year period based on the initial capitalization of the proposed group and its plan of operation. The forecast shall be prepared by a certified public accountant, a qualified actuary, or both, be in sufficient detail for a complete analysis to be performed, and be accompanied by a list of the assumptions utilized in making the forecast.

(3) An individual application, under G.S. 58-47-125, of each member applying for coverage in the proposed group on the inception date of the proposed group, with a current GAAP financial statement of the member. The financial statements are confidential, but the Commissioner may use them in any judicial or administrative proceeding.

(4) A breakdown of all forecasted administrative expenses for the proposed group's fiscal year in a dollar amount and as a percentage of the estimated annual premium.

(5) The proposed group's procedures for evaluating the current and continuing financial strength of members.

(6) Evidence of the coverage required by G.S. 58-47-95.

(7) Demonstration provided by the board, satisfactory to the Commissioner, that the proposed group's member employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk.

(8) An assessment plan under G.S. 58-47-135(a).

(9) A listing of the estimated premium to be developed for each member individually and in total for the proposed group. Payroll data for each of the three preceding years shall be furnished by risk classification.

(10) An executed agreement by each member showing the member's obligation to pay to the proposed group not less than twenty-five percent (25%) of the member's estimated annual premium not later than the first day of coverage afforded by the proposed group.

(11) Composition of the initial board.

(12) An indemnity agreement on a form prescribed by the Commissioner.

(13) Proof, satisfactory to the Commissioner, that either the applicant has within its own organization ample facilities and competent personnel to service its program for underwriting, claims, and industrial safety engineering, or that the applicant will contract for any of these services. If the applicant is to perform any servicing,

biographical affidavits of those persons who will be responsible for or performing servicing shall be included with the information in subdivision (1) of this subsection. If a group contracts with a service company or TPA to administer and adjust claims, the group shall provide proof of compliance with the other provisions of this Part.

(14) A letter stipulating the applicant's acceptance of membership in the North Carolina Self-Insurance Guaranty Association under Article 4 of Chapter 97 of the General Statutes.

(15) Any other specific information the Commissioner considers relevant to the organization of the proposed group.

(g) Every applicant shall execute and file with the Commissioner an agreement, as part of the application, in which the applicant agrees to deposit with the Commissioner cash or securities acceptable to the Commissioner.

"**§ 58-47-70. License denial; termination; revocation; restrictions.**

(a) If the Commissioner denies a license, the Commissioner shall inform the applicant of the reasons for the denial. The Commissioner may issue a license to an applicant that remedies the reasons for a denial within 60 days after the Commissioner's notice. The Commissioner may grant additional time to an applicant to remedy any deficiencies in its application. A request for an extension of time shall be made in writing by the applicant within 30 days after the Commissioner's notice. If the applicant fails to remedy the reasons for the denial, the application shall be withdrawn or denied.

(b) A group shall not terminate its license or cease the writing of renewal business without obtaining prior written approval from the Commissioner. The Commissioner shall not grant the request of any group to terminate its license unless the group has closed or reinsured all of its incurred workers' compensation obligations and has settled all of its other legal obligations, including known and unknown claims and associated expenses.

(c) No group shall transfer its workers' compensation obligations under an assumption reinsurance agreement without complying with Part 2 of Article 10 of this Chapter.

(d) Every group is subject to Article 19 of this Chapter. No group shall merge with another group unless both groups are engaged in the same or a similar type of business.

"**§ 58-47-75. Reporting and records.**

(a) As used in this section:

(1) 'Audited financial report' has the same meaning as in the NAIC Model Rule Requiring Annual Audited Financial Reports, as specified in G.S. 58-2-205.

(2) 'Duplicate record' means a counterpart produced by the same impression as the original record, or from the same matrix, or by mechanical or electronic rerecording or by chemical reproduction,

or by equivalent techniques, such as imaging or image processing, that accurately reproduce the original record.

(3) 'Original record' means the writing or recording itself or any counterpart intended to have the same effect by a person executing or issuing it, in the normal and ordinary course of business, or data stored in a computer or similar device, the printout or other output readable by sight, shown to reflect the data accurately. An 'original' of a photograph includes the negative or any print from the negative.

(b) Each group shall file with the Commissioner the following:

(1) A statement in accordance with G.S. 58-2-165.

(2) An audited financial report.

(3) Annual payroll information within 90 days after the close of its fiscal year. The report shall summarize the payroll by annual amount paid and by classifications using the rules, classifications, and rates set forth in the most recently approved Workers' Compensation and Employers' Liability Insurance Manual governing audits of payrolls and adjustments of premiums. Each group shall maintain true and accurate payroll records. The payroll records shall be maintained to allow for verification of the completeness and accuracy of the annual payroll report.

(c) Each group shall make its financial statement and audited financial report available to its members upon request.

(d) All records shall be maintained by the group for the years during which an examination under G.S. 58-2-131 has not yet been completed.

(e) All records that are required to be maintained by this section shall be either original or duplicate records.

(f) If only duplicate records are maintained, the following requirements apply:

(1) The data shall be accessible to the Commissioner in legible form, and legible, reproduced copies shall be available.

(2) Before the destruction of any original records, the group in possession of the original records shall:

a. Verify that the records stored consist of all information contained in the original records, and that the original records can be reconstructed therefrom in a form acceptable to the Commissioner; and

b. Implement disaster preparedness or disaster recovery procedures that include provisions for the maintenance of duplicate records at an off-site location.

(3) Adequate controls shall be established with respect to the transfer and maintenance of data.

(g) Each group shall maintain its records under G.S. 58-7-50, G.S. 58-7-55, and the Act.

(h) All books of original entry and corporate records shall be retained by the group or its successor for a period of 15 years after the group ceases to exist.

"**§ 58-47-80. Assets and invested assets.**

Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-177, 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, and 58-7-200.

"**§ 58-47-85. Surplus requirements.**

Every group shall maintain minimum surplus under one of the options in subdivision (1), (2), or (3) of this section:

(1) Maintain minimum surplus in accordance with Article 12 of this Chapter. A group organized and authorized before the effective date of this section shall comply with this section under the following schedule:

a. Forty percent (40%) of the surplus, in accordance with Article 12, by January 1, 1999.

b. Fifty-five percent (55%) of the surplus, in accordance with Article 12, by January 1, 2000.

c. Seventy percent (70%) of the surplus, in accordance with Article 12, by January 1, 2001.

d. Eighty-five percent (85%) of the surplus, in accordance with Article 12, by January 1, 2002.

e. One hundred percent (100%) of the surplus, in accordance with Article 12, by January 1, 2003.

The Commissioner shall not approve any dividend request that results in a surplus that is less than one hundred percent (100%) of the minimum surplus required by Article 12 of this Chapter.

(2) Maintain minimum surplus at an amount equal to ten percent (10%) of the group's total undiscounted outstanding claim liability, according to the group's annual statement filing, or such other amount as the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group. In addition, the group shall:

a. Maintain specific excess insurance or reinsurance that provides the coverage limits in G.S. 58-47-95(a). The group shall retain no specific risk greater than five percent (5%) of the group's total annual earned premium according to the group's annual statement filing.

b. Maintain aggregate excess insurance or reinsurance with a coverage limit being the greater of two million dollars ($2,000,000) or twenty percent (20%) of the group's annual earned premium, according to the group's annual statement filing. The aggregate excess attachment point shall be one hundred ten percent (110%) of the annual earned premium,

according to the group's annual statement filing. The required attachment point shall be reduced by each point, or fraction of a point, that a group's expense ratio exceeds thirty percent (30%). Conversely, the required attachment point may be increased by each point, or fraction of a point, that a group's expense ratio is less than thirty percent (30%), but in no event shall the attachment point be greater than one hundred fifteen percent (115%) of the annual earned premium.

c. Adopt a policy whereby every member:

1. Pays a deposit to the group of twenty-five percent (25%) of the member's estimated annual earned premium, or another amount that the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group; or

2. Once every year files with the group the member's most recent year-end balance sheet, compiled by an independent certified public accountant. The balance sheet shall demonstrate that the member's financial position does not show a deficit equity and is appropriate for membership in the group. At the request of the Commissioner, the group shall make these filings available for review. These filings shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding.

(3) Maintain minimum surplus at an amount equal to three hundred thousand dollars ($300,000). The group shall immediately assess its members if, at any time, the group's surplus is less than the minimum surplus amount. In addition, the group shall maintain:

a. Specific excess insurance or reinsurance that provides coverage limits pursuant to G.S. 58-47-95(a). The group shall retain no specific risk greater than five percent (5%) of the group's total annual earned premium according to the group's annual statement filing.

b. Aggregate excess insurance or reinsurance with a coverage limit being the greater of two million dollars ($2,000,000) or twenty percent (20%) of the group's annual earned premium, according to the group's annual statement filing. The aggregate excess attachment point shall be one hundred ten percent (110%) of the annual earned premium, according to the group's annual statement filing. The required attachment point shall be reduced by each point, or

fraction of a point, that a group's expense ratio exceeds thirty percent (30%). Conversely, the required attachment point may be increased by each point, or fraction of a point, that a group's expense ratio is less than thirty percent (30%), but in no event shall the attachment point be greater than one hundred fifteen percent (115%) of the annual earned premium.

The Commissioner may require different levels, or waive the requirement, of specific and aggregate excess loss coverage consistent with the market availability of excess loss coverage, the group's claims experience, and the group's financial condition.

"**§ 58-47-90. Deposits.**

(a) Each group shall deposit with the Commissioner an amount equal to ten percent (10%) of the group's total annual earned premium, according to the group's annual statement filing, but not less than six hundred thousand dollars ($600,000), or another amount that the Commissioner prescribes based on, but not limited to, the financial condition of the group and the risk retained by the group.

(b) G.S. 58-5-1, 58-5-20, 58-5-25, 58-5-30, 58-5-35, 58-5-40, 58-5-63, 58-5-75, 58-5-80, 58-5-90(a) and (c), 58-5-95, 58-5-110, 58-5-115, and 58-5-120 apply to groups.

(c) A group organized and authorized before January 1, 1998, has until January 1, 2001, to comply with subsection (b) of this section. However, a dividend request shall not be approved by the Commissioner until the group has replaced its surety bonds with the deposit required by subsection (b) of this section.

(d) No judgment creditor, other than a claimant entitled to benefits under the Act, may levy upon any deposits made under this section.

(e) Surety bonds shall be in a form prescribed by the Commissioner and issued by an insurer authorized by the Commissioner to write surety business in North Carolina.

(f) Any surety bond may be exchanged or replaced with another surety bond that meets the requirements of this section if 90 days' advance written notice is provided to the Commissioner. An endorsement to a surety bond shall be filed with the Commissioner within 30 days after its effective date.

(g) If a group ceases to self-insure, dissolves, or transfers its workers' compensation obligations under an assumption reinsurance agreement, the Commissioner shall not release any deposits until the group has fully discharged all of its obligations under the Act.

"**§ 58-47-95. Excess insurance and reinsurance.**

(a) Each group, on or before its effective date of operation and on a continuing basis thereafter, shall maintain specific and aggregate excess loss coverage through an insurance policy or reinsurance contract. Groups shall maintain limits and retentions commensurate with their exposures. A group's retention shall be the lowest retention suitable for groups with similar exposures and annual premium. The Commissioner may require different levels, or waive the requirement, of specific and aggregate excess loss coverage consistent with the market availability of excess loss coverage, the group's claims experience, and the group's financial condition.

(b) Any excess insurance policy or reinsurance contract under this section shall be issued by a licensed insurance company, an approved surplus lines insurance company, or an accredited reinsurer, and shall:

(1) Provide for at least 30 days' written notice of cancellation by certified mail, return receipt requested, to the group and to the Commissioner.

(2) Be renewable automatically at its expiration, except upon 30 days' written notice of nonrenewal by certified mail, return receipt requested, to the group and to the Commissioner.

(c) Every group shall provide to the Commissioner evidence of its excess insurance or reinsurance coverage, and any amendments, within 30 days after their effective dates. Every group shall, at the request of the Commissioner, furnish copies of any excess insurance policies or reinsurance contracts and any amendments.

"**§ 58-47-100. Examinations.**

G.S. 58-2-131, 58-2-132, and 58-2-133 apply to groups.

"**§ 58-47-105. Dividends and other distributions.**

(a) Group dividends and other distributions shall be made in accordance with G.S. 58-7-130, 58-8-25(b), and 58-19-30. A group shall be in compliance with this Part before payment of dividends or other distributions to its members. No group shall pay dividends or other distributions to its members until two years after the group's licensing date.

(b) Payment of dividends to the members of any group shall not be contingent upon the maintenance or continuance of membership in the group.

"**§ 58-47-110. Premium rates.**

(a) As used in this section:

(1) 'Bureau' means the North Carolina Rate Bureau in Article 36 of this Chapter.

(2) 'Expenses' means that portion of a premium rate attributable to acquisition, field supervision, collection expenses, and general expenses, as determined by the group.

(3) 'Multiplier' means a group's determination of the expenses, other than loss expense and loss adjustment expense, associated with writing workers' compensation and employers' liability insurance, which shall be expressed as a single nonintegral number to be applied equally and uniformly to the prospective loss costs approved by the Commissioner in making rates for each classification of risks utilized by that group.

(4) 'Prospective loss costs' means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit and that is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and forecasted through trending to a future point in time.

(5) 'Supplementary rating information' means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, rate-related underwriting rule, experience rating plan, statistical plan, and any other similar information needed to determine the applicable rate in effect or to be in effect.

(b) Rates and the effective date shall be submitted by the group to the Commissioner for prior approval in the form of a rate filing. The rate filing:

(1) Shall be on a form prescribed by the Commissioner and shall be supported by competent analysis, prepared by an actuary who is a member in good standing of the Casualty Actuarial Society or the American Academy of Actuaries, demonstrating that the resulting rates meet the standards of not being excessive, inadequate, or unfairly discriminatory;

(2) Shall have the final rates and the effective date determined independently and individually by the group;

(3) Shall have manual rates that are the combination of the prospective loss costs and the multiplier;

(4) Shall file any other information that the group considers relevant and shall provide any other information requested by the Commissioner;

(5) Shall be considered complete when the required information and all additional information requested by the Commissioner is received by the Commissioner. When a filing is not accompanied by the information required under this section, the Commissioner shall inform the group within 30 days after the initial filing that the filing is incomplete and shall note the deficiencies. If information required by a rate filing or requested by the Commissioner is not maintained or cannot be provided, the group shall certify that to the Commissioner;

(6) May include deviations to the prospective loss cost based on the group's anticipated experience. Sufficient documentation supporting the deviations and the impact of the deviation shall be included in the rate filing. Expense loads, whether variable, fixed, or a combination of variable and fixed, may vary by individual classification or grouping. Each filing that varies the expense load by class shall specify the expense factor applicable to each class and shall include information supporting the justification for the variation;

(7) Shall include any proposed use of a premium-sized discount program, a schedule rating program, a small deductible credit program or an expense constant or minimum premium, and the use shall be supported in the rate filing; and

(8) Shall be deemed approved, unless disapproved by the Commissioner in writing, within 60 days after the rate filing is

made in its entirety. A group is not required to refile rates previously approved until two years after the effective date of this Part.

(c) At the time of the rate filing, a group may request to have its approved multiplier remain in effect and continue to use either the prospective loss cost filing in effect at the time of the rate filing or the prospective loss cost filing in effect at the time of the filing, along with all other subsequent prospective loss cost filings, as approved.

(d) To the extent that a group's manual rates are determined solely by applying its multiplier, as presented and approved in the rate filing, to the prospective loss costs contained in the Bureau's reference filing and printed in the Bureau's rating manual, the group need not develop or file its final rate pages with the Commissioner. If a group chooses to print and distribute final rate pages for its own use, based solely upon the application of its filed prospective loss costs, the group need not file those pages with the Commissioner. If the Bureau does not print the prospective loss costs in its manual, the group shall submit its rates to the Commissioner.

(e) If a new filing of rules, relativities, and supplementary rating information is filed by the Bureau and approved:

(1) The group shall not file anything with the Commissioner if the group decides to use the revisions as filed, with the effective date as filed together with the prospective loss multiplier on file with the Commissioner.

(2) The group shall notify the Commissioner of its effective date before the Bureau filing's effective date if the group decides to use the revisions as filed but with a different effective date.

(3) The group shall notify the Commissioner before the Bureau filing's effective date if the group decides not to use the revision or revisions.

(4) The group shall file the modification with the Commissioner, for approval, specifying the basis for the modification and the group's proposed effective date if different from the Bureau filing's effective date, if the group decides to use the revision with deviations.

(f) Every group shall adhere to the uniform classification plan and experience rating plan filed by the Bureau.

(g) Groups shall maintain data in accordance with the uniform statistical plan approved by the Commissioner.

(h) Each group shall submit annually a rate certification, signed by an actuary who is a member in good standing of the Casualty Actuarial Society or the American Academy of Actuaries, which states that the group's prospective rates are not excessive, inadequate, or unfairly discriminatory. The certification is to accompany the group's rate filing. If a rate filing is not required, the actuarial rate certification is to be submitted by the end of the calendar year.

"**§ 58-47-115. Premium payment requirements.**

Groups shall collect members' premiums for each policy period in a manner so that at no time the sum of a member's premium payments is less than the total estimated earned premium for that member.

"§ 58-47-120. Board; composition, powers, duties, and prohibitions.

(a) Each group shall be governed by a board or other governing body comprising no fewer than three persons, elected for stated terms of office, and subject to the Commissioner's approval. All board members shall be residents of this State or members of the group. At least two-thirds of the board shall comprise employees, officers, or directors of members; provided that the Commissioner may waive this requirement for good cause. The group's TPA, service company, or any owner, officer, employee, or agent of, or any other person affiliated with, the TPA or service company shall not serve as a board member. The board shall ensure that all claims are paid promptly and take all necessary precautions to safeguard the assets of the group.

(b) The board shall be responsible for the following:

(1) Maintaining minutes of its meetings and making the minutes available to the Commissioner.

(2) Providing for the execution of its policies, including providing for day-to-day management of the group and delineating in the minutes of its meetings the areas of authority it delegates.

(3) Designating a chair to facilitate communication between the group and the Commissioner.

(4) Adopting a policy of reimbursement from the assets of the group for out-of-pocket expenses incurred as board members, if so desired.

(c) The board shall not:

(1) Be compensated by the group, TPA, or service company except for out-of-pocket expenses incurred as board members.

(2) Extend credit to members for payment of a premium, except under payment requirements set forth in this Part.

(3) Borrow any money from the group or in the name of the group, except in the ordinary course of business, without first informing the Commissioner of the nature and purpose of the loan and obtaining the Commissioner's approval.

(d) The board shall adopt bylaws to govern the operation of the group. The bylaws shall comply with the provisions of this section and shall include:

(1) The method for selecting the board members, including terms of office.

(2) The method for amending the bylaws and the plans of operation and assessment.

(3) The method for establishing and maintaining the group.

(4) The procedures and requirements for dissolving the group.

(e) Each group shall file a copy of its bylaws with the Commissioner. Any changes to the bylaws shall be filed with the Commissioner no later than 30 days

before their effective dates. The Commissioner may order the group to rescind or revoke any bylaw if it violates this section or any other applicable law or administrative rule.

(f) The board shall adopt and administer a plan of operation to assure the fair, reasonable, and equitable administration of the group. All members shall comply with the plan. The plan shall comply with this section and include:

(1) Procedures for administering the assets of the group.
(2) A plan of assessment.
(3) Loss control services to be provided to the members.
(4) Rules for payment and collection of premium.
(5) Basis for dividends.
(6) Reimbursement of board members.
(7) Intervals for meetings of the board, which shall be held at least semiannually.
(8) Procedures for the maintenance of records of all transactions of the group.
(9) Procedures for the selection of the board members.
(10) Additional provisions necessary or proper for the execution of the powers and duties of the group.
(11) Qualifications for group membership, including underwriting guidelines and procedures to identify members that are in hazardous financial conditions.

(g) The plan and any amendments become effective upon approval in writing by the Commissioner.

(h) Each year the board shall review:

(1) The performance evaluation of the TPA or service company, if applicable.
(2) Loss control services.
(3) Investment policies.
(4) Delinquent debts.
(5) Membership cancellation procedures.
(6) Admission of new members.
(7) Claims administration and reporting.
(8) Payroll audits and findings.
(9) Excess insurance or reinsurance coverage.

The board's findings from its review shall be documented in the board's minutes.

(i) G.S. 58-7-140 applies to board members.

"**§ 58-47-125. Admission and termination of group members.**

(a) Prospective group members shall submit applications for membership to the board. The board, a designated employee of the group, or TPA shall approve an application for membership under the bylaws of the group. Members shall have bona fide offices in this State and members' employees shall be primarily engaged in business activities within this State. Members shall receive certificates of coverage from the board on a form acceptable to the Commissioner.

(b) The group shall make available to the Commissioner properly executed applications and indemnity agreements for all members, on forms prescribed by the Commissioner. If the applications and indemnity agreements are not executed properly and maintained, the Commissioner may order the group to cease writing all new business until all of the agreements are executed properly and obtained.

(c) Members may elect to terminate their participation in a group and may be canceled by the group under G.S. 97-99 and the bylaws of the group.

"§ 58-47-130. Disclosure.

Every group through its board, TPA, service company, agents, or other representatives shall require, before accepting an application, each applicant for membership to acknowledge in writing that the applicant has received the following:

(1) A document disclosing that the members are jointly and severally liable for the obligations of the group.

(2) A copy of the group's plan of assessment.

(3) The amount of specific and aggregate stop loss or excess insurance or reinsurance carried by the group, the amount and kind of risk retained by the group, and the name and rating of the insurer providing stop loss, excess insurance, or reinsurance.

"§ 58-47-135. Assessment plan and indemnity agreement.

(a) Each group shall establish an assessment plan that provides for a reasonable and equitable mechanism for assessing its members. The plan and any amendments shall be approved by the Commissioner. The plan shall include descriptions of the circumstances that initiate an assessment, basis, and allocation to members of the amount being assessed, and collection of the assessment.

(b) The board shall notify the Commissioner of an assessment no fewer than 60 days before an assessment.

(c) The Commissioner shall impose an assessment on members if the board or third-party administrator fails to take action to correct a hazardous financial condition.

(d) Every group shall file an indemnity agreement on a form prescribed by the Commissioner, which jointly and severally binds the members of the group to comply with the provisions of the act and pay obligations imposed by the Act.

"§ 58-47-140. Other provisions of this Chapter.

G.S. 58-1-10, 58-2-45, 58-2-50, 58-2-70, 58-2-100, 58-2-105, 58-2-155, 58-2-161, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-81, 58-3-100, 58-3-120, 58-3-125, 58-6-25, 58-7-21, 58-7-26, 58-7-30, 58-7-33, and Articles 13, 19, 30, 33, 34, and 63 of this Chapter apply to groups.

"Part 2. Third-Party Administrators and Service Companies for Individual and Group Self-Insurers.

"§ 58-47-150. Definitions.

As used in this Part:

(1) 'Books and records' means all files, documents, and databases in a paper form, electronic medium, or both.

(2) 'Self-insurer' means a group of employers licensed by the Commissioner under Part 1 of this Article or a single employer licensed by the Commissioner under Article 5 of Chapter 97 of the General Statutes to retain its liability under the Workers' Compensation Act and to pay directly the compensation in the amount and manner and when due as provided for in the Act.

(3) 'Service company' means an entity that has contracted with a self-insurer for the purpose of providing any services related to claims adjustment, loss control, or both.

(4) 'Third-party administrator' or 'TPA' means a person engaged by a self-insurer to execute the policies established by the self-insurer and to provide day-to-day management of the self-insurer. 'Third-Party Administrator' and 'TPA' does not mean:

a. A self-insurer acting on behalf of its employees or the employees of one or more of its affiliates.

b. An insurer that is licensed under this Chapter or that is acting as an insurer with respect to a policy lawfully issued and delivered by it and under the laws of a state in which the insurer is licensed to write insurance.

c. An agent or broker who is licensed by the Commissioner under Article 33 of this Chapter whose activities are limited exclusively to the sale of insurance.

d. An adjuster licensed by the Commissioner under Article 33 of this Chapter whose activities are limited to adjustment of claims.

e. An individual who is an officer, a member, or an employee of a board.

(5) 'Underwriting' means the process of selecting risks and classifying them according to their degrees of insurability so that the appropriate rates may be assigned. The process also includes rejection of those risks that do not qualify.

"**§ 58-47-155. TPAs and service companies; authority; qualifications.**

(a) No person shall act as, offer to act as, or hold himself or herself out as a TPA or a service company with respect to risks located in this State for a self-insurer unless that person complies with this Article.

(b) A TPA or service company shall post with the self-insurer a fidelity bond or other appropriate coverage, issued by an authorized insurer, in a form acceptable to the Commissioner, in an amount commensurate with the risk, and with the governing board of the self-insurer as obligee or beneficiary.

(c) A TPA or service company shall maintain errors and omissions coverage or other appropriate liability insurance in a form acceptable to the Commissioner and in an amount commensurate with the risk. The governing body of the self-insurer shall be obligee or beneficiary of the coverage or insurance.

(d) If the Commissioner determines that a TPA or service company or any other person has not materially complied with this Article or with any rule adopted or order issued under this Article, after notice and opportunity to be heard, the Commissioner may order for each separate violation a civil penalty under G.S. 58-2-70(d).

(e) If the Commissioner finds that because of a material noncompliance that a self-insurer has suffered any loss or damage, the Commissioner may maintain a civil action brought by or on behalf of the self-insurer and its covered members or persons and creditors for recovery of compensatory damages for the benefit of the self-insurer and its covered members or persons and creditors, or for other appropriate relief.

(f) Nothing in this Article affects the Commissioner's right to impose any other penalties provided for in this Chapter or limits or restricts the rights of covered members or persons, claimants, and creditors.

(g) If an order of rehabilitation or liquidation of the self-insurer has been entered under Article 30 of this Chapter, and the receiver appointed under that order determines that the TPA or service company or any other person has not materially complied with this Article or any rule adopted or order issued under this Article, and the self-insurer suffered any loss or damage from the noncompliance, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the self-insurer.

"**§ 58-47-160. Written agreement; composition; restrictions.**

(a) No person may act as a TPA or service company without a written agreement between the TPA or service company and the self-insurer. The written agreement shall be retained by the self-insurer and the TPA or service company for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by this Article, to the extent those requirements apply to the functions performed by the TPA or service company.

(b) Groups shall file with the Commissioner the written agreement, and any amendments to the agreement, within 30 days after execution. Single employers shall furnish the Commissioner, upon request, the written agreement and any amendments to the agreement. The information required by this section, including any trade secrets, shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding instituted against the TPA or service company.

(c) The written agreement shall set forth the duties and powers of the TPA or service company and the self-insurer. The Commissioner shall disapprove any such written agreement that:

(1) Subjects the self-insurer to excessive charges for expenses or commission.

(2) Vests in the TPA or service company any control over the management of the affairs of the self-insurer to the exclusion of the governing board of the self-insurer.

(3) Is entered into with any TPA or service company if the person acting as the TPA or service company, or any of the officers or

directors of the TPA or service company, is of known bad character or has been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance.

(4) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the self-insurer.

(d) The self-insurer, TPA, or service company may, by written notice, terminate the agreement as provided in the agreement. The self-insurer may suspend the underwriting authority of the TPA during the pendency of any dispute regarding the cause for termination of the agreement. The self-insurer shall fulfill any lawful obligations with respect to policies affected by the agreement, regardless of any dispute between the self-insurer and the TPA or service company.

(e) The contract may not be assigned in whole or part by the TPA or service company without prior approval by the governing board of the self-insurer and the Commissioner.

"**§ 58-47-165. Books and records.**

(a) Every TPA or service company shall maintain and make available to the self-insurer complete books and records of all transactions performed on behalf of the self-insurer. The books and records shall be maintained by the self-insurer, TPA, or service company in accordance with G.S. 58-47-180.

(b) The Commissioner shall have access to books and records maintained by a TPA or service company for the purposes of examination, audit, or inspection. The Commissioner shall keep confidential any trade secrets contained in those books and records, including the identity and addresses of the covered members of a self-insurer, except that the Commissioner may use the information in any judicial or administrative proceeding instituted against the TPA or service company.

(c) The Commissioner may use the TPA or service company as an intermediary in the Commissioner's dealings with the self-insurer if the Commissioner determines that this will result in a more rapid and accurate flow of information from the self-insurer and will aid in the self-insurer's compliance with this Article and the Workers' Compensation Act.

(d) The self-insurer shall own the books and records generated by the TPA or service company pertaining to the self-insurer's business.

(e) The self-insurer shall have access to and rights to duplicate all books and records related to its business.

(f) If the self-insurer and the TPA or service company cancel their agreement, notwithstanding the provisions of subsection (a) of this section, the TPA or service company, shall transfer all books and records to the new TPA, service company, or the self-insurer in a form acceptable to the Commissioner. The new TPA or service company shall acknowledge, in writing, that it is responsible for retaining the books and records of the previous TPA, service company, or the self-insurer as required in subsection (a) of this section.

"**§ 58-47-170. Payments to TPA or service company.**

If a self-insurer uses the services of a TPA, the payment to the TPA of any premiums or charges for insurance by or on behalf of the insured party is considered payment to the self-insurer. The payment of return premiums or claim payments forwarded by the self-insurer to the TPA or service company is not considered payment to the insured party or claimant until the payments are received by the insured party or claimant. This section does not limit any right of the self-insurer against the TPA or service company resulting from the failure of the TPA or service company to make payments to the self-insurer, insured parties, or claimants.

"**§ 58-47-175. Approval of advertising.**

A TPA or service company may use only the advertising pertaining to or affecting the business underwritten by a self-insurer that has been approved in writing by the self-insurer before its use.

"**§ 58-47-180. Premium collection and payment of claims.**

(a) The TPA or service company, at a minimum, shall:

(1) Periodically render an accounting to the self-insurer detailing all transactions performed by the TPA or service company pertaining to the business underwritten, premium or other charges collected, and claims paid by the self-insurer, when applicable.

(2) Deposit all receipts directly into an account maintained in the name of the self-insurer.

(3) Pay claims on drafts or checks of and authorized by the self-insurer.

(4) Not withdraw from the self-insurer's account except for authority limited to pay claims and refund premiums.

(5) Remit return premium, directly from the self-insurer's account, to the person entitled to the return premium.

(b) Any check disbursement authority granted to the TPA or service company may be terminated upon the self-insurer's written notice to the TPA or service company or upon termination of the agreement. The self-insurer may suspend the check disbursement authority during the pendency of any dispute regarding the cause for termination.

"**§ 58-47-185. Notices; disclosure.**

(a) When the services of a TPA are used, the TPA shall provide a written notice approved by the self-insurer to covered members advising them of the identity of, and relationship among, the TPA, the member, and the self-insurer.

(b) When a TPA collects funds, the reason for collection of each item shall be identified to the member and each item shall be shown separately from any premium. Additional charges may not be made for services to the extent the services have been paid for by the self-insurer.

(c) The TPA shall disclose to the self-insurer all charges, fees, and commissions received from all services in connection with the provision of administrative services for the self-insurer, including any fees or commissions paid by self-insurers for obtaining reinsurance.

(d) The TPA or service company shall disclose to the self-insurer the nature of other business in which it is involved.

"**§ 58-47-190. Compensation.**

A TPA or service company shall not enter into any agreement or understanding with a self-insurer that makes the amount of the TPA's or service company's commissions, fees, or charges contingent upon savings affected in the adjustment, settlement, and payment of losses covered by the self-insurer's obligations. This section does not prohibit a TPA or service company from receiving performance-based compensation for providing medical services through a physician-based network or auditing services and does not prevent the compensation of a TPA or service company from being based on premiums or charges collected or the number of claims paid or processed.

"**§ 58-47-195. Examinations.**

TPAs and service companies may be examined under G.S. 58-2-131, 58-2-132, and 58-2-133.

"**§ 58-47-200. Unfair trade practices.**

TPAs and service companies are subject to Article 63 of this Chapter.

"**§ 58-47-205. Other requirements.**

(a) A TPA or service company, or any owner, officer, employee, or agent of a TPA or service company, or any other person affiliated with or related to the TPA or service company shall not serve as a trustee of a self-insurer.

(b) Each TPA or service company shall make available for inspection by the Commissioner copies of all contracts with persons using the services of the TPA."

Section 4. Chapter 97 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 5.
"Individual Employers.

"**§ 97-165. Definitions.**

As used in this Article:

(1) 'Act' means the Workers' Compensation Act established in Article 1 of this Chapter.

(2) 'Certified audit' means an audit on which a certified public accountant expresses his or her professional opinion that the accompanying statements fairly present the financial position of the self-insurer, in conformity with generally accepted accounting principles as considered necessary by the auditor under the circumstances.

(3) 'Certified public accountant' or 'CPA' means a CPA who is in good standing with the American Institute of Certified Public Accountants and in all states in which the CPA is licensed to practice. A CPA shall be recognized as independent as long as the CPA conforms to the standards of the profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants and Rules and Regulations and Code

of Ethics and Rules of Professional Conduct of the North Carolina State Board of Certified Public Accountant Examiners, or similar code. The Commissioner may hold a hearing to determine whether a CPA is independent and, considering the evidence presented, may rule that the CPA is not independent for purposes of expressing an opinion on the GAAP financial statement and require the individual to replace the CPA with another whose relationship with the individual is independent within the meaning of this definition.

(4) 'Commissioner' means the Commissioner of Insurance.

(5) 'Corporate surety' means an insurance company authorized by the Commissioner to write surety business in this State.

(6) 'GAAP financial statement' means a financial statement as defined by generally accepted accounting principles.

(7) 'Hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a self-insurer is insolvent or, although not yet financially impaired or insolvent, is unlikely to be able to meet obligations with respect to known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.

(8) 'Management' means those persons who are authorized to direct or control the operations of a self-insurer.

(9) 'Qualified actuary' means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries, who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries, and is in compliance with G.S. 58-2-171.

(10) 'Self-insurer' means a single employer who retains liability under the Act and is licensed under this Article.

"**§ 97-170. License applications; required information.**

(a) No employer shall self-insure its workers' compensation liabilities under the Act unless it is licensed by the Commissioner under this Article.

(b) An applicant for a license as a self-insurer shall file with the Commissioner the information required by subsection (d) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. No application is complete until the Commissioner has received all required information.

(c) Only an applicant whose employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk and whose total fixed assets amount to five hundred thousand dollars ($500,000) or more may apply for a license. In judging the applicant's financial strength and liquidity relative to its ability to comply with the Act, the Commissioner shall consider the applicant's:

(1) Organizational structure and management;

(2) Financial strength;

(3) Source and reliability of financial information;
(4) Risks to be retained;
(5) Workers' compensation loss history;
(6) Number of employees;
(7) Claims administration;
(8) Excess insurance; and
(9) Access to excess insurance or reinsurance.

(d) The license application shall comprise the following information:

(1) Company name, organizational structure, location of principal office, contact person, organization date, type of operations within this State, management background, and addresses of all plants or offices in this State.
(2) Certified audited GAAP financial statements prepared by a CPA for the two most recent years. The financial statement formulation shall facilitate application of ratio and trend analysis.
(3) Evidence of the insurance required by G.S. 97-190.
(4) Demonstration, satisfactory to the Commissioner, that the employee base is actuarially sufficient in numbers and provides an actuarially appropriate spreading of risk.
(5) For applicants with 20 or more full-time employees, a certificate or other evidence of safety inspection, satisfactory to the Commissioner, that certifies that all safety requirements of the Department of Labor have been met.
(6) Summary of workers' compensation benefits paid for the last three calendar years, as well as the total liability for all open claims within 30 days or some other period acceptable to the Commissioner not to exceed 90 days, before the filing of the application.
(7) Summary, by risk classification, of annual payroll and number of employees within the State.
(8) Book value of fixed assets located within the State.
(9) Proof of compliance with the claims administration provisions of Article 47 of Chapter 58 of the General Statutes.
(10) A letter of assent, stipulating the applicant's acceptance of membership status in the North Carolina Self-Insurance Guaranty Association under Article 4 of this Chapter.

(e) Every applicant shall execute and file with the Commissioner an agreement, as part of the application, in which the applicant agrees to deposit with the Commissioner cash, acceptable securities, or a surety bond issued by a corporate surety that will guarantee the applicant's compliance with this Article and the Act pursuant to G.S. 97-185.

"§ 97-175. License.

(a) After the review of the application and all supporting materials, the Commissioner shall either grant or deny a license. If a license is denied, the

Commissioner shall notify the applicant of the denial and inform the applicant of the deficiencies that constitute the basis for denial.

(b) If the deficiencies are resolved within 60 days after the Commissioner's notice of denial, the applicant shall be granted a license. The applicant may be granted additional time to remedy the deficiencies in its application. A request for an extension of time shall be made in writing by the applicant within 30 days after notice of denial by the Commissioner. If the requirements of this Article have not been met, the application shall be withdrawn or denied.

"**§ 97-180. Reporting and records.**

(a) Every self-insurer shall submit, within 120 days after the end of its fiscal year, a certified audited GAAP financial statement, prepared by a CPA, for that fiscal year. The financial statement formulation shall facilitate the application of ratio and trend analysis.

(b) Every self-insurer shall submit within 120 days after the end of its fiscal year a certification from a qualified actuary setting forth the actuary's opinion relating to loss and loss adjustment expense reserves for workers' compensation obligations for each state in which the self-insurer does business. The certification shall show liabilities, excess insurance carrier and other qualifying credits, if any, and net retained workers' compensation liabilities. The qualified actuary shall present an annual report to the self-insurer on the items within the scope of and supporting the certification, within 90 days after the close of the self-insurer's fiscal year. Upon request, the report shall be submitted to the Commissioner.

(c) Every self-insurer shall submit within 120 days after the end of its fiscal year a report in the form of a sworn statement prescribed by the Commissioner, setting forth the total workers' compensation benefits paid in the previous fiscal year, as well as the total outstanding workers' compensation liabilities for each loss year, recorded at the close of its fiscal year for the net retained liability.

(d) Every self-insurer shall submit within 120 days after the end of its fiscal year annual payroll information. The report shall summarize payroll, by annual amount paid, and the number of employees, by classification, using the rules, classifications, and rates in the most recently approved Workers' Compensation and Employers' Liability Insurance Manual governing the audits of payrolls and the adjustments of premiums. Every self-insurer shall maintain true and accurate payroll records. These payroll records shall be maintained to allow for verification of the completeness and accuracy of the annual payroll report.

(e) Every self-insurer shall report promptly to the Commissioner changes in the names and addresses of the businesses it self-insures or intends to self-insure, as well as significant changes in the financial condition, including bankruptcy filings, and changes in its business structure, including its divisions, subsidiaries, affiliates, and internal organization. Any change shall be reported in writing to the Commissioner within 10 days after the effective date of the change.

"**§ 97-185. Deposits or surety bond.**

(a) Every self-insurer shall deposit with the Commissioner an amount equal to twenty-five percent (25%) of the self-insurer's total undiscounted outstanding claim

liability per the most recent certification from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars ($500,000), or such other amount as the Commissioner prescribes based on, but not limited to, the financial condition of the self-insurer and the risk retained by the self-insurer.

(b) A self-insurer organized and authorized before the effective date of this section shall have 24 months from the effective date of this section to comply with this section.

(c) Deposits received, changes to existing deposits, or deposits exchanged after the effective date of this section, shall comprise one or more of the following:

(1) Interest-bearing bonds of the United States of America.

(2) Interest-bearing bonds of the State of North Carolina, or of its cities or counties.

(3) Certificates of deposit issued by any solvent bank domesticated in the State of North Carolina that have a maturity of one year or greater.

(4) Surety bonds in a form acceptable to the Commissioner and issued by a corporate surety.

(5) Any other investments that are approved by the Commissioner.

(d) All bonds or securities that are posted as a security deposit shall be valued annually at market value. If market value is less than face value, the Commissioner may require the self-insurer to post additional securities. In making this determination, the Commissioner shall consider the self-insurer's financial condition, the amount by which market value is less than face value, and the likelihood that the securities will be needed to provide benefits.

(e) Securities deposited under this section shall be assigned to the Commissioner, the Commissioner's successors, assigns, or trustees, on a form prescribed by the Commissioner in a manner that renders the securities negotiable by the Commissioner. If a self-insurer is deemed by the Commissioner to be in a hazardous financial condition, the Commissioner may sell or collect, or both, such amounts that will yield sufficient funds to meet the self-insurer's obligations under the Act. Interest accruing on any negotiable security deposited under this Article shall be collected and transmitted to the self-insurer if the self-insurer is not in a hazardous financial condition.

(f) No judgment creditor, other than a claimant entitled to benefits under the Act, may levy upon any deposits made under this section.

(g) Securities held by the Commissioner under this section may be exchanged or replaced by the self-insurer with other securities of like nature and amount as long as the self-insurer is not in a hazardous financial condition. No release shall be effectuated until replacement securities or bonds of an equal value have been substituted. Any surety bond may be exchanged or replaced with another surety bond that meets the requirements of this section if 90 days' advance written notice is given to the Commissioner. If a self-insurer ceases to self-insure or desires to replace securities with an acceptable surety bond or bonds, the self-insurer shall notify the Commissioner, and may recover all or a portion of the securities deposited with the

Commissioner upon posting instead an acceptable special release bond issued by a corporate surety in an amount equal to the total value of the securities. The special release bond shall cover all existing liabilities under the Act plus an amount to cover future loss development and shall remain in force until all obligations under the Act have been discharged fully.

(h) If a self-insurer ceases to self-insure, no deposits shall be released by the Commissioner until the self-insurer has discharged fully all of the self-insurer's obligations under the Act.

(i) An endorsement to a surety bond shall be filed with the Commissioner within 90 days after the effective date of the endorsement.

"**§ 97-190. Excess insurance.**

(a) Every self-insurer, as a prerequisite for licensure under this Article, shall maintain specific and aggregate excess loss coverage through an insurance policy. A self-insurer shall maintain limits and retentions commensurate with its risk. A self-insurer's retention shall be the lowest retention suitable for the self-insurer's exposures and level of annual premium. The Commissioner may require different levels, or waive the requirement, of specific and aggregate excess loss coverage consistent with the market availability of excess loss coverage, the self-insurer's claims experience, and the self-insurer's financial condition.

(b) An excess insurance policy required by this section shall be issued by either a licensed insurance company or an approved surplus lines insurance company and shall:

(1) Provide for at least 30 days' written notice of cancellation by registered or certified mail, return receipt requested, to the self-insurer and to the Commissioner.

(2) Be renewable automatically at its expiration, except upon 30 days' written notice of nonrenewal by certified mail, return receipt requested, to the self-insurer and to the Commissioner.

(c) Every self-insurer shall provide to the Commissioner evidence of coverage and any amendments within 30 days after their effective dates. Every self-insurer shall, at the request of the Commissioner, furnish copies of its excess insurance policies and amendments.

"**§ 97-195. Revocation of license.**

(a) The Commissioner summarily may revoke a license if there is satisfactory evidence for the revocation. In determining whether to revoke a license summarily, the Commissioner may consider any or all of the following:

(1) Determination of insolvency by a court of competent jurisdiction.

(2) Institution of bankruptcy proceedings.

(3) If the self-insurer is in a hazardous financial condition.

(b) The Commissioner, upon at least 45 days' notice, may revoke a license if there is satisfactory evidence for the revocation. In determining whether to revoke a license under this subsection, the Commissioner may consider any or all of the following:

(1) Whether the self-insurer has experienced a material loss or deteriorating operating trends, or reported a deficit financial position.
(2) Whether any affiliate or subsidiary is insolvent, threatened with insolvency, or delinquent in payment of its monetary or any other obligation.
(3) Whether the self-insurer has failed to pay premium taxes pursuant to Article 8B of Chapter 105 of the General Statutes.
(4) Whether the self-insurer has failed to pay an assessment under G.S. 97-100.
(5) Contingent liabilities, pledges, or guaranties that either individually or collectively involve a total amount that in the Commissioner's opinion may affect a self-insurer's solvency.
(6) Whether the management of a self-insurer has failed to respond to the Commissioner's inquiries about the condition of the self-insurer or has furnished false and misleading information in response to an inquiry by the Commissioner.
(7) Whether the management of a self-insurer has filed any false or misleading sworn financial statement, has released a false or misleading financial statement to a lending institution or to the general public, or has made a false or misleading entry or omitted an entry of material amount in the filed financial information.
(8) Whether the self-insurer has experienced or will experience in the foreseeable future, cash flow or liquidity problems.
(9) Whether the self-insurer has not complied with the other provisions of this Article or the Act.
(10) Whether the self-insurer has failed to make proper and timely payment of claims as required by this Article.

(c) Any self-insurer subject to license revocation under subsection (a) or (b) of this section may request an administrative hearing before the Commissioner to review that order. If a hearing is requested, a notice of hearing shall be served, and the notice shall state the time and place of hearing and the conduct, condition, or ground on which the Commissioner based the order. Unless mutually agreed upon between the Commissioner and the self-insurer, the hearing shall occur not less than 10 days nor more than 30 days after notice is served and shall be either in Wake County or in some other place designated by the Commissioner. The Commissioner shall hold all hearings under this section privately unless the self-insurer requests a public hearing, in which case the hearing shall be public. The request for a hearing shall not stay the effect of the order.

"**§ 97-200. Claims administration.**

(a) A self-insurer shall not utilize any claims adjuster unless the adjuster is licensed under G.S. 58-33-25.

(b) Every self-insurer shall comply with the provisions of Article 47 of Chapter 58 of the General Statutes that are related to claims administration."

Section 5. G.S. 97-93 reads as rewritten:

"**§ 97-93. Employers required to carry insurance or prove financial ability to pay for benefits; employers required to post notice; self-insured employers regulated by Commissioner of Insurance.**

(a) Every employer subject to the provisions of this Article relative to the payment of compensation shall either:

(1) Insure and keep insured his liability under this Article in any authorized corporation, association, organization, or in any mutual insurance association formed by a group of employers so authorized; or

~~(2) Furnish to the Commissioner of Insurance satisfactory proof of the employer's financial ability, either alone or through membership in a group of two or more employers who are members of the same trade or professional association and who agree to pool their liabilities under this Article, to directly pay the compensation in the amount and manner and when due as provided for in this Article. The trade or professional association must have been incorporated in North Carolina and in existence at least five years prior to the date of application to the Commissioner of Insurance to form a self-insurer's fund and shall submit a written determination from the Internal Revenue Service that it is exempt from taxation under 26 U.S.C. § 501(c).~~

~~A group organized and approved under this subdivision prior to July 1, 1995, is not required to consist of employers of the same trade or professional association, have existed for five years, have been incorporated in North Carolina, or furnish the determination of tax-exempt status under 26 U.S.C. § 501(c).~~

(3) Obtain a license from the Commissioner of Insurance under Article 5 of this Chapter or under Article 47 of Chapter 58 of the General Statutes.

~~(b) In the case of subdivision (a)(2) of this section, the Commissioner of Insurance may require the deposit of an acceptable security, indemnity, or bond to secure the payment of compensation liabilities as they are incurred. Any individual employer or group of employers who furnish proof of financial ability under subdivision (a)(2) of this section shall be governed in all respects by this Article and by rules adopted by the Commissioner of Insurance.~~

~~(c) Payment of dividends to the members of any group of employers who agree to pool their liabilities under subdivision (a)(2) of this section shall not be contingent upon the maintenance or continuance of membership in such pools.~~

~~(d) Groups of two or more employers who agree to pool their liabilities under subdivision (a)(2) of this section are subject, in addition to the provisions cited in G.S. 58-2-145(a), to G.S. 58-2-165, G.S. 58-3-81, 58-6-25, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-177, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188,~~

~~58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and Articles 13, 19, 30, and 34 of Chapter 58 of the General Statutes.~~

(e) Every employer who is in compliance with the provisions of subsection (a) of this section shall post in a conspicuous place in places of employment a notice stating that employment by this employer is subject to the North Carolina Workers' Compensation Act and stating whether the employer has a policy of insurance against liability or qualifies as a self-insured employer. In the event the employer allows its insurance to lapse or ceases to qualify as a self-insured employer, the employer shall, within five working days of this occurrence, remove any notices indicating otherwise."

Section 6. G.S. 97-143 reads as rewritten:

"**§ 97-143. Use of deposits made by insolvent member self-insurers.**

After the Commissioner has notified the Association, under G.S. 97-136(a), that a member is insolvent, the Commissioner shall assign and deliver to the Association, and the Association is authorized to expend the deposit made by the insolvent member ~~pursuant to G.S. 97-93(b),~~ under G.S. 58-47-90 or G.S. 97-185, to the extent the deposit is needed by the Association to pay covered claims against ~~the premium taxes owed by~~ the insolvent member as required by this Article, and to the extent the deposit is needed to pay expenses of the Association relating to covered claims against the insolvent member. The Association shall account to the Commissioner and the insolvent member or its successor for all deposits received from the Commissioner under this section."

Section 7. G.S. 58-2-145 and G.S. 97-96 are repealed.

Section 8. G.S. 97-130(6) reads as rewritten:

"(6) 'Member self-insurer' or 'member' means a self-insurer which is authorized by the Commissioner to self-insure pursuant to G.S. ~~97-93, 97-94 and 97-96.~~ 97-93 and G.S. 97-94."

Section 9. G.S. 97-131(b)(3) reads as rewritten:

"(3) In determining the membership of the Association pursuant to subdivisions (1) and (2) of this subsection for any date after the effective date of this Article, no employer or group of employers claiming self-insurer status may be deemed to be a member of the Association on any date after the effective date of this Article, unless that employer or group of employers is at that time authorized as a self-insurer by the Commissioner pursuant to G.S. ~~97-93, 97-94, and 97-96.~~ 97-93 and G.S. 97-94."

Section 10. This act becomes effective December 1, 1997.

MINUTES

HOUSE COMMITTEE ON INSURANCE

JULY 03, 1997

The House Committee on Insurance met in Room 643 of the Legislative Office Building on July 03, 1997 at 12:18 p.m. Chairman Dockham presided. Members present were: Representative Allred, Barbee, Cole, Dickson, Esposito, Gardner, Hardaway, Hensley, Holmes, Hurley, Ives, McComas, Miller, Russell, Tallent, Wainwright and Wright. A list of visitors attending is attached. Attachment I

Chairman Dockham called the meeting to order at 12:18; thanked everyone for coming on the day before a holiday and the following bills were considered:

Senate Bill 254, entitled, AN ACT TO PROHIBIT DISCRIMINATION IN HEALTH INSURANCE AND EMPLOYMENT BASED ON GENETIC INFORMATION was before the committee for consideration (bill summary attached, Attachment II). This is Senator Odom's bill and Senator Cole moved to accept the Committee Substitute to be adopted for consideration. After a vote in the affirmative the substitute was before us for discussion. Representative Dixon explained the bill. The proposed House Committee Substitute for Senate Bill 254 prohibits insurers from refusing to issue health insurance to an individual because of genetic information obtained about that individual or group because of genetic information. It prohibits raising the premiums or contribution rates paid by a group for a group plan because of genetic information about an individual in that group. It also prohibits charging an individual higher insurance premiums because of genetic information obtained about that individual.

Staff then commented about the bill. Linwood Jones told the committee that it is a shorter version of the bill because when the committee voted (earlier in the week on the big Health State Insurance Bill) that most of it was taken care of at that time. (Attachment III)

Representative Dixon made a motion that the proposed Committee Substitute for Senate Bill 254 be given a favorable report, unfavorable to the original bill. After no further discussion or further debate, it was voted a favorable report. Representative Dixon then said he would handle this bill on the floor of the House.

Senate Bill 455, entitled, AN ACT TO IMPROVE HMO SERVICES BY PROTECTING PHYSICIAN COMMUNICATIONS REGARDING TREATMENT, REQUIRING COVERAGE FOR EMERGENCY CARE, AND REDUCING THE APPROVAL PERIOD FOR RATE FILINGS by Senator Hoyle. Since Senator Hoyle could not be with the committee, Chairman Dockham asked staff to explain the bill. It was moved that the substitute be before the committee by Representative Gardner and accepted. Linwood Jones explained that in Section I on page one, that the participating plan provider be limited in discussing with an enrollee the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment. This is better known as the "anti gag rule". Mr. Jones explained (page 2) that if a prudent layperson acting reasonability and believed that an emergency medical condition existed that he has the right to go to the emergency room without prior authorization. He said the last change was on page 5 and simply states that the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing for forms and within (60)45 days after the filing for premiums, they shall be deemed to be approved. This was 60 days that is changing to 45 day.

Representative Charlotte Gardner speaking on behalf of Representative Howard who could not be in the committee meeting brought forth an amendment that amends the title by deleting the word "AND" and on page l, line 5 by inserting the before the period the words ", AND REQUIRING COLLABORATION WITH LOCAL HEALTH DELPARTMENTS' and to add the following new section: Collaboration with local health departments. A health maintenance organization shall cooperate and collaborate with the local health department serving a county or counties in the health maintenance organization's service area with respect to health promotion and disease prevention efforts of the local health department that are necessary to protect the public health. (Attachment IV)

There were a lot of objections to the amendment and several HMO representatives spoke on the amendment and especially to the word "shall" which makes it sound mandatory.

Dr. Debnam, Deputy State Health Director in the Department of Environment, Health and Natural Resources explained that this language is in keeping with the federal language. This was taken directly from the National Insurers language and that the concept is the same.

Several legislators had a lot of concerns about this amendment. After extensive discussion between the committee members and representatives of the HMO Associations the major concern was that because of this amendment and the objections to this that the bill could be slowed down and that the committee substitute not pass during this session of The General Assembly. Several committee members voiced their concern about this amendment slowing down the legislation on this bill.

Representative Gardner withdrew her amendment. The proposed committee substitute for Senate Bill 455 was now before the committee. Representative Cole moved that the committee substitute be given a favorable report. Representative Wainwright stated that he had great concern over line 23 on page 3. He would like the word "knowingly" put in between the words condition and made. He thought it would help the bill to have this word included on this line. After several minutes of discussion about this word, Mr. Wainwright had the staff draw up an amendment that would add the word "knowingly".

The vote was taken for the amendment. There was a show of hands, with 9 in favor and 9 in opposition with the Chair voting in opposition to the amendment. Thus, the vote was 10 to 9 and the amendment failed. After further discussion, further debate, Representative Cole made the motion for a favorable report.

Chairman Jerry C. Dockham

Joanna Mills, Clerk

Attachment I

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

July 3, 1997

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn Terry	N.C. State Health Plan
David G. DeVries	N.C. State Health Plan
Harold Wright	NC State Health Plan
John McMillan	Manning, Fulton + Skinner P.A.
[illegible]	ACLU-NC
Deborah Ross	ACLU-NC
George Reed	NC Commission of Indian Affairs
[illegible]	NASW-NC
Robin Huffman	NCABHC
JACK PAGE	DOCTOR OF DAY
David Ferrell	Hyde, McNamara, Caldwell, McElroy & Clarke
J. Allen Adams	Retired State Employees Association of NC
Tracy Pearrell	NC Retired School Personnel
Leigh (?) Hammond	NC Retired Govt Employees Assn.
Sandy Sands	NCSR
Gloria Rangel	NCSOS

VISITOR REGISTRATION SHEET

INSURANCE — July 3, 1997

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jenni Doutt	
Sally Cameron	NC Psychological
Ann Duncan	WCSR (Wellpath)
Lea Wilkins	HHS Assn.
Hans Ryder	
Eddie Caldwell	NCCEP
Mac Burton	N.C. Pediatric Medical Society
Jean Devlin	DENR
Lynn Dresslar	UNC-Lineberger Cancer Ctr
Brenda Simmons	NC Equity
Robert Rader	Jordan Price Wall
C. Douglas Sloan	Young Moore & Henderson
Robert Paschal	Young, Moore & Henderson
Susan Valauri	Nationwide
Rachael Pope	NC DOI

VISITOR REGISTRATION SHEET

INSURANCE — July 3, 1997

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
W.R. Hale	NC Ins Dept
Starla N. McKenny	NC DOT

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham** for the Committee on **Insurance**.

☒ Committee Substitute for
S.B. 455 A BILL TO BE ENTITLED AN ACT TO IMPROVE HMO SERVICES BY PROTECTING PHYSICIAN COMMUNICATIONS REGARDING TREATMENT, REQUIRING COVERAGE FOR EMERGENCY CARE, AND REDUCING THE APPROVAL PERIOD FOR RATE FILINGS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☒ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

North Carolina General Assembly
Legislative Services Office

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Research Division
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300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-2578

Attachment III

July 3, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: Senate Bill 254 (Genetic Testing)(House PCS)

Section 1 of the proposed House Committee Substitute for Senate Bill 254 prohibits insurers from doing the following:

(1) Refusing to issue health insurance to an individual because of genetic information obtained about that individual or to a group because of genetic information about one or more individuals in that group.
(2) Raising the premiums or contribution rates paid by a group for a group plan because of genetic information about an individual in that group.
(3) Charging an individual higher insurance premiums because of genetic information obtained about that individual.

"Genetic information" means "information about genes, gene products, or inherited characteristics that may derive from an individual or a family member. However, it does not include the results of routine physical measurements, blood chemistries, blood counts, urine analysis, tests for drug abuse, and HIV tests.

Section 2 prohibits public and private employers from firing or refusing to employ a person because of genetic information about the person or the person's family or because the person has requested genetic tests or counseling. Section 3 also protects these persons or others acting on their behalf under the retaliatory employment discharge provisions of the law.

Section 4 makes clear that the health insurance portion of the bill applies only to typical health insurance policies, not certain specialized policies.

Section 5 makes this bill effective when it becomes law.

S254-SMRN-001

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham** for the Committee on **Insurance**.

☒ Committee Substitute for
S.B. 254 A BILL TO BE ENTITLED AN ACT TO PROHIBIT DISCRIMINATION IN HEALTH INSURANCE AND EMPLOYMENT BASED ON GENETIC INFORMATION.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☒ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 254*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/3/97
Proposed House Committee Substitute S254-PCS7826

Short Title: Genetic Info/No Discrimination. (Public)

Sponsors:

Referred to:

February 27, 1997

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT DISCRIMINATION IN HEALTH INSURANCE AND EMPLOYMENT BASED ON GENETIC INFORMATION.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-215. Genetic information in health insurance.**

(a) Definitions. -- As used in this section:

(1) 'Genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member. 'Genetic information' does not include the results of routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation.

'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Group health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance
m. Blanket accident and sickness.

(3) 'Insurer' means an insurance company subject to this Chapter; a service corporation organized under Article 65 of this Chapter; a health maintenance organization organized under Article 67 of this Chapter; or a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) For the purpose of this section, routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus are not to be considered genetic tests.

(c) No insurer shall:

(1) Raise the premium or contribution rates paid by a group for a group health benefit plan on the basis of genetic information obtained about an individual member of the group.

(2) Refuse to issue or deliver a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan.

(3) Charge a higher premium rate or charge for a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan."

Section 2. Article 3 of Chapter 95 of the General Statutes is amended by adding the following new section to read:

"**§ 95-28.1A. Discrimination against persons based on genetic testing or genetic information prohibited.**

(a) No person, firm, corporation, unincorporated association, State agency, unit of local government, or any public or private entity shall deny or refuse employment to any person or discharge any person from employment on account of the person's

having requested genetic testing or counseling services, or on the basis of genetic information obtained concerning the person or a member of the person's family. This section shall not be construed to prevent the person from being discharged for cause.

(b) As used in this section, the term 'genetic test' means a test for determining the presence or absence of genetic characteristics in an individual or a member of the individual's family in order to diagnose a genetic condition or characteristic or ascertain susceptibility to a genetic condition. The term 'genetic characteristic' means any scientifically or medically identifiable genes or chromosomes, or alterations or products thereof, which are known individually or in combination with other characteristics to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder, and which are asymptomatic of any disease or disorder. The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 3. G.S. 95-241(a) reads as rewritten:

"(a) No person shall discriminate or take any retaliatory action against an employee because the employee in good faith does or threatens to do any of the following:

(1) File a claim or complaint, initiate any inquiry, investigation, inspection, proceeding or other action, or testify or provide information to any person with respect to any of the following:
   a. Chapter 97 of the General Statutes.
   b. Article 2A or Article 16 of this Chapter.
   c. Article 2A of Chapter 74 of the General Statutes.
   d. G.S. 95-28.1.
   e. G.S. 95-28.1A.

(2) Cause any of the activities listed in subdivision (1) of this subsection to be initiated on an employee's behalf.

(3) Exercise any right on behalf of the employee or any other employee afforded by Article 2A or Article 16 of this Chapter or by Article 2A of Chapter 74 of the General Statutes."

Section 4. Nothing in this act applies to specified accident, specified disease, hospital indemnity, disability, or long-term care health insurance policies.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 254*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/3/97
Proposed House Committee Substitute S254-PCS7826

Short Title: Genetic Info/No Discrimination. (Public)

Sponsors:

Referred to:

February 27, 1997

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT DISCRIMINATION IN HEALTH INSURANCE AND EMPLOYMENT BASED ON GENETIC INFORMATION.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-215. Genetic information in health insurance.**

(a) Definitions. -- As used in this section:

(1) 'Genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member. 'Genetic information' does not include the results of routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation.

'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Group health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance
m. Blanket accident and sickness.

(3) 'Insurer' means an insurance company subject to this Chapter; a service corporation organized under Article 65 of this Chapter; a health maintenance organization organized under Article 67 of this Chapter; or a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) For the purpose of this section, routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus are not to be considered genetic tests.

(c) No insurer shall:

(1) Raise the premium or contribution rates paid by a group for a group health benefit plan on the basis of genetic information obtained about an individual member of the group.

(2) Refuse to issue or deliver a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan.

(3) Charge a higher premium rate or charge for a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan."

Section 2. Article 3 of Chapter 95 of the General Statutes is amended by adding the following new section to read:

"**§ 95-28.1A. Discrimination against persons based on genetic testing or genetic information prohibited.**

(a) No person, firm, corporation, unincorporated association, State agency, unit of local government, or any public or private entity shall deny or refuse employment to any person or discharge any person from employment on account of the person's

having requested genetic testing or counseling services, or on the basis of genetic information obtained concerning the person or a member of the person's family. This section shall not be construed to prevent the person from being discharged for cause.

(b) As used in this section, the term 'genetic test' means a test for determining the presence or absence of genetic characteristics in an individual or a member of the individual's family in order to diagnose a genetic condition or characteristic or ascertain susceptibility to a genetic condition. The term 'genetic characteristic' means any scientifically or medically identifiable genes or chromosomes, or alterations or products thereof, which are known individually or in combination with other characteristics to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder, and which are asymptomatic of any disease or disorder. The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 3. G.S. 95-241(a) reads as rewritten:

"(a) No person shall discriminate or take any retaliatory action against an employee because the employee in good faith does or threatens to do any of the following:

(1) File a claim or complaint, initiate any inquiry, investigation, inspection, proceeding or other action, or testify or provide information to any person with respect to any of the following:
   a. Chapter 97 of the General Statutes.
   b. Article 2A or Article 16 of this Chapter.
   c. Article 2A of Chapter 74 of the General Statutes.
   d. G.S. 95-28.1.
   e. G.S. 95-28.1A.

(2) Cause any of the activities listed in subdivision (1) of this subsection to be initiated on an employee's behalf.

(3) Exercise any right on behalf of the employee or any other employee afforded by Article 2A or Article 16 of this Chapter or by Article 2A of Chapter 74 of the General Statutes."

Section 4. Nothing in this act applies to specified accident, specified disease, hospital indemnity, disability, or long-term care health insurance policies.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 254*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/3/97
Proposed House Committee Substitute S254-PCS7826

Short Title: Genetic Info/No Discrimination. (Public)

Sponsors:

Referred to:

February 27, 1997

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT DISCRIMINATION IN HEALTH INSURANCE AND EMPLOYMENT BASED ON GENETIC INFORMATION.

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(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation.

'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Group health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance
m. Blanket accident and sickness.

(3) 'Insurer' means an insurance company subject to this Chapter; a service corporation organized under Article 65 of this Chapter; a health maintenance organization organized under Article 67 of this Chapter; or a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) For the purpose of this section, routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus are not to be considered genetic tests.

(c) No insurer shall:

(1) Raise the premium or contribution rates paid by a group for a group health benefit plan on the basis of genetic information obtained about an individual member of the group.

(2) Refuse to issue or deliver a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan.

(3) Charge a higher premium rate or charge for a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan."

Section 2. Article 3 of Chapter 95 of the General Statutes is amended by adding the following new section to read:

"**§ 95-28.1A. Discrimination against persons based on genetic testing or genetic information prohibited.**

(a) No person, firm, corporation, unincorporated association, State agency, unit of local government, or any public or private entity shall deny or refuse employment to any person or discharge any person from employment on account of the person's

having requested genetic testing or counseling services, or on the basis of genetic information obtained concerning the person or a member of the person's family. This section shall not be construed to prevent the person from being discharged for cause.

(b) As used in this section, the term 'genetic test' means a test for determining the presence or absence of genetic characteristics in an individual or a member of the individual's family in order to diagnose a genetic condition or characteristic or ascertain susceptibility to a genetic condition. The term 'genetic characteristic' means any scientifically or medically identifiable genes or chromosomes, or alterations or products thereof, which are known individually or in combination with other characteristics to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder, and which are asymptomatic of any disease or disorder. The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 3. G.S. 95-241(a) reads as rewritten:

"(a) No person shall discriminate or take any retaliatory action against an employee because the employee in good faith does or threatens to do any of the following:

(1) File a claim or complaint, initiate any inquiry, investigation, inspection, proceeding or other action, or testify or provide information to any person with respect to any of the following:
   a. Chapter 97 of the General Statutes.
   b. Article 2A or Article 16 of this Chapter.
   c. Article 2A of Chapter 74 of the General Statutes.
   d. G.S. 95-28.1.
   e. G.S. 95-28.1A.

(2) Cause any of the activities listed in subdivision (1) of this subsection to be initiated on an employee's behalf.

(3) Exercise any right on behalf of the employee or any other employee afforded by Article 2A or Article 16 of this Chapter or by Article 2A of Chapter 74 of the General Statutes."

Section 4. Nothing in this act applies to specified accident, specified disease, hospital indemnity, disability, or long-term care health insurance policies.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 455*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97
Third Edition Engrossed 4/30/97

PROPOSED COMMITTEE SUBSTITUTE
S455-CSRN-004
THIS IS A DRAFT

Short Title: Improve HMO Services. (Public)

Sponsors:

Referred to:

March 24, 1997

A BILL TO BE ENTITLED

AN ACT TO IMPROVE HMO SERVICES BY PROTECTING PHYSICIAN COMMUNICATIONS REGARDING TREATMENT, REQUIRING COVERAGE FOR EMERGENCY CARE, AND REDUCING THE APPROVAL PERIOD FOR RATE FILINGS.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"§ 58-3-176. Treatment discussions not limited.

(a) An insurer shall not limit either of the following:

(1) The participating plan provider's ability to discuss with an enrollee the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment.

(2) The participating plan provider's professional obligations to patients as specified under the provider's professional license.

(b) Nothing in this section shall be construed to expand or revise the scope of benefits covered by a health benefit plan.

(c) As used in this section:

(1) 'Health benefit plan' means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter."

Section 2. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-190. Coverage required for emergency care.**

(a) Every insurer shall provide coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered if:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

(e) Both the emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or, with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Insurers shall provide information to their covered persons on all of the following:

(1) Coverage of emergency medical services.

(2) The appropriate use of emergency services, including the use of the '911' system and other

telephone access systems utilized to access prehospital emergency services.

(3) Any cost-sharing provisions for emergency medical services.

(4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:

(1) 'Emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

(2) 'Emergency services' means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

(3) 'Health benefit plan' means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(4) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(5) 'To stabilize' means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred."

Section 3. G.S. 58-67-50(c) reads as rewritten:

"(c) The Commissioner shall, within a reasonable period, approve any form if the requirements of subsection (a) of this section are met and any schedule of premiums if the requirements of subsection (b) of this section are met. It shall be unlawful to issue the form or to use the schedule of premiums until approved. If the Commissioner disapproves the filing, the

Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing for forms and within ~~60~~ 45 days after the filing for premiums, they shall be deemed to be approved."

Section 4. Section 2 of this act becomes effective January 1, 1998, and applies to health benefit plans issued, renewed, or amended on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 455*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97
Third Edition Engrossed 4/30/97
Proposed Committee Substitute S455-PCS1853

Short Title: Improve HMO Services. (Public)

Sponsors:

Referred to:

March 24, 1997

A BILL TO BE ENTITLED

AN ACT TO IMPROVE HMO SERVICES BY PROTECTING PHYSICIAN COMMUNICATIONS REGARDING TREATMENT, REQUIRING COVERAGE FOR EMERGENCY CARE, AND REDUCING THE APPROVAL PERIOD FOR RATE FILINGS.

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(2) The participating plan provider's professional obligations to patients as specified under the provider's professional license.

(b) Nothing in this section shall be construed to expand or revise the scope of benefits covered by a health benefit plan.

(c) As used in this section:

(1) 'Health benefit plan' means any of the following if written by an insurer: an accident and health insurance policy or certificate; a

nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

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e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter."

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(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered if:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

(e) Both the emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Insurers shall provide information to their covered persons on all of the following:

(1) Coverage of emergency medical services.

(2) The appropriate use of emergency services, including the use of the '911' system and other telephone access systems utilized to access prehospital emergency services.

(3) Any cost-sharing provisions for emergency medical services.

(4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:

(1) 'Emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

(2) 'Emergency services' means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital

care and ancillary services routinely available to the emergency department.

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e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

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(5) 'To stabilize' means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred."

Section 3. G.S. 58-67-50(c) reads as rewritten:

"(c) The Commissioner shall, within a reasonable period, approve any form if the requirements of subsection (a) of this section are met and any schedule of premiums if the requirements of subsection (b) of this section are met. It shall be unlawful to

issue the form or to use the schedule of premiums until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing for forms and within ~~60~~ 45 days after the filing for premiums, they shall be deemed to be approved."

Section 4. Section 2 of this act becomes effective January 1, 1998, and applies to health benefit plans issued, renewed, or amended on or after that date. The remainder of this act is effective when it becomes law.

Attachment IX

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 455

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

S455-ARN-001

Page 1 of __

Date_____,1997

Comm. Sub. [X]
Amends Title [X]
Draft Edition

Representative _____

moves to amend the bill on page 1, line 4 by deleting the word "AND' and on page 1, line 5 by inserting the before the period the words ", AND REQUIRING COLLABORATION WITH LOCAL HEALTH DEPARTMENTS";

and on page 6, between lines 7 and 8, by inserting the following new section:

"Section 4. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

'**58-67-66. Collaboration with local health departments.** A health maintenance organization shall cooperate and collaborate with the local health department serving a county or counties in the health maintenance organization's service area with respect to health promotion and disease prevention efforts of the local health department that are necessary to protect the public health.'";

and by renumbering the remaining section accordingly.

SIGNED _____
Amendment Sponsor

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 455

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

S455-ARN-001

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

MINUTES

HOUSE COMMITTEE ON INSURANCE

JULY 16, 1997

The House Committee on Insurance met in Room 643 of the Legislative Office Building on July 16, 1997 at 12:02 p.m. Chairman Dockham presided. Members present were: Representatives Barbee, Bowie, Dedmon, Dickson, Hardaway, Hurley, McComas, Miner, Russell and Tallent. The pages were introduced; Tiffany Jones from Washington County and Andrea Kanott from Carteret County. The visitors were welcomed by Chairman Dockham. A list of visitors attending is attached. (Attachment I)

Chairman Dockham asked Representative Miner to come forward and chair the committee while Representative Dockham introduced his House Bill 435. Representative Miner then called on Representative Dockham to explain the bill. Representative Dixon moved that the proposed Committee Substitute for House Bill 435 be adopted. Representative Dockham said that this just makes technical changes to the State Employee Health Plan. Mr. Sam Byrd was introduced to explain those changes. There are three sections in this committee substitute that he brings to our attention. The first being Section 8 which deals with the hospital admission being denied or the hospital stay being extended without pre-certification. The penalty could be as much as five-hundred dollars. This penalty has been taken by a large number of people because when compared to a large hospital bill, the five hundred dollars in a small amount. This change in Section 8 would change that $500.00 penalty to be as much as the entire claim being the penalty. With the penalty being this large, people would be sure to get pre-certification before entering the hospital and permission to have a longer stay in the hospital.

Sections 14 & 15 also have technical changes. These sections deal with processing claims for chemical dependency and mental health benefits. The Board of Trustees is asking that the limits be dropped as they were dropped in 1992 for the rest of the plans.

The plan at this time has a $25,000.00 life-time limit and an $8,000.00 annual limit. Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency, are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

Representative Dub Dixon made the motion for a favorable report. Chairman Miner asked for anyone in audience who would like to speak on the bill. Mr. Dave Debrise, the Executive Administrator of the plan spoke in favor of the bill and asked the committee to please vote in favor of the bill. The committee voted favorable to committee substitute and unfavorable to original bill.

Chairman Dockham thanked Representative Minor for taking over in his place as Chairman while he introduced his bill. He then welcomed Senator Martin to explain his Senate Bill 299. Senator Martin said that this bill is to provide long-term care benefits for qualified employees, retired employees, and their dependents under the Teachers' and State Employees' Comprehensive Major Medical Plan. Representative Bowie made a motion that the bill be given a favorable report. The Chairman then called for further discussion and further debate. Further explanation was made by staff, Mr. Sam Byrd who said he didn't have anything to add except that the bill has passed unanimously in Pensions and Retirement and the same in the Senate which showed it is a good bill and a needed one. The vote was taken and the bill was given a favorable report.

Senator Forrester was then recognized to explain his Senate Bill 273. The summary was passed out to the committee members and Sen. Forrester explained the bill. This bill simply says that it is simply to let the patient and the Doctor decide how long the hospital stay will be after the mastectomy. It has been that the patient was discharged the very next day, making it premature for her condition. In this bill the discharge plain must ensure that the length of hospitalization is based on the individual patient's unique characteristics, including health and medical history. See attachments III, IV and V. Representative Hardaway made a motion to give the bill a favorable report. Senate Bill 273 then passed with a favorable report. This bill will be handled on the floor by Representative Russell.

Senator Jenkins could not be at the Insurance Committee Meeting today so Bill Hale spoke on his behalf to explain Senate Bill 843. An amendment by Representative Barbee came before the Committee for discussion. This was handed out to the members as well as the explanation of the bill as well as a letter from the Dept. of Insurance written by the Deputy Commissioner, William K. Hale.(See attachment VI, VII, VIII).

Mr. Bill Hale explained what this bill would do. This bill has fourteen parts to it as explained in this attachment. Simply put, the proposed House Committee Substitute for SB-843 makes numerous changes to the insurance laws. These changes are generally technical in nature, such as repeals of obsolete or unnecessary provisions, clarifications of existing laws, and similar changes. The bill is an agency bill of the Department of Insurance.

Representative Russell made a motion to accept the amendment. The amendment and proposed House Committee Substitute for Senate Bill 843 were rolled into a new committee substitute and be given a favorable report, unfavorable to original bill.

Chairman Jerry C. Dockham

Joanna S. Mills, Clerk

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Jerry C. Dockham** for the Committee on **INSURANCE**.

☐ Committee Substitute for
S.B. 299 A BILL TO BE ENTITLED AN ACT TO PROVIDE LONG-TERM CARE BENEFITS FOR QUALIFIED EMPLOYEES, RETIRED EMPLOYEES, AND THEIR DEPENDENTS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

☑ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Jerry C. Dockham** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 435 A BILL TO BE ENTITLED AN ACT TO MAKE TECHNICAL CHANGES IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☑ With a favorable report as to committee substitute bill (#_____), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #_____), (and recommendation that the committee substitute bill #____) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Jerry C. Dockham** for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 843 A BILL TO BE ENTITLED AN ACT TO REPEAL OBSOLETE LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES; AND TO EXTEND THE EXPIRATION DATE OF THE 1986 RISK SHARING PLAN LAW.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .....)

☒ With a favorable report as to House committee substitute bill (#_____); ☐ ~~which changes the title,~~ unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 843
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97
Proposed House Committee Substitute S843-PCS2802

Short Title: Insurance Technical Changes. (Public)

Sponsors:

Referred to:

April 15, 1997

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES; AND TO EXTEND THE EXPIRATION DATE OF THE 1986 RISK SHARING PLAN LAW.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1. G.S. 58-3-125, 58-6-10, 58-7-150, 58-41-35, and 58-71-90 are repealed.

Section 2. G.S. 58-2-120 reads as rewritten:

"**§ 58-2-120. Reports of Commissioner to the Governor and General Assembly.**

~~The Commissioner shall biennially submit to the General Assembly, through the Governor, a report of his official acts, including a summary of official rulings and regulations.~~ The Commissioner shall, from time to time, report to the Governor and the General Assembly any change ~~which~~ that in ~~his~~ the Commissioner's opinion should be made in the laws relating to insurance and other subjects pertaining to ~~his department. On or before the first day of February of each year in which the General Assembly is in session he shall make to the Governor the recommendations called for in this section, to be transmitted to the General Assembly, with the last annual report of this Department, including receipts and disbursements.~~ the Department."

Section 3. G.S. 58-87-10(e) reads as rewritten:

"(e) Revenue Source. -- Revenue is credited to the Workers' Compensation Fund from appropriations made to the Department of Insurance for this purpose. In addition, every eligible unit that elects to participate shall pay into the Fund an amount set annually by the State Fire and Rescue Commission to ensure that the Fund will be able to meet its payment obligations under this section. The amount shall be set as a per capita fixed dollar amount for each member of the roster of the eligible unit.

The payment shall be made to the State Fire and Rescue Commission on or before July 1 of each year. The Commission shall remit the payments it receives to the State Treasurer, who shall credit the payments to the Fund. ~~If the Commission does not receive an annual payment from an eligible unit by July 1, then that unit shall not receive workers' compensation coverage from the Fund for the fiscal year that begins that July 1.~~"

Section 4. G.S. 120-123(55) and (65) are repealed.

Section 5. G.S. 58-36-15(e) reads as rewritten:

"(e) The Commissioner may require the filing of supporting data including:

(1) The Bureau's interpretation of any statistical data relied upon;

(2) Descriptions of the methods employed in setting the rates;

(3) Analysis of the incurred losses submitted on an accident year or policy year basis into their component parts; to wit, paid losses, reserves for losses and loss expenses, and reserves for losses incurred but not reported;

(4) The total number and dollar amount of paid claims;

(5) The total number and dollar amount of case basis reserve claims;

(6) Earned and written premiums at current rates by rating territory;

(7) Earned premiums and incurred losses according to classification plan categories; and

(8) Income from investment of unearned premiums and loss and loss expense reserves generated by business within this State.

~~Provided, however, that with respect to business written prior to January 1, 1980, the Commissioner shall not require the filing of such supporting data which has not been required to be recorded under statistical plans approved by the Commissioner.~~"

Section 6. G.S. 58-3-115 reads as rewritten:

"**§ 58-3-115. Twisting with respect to insurance policies; penalties.**

No insurer shall make or issue, or cause to be issued, any written or oral statement that willfully misrepresents or willfully makes an incomplete comparison as to the terms, conditions, or benefits contained in any policy of insurance for the purpose of inducing or attempting to induce a policyholder in any way to terminate or surrender, exchange, or convert any insurance policy. Any person who violates this section is subject to the provisions of ~~G.S. 58-2-70, 58-3-90 through 58-3-100, and 58-3-125.~~ G.S. 58-2-70 or G.S. 58-3-100."

Section 7. G.S. 58-30-75(7) reads as rewritten:

"(7) Without first obtaining the written consent of the ~~Commissioner pursuant to G.S. 58-7-150,~~ Commissioner, the insurer has (i)

transferred, or attempted to transfer, in a manner contrary to Article 19 of this Chapter, substantially its entire property or business, or (ii) has entered into any transaction, the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person."

Section 8. G.S. 58-41-40(a) reads as rewritten:

"(a) There is no liability on the part of and no cause of action for defamation or invasion of privacy arises against any insurer or its authorized representatives, agents, or employees, or any licensed insurance agent or broker, for any communication or statement made, unless shown to have been made in bad faith with malice, in any of the following:

(1) A written notice of cancellation under ~~G.S. 58-41-15,~~ G.S. 58-41-15 or of nonrenewal under G.S. 58-41-20, ~~or of cessation of business through an agency under G.S. 58-41-35,~~ specifying the reasons ~~therefor;~~ for cancellation.

(2) Communications providing information pertaining to ~~such cancellation, nonrenewal, or cessation of business through an agency;~~ the cancellation or nonrenewal.

(3) Evidence submitted at any court proceeding, administrative hearing, or informal inquiry in which ~~such cancellation, nonrenewal, or cessation of business through an agency~~ the cancellation or nonrenewal is an issue."

PART II. AMENDMENTS NECESSARY BECAUSE OF 1995 REWRITE OF G.S. 58-2-50.

Section 9. G.S. 58-34-2(j) reads as rewritten:

"(j) The Commissioner shall disapprove any such contract that:

(1) Does not contain the required contract provisions specified in subsection (d) of this section;

(2) Subjects the insurer to excessive charges for expenses or commission;

(3) Vests in the MGA any control over the management of the affairs of the insurer to the exclusion of the board of directors of the insurer;

(4) Is entered into with any person if the person or its officers and directors are of known bad character or have been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance; or

(5) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the insurer.

Failure of the Commissioner to disapprove any such contract within 30 days after the contract has been filed with the Commissioner constitutes the Commissioner's

approval of the contract. An insurer may continue to accept business from ~~such~~ the person until the Commissioner disapproves the contract. Any disapproval shall be in writing. The Commissioner ~~may, after a hearing held under G.S. 58-2-50,~~ may withdraw approval of any contract the Commissioner has previously approved ~~upon finding~~ if the Commissioner determines that the basis of the original approval no longer exists or that the contract has, in actual operation, shown itself to be subject to disapproval on any of the grounds in this subsection. If the Commissioner withdraws approval of a contract, the Commissioner shall give the insurer notice of, and written reasons for, the withdrawal of approval. The Commissioner shall grant any party to the contract a hearing upon request."

Section 10. G.S. 58-34-15(b) reads as rewritten:

"(b) If the Commissioner disapproves any management contract, ~~notice of such action shall be given to the insurer assigning the reasons therefor in writing.~~ the Commissioner shall give notice of, and written reasons for, the disapproval to the insurer. The Commissioner shall grant any party to the contract a hearing upon ~~request according to G.S. 58-2-50.~~ request."

Section 11. G.S. 58-40-100 reads as rewritten:

"**§ 58-40-100. Request for review of rate, rating plan, rating system or underwriting rule.**

(a) Any person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer or rating organization may request in writing that the insurer or rating organization ~~to~~ review the manner in which the rate, plan, system, or rule has been applied with respect to ~~insurance afforded him. Such request may be made by his authorized representative, and shall be in writing.~~ the person's insurance. The person's authorized representative may make the request. If the request is not granted within 30 days after it is made, the requestor may treat it as rejected. Any person aggrieved by the action of an insurer or rating organization in refusing the review requested or in failing or refusing to grant all or part of the relief requested, may file a written complaint and request for hearing with the Commissioner, and shall specify the grounds relied upon. If the Commissioner has information concerning a similar ~~complaint he~~ complaint, the Commissioner may deny the hearing. If the Commissioner believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, ~~he~~ the Commissioner shall deny the hearing. If the Commissioner finds that the complaint charges a violation of this Article and that the complainant would be aggrieved if the violation is proven, ~~he~~ the Commissioner shall proceed as provided in G.S. ~~58-2-50 or~~ 58-2-70.

(b) Repealed by Session Laws 1985 (Regular Session, 1986), c. 1027, s. 15."

Section 12. G.S. 58-42-1 reads as rewritten:

"**§ 58-42-1. Establishment of plans.**

If the Commissioner finds, after a ~~hearing held in accordance with G.S. 58-2-50,~~ hearing, that in all or any part of this State, any amount or kind of insurance authorized by G.S. 58-7-15(4) through G.S. 58-7-15(22) is not readily available in the

voluntary market and that the public interest requires the availability of that insurance, ~~he~~ the Commissioner may either:

(1) Promulgate plans to provide insurance coverage for any risks in this State that are, based on reasonable underwriting standards, entitled to obtain but are otherwise unable to obtain coverage; or

(2) Call upon insurers to prepare plans for ~~his~~ the Commissioner's approval."

Section 13. G.S. 58-45-50 reads as rewritten:

"**§ 58-45-50. Appeal from acts of Association to Commissioner; appeal from Commissioner to superior court.**

Any person or any insurer who may be aggrieved by an act, ruling or decision of the Association other than an act, ruling or decision relating to the cause or amount of a claimed loss, may, within 30 days after ~~such ruling~~ the ruling, appeal to the Commissioner. Any hearings held by the Commissioner ~~pursuant to such an~~ under the appeal shall be in accordance with ~~the procedure set forth in G.S. 58-2-50.~~ rules adopted by the Commissioner: Provided, however, the Commissioner is authorized to appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ those appeals and a ruling based upon ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the Commissioner. All persons or insureds aggrieved by any order or decision of the Commissioner may appeal as ~~is~~ provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than 20 days before each hearing, the appellant shall file with the Commissioner or his designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. ~~Each such hearing shall be recorded and transcribed. The cost of such recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by the other party.~~ The procedures governing recordings of hearings and, if necessary, transcripts of recordings, as well as the fees for copies of recordings and transcripts, shall be determined by rules adopted by the Commissioner. Each party shall, on a date determined by the Commissioner or his designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or his designated hearing officer and serve on the other party, a proposed order. The Commissioner or his designated hearing officer shall then issue an order."

Section 14. G.S. 58-45-70 reads as rewritten:

"**§ 58-45-70. Commissioner may examine affairs of Association.**

The Commissioner may from time to time make an examination into the affairs of the Association when ~~he~~ the Commissioner deems it to be ~~prudent and in undertaking such examination he~~ prudent, and as part of the examination the

Commissioner may hold a public ~~hearing pursuant to the provisions of G.S. 58-2-50.~~ hearing. ~~The expenses of such examination shall be borne and paid by the Association.~~ The Association shall pay the expenses of the examination."

Section 15. G.S. 58-46-20(c) reads as rewritten:

"(c) The Commissioner may designate the kinds of property insurance policies on principal residences to be offered by the association, including insurance policies under Article 36 of this Chapter, and the commission rates to be paid to agents or brokers for these policies, if ~~he~~ the Commissioner finds, after a ~~hearing held in accordance with G.S. 58-2-50,~~ hearing, that the public interest requires the designation. The provisions of Chapter 150B of the General Statutes do not apply to any procedure under this subsection, except that G.S. 150B-39 and G.S. 150B-41 shall apply to a hearing under this subsection. Within 30 days after the receipt of notification from the Commissioner of a change in designation ~~pursuant to~~ under this subsection, the association shall submit a revised plan and articles of association for approval in accordance with subsection (b) of this section."

Section 16. G.S. 58-46-30 reads as rewritten:

"**§ 58-46-30. Appeals; judicial review.**

The association shall provide reasonable means, to be approved by the Commissioner, whereby any person or insurer affected by any act or decision of the administrators of the Plan or underwriting association, other than an act or decision relating to the cause or amount of a claimed loss, may be heard in person or by an authorized representative, before the governing board of the association or a designated committee. Any person or insurer aggrieved by any decision of the governing board or designated committee, may be appealed to the Commissioner within 30 days from the date of ~~such~~ the ruling or decision. The Commissioner, after hearing held ~~pursuant to the procedure set forth in G.S. 58-2-50,~~ under rules adopted by the Commissioner, shall issue an order approving or disapproving the act or decision with respect to the matter ~~which~~ that is the subject of appeal. The Commissioner ~~is authorized to~~ may appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ the appeals and a ruling based on ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the ~~Commissioner personally.~~ Commissioner. All persons or insurers or their representatives aggrieved by any order or decision of the Commissioner may appeal as provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than 20 days before each hearing, the appellant shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. ~~Each such hearing shall be recorded and transcribed. The cost of such recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by~~

~~the other party.~~ The procedures governing recordings of hearings and, if necessary, transcripts of recordings, as well as the fees for copies of recordings and transcripts, shall be determined by rules adopted by the Commissioner. Each party shall, on a date determined by the Commissioner or ~~his~~ the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or ~~his~~ the designated hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the designated hearing officer shall then issue an order."

PART III. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION AND RECEIVERSHIPS.

Section 17. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity licensed under Articles 7, 16, 26, 49, 65, or 67 of this Chapter and any employer that has furnished to the Commissioner satisfactory proof of its financial responsibility under G.S. 97-93(a)(2). For purposes of this Article, 'insurer' also includes continuing care retirement ~~centers~~ communities licensed under Article 64 of this Chapter."

Section 18. The title of Article 64 of Chapter 58 of the General Statutes reads as rewritten:

"ARTICLE 64.

~~"Registration, Disclosure, Contract, and Financial Monitoring Requirements for~~ Continuing Care ~~Facilities.~~ Retirement Communities."

Section 19. G.S. 58-64-1 reads as rewritten:

"**§ 58-64-1. Definitions.**

As used in this Article, unless otherwise specified:

(1) 'Continuing care' means the furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, ~~pursuant to~~ under an agreement effective for the life of the individual or for a period ~~in excess of~~ longer than one year.

(2) 'Entrance fee' means a payment that assures a resident a place in a facility for a term of years or for life.

(3) 'Facility' means the ~~place or places~~ retirement community or communities in which a provider undertakes to provide continuing care to an individual.

(4) 'Health related services' means, at a minimum, nursing home admission or assistance in the activities of daily living, exclusive of the provision of meals or cleaning services.

(5) 'Living unit' means a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents.

(6) 'Provider' means the promoter, developer, or owner of a ~~continuing care~~ facility, whether a natural person, partnership, or

other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract, or that represents ~~himself~~ himself, herself, or itself as providing continuing care or 'life care.'

(7) 'Resident' means a purchaser of, a nominee of, or a subscriber to, a continuing care contract.

(8) 'Hazardous financial condition' means a provider is insolvent or in eminent danger of becoming insolvent."

Section 20. G.S. 58-64-40(b) reads as rewritten:

"(b) The board of directors or other governing body of a ~~continuing care~~ facility or its designated representative shall hold annual meetings with the residents of the ~~continuing care~~ facility for free discussions of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility and discussions of proposed changes in policies, programs, and services. Residents shall be entitled to at least seven days advance notice of each meeting. An agenda and any materials that will be distributed by the governing body at the meetings shall remain available upon request to residents."

Section 21. G.S. 58-64-80 reads as rewritten:

"**§ 58-64-80. Advisory Committee.**

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

Section 21.1. Article 64 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-64-46. Receiverships; exception for facility beds.**

When the Commissioner has been appointed as a receiver under Article 30 of this Chapter for a provider or facility subject to this Article, and if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that the best interests of the facility or the welfare of persons who have previously contracted with the provider or may contract with the facility may be best served by the addition of adult care home beds, the Department of Human Resources may, notwithstanding any other provision of law, accept and approve the addition of beds for that facility."

PART IV. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 22. G.S. 58-36-1(2) reads as rewritten:

"(2) The Bureau shall provide reasonable means to be approved by the Commissioner whereby any person affected by a rate or loss

costs made by it may be heard in person or by ~~his~~ the person's authorized representative before the governing committee or other proper executive of the Bureau."

Section 23. G.S. 58-36-1(5)c. reads as rewritten:

"c. Failure or refusal by any assigned employer risk to make full disclosure to the Bureau, servicing carrier, or insurer writing a policy of information regarding the employer's true ownership, change of ownership, operations, or payroll, or any other failure to disclose fully any records pertaining to workers' compensation insurance shall be sufficient grounds for ~~the Bureau to authorize~~ the termination of the policy of that employer."

Section 24. G.S. 58-36-10 reads as rewritten:

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

The following standards ~~shall~~ apply to the making and use of ~~rates.~~ rates or loss costs:

(1) Rates or loss costs shall not be excessive, inadequate or unfairly discriminatory.

(2) Due consideration shall be given to actual loss and expense experience within this State for the most recent three-year period for which ~~such~~ that information is available; to prospective loss and expense experience within this State; to the hazards of conflagration and catastrophe; to a reasonable margin for underwriting profit and to contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to investment income earned or realized by insurers from their unearned premium, loss, and loss expense reserve funds generated from business within this State; to past and prospective expenses specially applicable to this State; and to all other relevant factors within this State: Provided, however, that countrywide expense and loss experience and other countrywide data may be considered only where credible North Carolina experience or data is not available.

(3) In the case of fire insurance rates, as are subject to the ratemaking authority of the Bureau, consideration may be given to the experience of such fire insurance business during the most recent five-year period for which ~~such~~ that experience is available. In the case of fire insurance rates that are subject to the ratemaking authority of the Bureau, consideration shall be given to the insurance public protection classifications of rural fire districts based upon standards established by the Commissioner. To the extent credits are provided for proximity to fire hydrants, the Bureau may also provide appropriate credits in public protection

classifications for optional water sources, such as ponds, lakes, or other bodies of water, in accordance with standards and procedures filed with and approved by the Commissioner.

(4) Risks may be grouped by classifications and lines of insurance for establishment of ~~rates~~ rates, loss costs, and base premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans ~~which~~ that establish standards for measuring variations in hazards or expense provisions or both. ~~Such~~ Those standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. The Bureau ~~is directed to~~ shall establish and implement a comprehensive classification rating plan for motor vehicle insurance under its jurisdiction within 90 days of September 1, 1977. No such classification plans shall base any standard or rating plan for private passenger (nonfleet) motor vehicles, in whole or in part, directly or indirectly, upon the age or sex of the persons insured. The Bureau shall at least once every three years make a complete review of the filed classification rates to determine whether they are proper and supported by statistical evidence, and shall at least once every 10 years make a complete review of the territories for nonfleet private passenger motor vehicle insurance to determine whether they are proper and reasonable.

(5) In the case of workers' compensation insurance and employers' liability insurance written in connection therewith, due consideration shall be given to the past and prospective effects of changes in compensation benefits and in legal and medical fees that are provided for in General Statutes Chapter 97."

Section 25. G.S. 58-36-15(a) reads as rewritten:

"(a) The Bureau shall file with the Commissioner copies of the rates, loss costs, classification plans, rating plans and rating systems used by its members. Each rate or loss costs filing shall become effective on the date specified in the filing, but not earlier than 105 days ~~from~~ after the date the filing is received by the Commissioner: Provided that (1) rate or loss costs filings for workers' compensation insurance and employers' liability insurance written in connection therewith shall not become effective earlier than 120 days from the date the filing is received by the Commissioner or on the date ~~as~~ provided ~~under~~ in G.S. 58-36-100, whichever is earlier; and (2) any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the Bureau."

Section 26. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar year the Bureau shall submit to the Commissioner the experience, data, statistics, and information referred to in subsection (c) of this section and required under G.S. 58-36-100 and a residual market rate ~~or~~ and prospective loss costs review based on ~~such~~ those data for

workers' compensation insurance and employers' liability insurance written in connection therewith. Any rate or loss costs increase for ~~such~~ that insurance that is implemented ~~pursuant to~~ under this Article shall become effective solely to ~~such insurance as is written having~~ insurance with an inception date on or after the effective date of the rate or loss costs increase."

Section 27. G.S. 58-36-15(g) reads as rewritten:

"(g) The following information must be included in policy form, rule, and rate or loss costs filings under this Article and under Article 37 of this Chapter:

(1) A detailed list of the rates, loss costs, rules, and policy forms filed, accompanied by a list of those superseded; and

(2) A detailed description, properly referenced, of all changes in policy forms, rules, prospective loss costs, and rates, including the effect of each change."

Section 28. G.S. 58-36-30(a) reads as rewritten:

"(a) ~~No insurer, officer, agent or representative thereof~~ Except as permitted by G.S. 58-36-100 for workers' compensation loss costs filings, no insurer and no officer, agent, or representative of an insurer shall knowingly issue or deliver or knowingly permit the issuance or delivery of any policy of insurance in this State ~~which~~ that does not conform to the rates, rating plans, classifications, schedules, rules and standards made and filed by the Bureau. ~~However, an~~ An insurer may deviate from the rates ~~promulgated~~ adopted by the Bureau ~~provided~~ if the insurer has filed the proposed deviation ~~to be applied both~~ with the Bureau and the Commissioner, ~~and provided the deviation is uniform in its application to all risks in the State of the class to which the deviation is to apply; and provided such deviation is approved by the Commissioner.~~ if the proposed deviation is based on sound actuarial principles, and if the proposed deviation is approved by the Commissioner. ~~The Commissioner shall approve proposed deviations if they do not render the rates excessive, inadequate or unfairly discriminatory. If approved, the deviation may thereafter be amended, subject to the provisions of this subsection.~~ Amendments to deviations are subject to the same requirements as initial filings. ~~The deviation may be terminated~~ An insurer may terminate a deviation only if the deviation has been in effect for a period of six months before the effective date of the termination and the insurer notifies the Commissioner of the termination no later than 15 days before the effective date of the termination."

Section 29. G.S. 58-36-30(c) reads as rewritten:

"(c) ~~Any deviation with respect to workers' compensation and employers' liability insurance written in connection therewith as filed under subsection (a) of this section shall apply uniformly to all classifications.~~ Any approved rate under subsection (b) of this section with respect to workers' compensation and employers' liability insurance written in connection therewith shall be furnished to the Bureau."

Section 30. Effective September 1, 1997, G.S. 58-36-100(a) reads as rewritten:

"(a) ~~Nothing in this section requires the Bureau or its member insurers to refile rates previously implemented before two years after the effective date of this section.~~

~~Any member insurer of the Bureau may continue to use all rates and deviations filed and approved for its use until disapproved, or the insurer makes its own filing to change its rates, either by making an independent filing or by filing a reference filing adoption form adopting the Bureau's prospective loss costs, or modification thereof.~~ Except as provided in ~~subsection~~ subsections (k) and (m) of this section, ~~with the initial prospective loss costs reference filing,~~ the Bureau shall no longer develop or file any minimum premiums, minimum premium formulas, or expense constants. If an insurer wishes to amend minimum premium ~~formulas,~~ formulas or expense constants, it must file the minimum premium rules, formulas, or amounts it proposes to use. A copy of each filing submitted to the Commissioner under subsections (e) and (g) of this section shall also be sent to the Bureau."

Section 31. Effective September 1, 1997, G.S. 58-36-100(b)(1) reads as rewritten:

"(1) 'Expenses'. -- That portion of a rate attributable to acquisition, field supervision, collection expenses, any tax levied by the State or by any political subdivision of the State, licensing costs, fees, and general expenses, as determined by the insurer."

Section 32. Effective September 1, 1997, G.S. 58-36-100(c) reads as rewritten:

"(c) Except as provided in subsection (m) of this section, for workers' compensation and employers' liability insurance written in connection with workers' compensation insurance, the Bureau shall no longer develop or file advisory final rates that contain provisions for expenses (other than loss adjustment expenses) and profit. The Bureau shall instead develop and file for approval with the Commissioner, in accordance with this section, reference filings containing advisory prospective loss costs and the underlying loss data and other supporting statistical and actuarial information for any calculations or assumptions underlying these loss costs. Loss-based ~~assessments, any tax levied by the State or any political subdivision of the State, licensing costs, and fees~~ assessments will be included in prospective loss costs."

Section 32.1. Effective September 1, 1997, G.S. 58-36-100(k) reads as rewritten:

"(k) The Bureau shall file with the Commissioner, for approval, filings containing a revision of rules and supplementary rating information. This includes policy-writing rules, rating plans, classification codes and descriptions, and rules that include factors or relativities, such as ~~employers' liability~~ increased limits ~~factors,~~ factors and related minimum premiums, classification relativities, or similar ~~factors, but excludes minimum premiums.~~ factors. The Bureau may print and distribute manuals of rules and supplementary rating ~~information, excluding minimum premiums.~~ information."

PART V. INSURANCE COMPANY FINANCIAL OPERATIONS.

Section 33. G.S. 58-5-63(a) reads as rewritten:

"(a) All insurance companies making deposits under this Article are entitled to interest on those ~~deposits, which shall remain in the deposit accounts.~~ deposits. The right to interest is subject to a company paying its insurance policy liabilities. If any company fails to pay those liabilities, interest accruing after the failure is payable to

the Commissioner for the payment of those liabilities under subsection (b) of this section."

Section 34. G.S. 58-7-21(a) reads as rewritten:

"(a) As used in this section and in G.S. ~~58-7-26, 58-7-30, and 58-7-31:~~ 58-7-26 and G.S. 58-7-30:

(1) 'Reinsurance' means a transfer of insurance risk from a ceding insurer to an assuming insurer.

(2) 'Insurance risk' means an uncertainty regarding the ultimate amount of any claim payment (underwriting risk) or an uncertainty regarding the timing of the payments (timing risk), or both."

Section 35. G.S. 58-7-31(b)(3) reads as rewritten:

"(3) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement; except that neither offsetting experience refunds against current and prior years' losses under the reinsurance agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the reinsurance agreement upon voluntary termination of in-force reinsurance by the ceding insurer are a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions that allow the reinsurer to reduce its risk or increase its risk charge under the reinsurance agreement."

Section 36. G.S. 58-7-31(d)(1) reads as rewritten:

"(1) Reinsurance agreements entered into after October 1, 1993, that involve the reinsurance of business issued ~~prior to~~ before the effective date of the reinsurance agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days after its date of execution. Each filing shall include data detailing the ~~final impact~~ financial effect of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this ~~statute~~ section and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Commissioner. The actuary ~~should~~ shall maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that ~~such~~ that work conforms to this ~~statute.~~ section."

Section 37. G.S. 58-7-173(12) reads as rewritten:

"(12) Secured obligations of duly constituted churches and of church-holding companies; and the cost of investments made under this subdivision shall not exceed the lesser of one percent (1%) of the

insurer's admitted assets ~~of~~ or five percent (5%) of the insurer's capital and surplus."

Section 38. The catchline of G.S. 58-7-177 reads as rewritten:

"**§ 58-7-177. Investments in ~~subsidiaries and affiliated corporations.~~ subsidiaries.**"

Section 39. G.S. 58-8-5(a)(3) reads as rewritten:

"(3) ~~Said officers shall cause said certificate to be published once a week for two consecutive weeks in a newspaper in Raleigh and in the county where the company's principal office is located, or posted at the courthouse door if no newspaper be published within the county. Said printed or posted notices shall be in such form and of such size as the Commissioner may approve, and in addition to setting forth in full the certificate required in subdivision (2) shall state that application for amending the company's charter in the manner specified has been proposed by the board of directors, and shall also state the time set for a meeting of policyholders thereby called to be held at the principal office of the company to take action on the proposed amendment. A true copy of such notice shall be filed with the Commissioner, and also with that official who performs the functions of Commissioner in each state where the company is licensed to do business. Such publication and filing of notices shall be completed at least 30 days prior to the date set therein for the meeting of policyholders and due proof thereof shall be filed with the Commissioner at least 15 days prior to the date of such meeting.~~ If the meeting at which the proposed amendment is to be considered is a special meeting, rather than a regular annual meeting of policyholders, ~~such special~~ that meeting can be called only after the Commissioner has given ~~his~~ approval in ~~writing, and the published notice shall show the fact of such approval;~~ writing;"

Section 40. G.S. 58-8-25 reads as rewritten:

"**§ 58-8-25. Dividends to policyholders.**

(a) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes other than life insurance or workers' compensation insurance and employers' liability insurance in connection therewith, may declare and pay a dividend to policyholders from its ~~surplus,~~ unassigned surplus as reflected in the company's most recent annual or quarterly statement filed with the Commissioner, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period, upon the basis of each general kind of insurance covered by ~~such~~ those policies and by territorial divisions of the location of risks by states, except that in fixing the amount of dividends to be paid on each general kind of insurance, ~~which~~

the dividends shall be uniform in rate and applicable to the majority of risks within ~~such~~ that general kind of insurance, and exceptions may be made as to any class or classes of risk and a different rate or amount of dividends paid on ~~such~~ the class or classes if the conditions applicable to ~~such~~ the class or classes differ substantially from the condition applicable to the kind of insurance as a whole. Every such company shall have an equal rate of dividend for the same term on all policies insuring risks in the same classification. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks.

(b) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes workers' compensation insurance and employers' liability insurance in connection therewith may declare and pay a dividend to policyholders from its ~~surplus,~~ unassigned surplus as reflected in the company's most recent statement filed with the Commissioner under G.S. 58-2-165, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau, or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks."

Section 41. G.S. 58-9-6(a) reads as rewritten:

"(a) The Commissioner shall issue an intermediary license or an exemption from the license, subject to G.S. 58-9-2(b)(2) or G.S. 58-9-2(c)(3), to any person who has complied with the requirements of this Article. A license issued to a noncorporate entity authorizes all of the members of the entity and any designated employees to act as intermediaries under the license, and those persons shall be named in the application and any supplements. A license issued to a corporation authorizes all of the officers and any designated employees and directors of the corporation to act as

intermediaries on behalf of the corporation, and those persons shall be named in the application and any supplements."

Section 42. G.S. 58-9-11(b) reads as rewritten:

"(b) An insurer shall not engage the services of any person to act as a broker on its behalf unless the person is licensed ~~under G.S. 58-9-6.~~ or exempted under this Article. An insurer shall not employ an individual who is employed by a broker with which it transacts business, unless the broker is under common control with the insurer under Article 19 of this Chapter."

Section 43. G.S. 58-9-21(a) reads as rewritten:

"(a) A reinsurer shall not engage the services of any person to act as a manager on its behalf unless the person is licensed ~~under G.S. 58-9-6.~~ or exempted under this Article."

Section 44. G.S. 58-12-2(3) reads as rewritten:

"(3) Domestic insurer. -- Any insurance company organized in this State under ~~Article 7~~ Article 7 or Article 15 of this Chapter."

Section 45. G.S. 58-13-10 reads as rewritten:

"**§ 58-13-10. Scope.**

(a) This Article applies to all domestic insurers and to all kinds of insurance written by those insurers ~~under Articles 1 through 66~~ of this Chapter. Foreign insurers ~~are to~~ shall comply in substance with the requirements and limitations of this section. ~~This Article does not apply to variable contracts for which separate accounts are required to be maintained nor to statutory deposits that are required to be maintained by insurance regulatory agencies as a requirement for doing business in such jurisdictions.~~

(b) This Article does not apply to:

(1) Variable contracts for which separate accounts are required to be maintained.

(2) Statutory deposits that are required to be maintained by insurance regulatory agencies as a requirement for doing business.

(3) Real estate authorized under G.S. 58-7-187 and encumbered by a mortgage loan with a first lien."

Section 46. G.S. 58-13-15 reads as rewritten:

"**§ 58-13-15. Definitions.**

As used in this Article:

(1) 'Assets' means all property, real or personal, tangible or intangible, legal or equitable, owned by an insurer.

(2) 'Claimants' means any owners, beneficiaries, assignees, certificate holders, or third-party beneficiaries of any insurance benefit or right arising out of and within the coverage of an insurance policy covered by this Article.

(3) 'Reserve assets' means those assets of an insurer that are authorized investments for policy reserves in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~ this Chapter.

(4) 'Policyholder-related liabilities' means those liabilities that are required to be established by an insurer for all of its outstanding insurance policies in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~ this Chapter."

Section 47. G.S. 58-13-20(b) reads as rewritten:

"(b) The Commissioner ~~has the right to~~ may examine any of ~~such~~ these assets, reinsurance agreements, or deposit arrangements at any time in accordance with ~~his~~ the Commissioner's authority to make examinations of insurers as conferred by other provisions ~~of Articles 1 through 64~~ of this Chapter."

Section 48. G.S. 58-19-5(5) reads as rewritten:

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

Section 49. G.S. 58-19-10(b)(1) reads as rewritten:

"(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts that do not exceed the lesser of ten percent (10%) of ~~such~~ the insurer's admitted assets or fifty percent (50%) of ~~such~~ the insurer's surplus as regards policyholders, provided that after ~~such~~ those investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of ~~such~~ the investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included: (i) total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of ~~such~~ the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and (ii) all amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;".

PART VI. HANDICAPPED PERSONS.

Section 50. G.S. 168-10 reads as rewritten:

"§ 168-10. Eliminate discrimination in treatment of handicapped and disabled.

Each handicapped person shall have the same consideration as any other person for individual accident and health insurance coverage, and no insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes solely on the basis of ~~such~~ the person's handicap, shall deny ~~such~~ coverage or benefits. The availability of ~~such~~ ~~insurance~~ coverage or benefits shall not be denied solely ~~due to~~ because of the

~~handicap, provided, however, that no such insurer shall be prohibited from excluding by waiver or otherwise, any pre-existing conditions from such coverage, and further provided that~~ handicap; however, any such insurer may charge the appropriate premiums or fees for the risk insured on the same basis and conditions as insurance issued to other ~~persons.~~ persons, in accordance with actuarial and underwriting principles prescribed in Chapter 58 of the General Statutes. ~~Nothing contained herein or in any other statute shall restrict or preclude any insurer governed by Chapter 58 of the General Statutes from setting and charging a premium or fee based upon the class or classes of risks and on sound actuarial and underwriting principles as determined by such insurer, or from applying its regular underwriting standards applicable to all classes of risks. The provisions of this section shall apply to both corporations governed by Chapter 58 of the General Statutes.~~"

Section 51. G.S. 168-22(b) reads as rewritten:

"(b) A family care home ~~shall be~~ is deemed a residential use of property for the purposes of determining charges or assessments imposed by political subdivisions or businesses for water, sewer, power, telephone service, cable television, garbage and trash collection, repairs or improvements to roads, streets, and sidewalks, and other services, utilities, and ~~improvements, and for purposes of classification for insurance.~~ improvements."

PART VII. AUTOMOBILE INSURANCE.

Section 52. G.S. 58-36-75(c) is repealed.

Section 53. G.S. 58-36-5(c) reads as rewritten:

"(c) The ~~Bureau, when created,~~ Bureau shall adopt ~~such~~ rules ~~and regulations~~ for its orderly procedure ~~as shall be~~ that are necessary for its maintenance and operation. No ~~such~~ rules ~~and regulations~~ shall discriminate against any type of insurer because of its plan of operation, nor shall any insurer be prevented from returning any unused or unabsorbed premium, deposit, savings or earnings to its policyholders or subscribers. ~~The expense of such Bureau shall be borne by its members by quarterly contributions to be made in advance, such contributions to be made in advance by prorating such expense among the members in accordance with the amount of gross premiums derived from the above lines of insurance in North Carolina during the preceding year and members entering the Bureau since that date to advance an amount to be fixed by the governing committee. After the first fiscal year of operation of the Bureau the~~ The necessary expense of the Bureau shall be advanced by the members in accordance with rules ~~and regulations to be~~ established and adopted by the governing committee. The Bureau ~~shall be empowered to~~ may subscribe for or purchase any necessary service, ~~and~~ employ and fix the salaries of such personnel and assistants as are ~~necessary.~~ necessary, charge reasonable fees for its products and services, and engage in any lawful activities related to the objects, functions, duties, responsibilities, or authority of the Bureau."

Section 53.1. G.S. 58-37-1(7) reads as rewritten:

"(7) 'Motor vehicle insurance' means direct insurance against liability arising out of the ownership, operation, maintenance or use of a motor vehicle for bodily injury including death and property

damage and includes medical payments and uninsured and underinsured motorist coverages.

With respect to motor carriers who are subject to the financial responsibility requirements established under the Motor Carrier Act of 1980, the term, 'motor vehicle insurance' includes coverage with respect to environmental restoration. As used in this subsection the term, 'environmental restoration' means restitution for the loss, damage, or destruction of natural resources arising out of the accidental discharge, dispersal, release, or escape into or upon the land, atmosphere, water course, or body of water of any commodity transported by a motor carrier. Environmental restoration includes the cost of removal and the cost of necessary measures taken to minimize or mitigate damage to human health, the natural environment, fish, shellfish, and wildlife."

Section 53.2. G.S. 58-37-35(b)(2) reads as rewritten:

"(2) Additional ceding privileges for motor vehicle insurance shall be provided by the Board of Governors if there is a substantial public demand for a coverage or coverage limit of any component of motor vehicle insurance up to the following:

Bodily injury liability: one hundred thousand dollars ($100,000) each person, three hundred thousand dollars ($300,000) each accident;

Property damage liability: fifty thousand dollars ($50,000) each accident;

Medical payments: two thousand dollars ($2,000) each person;

Underinsured motorist: one ~~hundred thousand~~ million dollars ~~($100,000)~~ ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;

Uninsured motorist: one ~~hundred thousand~~ million dollars ~~($100,000)~~ ($1,000,000) each person and each accident for bodily injury and ~~fifteen~~ fifty thousand dollars ~~($15,000)~~ ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

Section 53.3. G.S. 58-37-35(e) reads as rewritten:

"(e) The Commissioner and member companies shall provide for a Board of ~~Governors within 30 days after May 24, 1973. If any member seat on the initial Board of Governors is not filled in accordance with this Article within such time, then, in that event the Commissioner shall appoint natural persons from any of the classifications specified in subsection (d) of this section to serve the initial term on the Board of Governors. As soon as possible after its selection, the Commissioner shall call for the initial meeting of the Board.~~ Governors. ~~After the~~ The Board of Governors ~~have been selected it~~ shall ~~then~~ elect from its membership a chairman and shall ~~then~~ meet ~~thereafter as often as~~ at the call of the chairman ~~shall require~~ or at the request of ~~three~~ four members of the Board of Governors. The chairman shall retain the right to vote on all issues. ~~Five~~ Seven members of the Board of Governors

shall constitute a quorum. The same member may not serve as chairman for more than two consecutive ~~years.~~ years; provided, however, that a member may continue to serve as chairman until a successor chairman is elected and qualified."

Section 53.4. G.S. 58-37-40(e) reads as rewritten:

"(e) Upon approval of the Commissioner of the plan so submitted or promulgation of a plan deemed approved by the Commissioner, all insurance companies licensed to write motor vehicle insurance in this State or any component thereof as a prerequisite to further engaging in writing the insurance shall formally subscribe to and participate in the plan so approved.

The plan of operation shall provide for, among other matters, (i) the establishment of necessary facilities; (ii) the management of the Facility; (iii) the preliminary assessment of all members for initial expenses necessary to commence operations; (iv) the assessment of members if necessary to defray losses and expenses; (v) the distribution of gains to defray losses incurred since September 1, 1977; (vi) the distribution of gains by credit or reduction of recoupment ~~or allocation~~ surcharges to policies subject to recoupment ~~or allocation~~ surcharges pursuant to this Article (the Facility may apportion the distribution of gains among the coverages eligible for cession pursuant to this Article); (vii) the recoupment ~~or allocation~~ of losses sustained by the Facility since September 1, 1977, pursuant to this Article, which losses may be recouped by equitable pro rata assessment of member ~~companies;~~ companies or by way of a surcharge on motor vehicle policies issued by member companies or through the Facility; (viii) the standard amount (one hundred percent (100%) or any equitable lesser amount) of coverage afforded on eligible risks which a member company may cede to the Facility; and (ix) the procedure by which reinsurance shall be accepted by the Facility. The plan shall further provide that:

(1) Members of the Board of Governors shall receive reimbursement from the Facility for their actual and necessary expenses incurred on Facility business, en route to perform Facility business, and while returning from Facility business plus a per diem allowance of twenty-five dollars ($25.00) a day which may be waived.

(2) In order to obtain a transfer of business to the Facility effective when the binder or policy or renewal thereof first becomes effective, the company must within 30 days of the binding or policy effective date notify the Facility of the identification of the insured, the coverage and limits afforded, classification data, and premium. The Facility shall accept risks at other times on receipt of necessary information, but acceptance shall not be retroactive. The Facility shall accept renewal business after the member on underwriting review elects to again cede the business."

Section 54. G.S. 58-37-40(f) reads as rewritten:

"(f) The plan of operation shall provide that every member shall, following payment of any pro rata assessment, ~~commence~~ begin recoupment of that assessment by way of a surcharge on motor vehicle insurance policies issued by the member or through the Facility until the assessment has been recouped. ~~Such~~ Any surcharge

under this subsection or under subsection (e) of this section shall be a percentage of premium adopted by the Board of Governors of the Facility; and the charges determined on the basis of the surcharge shall be combined with and displayed as a part of the applicable premium charges. ~~Provided, however, that recoupment~~ Recoupment of losses sustained by the Facility ~~since September 1, 1977,~~ with respect to nonfleet private passenger motor vehicles may be ~~recouped~~ made only by surcharging nonfleet private passenger motor vehicle insurance policies. ~~policies (i) that are subject to the classification plan promulgated pursuant to G.S. 58-36-65 and (ii) to which one or more driving record points have been assigned pursuant to said plan, subject to the provisions of G.S. 58-36-75.~~ If the amount collected during the period of surcharge exceeds assessments paid by the member to the Facility, the member shall pay over the excess to the Facility on a date specified by the Board of Governors. If the amount collected during the period of surcharge is less than the assessments paid by the member to the Facility, the Facility shall pay the difference to the member. Except as ~~hereinafter provided,~~ otherwise provided in this Article, the amount of recoupment shall not be considered or treated as a rate or premium for any purpose. The Board of Governors shall adopt and implement a plan for compensation of agents of Facility members when recoupment surcharges are imposed; ~~such~~ that compensation shall not exceed the compensation or commission rate normally paid to the agent for the issuance or renewal of the automobile liability policy issued through the North Carolina Reinsurance Facility affected by ~~such surcharge; provided, however, that~~ the surcharge. However, the surcharge ~~provided for in this section~~ shall include an amount necessary to recover the amount of the assessment to member companies and the compensation paid by each member, ~~pursuant to~~ under this section, to agents."

Section 55. G.S. 58-37-35(g)(8) reads as rewritten:

"(8) To establish fair and reasonable procedures for the sharing among members of any loss on Facility business ~~which~~ that cannot be recouped ~~pursuant to~~ under G.S. 58-37-40~~(f)~~ (e) ~~or which cannot be recouped or allocated under G.S. 58-37-75,~~ and other costs, charges, expenses, liabilities, income, property and other assets of the Facility and for assessing or distributing to members their appropriate shares. ~~Such~~ The shares may be based on the member's premiums for voluntary business for the appropriate category of motor vehicle insurance or by any other fair and reasonable method."

Section 56. G.S. 58-37-35(l) reads as rewritten:

"(l) The classifications, rules, rates, rating plans and policy forms used on motor vehicle insurance policies reinsured by the Facility may be made by the Facility or by any licensed or statutory rating organization or bureau on its behalf and shall be filed with the Commissioner. The Board of Governors shall establish a separate subclassification within the Facility for 'clean ~~risks' as herein defined.~~ risks'. For the purpose of this Article, a 'clean risk' ~~shall be~~ is any owner of a nonfleet private passenger motor vehicle as defined in G.S. 58-40-10, if the owner, principal

operator, and each licensed operator in the owner's household have two years' driving experience as licensed drivers and if none of the persons has been assigned any Safe Driver Incentive Plan points under Article 36 of this Chapter during the three-year period immediately preceding either (i) the date of application for a motor vehicle insurance policy or (ii) the date of preparation of a renewal of a motor vehicle insurance policy. ~~Such~~ The filings may incorporate by reference any other material on file with the Commissioner. Rates shall be neither excessive, inadequate nor unfairly discriminatory. If the Commissioner finds, after a hearing, that a rate is either excessive, inadequate or unfairly discriminatory, ~~he~~ the Commissioner shall issue an order specifying in what respect it is deficient and stating when, within a reasonable period thereafter, ~~such rate shall be deemed~~ the rate is no longer effective. ~~Said~~ The order is subject to judicial review as set out in Article 2 of this Chapter. Pending judicial review of ~~said~~ the order, the filed classification plan and the filed rates may be used, charged and collected in the same manner as set out in G.S. 58-40-45 of this Chapter. ~~Said~~ The order shall not affect any contract or policy made or issued ~~prior to~~ before the expiration of the period set forth in the order. All rates shall be on an actuarially sound basis and shall be calculated, insofar as is possible, to produce neither a profit nor a loss. However, the rates made by or on behalf of the Facility with respect to 'clean ~~risks', as defined above,~~ risks' shall not exceed the rates charged 'clean risks' who are not reinsured in the Facility. The difference between the actual rate charged and the actuarially sound and self-supporting rates for 'clean risks' reinsured in the Facility may be recouped in similar manner as assessments ~~pursuant to G.S. 58-37-40(f) or allocated pursuant to G.S. 58-37-75.~~ under G.S. 58-37-40(f). Rates shall not include any factor for underwriting profit on Facility business, but shall provide an allowance for contingencies. There shall be a strong presumption that the rates and premiums for the business of the Facility are neither unreasonable nor excessive."

Section 57. G.S. 58-37-75 is repealed.

PART VIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 58. G.S. 58-50-60 reads as rewritten:

"**§ 58-50-60. Rules for precertification practices.**

(a) This section applies to all accident and health insurers under Articles 1 through 64 of this Chapter, all third-party administrators and preferred provider arrangements, all entities subject to Articles 65 through 67 of this Chapter, and all self-funded ~~health benefit~~ workers' compensation insurance plans.

(b) The Commissioner shall adopt reasonable rules governing ~~precertification practices and forms~~ utilization review and utilization review organizations ~~affiliated~~ that do business with the entities subject to this section."

Section 59. G.S. 58-50-65(a) reads as rewritten:

"(a) ~~Nothing~~ Except as provided in this subsection, nothing in Articles 50 through 55 of this Chapter ~~shall apply~~ applies to ~~or affect~~ any ~~policy of~~ liability or workers' compensation ~~insurance, except that~~ insurance policy. Except for G.S. 58-50-55(a), the provisions of ~~G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall~~ this Article and Articles 65 and 67 of this Chapter and any administrative rules adopted

under those Articles relating to preferred providers and utilization review apply to ~~policies of~~ workers' compensation ~~insurance.~~ insurance policies and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care rules adopted by the Commissioner under this Chapter and managed care rules adopted by the Industrial Commission under G.S. 97-25.2, the Industrial Commission's rules govern. If there is any conflict between managed care provisions in this Chapter and in Chapter 97 of the General Statutes with respect to workers' compensation, the provisions in Chapter 97 govern."

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 60. The phrase "certificate of authority" is deleted and replaced by the word "license" wherever it occurs in each of the following sections of the General Statutes:

G.S. 58-4-15.	Revocation of certificate of authority.
G.S. 58-7-55.	Exceptions to requirements of G.S. 58-7-50.
G.S. 58-7-70.	Effects of redomestication.
G.S. 58-15-5.	Definitions.
G.S. 58-16-35.	Unauthorized Insurers Process Act.
G.S. 58-24-45.	Organization.
G.S. 58-24-145.	Injunction -- Liquidation -- Receivership of domestic society.
G.S. 58-28-5.	Transacting business without certificate of authority prohibited; exceptions.
G.S. 58-28-15.	Validity of acts or contracts of unauthorized company shall not impair obligation of contract as to the company; maintenance of suits; right to defend.
G.S. 58-28-45.	Uniform Unauthorized Insurers Act.
G.S. 58-30-10.	Definitions.
G.S. 58-30-55.	Condition on release from delinquency proceedings.
G.S. 58-30-260.	Conservation of property of foreign or alien insurers found in this State.
G.S. 58-33-132.	Qualifications of instructors.
G.S. 58-41-55.	Penalties; restitution.
G.S. 58-48-35.	Powers and duties of the Association.
G.S. 58-48-45.	Duties and powers of the Commissioner.
G.S. 58-57-80.	Penalties.

PART X. RISK SHARING PLAN SUNSET EXTENSION.

Section 61. G.S. 58-42-55 reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article ~~shall expire~~ expires on July 1, ~~1997.~~ 1999."

PART XI. HEALTH INSURANCE CLARIFYING CHANGES.

Section 62. G.S. 58-50-130(a), as amended by S.L. 1997-259, is amended by adding the following new subdivision:

"(4b) Late enrollees may only be excluded from coverage for the greater of 18 months or an 18-month preexisting-condition exclusion; however, if both a period of exclusion from coverage and a

preexisting-condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of such period in the health benefit plan currently held by the small employer."

Section 63.1. G.S. 58-51-55(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to group health insurance ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

Section 63.2. G.S. 58-65-90(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to subscriber ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 63.3. G.S. 58-67-75(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to group ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 63.4. G.S. 58-51-15(h), as enacted by S.L. 1997-259, reads as rewritten:

"(h) Preexisting Condition Exclusion Clarification. -- Sub-subdivision (a)(2)b. of this section does not apply to:

(1) Policies issued to eligible individuals under G.S. 58-68-60.

(2) Excepted benefits as described in ~~G.S. 58-68-25(b).~~ G.S. 58-68-25(b)(1)."

Section 63.5. G.S. 58-68-40(e), as enacted by S.L. 1997-259, reads as rewritten:

"(e) Exception for ~~Coverage Offered Only to Bona Fide Association Members.~~ Coverage. -- Subsection (a) of this section does not apply to:

(1) Health insurance coverage offered by a health insurer if the coverage is made available in the small group market only through one or more bona fide associations.

(2) A self-employed individual as defined in ~~G.S. 58-50-110(21a).~~ G.S. 58-50-110(21a), except as otherwise provided for the basic and standard health care plans under the North Carolina Small Employer Group Health Coverage Reform Act."

Section 63.6. G.S. 58-68-60(b)(2), as enacted by S.L. 1997-259, reads as rewritten:

"(2) Who is not eligible for coverage under (i) ~~an ERISA~~ a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of the Act (or any successor program), and does not have other health insurance coverage;".

Section 63.7. G.S. 58-50-65(d) reads as rewritten:

"(d) The provisions of G.S. ~~58-51-5(5)~~ 58-51-5(a)(5) and G.S. 58-51-15(a)(1), (4), and (10) may be omitted from railroad ticket policies sold only at railroad stations or at railroad ticket offices by railroad employees."

PART XII. COMMERCIAL INSURANCE FORM DOCUMENT RETENTION.

Section 64. G.S. 58-41-50(g) reads as rewritten:

"(g) An insurer subject to this Article may develop and use an individual form or rate as a result of the uniqueness of a particular risk. The form or rate shall be developed, filed, and used in accordance with rules adopted by the Commissioner. Rules adopted by the Commissioner under this section may provide for retention of certain documents and data by insurers instead of insurers filing those records with the Commissioner."

PART XIII. BAIL BONDS.

Section 65. G.S. 58-71-82 reads as rewritten:

"**§ 58-71-82. Dual license holding.**

If an individual holds a professional bondsman's license or a runner's license and a surety bondsman's license simultaneously, they are considered one license for the purpose of disciplinary actions involving suspension, revocation, or ~~renewal~~ nonrenewal under this Article. Separate renewal fees must be paid for each license, however."

PART XIV. EFFECT OF HEADINGS.

Section 66. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART XV. EFFECTIVE DATE.

Section 67. Sections 30 through 32.1 of this act become effective September 1, 1997. Section 61 of this act becomes effective June 30, 1997. Sections 62, 63.4, 63.5, and 63.6 of this act become effective July 1, 1997. Sections 63.1, 63.2, and 63.3 become effective January 1, 1998. The remainder of this act is effective when it becomes law.

Attachment I

VISITOR REGISTRATION SHEET

House Insurance Committee — July 16, 1997

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
SAM JOHNSON	ATTY
JOHN BUCHAN	INS AGENT
HAROLD Webb	Lobbyist
DAVE HORNE	SAGAFS
Amy Jo BANN	"
John Bowdich	Zeb Alley P.A.
	Smith Hall & Strayer P.A.
	NCAHC
	Integon Corp
	Bailey & Dixon LLP
Susan Valauri	Nationwide
Robert PASchall	Young, Moore
	NCAIS
Cleta Courtney	Clerk - Rep. Luebke
Brenda Summers	NC Equity

VISITOR REGISTRATION SHEET

House Insurance Committee — July 16, 1997

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Robert Doolittle MD (GSO)	here as doctor of the day.
Tommy Holt	Carolina Health Care Systems
Debbie Brantley	DHR
Mac Borden	N.C. Pediatric Medical Society
David G. McVicar	N.C. State Health Plan.
Harold Wright	State Health Plan
Stavia H. McKinney	NC DOI
Bill Hale	NC DOI
Jovita Mask	Carolina Association of Professional Insurance Agents
TROY JACKSON	N.C. Assoc. of Life Underwriters
Ernest Hayes	CAPIA
Richard E. Chase	NCALU
Robert Bird	IIABNC
Lane Wharton	Blue Cross & Shield

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Tina M Meehan	UHC of N.C.
Peyton Maynard	GP
Maria Simi	NCSOPS
Troy L Green	SEANC
Danece Arnold	SEANC
Pat Brafford	SEANC
Jerry Hoodosty	AARP
Stacy Flannery	SEANC
Lynn Wilson	SEANC
Steve Wenn	NCMS
Leigh (Orr) H Hammond	NC Retired Gov't Emp. Assn
J. Colin Cd	+ ADDICTION PROF NC
Karen Adams	Gov's office
Ben Arnold	NCPA
Robert Brown	Jordan Price Wall

VISITOR REGISTRATION SHEET

House Insurance Committee — Name of Committee

July 16, 1997 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Stan Williams	NC HHS Assn.
Susan Pullen	Attorney
Velotton Poe	ZDA, PA
Tony Rapp	
Jon Kaeyer	Moore & Van Allen

Tues

Attachment II

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H. Com Sub adopted

H 1

HOUSE BILL 435 Law to Com Sub / Unfav. to original

Short Title: State Health Plan Tech Amds/AB. (Public)

Sponsors: Representatives Dockham; and Brawley.

Referred to: Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CHANGES IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.1(1a) reads as rewritten:

"(1a) Covered Services. -- Any medically necessary, reasonable, and customary items of service, at least a portion of the expense of which is covered under at least one of the plans covering the person for whom claim is made or service provided. ~~To the extent legally possible, it~~ It shall be synonymous with allowable ~~expenses.~~ expenses, and with benefit or benefits."

Section 2. G.S. 135-40.1(7.1) reads as rewritten:

"(7.1) Experimental/Investigational Medical Procedures. -- ~~The use of any treatment, procedure, facility, equipment, drug, device, or supply not recognized as having scientifically established medical value nor accepted as standard medical treatment for the condition being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor, nor any such items requiring federal or other governmental agency approval not granted at the time services were rendered. The Executive Administrator and Board of Trustees may overturn the advice of the Claims Processor upon convincing evidence from the American Medical Association, North Carolina Medical Society, the United States Health Care~~

~~Financing Administration, medical technological journals, associations of health care providers, and other major United States insurers of health care expenses on a consensus of medical value and accepted standard medical treatment.~~ The use of a service, supply, drug, or device not recognized as standard medical care for the condition, disease, illness, or injury being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor. Determinations are made after independent review of scientific data. Opinions of experts in a particular field and opinions and assessments of nationally recognized review organizations may also be considered by the Plan but are not determinative or conclusive. The fact that an experimental/investigational treatment is the only available treatment for a particular condition will not result in coverage if the treatment is experimental/investigational in the treatment of the particular condition, nor is it relevant for purposes of coverage that the member has tried other more conventional therapies without success. The following criteria are the basis for determination that a service or supply is investigational. If a service or supply meets one or more of these criteria, it is deemed experimental/investigational:

a. Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of the condition being treated, except that of label use of chemotherapeutic drugs is provided in accordance with the requirements of G.S. 135-40.6(8)(a). Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

b. There is insufficient or inconclusive scientific evidence in peer review medical literature to permit the Plan's evaluation of the therapeutic value of the service or supply.

c. There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes.

d. Is provided as part of a research or clinical trial.

e. Are provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives.

f. Are subject to approval or review of an Institutional Review Board or other body that approves or reviews research.

g. Are provided pursuant to informed consent documents that describe the service as experimental, investigational, or part of a research study."

Section 3. G.S. 135-40.6(6)i. reads as rewritten:

"i. No benefits are payable for organ transplants not listed in G.S. 135-40.6(5)a, nor will benefits be payable for surgical procedures or organ transplants determined ~~in the opinion of the~~ by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor to be experimental."

Section 4. G.S. 135-40.7 is amended by adding the following subdivisions:

"(19) Any service, treatment, facility, equipment, drugs, supply, or procedure that is experimental or investigational as defined in G.S. 1350-40.1(7.1).

(20) Complications arising from noncovered services.

(21) Charges related to a noncovered service, even if the charges would have been covered if rendered in connection with a covered service."

Section 5. G.S. 135-40.6(6)j. reads as rewritten:

"j. No benefits are payable for radial keratotomy surgical ~~procedures.~~ procedures or for services to correct vision when performed in lieu of the use of corrective lenses."

Section 6. G.S. 135-40.6A(c) reads as rewritten:

"(c) No procedure for prior approval may be established except as provided by this ~~section~~ Article as it may be amended from time to time."

Section 7. G.S. 135-40.6(1) reads as rewritten:

"(1) In-Hospital Benefits. -- The Plan pays in-hospital benefits for each single confinement, when charged by a hospital, for room accommodations, including bed, board and general nursing care, but not to exceed the charge for semiprivate room or ward accommodations, or the rate negotiated for the Plan. Under the DRG reimbursement system, the coinsurance shall be based on the lower of the DRG amount or charges.

The Plan will pay the following covered charges, when charged by a hospital, for each confinement.

a. Intensive and cardiac nursing care.

b. All recognized drugs and medicines for use in the hospital.

c. Radiation services, including diagnostic x-rays, x-ray therapy, radiation therapy and treatment.

d. Clinical and pathological laboratory examinations.

e. Electrocardiograms and electroencephalograms.

f. Physical therapy.

g. Intravenous solutions.

h. Oxygen and oxygen therapy, plus the use of equipment.
i. Dressings, ordinary splints, plaster casts and sterile supplies.
j. Use of operating, delivery, recovery and treatment rooms and equipment.
k. Routine nursery charges, if the mother is eligible to receive maternity benefits.
l. Anesthetics and the administration thereof by the hospital's employee anesthesiologist.
m. Devices or appliances surgically inserted within the body.
n. Processing and administering of blood and blood plasma.
o. Children are entitled to benefits for treatment of illnesses or congenital defect, incubation or isolette care, and treatment of prematurity or postmaturity.

If the mother is a covered individual, benefits are provided for the newborn's circumcision and routine nursery care.

p. When a covered individual is admitted to or transferred to a section of a hospital providing ambulant, convalescent, or rehabilitative care, benefits are provided up to the average number of days of service for treatment of the particular diagnosis or condition involved, or more if medical necessity requires.
q. The Plan pays benefits for laboratory testing and administration of blood provided to a covered individual.

When a covered individual is the recipient of transplanted organs or bones, benefits are provided for services to the donor which are directly and specifically related to the transplantation.

r. Repealed by Session Laws 1991, c. 427, s. 31.
s. The use of nebulizers when authorized as medically necessary by the attending physician."

Section 8. G.S. 135-40.6(2)f. reads as rewritten:

"f. Prior to admission for scheduled inpatient hospitalization, the admitting physician shall contact the Plan and secure approval certification for an inpatient admission, including a length of stay, based upon clinical criteria established by the medical community, before any in-hospital benefits are allowed under G.S. 135-40.8(a). Immediately following an emergency or unscheduled inpatient hospitalization, the admitting physician shall contact the Plan and secure approval certification for the admission's length of stay before any in-hospital benefits are allowed under G.S. 135-40.8(a). ~~Effective January 1, 1987, failure~~ Failure to secure certification, or denial of certification, shall result in

~~in-hospital benefits being allowed at the rate maximum amount of out-of-pocket expenses established by G.S. 135-40.8(b).~~ a penalty of fifty percent (50%) of the eligible expenses up to five hundred dollars ($500.00) per admission and the denial of services that were not medically necessary or appropriate, as determined by the Claims Processor. Denial of certification by the Plan shall be made only after contact with the admitting physician and shall be subject to appeal to the Executive Administrator and Board of Trustees. Inpatient hospital admission and length of stay certifications required by this subdivision do not apply to inpatient admissions outside of the United States. While approval certification for inpatient admissions is required to be initiated by the admitting physician, the employee or individual covered by the Plan shall be responsible for insuring that the required certification is secured. Failure to secure certification for inpatient hospitalization shall not result in a penalty to the employee or individual when approval would have been given if requested."

Section 9. G.S. 135-40.1 is amended by adding a new subdivision to read:

"(17a) Skilled Care. -- Medically necessary services that can only be rendered under State law or regulation by licensed health professionals such as a medical doctor, physician's assistant, physical therapist, occupational therapist, speech therapist, certified clinical social worker, certified nurse midwife, licensed practical nurse, or registered nurse."

Section 10. G.S. 135-40.6(3) reads as rewritten:

"(3) Skilled Nursing Facility Benefits. -- The Plan will pay benefits in a skilled nursing facility licensed under applicable State laws as follows:

After discharge from a hospital for which inpatient hospital benefits were provided by this Plan for a period of not less than three days, and treatment consistent with the same illness or condition for which the covered individual was hospitalized, the daily charges will be paid for room and board in a semiprivate room or any multibed unit up to the maximum benefit specified in subsection (1) of this section, less the days of care already provided for the same illness in a hospital. Plan allowances for total daily charges may be negotiated but will not exceed the daily semiprivate hospital room rate as determined by the Plan.

Credit will be allowed toward private room charges in an amount equal to the facility's most prevalent charge for semiprivate accommodations. Charges will also be paid for general nursing care and other services which would ordinarily be covered

in a general hospital. In order to be eligible for these benefits, admission must occur within 14 days of discharge from the hospital.

In order to qualify for benefits provided by a skilled nursing facility, the following stipulations apply:

a. The services are medically required to be given on an inpatient basis because of the covered individual's need for medically necessary skilled nursing care on a continuing daily basis for any of the conditions for which he or she was receiving inpatient hospital services prior to transfer from a hospital to the skilled nursing facility or for a condition requiring such services which arose after such transfer and while he or she was still in the facility for treatment of the condition or conditions for which he or she was receiving inpatient hospital services,

b. Only on prior referral by and so long as, the patient remains under the active care of an attending doctor ~~who certifies that~~ and the patient requires continual hospital confinement ~~would be required~~ without the care and treatment of the skilled nursing facility, and

c. Approved in advance by the Claims Processor.

For facilities not qualified for delivery of services covered by the benefits of Title XVIII of the Social Security Act (Medicare), neither the Plan nor any of its members shall be billed or held liable by such facilities for charges that otherwise would be covered by Medicare."

Section 11. G.S. 135-40.6(8)c. reads as rewritten:

"c. Home Health Agency Services: Services provided in a covered individual's home, when ordered by the attending physician ~~who certifies that~~ and hospital or skilled nursing facility confinement would be required for the patient without such treatment and cannot be readily provided by family members. Services may include medical supplies, equipment, appliances, therapy services (when provided by a qualified speech therapist or licensed physiotherapist), and nursing services. Nursing services will be allowed for:

1. Services of a registered nurse (RN); or
2. Services of a licensed practical nurse (LPN) under the supervision of a RN; or
3. Services of a home health aide which are an adjunct to or extension of concurrent medically necessary skilled services under the supervision of a RN, limited to four hours a day.

Home health services shall be limited to 60 days per fiscal year, except that additional home health services may be provided on an individual basis if prior approval is obtained from the Claims Processor. Plan allowances for home health services shall be limited to licensed or Medicare certified home health agencies and shall not exceed ninety percent (90%) of the skilled nursing facility semiprivate rates as determined by the Plan, or charges negotiated by the Plan."

Section 12. G.S. 135-40.1(11) reads as rewritten:

"(11) Home Health Care Coverage. -- Coverage for home care and treatment established and approved in writing by a physician ~~who certifies that~~ for an individual whom continual hospital confinement would be required without the care and treatment specified by this coverage."

Section 13. G.S. 135-40.7(5) reads as rewritten:

"(5) Charges for any care, treatment, services or supplies other than those which are ~~certified by a physician who is attending the individual as being required for the~~ deemed medically necessary and appropriate treatment of the injury or ~~disease.~~ disease by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor. This subdivision shall not be construed, however, to require certification by an attending physician for a service provided by an advanced practice registered nurse acting within the nurse's lawful scope of practice, subject to the limitations of G.S. 135-40.6(10)."

Section 14. G.S. 135-40.7B reads as rewritten:

"**§ 135-40.7B. Special provisions for chemical dependency and mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered under this section: allowable institutional and professional charges for inpatient ~~psychiatric~~ care, outpatient ~~psychotherapy,~~ care intensive outpatient ~~crisis management,~~ program services, partial hospitalization treatment, and residential care and ~~treatment.~~ treatment:

(1) For mental illness treatment:

a. Licensed psychiatric hospitals;

b. Licensed psychiatric beds in licensed general hospitals;

c. Licensed residential treatment facilities;

d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;

e. Licensed intensive outpatient treatment programs; and
f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:
a. Licensed chemical dependency units in licensed psychiatric hospitals;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units.

~~The benefits provided by this section are separate and apart from those provided by G.S. 135-40.7A.~~

(c) Notwithstanding any other provisions of this Part, the following providers ~~are authorized to~~ and no others may provide necessary outpatient care and treatment for mental ~~illness~~ health under this section:

(1) ~~Licensed psychiatrists;~~ Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed or certified doctors of psychology;
(3) Certified clinical social workers;
(3a) Licensed professional counselors;
(4) ~~Psychiatric nurses;~~ Certified clinical specialists in psychiatric and mental health nursing;
(4a) Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
~~(5) Other social workers under the direct employment and supervision of a licensed psychiatrist or licensed doctor of psychology;~~
(6) Psychological associates with a ~~master's~~ masters degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology; and
~~(7) Licensed psychiatric hospitals and licensed general hospitals providing psychiatric treatment programs;~~
~~(8) Certified residential treatment facilities, community mental health centers, and partial hospitalization facilities; and~~
(9) Certified fee-based practicing pastoral counselors.

(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary outpatient care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:

a. Licensed physicians including, but not limited to physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);

b. Licensed or certified psychologists;

c. Psychiatrists;

d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;

e. Psychological associates with a masters degree in psychology working under the direct supervision of such physicians, psychologists, or psychiatrists;

f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;

g. Certified clinical social workers; until (sunset date);

h. Certified clinical specialists in psychiatric and mental health nursing; until (sunset date);

i. Licensed professional counselors; and

j. Certified fee-based practicing pastoral counselors until July 1, 1999, (sunset date).

(2) The following providers with appropriate substance abuse, training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, are authorized to provide treatment for chemical dependency in outpatient practice settings:

a. Licensed physicians who are certified in substance abuse by the American Society of Addition Medicine (ASAM);

b. Licensed or certified psychologists;

c. Psychiatrists;

d. Certified substance abuse counselors with a masters degree in a related field working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;

e. Psychological associates with a masters degree in psychology working under the employment and direct

supervision of such physicians, psychologists, or psychiatrists;

f. Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;

g. Certified clinical social workers; until (sunset date);

h. Certified clinical specialists in psychiatric and mental health nursing; until (sunset date);

i. Licensed professional counselors;

j. Licensed fee-based practicing pastoral counselors until July 1, 1999; and

k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:

1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and

2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and

3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(d) Benefits provided under this section shall be subject to a ~~managed, individualized care component~~ case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for ~~scheduled inpatient~~ nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, and intensive outpatient programs, (iv) ~~and~~ length-of-stay ~~reviews for unscheduled~~ certification of emergency inpatient admissions, and ~~(ii)~~ (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency ~~treatment psychotherapy.~~ treatment. Care which is not both medically necessary and medically appropriate will be noncertified and benefits will be denied. Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6.

(e) For the purpose of this section, 'emergency' is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others."

Section 15. G.S. 135-40.7A is repealed.

Section 16. G.S. 135-40.1(7) reads as rewritten:

"(7) Enrollment. -- New employees must enroll themselves and their dependents within 30 days from the date of ~~employment.~~ employment or from first becoming eligible on a noncontributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional prepaid hospital and medical benefit plans. Children born to covered employees having coverage type (2), or (3), as outlined in G.S. 135-40.3(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the Claims Processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2), or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born.

Newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parent's home, or the first of the month following the date of adoption or placement."

Section 17. G.S. 135-40.2(a) is amended by adding new subdivisions to read:

"(7) Any member enrolled pursuant to subdivision (1) or (1a) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

(8) Employees on approved Family and Medical Leave."

Section 18. G.S. 135-40.1(8) reads as rewritten:

"(8) Health Benefits Representative. -- The employee designated by the employing unit to administer the Comprehensive Major Medical Plan for the unit and its employees. The HBR is responsible for enrolling new employees, reporting changes, explaining benefits, reconciling group statements and remitting group fees. The State Retirement System is the Health Benefits Representative for retired members."

Section 19. G.S. 135-40.2(b)(2a) reads as rewritten:

"(2a) For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly. To be eligible for coverage as a former member of the General Assembly, application must be made within 30 days of the end of the term of office. Only members of the General Assembly covered by the Plan at the end of the term of office are eligible. If application is not made within the specified time period, the member forfeits eligibility."

Section 20. G.S. 135-40.2(b)(5) reads as rewritten:

"(5) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of G.S. 135-40.2(a)(6), Disability Income Plan beneficiaries, enrolled continuation members, and members of the General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within 30 days of the member's death."

Section 21. G.S. 135-40.2(b)(6) reads as rewritten:

"(6) Blind persons licensed by the State to operate vending facilities under contract with the Department of Human Resources, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

Spouses, dependent children, surviving spouses, and surviving dependent children of such members are not eligible for coverage."

Section 22. G.S. 135-40.2(b)(4a) is repealed.

Section 23. G.S. 135-40.2(b)(10) reads as rewritten:

"(10) Any eligible dependent child of the deceased retiree, teacher, State employee, ~~or~~ member of the General ~~Assembly,~~ Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, provided the child was covered at the time of death of the retiree, teacher, State employee, ~~or~~ member of the General ~~Assembly~~ Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, (or was in posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. ~~Any eligible spouse or dependent child of a person eligible under subdivision (8) of this subsection if the spouse or dependent child was enrolled before October 1, 1986.~~ An eligible surviving dependent child can remain covered until age 19, or age 26 if a full-time student, or indefinitely if certified as incapacitated under G.S. 135-40.1(3)b."

Section 24. G.S. 135-40.2(c) reads as rewritten:

"(c) No person shall be eligible for coverage as ~~an employee or retired employee and as a dependent of an employee or retired employee at the same time.~~ a dependent if eligible as an employee or retired employee, except when a spouse is eligible on a fully contributory basis. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time."

Section 25. G.S. 135-40.2(d) reads as rewritten:

"(d) Former employees who are receiving disability retirement benefits or disability income benefits pursuant to Article 6 of Chapter 135 of the General Statutes, provided the former employee has at least five years of retirement membership service, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on ~~the same basis as a retired employee.~~ a noncontributory basis. Such coverage shall terminate as of the end of the month in which such former employee is no longer eligible for disability retirement benefits or disability income benefits pursuant to Article 6 of this Chapter."

Section 26. G.S. 135-40.2 is amended by adding a new subsection to read:

"(i) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an

employee on leave without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by paying one hundred percent (100%) of the cost."

Section 27. G.S. 135-40.2(g) reads as rewritten:

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

Section 28. G.S. 135-40.3(b)(4) reads as rewritten:

"(4) Employees and dependents ~~reenrolled~~ enrolling or reenrolling within 12 months after a termination of ~~enrollment,~~ enrollment or employment, that were not enrolled at the time of this previous termination, regardless of the employing units involved, shall not be considered as newly-eligible employees or dependents for the purposes of waiting periods and preexisting conditions. Employees and dependents transferring from optional prepaid plans in accordance with G.S. 135-39.5B; employees and dependents immediately returning to service from an employing unit's approved periods of leave without pay for illness, injury, educational improvement, workers' compensation, parental duties, or for military reasons; employees and dependents immediately returning to service from a reduction in an employing unit's work force; retiring employees and dependents reenrolled in accordance with G.S. 135-40.3(b)(3); formerly-enrolled dependents reenrolling as eligible employees; formerly-enrolled employees reenrolling as eligible dependents; and employees and dependents reenrolled without waiting periods and preexisting conditions under specific rules and regulations adopted by the Executive Administrator and Board of Trustees in the best interests of the Plan shall not be considered reenrollments for the purpose of this subdivision. Furthermore, employees accepting permanent, full-time appointments who had previously worked in a part-time or temporary position and their qualified dependents shall not be covered by waiting periods and preexisting conditions under this division provided enrollment as a permanent, full-time employee is made when the employee and his dependents are first eligible to enroll."

Section 29. G.S. 135-40.3(c)(3) reads as rewritten:

"(3) Employees and retired employees may change from individual or parent/child(ren) coverage to parent/child(ren) or family coverage

or add dependents to existing family or parent/child(ren) coverage upon acquiring a dependent without a waiting period for preexisting conditions, and such dependents will be covered under the Plan the first of the month or the first of the second month following the dependent's eligibility for coverage, provided ~~upon~~ written application ~~at any time after acquiring a dependent, and such dependent will be covered under the Plan beginning the first of the next calendar month following receipt of such application by the Claims Processor.~~ is submitted to the Health Benefits Representative within 30 days of becoming eligible."

Section 30. G.S. 135-40.3(c)(4) reads as rewritten:

"(4) Employees or retired employees who wish to change from family coverage to parent/child(ren) or individual or from parent/child(ren) to individual coverage shall give written notice to ~~the Claims Processor within 31~~ their Health Benefits Representative within 30 days after any change in the status of dependents, (resulting from death, divorce, etc.) ~~which~~ that requires a change ~~from family coverage to individual coverage.~~ in contract type. The effective date will be the first of the month following the dependent's ineligibility event. If notification was not made within the 30 days following the dependent's ineligibility event, the dependent will be retroactively removed the first of the month following the dependent's ineligibility event, and the coverage type change will be the first of the month following written notification, except in cases of death, in which case the coverage type change will be made retroactive to the first of the month following the death."

Section 31. G.S. 135-40.3(c) is amended by adding two new subdivisions to read:

"(6) Employees or retired employees who wish to change from family to parent/child(ren) or individual coverage or from parent/child(ren) to individual coverage, even though their dependents continue to be eligible, shall give written notification to their Health Benefits Representative. Effective date of this type change will be the first of the month following written notification or any first of the month thereafter as desired by the employee.

(7) The effective date for newborns or adopted children will be date of birth, date of adoption, or placement with adoptive parent provided member is currently covered under a family or parent/child(ren) coverage. If the member wishes to add a newborn or adopted child and is currently enrolled on individual coverage, the member must submit application for coverage and a coverage type change within 30 days of the child's birth or date

of adoption or placement. Effective date for the coverage type change is the first of the month in which the child is born, adopted, or placed. Adopted children may also be covered the first of the month following placement or adoption."

Section 32. G.S. 135-40.11(a)(7) reads as rewritten:

"(7) The last day of the month in which an employee who is Medicare-eligible selects Medicare to be the primary payer of medical benefits. Coverage for a Medicare-eligible spouse of an employee shall also cease the last day of the month in which Medicare is selected to be the primary payer of medical benefits for the Medicare-eligible spouse. Such members are eligible to apply for conversion coverage."

Section 33. G.S. 135-40.11(b) is amended by adding a new subsection to read:

"(b1) Coverage under the Plan as a surviving dependent child whether covered as a dependent of a surviving spouse, or as an individual member (no living parent), ceases when the child ceases to be a dependent child as defined by G.S. 135-40.1(3) except coverage may continue under the Plan on a fully contributory basis for a period of not more than 36 months after loss of dependent status."

Section 34. G.S. 135-40.11(c)(1) reads as rewritten:

"(1) In the event of termination for any reason other than death, coverage under the Plan for an employee and his or her eligible spouse or dependent children, provided the eligible spouse or dependent children were covered under the Plan at termination of employment ~~or were covered on September 30, 1986,~~ may be continued for a period of not more than 18 months following termination of employment on a fully contributory basis. Employees who were covered under the Plan at termination of employment may be continued for a period of not more than 18 months or 29 months if determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI."

Section 35. G.S. 135-40.11(h) reads as rewritten:

"(h) Continuation coverage under this Plan shall not be continued past the occurrence of any one of the following events:

(1) The termination of the Plan.

(2) Failure of a Plan member to pay monthly in advance any required premiums.

(3) A ~~member~~ person becomes a covered employee or a dependent of a covered employee under any group health plan ~~or, in the case of a surviving spouse, when the surviving spouse remarries and becomes covered under a group health plan.~~ and that group health plan has no restrictions or limitations on benefits.

(4) A ~~member~~ person becomes eligible for Medicare ~~benefits.~~ benefits on or after the effective date of the continuation coverage.

(5) The person was determined to be no longer disabled, provided the 18-month coverage was extended to 29 months due to having been determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

(6) The person reaches the maximum applicable continuation period of 18, 29, or 36 months."

Section 36. G.S. 135-40.6(8)i. reads as rewritten:

"i. Physical Therapy: Recognized forms of physical therapy for restoration of bodily function, provided by a doctor, hospital, ~~or by a~~ licensed professional ~~physiotherapist.~~ physiotherapist, or certified physical therapy assistant. No benefits are provided for eye exercises or visual training."

Section 37. G.S. 135-40.6(8)r. reads as rewritten:

"r. Occupational Therapy: Recognized forms of occupational therapy provided by a doctor, hospital, ~~or by a~~ licensed professional occupational therapist, or certified occupational therapy assistant to restore fine motor skills for the resumption of bodily functions."

Section 38. (a) G.S. 135-40.6(8)o. reads as rewritten:

"o. Foot Surgery: ~~All foot~~ Foot surgery on bones and ~~joints in excess of one thousand dollars ($1,000), except for emergencies, shall require prior approval from the Claims Processor.~~ joints."

(b) G.S. 135-40.6A(a)(7) is repealed.

Section 39. G.S. 135-40.6A(b)(5) and G.S. 135-40.6A(b)(6) are repealed.

Section 40. G.S. 135-40.3(b)(5) reads as rewritten:

"(5) To administer the 12-month waiting period for preexisting conditions under this Article, the Plan must give credit against the 12-month period for the time that a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than ~~60~~ 63 days before the effective date of coverage. As used in this subdivision, a 'previous plan' means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement."

Section 41. This act becomes effective July 1, 1997.

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
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Attachment III

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July 16, 1997

MEMORANDUM

TO: Members of the House Insurance Committee

FROM: Linda Attarian, Staff Attorney

RE: **Senate Bill 273** Mastectomy/Hospital Stay
Primary Sponsor: Senator Forrester

Senate Bill 273 requires each entity providing coverage for a mastectomy, including coverage for postsurgery inpatient care, to ensure that the physician, in consultation with the patient, makes the decision as to whether to discharge. The discharge plan must ensure that the length of hospitalization is based on the individual patient's unique characteristics, including health and medical history.

Background Information:

Other States: To date, twelve states have enacted laws addressing outpatient mastectomies. Four states mandate a specific inpatient length of stay for which insurers must pay, (typically 48 hours), three states leave the decisions to patients and their doctors, two states stipulate hospitalization when it's "medically necessary", while one state (Maine) requires that a physician determine that the stay is medically appropriate in order to get coverage.

Description of the medical procedure:

A mastectomy can affect women of all ages, however most are older than 60. The term refers to a range of surgical procedures relating to the removal of breast tissue, which include:

- lumpectomy - the tumor and some adjacent tissue is removed. It is usually done with local anesthetic and is usually performed on an outpatient basis.
- segmental - removal of a wedge of the breast, including the tumor and the lobe where the tumor is found.
- simple - removal of one entire breast.
- modified radical - involves the removal of the entire breast plus the lymph nodes in the underarm area.

- radical - removal of a breast, underarm lymph nodes, and part of the underlying chest muscle. This procedure is the most evasive.

Position of the American Association of Health Plans:

Clinical protocols for HMOs typically have guidelines that call for outpatient mastectomies as a "best-case" scenario. Despite this guideline, mastectomy patients are usually hospitalized for 24 hours. The American Association of Health Plans (AAHP) conducted a survey of 1,000 plans across the country last year and did not find any who were mandating that mastectomies be done without an overnight hospital stay, however they did say that there may have been isolated instances when physicians felt pressured to do so. In their report, AAHP issued this statement: "It is the policy of the American Association of Health Plans that the decision about whether outpatient or inpatient care best meets the needs of a woman undergoing removal of a breast should be made by the woman's physician after consultation with the patient. As a matter of practice physicians should make all medical treatment decisions based on the best available scientific information and the unique characteristics of each patient."

provide coverage for breast reconstruction.

In most cases, the legislation clearly states that the coverage is limited to the treatment of breast cancer. Some of the bills contain provisions regarding the disclosure of these benefits to women.

While the mastectomy length of stay legislation resembles the drive thru delivery legislation, popular during the 1995 and 1996 legislative, there is a difference. The proposed minimum reimbursable length of stay for mastectomies is not standard. While 48 hours appears to be the favored option, bills have been introduced that would require coverage for 24, 48, 72, and 96 to 100 hours of inpatient care following surgery. In addition bills have been introduced requiring coverage for an appropriate length of stay, a medically necessary length of stay, and a length of stay determined by a physician.

And the differences in the length of stay provisions are not just occurring among states but also within the individual statehouses themselves. For example, **Connecticut** lawmakers have introduced bills for 48, 72, 96-100 hours, medically necessary care and a length of stay determined by a physician. For more details refer to the chart below.

(1) Johannes, L, More HMOs Order Outpatient Mastectomies, *The Wall Street Journal*, Wednesday, November 6, 1996.

1997 MASTECTOMY LEGISLATION

Note: An "X" marks states that have introduced a bill(s) in 1997 but the measure has not moved out of the chamber of introduction. For those states where lawmakers have been able to move a bill out of the chamber of origin, only the bills that are "moving" are included.

STATE	STATE ACTIVITY (Laws, Regulations)	1997 BILLS	1997 BILL STATUS
ALABAMA	--	S 224 (reconstructive surgery)	Passed Senate
ALASKA	--	--	--
ARIZONA	--	S 1459 (48 hours)	Passed Senate
ARKANSAS	--	S 1843 (48 hours, breast reconstructive surgery)	Passed Senate
CALIFORNIA		X (48 hours)	--
COLORADO	---	--	--
CONNECTICUT	--	X (48, 92, 96 to 100 hours, medically necessary care, physician/patient determined LOS, breast reconstruction, post-mastectomy breast reconstruction)	--

DELAWARE	--	--	--
FLORIDA	--	X (reconstructive surgery, medically necessary LOS, 48 hours)	--
GEORGIA	--	X (48 hours)	--
HAWAII	--	X (reconstructive surgery, study on coverage of reconstructive surgery)	--
IDAHO	--	--	--
ILLINOIS	--	S 711 (96 hours)	Passed Senate
INDIANA	--	H 1684 (reconstructive surgery)	Passed House
IOWA	--	X (48 hours)	--
KANSAS	--	H 2297 (reconstructive surgery)	--
KENTUCKY	--	--	--
LOUISIANA	--	X (48 hours, reconstructive surgery)	--
MAINE	--	X (48 hours, reconstructive surgery)	--
MARYLAND	--	S 117 (48 hours)	Passed Senate
MASSACHUSETTS	--	X (physician/patient determine LOS, reconstructive surgery, 48 hours)	--
MICHIGAN	--	--	--
MINNESOTA	--	X (48 hours, summary on inpatient care)	--
MISSISSIPPI	--	X (48 hours)	--
MISSOURI	--	X (reconstructive surgery)	--
MONTANA	--	S 324 (physician/patient determined LOS,	Passed Senate

		breast reconstruction)	
NEBRASKA	--	--	--
NEVADA	--	--	--
NEW HAMPSHIRE	--	--	--
NEW JERSEY	--	S 1704 (72 hours) S 1783 (reconstructive surgery)	Passed Both Houses Passed Both Houses
NEW MEXICO	--	S 964 (48 hours)	Passed Senate
NEW YORK	S 11 (97) provider/patient determined S 761 (97) - reconstruction	S 11 (provider/patient determined) S 761 (breast reconstruction)	Enacted Enacted
NORTH CAROLINA	--	S 273 (physician/patient determined LOS)	Passed Senate
NORTH DAKOTA	--	--	--
OHIO	--	X (prohibits requiring out-patient mastectomies, 48 hours)	--
OKLAHOMA	--	X (48 hours)	--
OREGON	--	X (breast reconstruction, 48 hours)	--
PENNSYLVANIA	--	X (breast reconstruction, physician determined LOS)	--
RHODE ISLAND	--	S 38 (48 hours)	Passed Senate
SOUTH CAROLINA	--	S 16 (24 hours)	Passed Senate
SOUTH DAKOTA	--	--	--
TENNESSEE	--	X (breast reconstruction, 48 hours)	--
TEXAS	--	X (reconstructive surgery, 48 hours)	--
UTAH	--	--	--
VERMONT	--	--	--

VIRGINIA	--	X (reconstructive surgery, 48 hours)	--
WASHINGTON	--	X (physician/patient determine LOS)	--
WEST VIRGINIA	--	X (breast reconstruction)	--
WISCONSIN	---	X (breast reconstruction, 48 hours)	--
WYOMING	--	--	--
TOTAL STATES	**1 state**	**36 states**	--

Source: Health Policy Tracking Service, April 1997.


Home

Attachment IV

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March 5, 1997

The Honorable James S. Forrester
North Carolina State Senate
State Legislative Building
16 West Jones Street
Raleigh, North Carolina

Dear Dr. Forrester:

In response to your request for the fiscal impact of Senate Bill 273, Inpatient Hospital Stays for Mastectomies, introduced by you, upon the Teachers' and State Employees' Comprehensive Major Medical Plan, the following is provided. As we read Senate Bill 273, it only applies to commercial accident and health insurers, hospital medical and service corporations (Blue Cross and Blue Shield), health maintenance organizations (HMOs), multiple employer welfare arrangements (MEWAs), and all other health benefit programs subject to Chapter 58 of the General Statutes. Consequently, it doesn't appear that the provisions of Senate 273 cover the self-insured indemnity program (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc., paid by Plan members) of the Teachers' and State Employees' Comprehensive Major Medical Plan. In fact, Senate Bill 273 does not need to include the State Employee Plan's indemnity program since an inpatient admission is controlled by an attending physician and since its inpatient hospital charges are reimbursed on the basis of diagnosis related groupings (DRGs), or per case amounts, and not entirely on lengths-of-stay. As an example, the indemnity program's DRG for a total mastectomy for malignancy without complications covers a hospital stay of up to 5 days. The program's arithmetic mean length-of-stay for this particular DRG is 2.10 days. In other words, a hospital's reimbursement for this DRG for this fiscal year is $5,055 (0.8562% of $5,904) whether the length-of-stay is 3 days, 5 days, or a day. Discharge during this period is a joint decision of the attending physician, the patient, and the hospital. Should medical complications arise, the DRG's length-of-stay can be extended upon advice of the attending physician and the reimbursable amount for the hospital is increased accordingly.

Although Senate Bill 273 affects health maintenance organizations (HMOs) licensed to do business in the State, the bill would not affect the costs to the State

Employee Plan for two reasons. First of all, employer costs to the State for the Plan are based upon the premium costs of the Plan's indemnity program. Even though the Plan includes twelve HMO alternatives, premium costs for these alternatives that exceed the employer premium costs for the Plan's indemnity program are required to be paid for by employees choosing an HMO option. Secondly, the Plan's twelve HMO alternatives require that all medical services be provided by, approved by, or otherwise controlled by a patient's primary care physician participating in the HMO. Consequently, it appears that the HMOs involved in the State Employee Plan already comply with the provisions of Senate Bill 273.

If you should need anything further on this matter, please let us know.

Sincerely,

Sam Byrd
Senior Fiscal Analyst

SB:ap

Attachment V

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 273

Short Title: Mastectomy/Hospital Stay. (Public)

Sponsors: Senators Forrester; Cochrane, Hoyle, Lucas, and Perdue.

Referred to: Pensions & Retirement and Insurance.

March 3, 1997

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE COVERAGE OF POSTMASTECTOMY INPATIENT CARE UNDER HEALTH INSURANCE PLANS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-171.1. Coverage for postmastectomy inpatient care.**

(a) Every entity providing a health benefit plan that provides coverage for mastectomy, including coverage for postmastectomy inpatient care, shall ensure that the decision whether to discharge the patient following mastectomy is made by the attending physician in consultation with the patient, and shall further ensure that the length of postmastectomy hospital stay is based on the unique characteristics of each patient taking into consideration the health and medical history of the patient.

(b) As used in this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Section 2. This act is effective when it becomes law and applies to health benefit plans issued, renewed, or amended on and after that date.

Attachment VI

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 2

SENATE BILL 843
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97

Short Title: Insurance Technical Changes. (Public)

Sponsors:

Referred to:

April 15, 1997

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES; AND TO EXTEND THE EXPIRATION DATE OF THE 1986 RISK SHARING PLAN LAW.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE PROVISIONS.

Section 1. G.S. 58-2-120, 58-3-125, 58-6-10, 58-7-150, and 58-41-35 are repealed.

Section 2. Article 47 of Chapter 58 of the General Statutes, the North Carolina Health Care Excess Liability Fund, which includes G.S. 58-47-1, 58-47-5, 58-47-10, 58-47-15, 58-47-20, 58-47-25, 58-47-30, 58-47-35, 58-47-40, 58-47-45, and 58-47-50, is repealed.

Section 3. Article 68 of Chapter 58 of the General Statutes, the North Carolina Health Insurance Trust Commission, which includes G.S. 58-68-1, 58-68-5, 58-68-10, 58-68-15, and 58-68-20, is repealed.

Section 4. G.S. 120-123(55) and (65) are repealed.

Section 5. G.S. 58-36-15(e) reads as rewritten:

"(e) The Commissioner may require the filing of supporting data including:

(1) The Bureau's interpretation of any statistical data relied upon;

(2) Descriptions of the methods employed in setting the rates;

(3) Analysis of the incurred losses submitted on an accident year or policy year basis into their component parts; to wit, paid losses,

reserves for losses and loss expenses, and reserves for losses incurred but not reported;

(4) The total number and dollar amount of paid claims;

(5) The total number and dollar amount of case basis reserve claims;

(6) Earned and written premiums at current rates by rating territory;

(7) Earned premiums and incurred losses according to classification plan categories; and

(8) Income from investment of unearned premiums and loss and loss expense reserves generated by business within this State.

~~Provided, however, that with respect to business written prior to January 1, 1980, the Commissioner shall not require the filing of such supporting data which has not been required to be recorded under statistical plans approved by the Commissioner.~~"

Section 6. G.S. 58-3-115 reads as rewritten:

"**§ 58-3-115. Twisting with respect to insurance policies; penalties.**

No insurer shall make or issue, or cause to be issued, any written or oral statement that willfully misrepresents or willfully makes an incomplete comparison as to the terms, conditions, or benefits contained in any policy of insurance for the purpose of inducing or attempting to induce a policyholder in any way to terminate or surrender, exchange, or convert any insurance policy. Any person who violates this section is subject to the provisions of ~~G.S. 58-2-70, 58-3-90 through 58-3-100, and 58-3-125.~~ G.S. 58-2-70 or G.S. 58-3-100."

Section 7. G.S. 58-30-75(7) reads as rewritten:

"(7) Without first obtaining the written consent of the ~~Commissioner pursuant to G.S. 58-7-150,~~ Commissioner, the insurer has (i) transferred, or attempted to transfer, in a manner contrary to Article 19 of this Chapter, substantially its entire property or business, or (ii) has entered into any transaction, the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person."

Section 8. G.S. 58-41-40(a) reads as rewritten:

"(a) There is no liability on the part of and no cause of action for defamation or invasion of privacy arises against any insurer or its authorized representatives, agents, or employees, or any licensed insurance agent or broker, for any communication or statement made, unless shown to have been made in bad faith with malice, in any of the following:

(1) A written notice of cancellation under ~~G.S. 58-41-15,~~ G.S. 58-41-15 or of nonrenewal under G.S. 58-41-20, ~~or of cessation of business through an agency under G.S. 58-41-35,~~ specifying the reasons ~~therefor;~~ for cancellation.

(2) Communications providing information pertaining to ~~such cancellation, nonrenewal, or cessation of business through an agency;~~ the cancellation or nonrenewal.

(3) Evidence submitted at any court proceeding, administrative hearing, or informal inquiry in which ~~such cancellation, nonrenewal, or cessation of business through an agency~~ the cancellation or nonrenewal is an issue."

PART II. AMENDMENTS NECESSARY BECAUSE OF 1995 REWRITE OF G.S. 58-2-50.

Section 9. G.S. 58-34-2(j) reads as rewritten:

"(j) The Commissioner shall disapprove any such contract that:

(1) Does not contain the required contract provisions specified in subsection (d) of this section;

(2) Subjects the insurer to excessive charges for expenses or commission;

(3) Vests in the MGA any control over the management of the affairs of the insurer to the exclusion of the board of directors of the insurer;

(4) Is entered into with any person if the person or its officers and directors are of known bad character or have been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance; or

(5) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the insurer.

Failure of the Commissioner to disapprove any such contract within 30 days after the contract has been filed with the Commissioner constitutes the Commissioner's approval of the contract. An insurer may continue to accept business from ~~such~~ the person until the Commissioner disapproves the contract. Any disapproval shall be in writing. The Commissioner may, after ~~a hearing held under G.S. 58-2-50,~~ notice and an opportunity for a hearing, withdraw approval of any contract the Commissioner has previously approved upon finding that the basis of the original approval no longer exists or that the contract has, in actual operation, shown itself to be subject to disapproval on any of the grounds in this subsection."

Section 10. G.S. 58-34-15(b) reads as rewritten:

"(b) If the Commissioner disapproves any management contract, ~~notice of such action shall be given to the insurer assigning the reasons therefor in writing.~~ the Commissioner shall give notice of, and written reasons for, the disapproval to the insurer. The Commissioner shall grant any party to the contract a hearing upon ~~request according to G.S. 58-2-50.~~ request."

Section 11. G.S. 58-40-100 reads as rewritten:

"**§ 58-40-100. Request for review of rate, rating plan, rating system or underwriting rule.**

(a) Any person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer or rating organization may request in writing that the insurer or rating organization ~~to~~ review the manner in

which the rate, plan, system, or rule has been applied with respect to ~~insurance afforded him. Such request may be made by his authorized representative, and shall be in writing.~~ the person's insurance. The person's authorized representative may make the request. If the request is not granted within 30 days after it is made, the requestor may treat it as rejected. Any person aggrieved by the action of an insurer or rating organization in refusing the review requested or in failing or refusing to grant all or part of the relief requested, may file a written complaint and request for hearing with the Commissioner, and shall specify the grounds relied upon. If the Commissioner has information concerning a similar ~~complaint he~~ complaint, the Commissioner may deny the hearing. If the Commissioner believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, ~~he~~ the Commissioner shall deny the hearing. If the Commissioner finds that the complaint charges a violation of this Article and that the complainant would be aggrieved if the violation is proven, ~~he~~ the Commissioner shall proceed as provided in G.S. ~~58-2-50 or~~ 58-2-70.

(b) Repealed by Session Laws 1985 (Regular Session, 1986), c. 1027, s. 15."

Section 12. G.S. 58-42-1 reads as rewritten:

"**§ 58-42-1. Establishment of plans.**

If the Commissioner finds, after a ~~hearing held in accordance with G.S. 58-2-50,~~ hearing, that in all or any part of this State, any amount or kind of insurance authorized by G.S. 58-7-15(4) through G.S. 58-7-15(22) is not readily available in the voluntary market and that the public interest requires the availability of that insurance, ~~he~~ the Commissioner may either:

(1) Promulgate plans to provide insurance coverage for any risks in this State that are, based on reasonable underwriting standards, entitled to obtain but are otherwise unable to obtain coverage; or

(2) Call upon insurers to prepare plans for ~~his~~ the Commissioner's approval."

Section 13. G.S. 58-45-50 reads as rewritten:

"**§ 58-45-50. Appeal from acts of Association to Commissioner; appeal from Commissioner to superior court.**

Any person or any insurer who may be aggrieved by an act, ruling or decision of the Association other than an act, ruling or decision relating to the cause or amount of a claimed loss, may, within 30 days after ~~such ruling~~ the ruling, appeal to the Commissioner. Any hearings held by the Commissioner ~~pursuant to such an~~ under the appeal shall be in accordance with ~~the procedure set forth in G.S. 58-2-50.~~ rules adopted by the Commissioner; Provided, however, the Commissioner is authorized to appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ those appeals and a ruling based upon ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the Commissioner. All persons or insureds aggrieved by any order or decision of the Commissioner may appeal as ~~is~~ provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than 20 days before each hearing, the appellant shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellee a

written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. Each ~~such~~ hearing shall be recorded and transcribed. ~~The cost of such recording and transcribing shall be borne equally by the appellant and appellee; provided that~~ The appellant and appellee shall share the cost of recording and transcribing equally; however, upon any final adjudication the prevailing party shall be reimbursed for ~~his~~ that party's share of ~~such~~ the costs by the other party. Each party shall, on a date determined by the Commissioner or ~~his~~ the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or ~~his~~ the designated hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the designated hearing officer shall then issue an order."

Section 14. G.S. 58-45-70 reads as rewritten:

"**§ 58-45-70. Commissioner may examine affairs of Association.**

The Commissioner may from time to time make an examination into the affairs of the Association when ~~he~~ the Commissioner deems it to be ~~prudent and in undertaking such examination he~~ prudent, and as part of the examination the Commissioner may hold a public ~~hearing pursuant to the provisions of G.S. 58-2-50.~~ hearing. ~~The expenses of such examination shall be borne and paid by the Association.~~ The Association shall pay the expenses of the examination."

Section 15. G.S. 58-46-20(c) reads as rewritten:

"(c) The Commissioner may designate the kinds of property insurance policies on principal residences to be offered by the association, including insurance policies under Article 36 of this Chapter, and the commission rates to be paid to agents or brokers for these policies, if ~~he~~ the Commissioner finds, after a ~~hearing held in accordance with G.S. 58-2-50,~~ hearing, that the public interest requires the designation. The provisions of Chapter 150B of the General Statutes do not apply to any procedure under this subsection, except that G.S. 150B-39 and G.S. 150B-41 shall apply to a hearing under this subsection. Within 30 days after the receipt of notification from the Commissioner of a change in designation ~~pursuant to~~ under this subsection, the association shall submit a revised plan and articles of association for approval in accordance with subsection (b) of this section."

Section 16. G.S. 58-46-30 reads as rewritten:

"**§ 58-46-30. Appeals; judicial review.**

The association shall provide reasonable means, to be approved by the Commissioner, whereby any person or insurer affected by any act or decision of the administrators of the Plan or underwriting association, other than an act or decision relating to the cause or amount of a claimed loss, may be heard in person or by an authorized representative, before the governing board of the association or a designated committee. Any person or insurer aggrieved by any decision of the governing board or designated committee, may be appealed to the Commissioner within 30 days from the date of ~~such~~ the ruling or decision. The Commissioner, after

hearing held ~~pursuant to the procedure set forth in G.S. 58-2-50,~~ under rules adopted by the Commissioner, shall issue an order approving or disapproving the act or decision with respect to the matter ~~which~~ that is the subject of appeal. The Commissioner ~~is authorized to~~ may appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ the appeals and a ruling based on ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the ~~Commissioner personally.~~ Commissioner. All persons or insurers or their representatives aggrieved by any order or decision of the Commissioner may appeal as provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than 20 days before each hearing, the appellant shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. Each ~~such~~ hearing shall be recorded and transcribed. ~~The cost of such recording and transcribing shall be borne equally by the appellant and appellee; provided that~~ The appellant and appellee shall share the cost of recording and transcribing equally; however, upon any final adjudication the prevailing party shall be reimbursed for ~~his~~ that party's share of ~~such~~ the costs by the other party. Each party shall, on a date determined by the Commissioner or ~~his~~ the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or ~~his~~ the designated hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the designated hearing officer shall then issue an order."

PART III. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION.

Section 17. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity licensed under Articles 7, 16, 26, 49, 65, or 67 of this Chapter and any employer that has furnished to the Commissioner satisfactory proof of its financial responsibility under G.S. 97-93(a)(2). For purposes of this Article, 'insurer' also includes continuing care retirement ~~centers~~ communities licensed under Article 64 of this Chapter."

Section 18. The title of Article 64 of Chapter 58 of the General Statutes reads as rewritten:

"ARTICLE 64.

~~"Registration, Disclosure, Contract, and Financial Monitoring Requirements for~~ Continuing Care ~~Facilities.~~ Retirement Communities."

Section 19. G.S. 58-64-1 reads as rewritten:

"§ 58-64-1. Definitions.

As used in this Article, unless otherwise specified:

(1) 'Continuing care' means the furnishing to an individual other than an individual related by blood, marriage, or adoption to the

person furnishing the care, of lodging together with nursing services, medical services, or other health related services, ~~pursuant to~~ under an agreement effective for the life of the individual or for a period ~~in excess of~~ longer than one year.

(2) 'Entrance fee' means a payment that assures a resident a place in a facility for a term of years or for life.

(3) 'Facility' means the ~~place or places~~ retirement community or communities in which a provider undertakes to provide continuing care to an individual.

(4) 'Health related services' means, at a minimum, nursing home admission or assistance in the activities of daily living, exclusive of the provision of meals or cleaning services.

(5) 'Living unit' means a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents.

(6) 'Provider' means the promoter, developer, or owner of a ~~continuing care~~ facility, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract, or that represents ~~himself~~ himself, herself, or itself as providing continuing care or 'life care.'

(7) 'Resident' means a purchaser of, a nominee of, or a subscriber to, a continuing care contract.

(8) 'Hazardous financial condition' means a provider is insolvent or in eminent danger of becoming insolvent."

Section 20. G.S. 58-64-40(b) reads as rewritten:

"(b) The board of directors or other governing body of a ~~continuing care~~ facility or its designated representative shall hold annual meetings with the residents of the ~~continuing care~~ facility for free discussions of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility and discussions of proposed changes in policies, programs, and services. Residents shall be entitled to at least seven days advance notice of each meeting. An agenda and any materials that will be distributed by the governing body at the meetings shall remain available upon request to residents."

Section 21. G.S. 58-64-80 reads as rewritten:

"**§ 58-64-80. Advisory Committee.**

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

the field of architecture or engineering, and one individual who is a health care professional."

PART IV. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 22. G.S. 58-36-1(2) reads as rewritten:

"(2) The Bureau shall provide reasonable means to be approved by the Commissioner whereby any person affected by a rate or loss costs made by it may be heard in person or by ~~his~~ the person's authorized representative before the governing committee or other proper executive of the Bureau."

Section 23. G.S. 58-36-1(5)c. reads as rewritten:

"c. Failure or refusal by any assigned employer risk to make full disclosure to the Bureau, servicing carrier, or insurer writing a policy of information regarding the employer's true ownership, change of ownership, operations, or payroll, or any other failure to disclose fully any records pertaining to workers' compensation insurance shall be sufficient grounds for ~~the Bureau to authorize~~ the termination of the policy of that employer."

Section 24. G.S. 58-36-10 reads as rewritten:

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

The following standards ~~shall~~ apply to the making and use of ~~rates.~~ rates or loss costs:

(1) Rates or loss costs shall not be excessive, inadequate or unfairly discriminatory.

(2) Due consideration shall be given to actual loss and expense experience within this State for the most recent three-year period for which ~~such~~ that information is available; to prospective loss and expense experience within this State; to the hazards of conflagration and catastrophe; to a reasonable margin for underwriting profit and to contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to investment income earned or realized by insurers from their unearned premium, loss, and loss expense reserve funds generated from business within this State; to past and prospective expenses specially applicable to this State; and to all other relevant factors within this State: Provided, however, that countrywide expense and loss experience and other countrywide data may be considered only where credible North Carolina experience or data is not available.

(3) In the case of fire insurance rates, as are subject to the ratemaking authority of the Bureau, consideration may be given to the experience of such fire insurance business during the most recent five-year period for which ~~such~~ that experience is available. In

the case of fire insurance rates that are subject to the ratemaking authority of the Bureau, consideration shall be given to the insurance public protection classifications of rural fire districts based upon standards established by the Commissioner. To the extent credits are provided for proximity to fire hydrants, the Bureau may also provide appropriate credits in public protection classifications for optional water sources, such as ponds, lakes, or other bodies of water, in accordance with standards and procedures filed with and approved by the Commissioner.

(4) Risks may be grouped by classifications and lines of insurance for establishment of ~~rates~~ rates, loss costs, and base premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans ~~which~~ that establish standards for measuring variations in hazards or expense provisions or both. ~~Such~~ Those standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. The Bureau ~~is directed to~~ shall establish and implement a comprehensive classification rating plan for motor vehicle insurance under its jurisdiction within 90 days of September 1, 1977. No such classification plans shall base any standard or rating plan for private passenger (nonfleet) motor vehicles, in whole or in part, directly or indirectly, upon the age or sex of the persons insured. The Bureau shall at least once every three years make a complete review of the filed classification rates to determine whether they are proper and supported by statistical evidence, and shall at least once every 10 years make a complete review of the territories for nonfleet private passenger motor vehicle insurance to determine whether they are proper and reasonable.

(5) In the case of workers' compensation insurance and employers' liability insurance written in connection therewith, due consideration shall be given to the past and prospective effects of changes in compensation benefits and in legal and medical fees that are provided for in General Statutes Chapter 97."

Section 25. G.S. 58-36-15(a) reads as rewritten:

"(a) The Bureau shall file with the Commissioner copies of the rates, loss costs, classification plans, rating plans and rating systems used by its members. Each rate or loss costs filing shall become effective on the date specified in the filing, but not earlier than 105 days ~~from~~ after the date the filing is received by the Commissioner: Provided that (1) rate or loss costs filings for workers' compensation insurance and employers' liability insurance written in connection therewith shall not become effective earlier than 120 days from the date the filing is received by the Commissioner or on the date ~~as~~ provided ~~under~~ in G.S. 58-36-100, whichever is

earlier; and (2) any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the Bureau."

Section 26. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar year the Bureau shall submit to the Commissioner the experience, data, statistics, and information referred to in subsection (c) of this section and required under G.S. 58-36-100 and a residual market rate ~~or~~ and prospective loss costs review based on ~~such~~ those data for workers' compensation insurance and employers' liability insurance written in connection therewith. Any rate or loss costs increase for ~~such~~ that insurance that is implemented ~~pursuant to~~ under this Article shall become effective solely to ~~such insurance as is written having~~ insurance with an inception date on or after the effective date of the rate or loss costs increase."

Section 27. G.S. 58-36-15(g) reads as rewritten:

"(g) The following information must be included in policy form, rule, and rate or loss costs filings under this Article and under Article 37 of this Chapter:

(1) A detailed list of the rates, loss costs, rules, and policy forms filed, accompanied by a list of those superseded; and

(2) A detailed description, properly referenced, of all changes in policy forms, rules, prospective loss costs, and rates, including the effect of each change."

Section 28. G.S. 58-36-30(a) reads as rewritten:

"(a) ~~No insurer, officer, agent or representative thereof~~ Except as permitted by G.S. 58-36-100 for workers' compensation loss costs filings, no insurer and no officer, agent, or representative of an insurer shall knowingly issue or deliver or knowingly permit the issuance or delivery of any policy of insurance in this State ~~which~~ that does not conform to the rates, rating plans, classifications, schedules, rules and standards made and filed by the Bureau. ~~However, an~~ An insurer may deviate from the rates ~~promulgated~~ adopted by the Bureau ~~provided~~ if the insurer has filed the proposed deviation ~~to be applied both~~ with the Bureau and the Commissioner, ~~and provided the deviation is uniform in its application to all risks in the State of the class to which the deviation is to apply; and provided such deviation is approved by the Commissioner.~~ if the proposed deviation is based on sound actuarial principles, and if the proposed deviation is approved by the Commissioner. ~~The Commissioner shall approve proposed deviations if they do not render the rates excessive, inadequate or unfairly discriminatory. If approved, the deviation may thereafter be amended, subject to the provisions of this subsection.~~ Amendments to deviations are subject to the same requirements as initial filings. ~~The deviation may be terminated~~ An insurer may terminate a deviation only if the deviation has been in effect for a period of six months before the effective date of the termination and the insurer notifies the Commissioner of the termination no later than 15 days before the effective date of the termination."

Section 29. G.S. 58-36-30(c) reads as rewritten:

"(c) ~~Any deviation with respect to workers' compensation and employers' liability insurance written in connection therewith as filed under subsection (a) of this section~~

~~shall apply uniformly to all classifications.~~ Any approved rate under subsection (b) of this section with respect to workers' compensation and employers' liability insurance written in connection therewith shall be furnished to the Bureau."

Section 30. Effective September 1, 1997, G.S. 58-36-100(a) reads as rewritten:

"(a) ~~Nothing in this section requires the Bureau or its member insurers to refile rates previously implemented before two years after the effective date of this section. Any member insurer of the Bureau may continue to use all rates and deviations filed and approved for its use until disapproved, or the insurer makes its own filing to change its rates, either by making an independent filing or by filing a reference filing adoption form adopting the Bureau's prospective loss costs, or modification thereof.~~ Except as provided in subsection (m) of this section, ~~with the initial prospective loss costs reference filing,~~ the Bureau shall no longer develop or file any minimum premiums, minimum premium formulas, or expense constants. If an insurer wishes to amend minimum premium ~~formulas,~~ formulas or expense constants, it must file the minimum premium rules, formulas, or amounts it proposes to use. A copy of each filing submitted to the Commissioner under subsections (e) and (g) of this section shall also be sent to the Bureau."

Section 31. Effective September 1, 1997, G.S. 58-36-100(b)(1) reads as rewritten:

"(1) 'Expenses'. -- That portion of a rate attributable to acquisition, field supervision, collection expenses, any tax levied by the State or by any political subdivision of the State, licensing costs, fees, and general expenses, as determined by the insurer."

Section 32. Effective September 1, 1997, G.S. 58-36-100(c) reads as rewritten:

"(c) Except as provided in subsection (m) of this section, for workers' compensation and employers' liability insurance written in connection with workers' compensation insurance, the Bureau shall no longer develop or file advisory final rates that contain provisions for expenses (other than loss adjustment expenses) and profit. The Bureau shall instead develop and file for approval with the Commissioner, in accordance with this section, reference filings containing advisory prospective loss costs and the underlying loss data and other supporting statistical and actuarial information for any calculations or assumptions underlying these loss costs. Loss-based ~~assessments, any tax levied by the State or any political subdivision of the State, licensing costs, and fees~~ assessments will be included in prospective loss costs."

PART V. INSURANCE COMPANY FINANCIAL OPERATIONS.

Section 33. G.S. 58-5-63(a) reads as rewritten:

"(a) All insurance companies making deposits under this Article are entitled to interest on those ~~deposits, which shall remain in the deposit accounts.~~ deposits. The right to interest is subject to a company paying its insurance policy liabilities. If any company fails to pay those liabilities, interest accruing after the failure is payable to the Commissioner for the payment of those liabilities under subsection (b) of this section."

Section 34. G.S. 58-7-21(a) reads as rewritten:

"(a) As used in this section and in G.S. ~~58-7-26, 58-7-30, and 58-7-31:~~ 58-7-26 and G.S. 58-7-30:

(1) 'Reinsurance' means a transfer of insurance risk from a ceding insurer to an assuming insurer.

(2) 'Insurance risk' means an uncertainty regarding the ultimate amount of any claim payment (underwriting risk) or an uncertainty regarding the timing of the payments (timing risk), or both."

Section 35. G.S. 58-7-31(b)(3) reads as rewritten:

"(3) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement; except that neither offsetting experience refunds against current and prior years' losses under the reinsurance agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the reinsurance agreement upon voluntary termination of in-force reinsurance by the ceding insurer are a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions that allow the reinsurer to reduce its risk or increase its risk charge under the reinsurance agreement."

Section 36. G.S. 58-7-31(d)(1) reads as rewritten:

"(1) Reinsurance agreements entered into after October 1, 1993, that involve the reinsurance of business issued ~~prior to~~ before the effective date of the reinsurance agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days after its date of execution. Each filing shall include data detailing the ~~final impact~~ financial effect of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this ~~statute~~ section and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Commissioner. The actuary ~~should~~ shall maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that ~~such~~ that work conforms to this ~~statute.~~ section."

Section 37. G.S. 58-7-173(12) reads as rewritten:

"(12) Secured obligations of duly constituted churches and of church-holding companies; and the cost of investments made under this subdivision shall not exceed the lesser of one percent (1%) of the insurer's admitted assets ~~of~~ or five percent (5%) of the insurer's capital and surplus."

Section 38. The catchline of G.S. 58-7-177 reads as rewritten:

"**§ 58-7-177. Investments in ~~subsidiaries and affiliated corporations.~~ subsidiaries.**"

Section 39. G.S. 58-8-5(a)(3) reads as rewritten:

"(3) ~~Said officers shall cause said certificate to be published once a week for two consecutive weeks in a newspaper in Raleigh and in the county where the company's principal office is located, or posted at the courthouse door if no newspaper be published within the county. Said printed or posted notices shall be in such form and of such size as the Commissioner may approve, and in addition to setting forth in full the certificate required in subdivision (2) shall state that application for amending the company's charter in the manner specified has been proposed by the board of directors, and shall also state the time set for a meeting of policyholders thereby called to be held at the principal office of the company to take action on the proposed amendment. A true copy of such notice shall be filed with the Commissioner, and also with that official who performs the functions of Commissioner in each state where the company is licensed to do business. Such publication and filing of notices shall be completed at least 30 days prior to the date set therein for the meeting of policyholders and due proof thereof shall be filed with the Commissioner at least 15 days prior to the date of such meeting.~~ If the meeting at which the proposed amendment is to be considered is a special meeting, rather than a regular annual meeting of policyholders, ~~such special~~ that meeting can be called only after the Commissioner has given ~~his~~ approval in ~~writing, and the published notice shall show the fact of such approval;~~ writing;"

Section 40. G.S. 58-8-25 reads as rewritten:

"**§ 58-8-25. Dividends to policyholders.**

(a) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes other than life insurance or workers' compensation insurance and employers' liability insurance in connection therewith, may declare and pay a dividend to policyholders from its ~~surplus;~~ unassigned surplus as reflected in the company's most recent annual or quarterly statement filed with the Commissioner, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period, upon the basis of each general kind of insurance covered by ~~such~~ those policies and by territorial divisions of the location of risks by states, except that in fixing the amount of dividends to be paid on each general kind of insurance, ~~which~~ the dividends shall be uniform in rate and applicable to the majority of risks within ~~such~~ that general kind of insurance, and exceptions may be made as to any class or

classes of risk and a different rate or amount of dividends paid on ~~such~~ the class or classes if the conditions applicable to ~~such~~ the class or classes differ substantially from the condition applicable to the kind of insurance as a whole. Every such company shall have an equal rate of dividend for the same term on all policies insuring risks in the same classification. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks.

(b) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes workers' compensation insurance and employers' liability insurance in connection therewith may declare and pay a dividend to policyholders from its ~~surplus,~~ unassigned surplus as reflected in the company's most recent statement filed with the Commissioner under G.S. 58-2-165, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau, or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks."

Section 41. G.S. 58-9-6(a) reads as rewritten:

"(a) The Commissioner shall issue an intermediary license or an exemption from the license, subject to G.S. 58-9-2(b)(2) or G.S. 58-9-2(c)(3), to any person who has complied with the requirements of this Article. A license issued to a noncorporate entity authorizes all of the members of the entity and any designated employees to act as intermediaries under the license, and those persons shall be named in the application and any supplements. A license issued to a corporation authorizes all of the officers and any designated employees and directors of the corporation to act as intermediaries on behalf of the corporation, and those persons shall be named in the application and any supplements."

Section 42. G.S. 58-9-11(b) reads as rewritten:

"(b) An insurer shall not engage the services of any person to act as a broker on its behalf unless the person is licensed ~~under G.S. 58-9-6.~~ or exempted under this Article. An insurer shall not employ an individual who is employed by a broker with which it transacts business, unless the broker is under common control with the insurer under Article 19 of this Chapter."

Section 43. G.S. 58-9-21(a) reads as rewritten:

"(a) A reinsurer shall not engage the services of any person to act as a manager on its behalf unless the person is licensed ~~under G.S. 58-9-6.~~ or exempted under this Article."

Section 44. G.S. 58-12-2(3) reads as rewritten:

"(3) Domestic insurer. -- Any insurance company organized in this State under ~~Article 7~~ Article 7 or Article 15 of this Chapter."

Section 45. G.S. 58-13-10 reads as rewritten:

"§ 58-13-10. Scope.

(a) This Article applies to all domestic insurers and to all kinds of insurance written by those insurers ~~under Articles 1 through 66~~ of this Chapter. Foreign insurers ~~are to~~ shall comply in substance with the requirements and limitations of this section. ~~This Article does not apply to variable contracts for which separate accounts are required to be maintained nor to statutory deposits that are required to be maintained by insurance regulatory agencies as a requirement for doing business in such jurisdictions.~~

(b) This Article does not apply to:

(1) Variable contracts for which separate accounts are required to be maintained.

(2) Statutory deposits that are required to be maintained by insurance regulatory agencies as a requirement for doing business.

(3) Real estate authorized under G.S. 58-7-187 and encumbered by a mortgage loan with a first lien."

Section 46. G.S. 58-13-15 reads as rewritten:

"§ 58-13-15. Definitions.

As used in this Article:

(1) 'Assets' means all property, real or personal, tangible or intangible, legal or equitable, owned by an insurer.

(2) 'Claimants' means any owners, beneficiaries, assignees, certificate holders, or third-party beneficiaries of any insurance benefit or right arising out of and within the coverage of an insurance policy covered by this Article.

(3) 'Reserve assets' means those assets of an insurer that are authorized investments for policy reserves in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~ this Chapter.

(4) 'Policyholder-related liabilities' means those liabilities that are required to be established by an insurer for all of its outstanding

insurance policies in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~ this Chapter."

Section 47. G.S. 58-13-20(b) reads as rewritten:

"(b) The Commissioner ~~has the right to~~ may examine any of ~~such~~ these assets, reinsurance agreements, or deposit arrangements at any time in accordance with ~~his~~ the Commissioner's authority to make examinations of insurers as conferred by other provisions ~~of Articles 1 through 64~~ of this Chapter."

Section 48. G.S. 58-19-5(5) reads as rewritten:

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

Section 49. G.S. 58-19-10(b)(1) reads as rewritten:

"(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts that do not exceed the lesser of ten percent (10%) of ~~such~~ the insurer's admitted assets or fifty percent (50%) of ~~such~~ the insurer's surplus as regards policyholders, provided that after ~~such~~ those investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of ~~such~~ the investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included: (i) total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of ~~such~~ the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and (ii) all amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;".

PART VI. HANDICAPPED PERSONS.

Section 50. G.S. 168-10 reads as rewritten:

"**§ 168-10. Eliminate discrimination in treatment of handicapped and disabled.**

Each handicapped person shall have the same consideration as any other person for individual accident and health insurance coverage, and no insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes solely on the basis of ~~such~~ the person's handicap, shall deny ~~such~~ coverage or benefits. The availability of ~~such insurance~~ coverage or benefits shall not be denied solely ~~due to~~ because of the ~~handicap, provided, however, that no such insurer shall be prohibited from excluding by waiver or otherwise, any pre-existing conditions from such coverage, and further~~

~~provided that~~ handicap; however, any such insurer may charge the appropriate premiums or fees for the risk insured on the same basis and conditions as insurance issued to other ~~persons.~~ persons, in accordance with actuarial and underwriting principles prescribed in Chapter 58 of the General Statutes. ~~Nothing contained herein or in any other statute shall restrict or preclude any insurer governed by Chapter 58 of the General Statutes from setting and charging a premium or fee based upon the class or classes of risks and on sound actuarial and underwriting principles as determined by such insurer, or from applying its regular underwriting standards applicable to all classes of risks. The provisions of this section shall apply to both corporations governed by Chapter 58 of the General Statutes.~~"

Section 51. G.S. 168-22(b) reads as rewritten:

"(b) A family care home ~~shall be~~ is deemed a residential use of property for the purposes of determining charges or assessments imposed by political subdivisions or businesses for water, sewer, power, telephone service, cable television, garbage and trash collection, repairs or improvements to roads, streets, and sidewalks, and other services, utilities, and ~~improvements, and for purposes of classification for insurance.~~ improvements."

PART VII. AUTOMOBILE INSURANCE.

Section 52. G.S. 58-36-75(c) is repealed.

Section 53. G.S. 58-36-85(a) reads as rewritten:

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

(1) Policy. -- A nonfleet private passenger motor vehicle liability insurance policy, including ~~a policy~~ one that provides medical payments, uninsured motorist, or underinsured motorist coverage, ~~whose named insured is one individual or two or more individuals who reside in the same household.~~ that is under the jurisdiction of the Rate Bureau.

(2) Terminate. -- To cancel or refuse to renew a policy."

Section 54. G.S. 58-37-40(f) reads as rewritten:

"(f) The plan of operation shall provide that every member shall, following payment of any pro rata assessment, ~~commence~~ begin recoupment of that assessment by way of a surcharge on motor vehicle insurance policies issued by the member or through the Facility until the assessment has been recouped. ~~Such~~ The surcharge shall be a percentage of premium adopted by the Board of Governors of the Facility; and the charges determined on the basis of the surcharge shall be combined with and displayed as a part of the applicable premium charges. ~~Provided, however, that recoupment~~ Recoupment of losses sustained by the Facility ~~since September 1, 1977,~~ with respect to nonfleet private passenger motor vehicles may be recouped only by surcharging policies ~~(i)~~ that are subject to the classification plan ~~promulgated pursuant to G.S. 58-36-65 and (ii) to which one or more driving record points have been assigned pursuant to said plan, subject to the provisions of G.S. 58-36-75.~~ under G.S. 58-36-65. If the amount collected during the period of surcharge exceeds assessments paid by the member to the Facility, the member shall pay over the excess to the Facility on a date specified by the Board of Governors. If the amount collected

during the period of surcharge is less than the assessments paid by the member to the Facility, the Facility shall pay the difference to the member. Except as ~~hereinafter provided,~~ otherwise provided in this Article, the amount of recoupment shall not be considered or treated as a rate or premium for any purpose. The Board of Governors shall adopt and implement a plan for compensation of agents of Facility members when recoupment surcharges are imposed; ~~such~~ that compensation shall not exceed the compensation or commission rate normally paid to the agent for the issuance or renewal of the automobile liability policy issued through the North Carolina Reinsurance Facility affected by ~~such surcharge; provided, however, that~~ the surcharge. However, the surcharge provided for in this section shall include an amount necessary to recover the amount of the assessment to member companies and the compensation paid by each member, ~~pursuant to~~ under this section, to agents."

Section 55. G.S. 58-37-35(b)(8) reads as rewritten:

"(8) To establish fair and reasonable procedures for the sharing among members of any loss on Facility business ~~which~~ that cannot be recouped ~~pursuant to~~ under G.S. 58-37-40(f) or ~~which cannot be recouped or allocated under G.S. 58-37-75,~~ allocated, and other costs, charges, expenses, liabilities, income, property and other assets of the Facility and for assessing or distributing to members their appropriate shares. ~~Such~~ The shares may be based on the member's premiums for voluntary business for the appropriate category of motor vehicle insurance or by any other fair and reasonable method."

Section 56. G.S. 58-37-35(l) reads as rewritten:

"(l) The classifications, rules, rates, rating plans and policy forms used on motor vehicle insurance policies reinsured by the Facility may be made by the Facility or by any licensed or statutory rating organization or bureau on its behalf and shall be filed with the Commissioner. The Board of Governors shall establish a separate subclassification within the Facility for 'clean ~~risks' as herein defined.~~ risks'. For the purpose of this Article, a 'clean risk' ~~shall be~~ is any owner of a nonfleet private passenger motor vehicle as defined in G.S. 58-40-10, if the owner, principal operator, and each licensed operator in the owner's household have two years' driving experience as licensed drivers and if none of the persons has been assigned any Safe Driver Incentive Plan points under Article 36 of this Chapter during the three-year period immediately preceding either (i) the date of application for a motor vehicle insurance policy or (ii) the date of preparation of a renewal of a motor vehicle insurance policy. ~~Such~~ The filings may incorporate by reference any other material on file with the Commissioner. Rates shall be neither excessive, inadequate nor unfairly discriminatory. If the Commissioner finds, after a hearing, that a rate is either excessive, inadequate or unfairly discriminatory, ~~he~~ the Commissioner shall issue an order specifying in what respect it is deficient and stating when, within a reasonable period thereafter, ~~such rate shall be deemed~~ the rate is no longer effective. ~~Said~~ The order is subject to judicial review as set out in Article 2 of this Chapter. Pending judicial review of ~~said~~ the order, the filed classification plan and the filed

rates may be used, charged and collected in the same manner as set out in G.S. 58-40-45 of this Chapter. ~~Said~~ The order shall not affect any contract or policy made or issued ~~prior to~~ before the expiration of the period set forth in the order. All rates shall be on an actuarially sound basis and shall be calculated, insofar as is possible, to produce neither a profit nor a loss. However, the rates made by or on behalf of the Facility with respect to 'clean ~~risks', as defined above,~~ risks' shall not exceed the rates charged 'clean risks' who are not reinsured in the Facility. The difference between the actual rate charged and the actuarially sound and self-supporting rates for 'clean risks' reinsured in the Facility may be recouped in similar manner as assessments ~~pursuant to G.S. 58-37-40(f) or allocated pursuant to G.S. 58-37-75.~~ under G.S. 58-37-40(f). Rates shall not include any factor for underwriting profit on Facility business, but shall provide an allowance for contingencies. There shall be a strong presumption that the rates and premiums for the business of the Facility are neither unreasonable nor excessive."

Section 57. G.S. 58-37-75 is repealed.

PART VIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 58. G.S. 58-50-60 reads as rewritten:

"**§ 58-50-60. Rules for precertification practices.**

(a) This section applies to all accident and health insurers under Articles 1 through 64 of this Chapter, all third-party administrators and preferred provider arrangements, all entities subject to Articles 65 through 67 of this Chapter, and all self-funded ~~health benefit~~ workers' compensation insurance plans.

(b) The Commissioner shall adopt reasonable rules governing ~~precertification practices and forms~~ utilization review and utilization review organizations ~~affiliated~~ that do business with the entities subject to this section."

Section 59. G.S. 58-50-65(a) reads as rewritten:

"(a) ~~Nothing~~ Except as provided in this subsection, nothing in Articles 50 through 55 of this Chapter ~~shall apply~~ applies to ~~or affect~~ any ~~policy of~~ liability or workers' compensation ~~insurance, except that~~ insurance policy. Except for G.S. 58-50-55(a), the provisions of ~~G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall~~ this Article and Articles 65 and 67 of this Chapter and any administrative rules adopted under those Articles relating to preferred providers and utilization review apply to ~~policies of~~ workers' compensation ~~insurance.~~ insurance policies and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care rules adopted by the Commissioner under this Chapter and managed care rules adopted by the Industrial Commission under G.S. 97-25.2, the Industrial Commission's rules govern. If there is any conflict between managed care provisions in this Chapter and in Chapter 97 of the General Statutes with respect to workers' compensation, the provisions in Chapter 97 govern."

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 60. The phrase "certificate of authority" is deleted and replaced by the word "license" wherever it occurs in each of the following sections of the General Statutes:

G.S. 58-4-15. Revocation of certificate of authority.

G.S. 58-7-55.	Exceptions to requirements of G.S. 58-7-50.
G.S. 58-7-70.	Effects of redomestication.
G.S. 58-15-5.	Definitions.
G.S. 58-16-35.	Unauthorized Insurers Process Act.
G.S. 58-24-45.	Organization.
G.S. 58-24-145.	Injunction -- Liquidation -- Receivership of domestic society.
G.S. 58-28-5.	Transacting business without certificate of authority prohibited; exceptions.
G.S. 58-28-15.	Validity of acts or contracts of unauthorized company shall not impair obligation of contract as to the company; maintenance of suits; right to defend.
G.S. 58-28-45.	Uniform Unauthorized Insurers Act.
G.S. 58-30-10.	Definitions.
G.S. 58-30-55.	Condition on release from delinquency proceedings.
G.S. 58-30-260.	Conservation of property of foreign or alien insurers found in this State.
G.S. 58-33-132.	Qualifications of instructors.
G.S. 58-41-55.	Penalties; restitution.
G.S. 58-48-35.	Powers and duties of the Association.
G.S. 58-48-45.	Duties and powers of the Commissioner.
G.S. 58-57-80.	Penalties.

PART X. RISK SHARING PLAN SUNSET EXTENSION.

Section 61. G.S. 58-42-55 reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article ~~shall expire~~ expires on July 1, ~~1997.~~ 1999."

PART XI. EFFECT OF HEADINGS.

Section 62. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART XII. EFFECTIVE DATE.

Section 63. Sections 30-32 of this act become effective September 1, 1997. The remainder of this act is effective when it becomes law.

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
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Attachment VII

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July 5, 1997

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones. Counsel

RE: Senate Bill 843 (Insurance Technical Amendments)

The proposed House Committee Substitute for SB 843 makes numerous changes to the insurance laws. These changes are generally technical in nature, such as repeals of obsolete or unnecessary provisions, clarifications of existing laws, and similar changes. The bill is an agency bill of the Department of Insurance.

The substitute bill does the following:

Part I. Deletes obsolete or unnecessary provisions, including a provision that prevents a fire and rescue unit from receiving workers ' compensation coverage for the fiscal year under the Fund that was set up for these units last year if they have not made their required contribution by July 1.

Part II. Makes changes in various statutes to conform to the changes made in 1995 to GS 58-2-50, concerning examinations and investigations by the Commissioner of Insurance and his staff. Provides that the Commissioner, through rules, will determine procedures governing recording of appeal hearings in the Beach and FAIR plans and how costs for those hearings and the transcripts will be divided.

Part III. Changes the name of continuing care retirement centers to continuing care retirement communities (also refers to them as "facilities") and provides that DHR may approve beds for a continuing care retirement community coming out of receivership if it's in the best interest of the facility, its residents, or prospective residents. This creates a limited exception to the possible moratorium on adult care beds still under consideration by the legislature.

Part IV. Makes conforming changes to several statutes due to the move two years ago from manual rating to loss cost rating for workers' compensation insurance.

Part V. Makes technical changes concerning insurance company financial operations.

Part VI. Makes clear that anti-discrimination law for the handicapped applies not only to insurers, but to HMOs, service corporations, and MEWAs. Eliminates provision that allowed for exclusion of pre-existing conditions.

Part VII. Makes several conforming and technical changes to auto insurance statutes, including raising the amount of UM and UIM coverage in a policy that can be ceded to the Reinsurance Facility to $1,000,000 – the amount that a driver can already obtain in such coverage.

Part VIII. Makes changes concerning workers' compensation self-insureds. Provides that if the Industrial Commission and the Department of Insurance both have rules on the use of managed care principles by self-insureds, the Industrial Commission's rules will control.

Part IX. Changes references to "certificate of authority" to license in several statutes.

Part X. Extends the sunset on the Department's ability to create joint underwriting associations another two years.

Part XI. Makes several changes to clarify provisions in the recently-enacted House Bill 434 on federal health insurance changes. These changes make clear that HB 434 does not allow late enrollees in small group plans to be completely excluded from coverage, clarifies that that self-employed individuals remain entitled to guaranteed-issue on basic and standard health care plans under the small group laws, and makes clear that the mental illness provisions do not apply to long-term care policies, disability policies, specialized disease policies, and similar types of limited benefit policies that are exempted by federal law.

Part XII. Provides that the Commissioner may allow certain commercial insurance documents to be retained instead of being filed by the insurer.

S843-SMRN-001

Call (Bill typing)

AGENDA

HOUSE COMMITTEE ON INSURANCE

July 16, 1997

OPENING REMARKS

Representative Dockham, Chairman

BILLS TO BE CONSIDERED

1. **HB-435-State Health Plan Tech. Amds.** → fav to Com Subi unfav. to original
   Representative Dockham - P.C.S. adopted (T.C Langer Minor Clarif). Dockham moved fav rpt of Com. Subi unfavorable to original.

Dockham floor sponsor

2. **SB-299-Long-Term Care Benefits** → fav. rpt.
   Senator Martin

floor sponsor Dockham

4. **SB-843-Insurance Technical Changes** — P.C.S. adopted - amendment offered/adopted
   Senator Jenkins motion by Rounsaville for fav. rpt.

Dan Rounsaville 3 floor handler

SB-273-Mastectomy/Hospital Stay Motion for fav. rpt by J Hardaway
Senator Forrester → favorable rpt

ADJOURNMENT

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

Attachment VIII

July 16, 1997

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 843 -- Insurance Technical Amendments and Corrections and Risk Sharing Plan Expiration Date Extension

This bill is divided into fourteen parts. The bill sections in all but two parts repeal obsolete or unnecessary laws, make technical amendments to existing laws, or make corrections in existing laws.

PARTS I through III: Sections 1 through 21.1 (pages 1 through 8) repeal obsolete or unnecessary laws, make conforming changes in a number of laws because of a 1995 amendment to one statute (G.S. 58-2-50), and correct the name given to continuing care retirement communities. These changes also include a provision that allows a fire and rescue unit to receive workers ' compensation coverage during the fiscal year under the Fund that was set up for these units last year if it has not made its required contribution by July 1; and provide that the Commissioner, through rules, will determine procedures governing recording of appeals from the Beach and FAIR plans and the costs for those recordings and the transcripts. Finally, this provides that DHR may approve beds for a continuing care retirement community in receivership if it's in the best interest of the facility, its residents, or prospective residents. This creates a limited exception to the possible moratorium on adult care beds still under consideration by the Legislature.

PART IV: Sections 22 through 32.1 (pages 8 through 12) add references in the Rate Bureau laws to the 1995 workers' compensation loss costs legislation. These references were inadvertently omitted in the 1995 legislation.

PART V: Sections 33 through 49 (pages 12 through 18) make technical changes in laws affecting insurance company financial operations and solvency.

PART VI: Sections 50 and 51 (page 18) make a technical change and a correction in laws affecting the handicapped, by making it clear that anti-discrimination law for the handicapped applies not only to insurers, but to HMOs, service corporations, and MEWAs. It also eliminates a provision that allowed for exclusion of pre-existing conditions, to conform with recent federal and North Carolina legislation.

PARTS VII and VIII: Sections 52 through 59 (pages 18 through 19) make technical amendments and corrections in laws on automobile insurance and workers' compensation self-insurance, including raising the amount of UM and UIM coverage in a policy that can be ceded to the Reinsurance Facility to $1,000,000 – the amount that a driver can already obtain in that coverage; make changes concerning workers' compensation self-insureds, and provide that if the Industrial Commission and the Department of Insurance both have rules on the use of managed care principles by self-insureds, the Industrial Commission's rules will control.

PART IX: Section 60 (pages 19 and 20) change the reference from "certificate of authority" to "license" for insurance companies to make use of the term consistent throughout the insurance statutes.

PART X: Section 61 extends for two years the expiration date of the 1986 Risk Sharing Plan Act. This has been done every regular long session since 1986.

PART XI. Sections 62 through 63.3 make several changes to clarify provisions in the recently-enacted House Bill 434 on federal health insurance changes (S.L. 1997-259). These changes make clear that HB 434 does not allow late enrollees in small group plans to be completely excluded from coverage, clarifies that that self-employed individuals remain entitled to guaranteed-issue on basic and standard health care plans under the small group laws, and makes clear that the mental illness provisions do not apply to long-term care policies, disability policies, specific disease policies, and similar types of limited benefit policies that are exempted by federal law.

PART XII. Provides that the Commissioner may allow certain commercial insurance documents (manuscript policies) to be retained instead of being filed by the insurer.

PART XIII: States that the headings in the bill do not affect the substance of the bill.

PART XIV: Provides for a September 1 effective date for some of the loss costs changes, which conform with the delayed effective date of changes in those statutes from the 1995 loss costs legislation. The risk sharing plan expiration date extension from July 1, 1997, to July 1, 1999, is effective June 30, 1997. The provisions amending the health insurance provisions in HB 434 are effective July 1, 1997. The provisions amending the mental health parity provisions in HB 434 are effective January 1, 1998. The rest of the changes are effective when they become law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 843
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97
Proposed House Committee Substitute S843-PCS2781

Short Title: Insurance Technical Changes. (Public)

Sponsors:

Referred to:

April 15, 1997

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES; AND TO EXTEND THE EXPIRATION DATE OF THE 1986 RISK SHARING PLAN LAW.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1. G.S. 58-3-125, 58-6-10, 58-7-150, 58-41-35, and 58-71-90 are repealed.

Section 2. G.S. 58-2-120 reads as rewritten:

"**§ 58-2-120. Reports of Commissioner to the Governor and General Assembly.**

~~The Commissioner shall biennially submit to the General Assembly, through the Governor, a report of his official acts, including a summary of official rulings and regulations.~~ The Commissioner shall, from time to time, report to the Governor and the General Assembly any change ~~which~~ that in ~~his~~ the Commissioner's opinion should be made in the laws relating to insurance and other subjects pertaining to ~~his department. On or before the first day of February of each year in which the General Assembly is in session he shall make to the Governor the recommendations called for in this section, to be transmitted to the General Assembly, with the last annual report of this Department, including receipts and disbursements.~~ the Department."

Section 3. G.S. 58-87-10(e) reads as rewritten:

"(e) Revenue Source. -- Revenue is credited to the Workers' Compensation Fund from appropriations made to the Department of Insurance for this purpose. In addition, every eligible unit that elects to participate shall pay into the Fund an amount set annually by the State Fire and Rescue Commission to ensure that the Fund will be able to meet its payment obligations under this section. The amount shall be set as a per capita fixed dollar amount for each member of the roster of the eligible unit.

The payment shall be made to the State Fire and Rescue Commission on or before July 1 of each year. The Commission shall remit the payments it receives to the State Treasurer, who shall credit the payments to the Fund. ~~If the Commission does not receive an annual payment from an eligible unit by July 1, then that unit shall not receive workers' compensation coverage from the Fund for the fiscal year that begins that July 1.~~"

Section 4. G.S. 120-123(55) and (65) are repealed.

Section 5. G.S. 58-36-15(e) reads as rewritten:

"(e) The Commissioner may require the filing of supporting data including:

(1) The Bureau's interpretation of any statistical data relied upon;

(2) Descriptions of the methods employed in setting the rates;

(3) Analysis of the incurred losses submitted on an accident year or policy year basis into their component parts; to wit, paid losses, reserves for losses and loss expenses, and reserves for losses incurred but not reported;

(4) The total number and dollar amount of paid claims;

(5) The total number and dollar amount of case basis reserve claims;

(6) Earned and written premiums at current rates by rating territory;

(7) Earned premiums and incurred losses according to classification plan categories; and

(8) Income from investment of unearned premiums and loss and loss expense reserves generated by business within this State.

~~Provided, however, that with respect to business written prior to January 1, 1980, the Commissioner shall not require the filing of such supporting data which has not been required to be recorded under statistical plans approved by the Commissioner.~~"

Section 6. G.S. 58-3-115 reads as rewritten:

"**§ 58-3-115. Twisting with respect to insurance policies; penalties.**

No insurer shall make or issue, or cause to be issued, any written or oral statement that willfully misrepresents or willfully makes an incomplete comparison as to the terms, conditions, or benefits contained in any policy of insurance for the purpose of inducing or attempting to induce a policyholder in any way to terminate or surrender, exchange, or convert any insurance policy. Any person who violates this section is subject to the provisions of ~~G.S. 58-2-70, 58-3-90 through 58-3-100, and 58-3-125.~~ G.S. 58-2-70 or G.S. 58-3-100."

Section 7. G.S. 58-30-75(7) reads as rewritten:

"(7) Without first obtaining the written consent of the ~~Commissioner pursuant to G.S. 58-7-150,~~ Commissioner, the insurer has (i)

transferred, or attempted to transfer, in a manner contrary to Article 19 of this Chapter, substantially its entire property or business, or (ii) has entered into any transaction, the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person."

Section 8. G.S. 58-41-40(a) reads as rewritten:

"(a) There is no liability on the part of and no cause of action for defamation or invasion of privacy arises against any insurer or its authorized representatives, agents, or employees, or any licensed insurance agent or broker, for any communication or statement made, unless shown to have been made in bad faith with malice, in any of the following:

(1) A written notice of cancellation under ~~G.S. 58-41-15,~~ G.S. 58-41-15 or of nonrenewal under G.S. 58-41-20, ~~or of cessation of business through an agency under G.S. 58-41-35,~~ specifying the reasons ~~therefor;~~ for cancellation.

(2) Communications providing information pertaining to ~~such cancellation, nonrenewal, or cessation of business through an agency;~~ the cancellation or nonrenewal.

(3) Evidence submitted at any court proceeding, administrative hearing, or informal inquiry in which ~~such cancellation, nonrenewal, or cessation of business through an agency~~ the cancellation or nonrenewal is an issue."

PART II. AMENDMENTS NECESSARY BECAUSE OF 1995 REWRITE OF G.S. 58-2-50.

Section 9. G.S. 58-34-2(j) reads as rewritten:

"(j) The Commissioner shall disapprove any such contract that:

(1) Does not contain the required contract provisions specified in subsection (d) of this section;

(2) Subjects the insurer to excessive charges for expenses or commission;

(3) Vests in the MGA any control over the management of the affairs of the insurer to the exclusion of the board of directors of the insurer;

(4) Is entered into with any person if the person or its officers and directors are of known bad character or have been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance; or

(5) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the insurer.

Failure of the Commissioner to disapprove any such contract within 30 days after the contract has been filed with the Commissioner constitutes the Commissioner's

approval of the contract. An insurer may continue to accept business from ~~such~~ the person until the Commissioner disapproves the contract. Any disapproval shall be in writing. The Commissioner ~~may, after a hearing held under G.S. 58-2-50,~~ may withdraw approval of any contract the Commissioner has previously approved ~~upon finding~~ if the Commissioner determines that the basis of the original approval no longer exists or that the contract has, in actual operation, shown itself to be subject to disapproval on any of the grounds in this subsection. If the Commissioner withdraws approval of a contract, the Commissioner shall give the insurer notice of, and written reasons for, the withdrawal of approval. The Commissioner shall grant any party to the contract a hearing upon request."

Section 10. G.S. 58-34-15(b) reads as rewritten:

"(b) If the Commissioner disapproves any management contract, ~~notice of such action shall be given to the insurer assigning the reasons therefor in writing.~~ the Commissioner shall give notice of, and written reasons for, the disapproval to the insurer. The Commissioner shall grant any party to the contract a hearing upon ~~request according to G.S. 58-2-50.~~ request."

Section 11. G.S. 58-40-100 reads as rewritten:

"§ 58-40-100. Request for review of rate, rating plan, rating system or underwriting rule.

(a) Any person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer or rating organization may request in writing that the insurer or rating organization ~~to~~ review the manner in which the rate, plan, system, or rule has been applied with respect to ~~insurance afforded him. Such request may be made by his authorized representative, and shall be in writing.~~ the person's insurance. The person's authorized representative may make the request. If the request is not granted within 30 days after it is made, the requestor may treat it as rejected. Any person aggrieved by the action of an insurer or rating organization in refusing the review requested or in failing or refusing to grant all or part of the relief requested, may file a written complaint and request for hearing with the Commissioner, and shall specify the grounds relied upon. If the Commissioner has information concerning a similar ~~complaint he~~ complaint, the Commissioner may deny the hearing. If the Commissioner believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, ~~he~~ the Commissioner shall deny the hearing. If the Commissioner finds that the complaint charges a violation of this Article and that the complainant would be aggrieved if the violation is proven, ~~he~~ the Commissioner shall proceed as provided in G.S. ~~58-2-50 or~~ 58-2-70.

(b) Repealed by Session Laws 1985 (Regular Session, 1986), c. 1027, s. 15."

Section 12. G.S. 58-42-1 reads as rewritten:

"§ 58-42-1. Establishment of plans.

If the Commissioner finds, after a ~~hearing held in accordance with G.S. 58-2-50,~~ hearing, that in all or any part of this State, any amount or kind of insurance authorized by G.S. 58-7-15(4) through G.S. 58-7-15(22) is not readily available in the

voluntary market and that the public interest requires the availability of that insurance, ~~he~~ the Commissioner may either:

(1) Promulgate plans to provide insurance coverage for any risks in this State that are, based on reasonable underwriting standards, entitled to obtain but are otherwise unable to obtain coverage; or

(2) Call upon insurers to prepare plans for ~~his~~ the Commissioner's approval."

Section 13. G.S. 58-45-50 reads as rewritten:

"**§ 58-45-50. Appeal from acts of Association to Commissioner; appeal from Commissioner to superior court.**

Any person or any insurer who may be aggrieved by an act, ruling or decision of the Association other than an act, ruling or decision relating to the cause or amount of a claimed loss, may, within 30 days after ~~such ruling~~ the ruling, appeal to the Commissioner. Any hearings held by the Commissioner ~~pursuant to such an~~ under the appeal shall be in accordance with ~~the procedure set forth in G.S. 58-2-50.~~ rules adopted by the Commissioner: Provided, however, the Commissioner is authorized to appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ those appeals and a ruling based upon ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the Commissioner. All persons or insureds aggrieved by any order or decision of the Commissioner may appeal as ~~is~~ provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than 20 days before each hearing, the appellant shall file with the Commissioner or his designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. ~~Each such hearing shall be recorded and transcribed. The cost of such recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by the other party.~~ The procedures governing recordings of hearings and, if necessary, transcripts of recordings, as well as the fees for copies of recordings and transcripts, shall be determined by rules adopted by the Commissioner. Each party shall, on a date determined by the Commissioner or his designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or his designated hearing officer and serve on the other party, a proposed order. The Commissioner or his designated hearing officer shall then issue an order."

Section 14. G.S. 58-45-70 reads as rewritten:

"**§ 58-45-70. Commissioner may examine affairs of Association.**

The Commissioner may from time to time make an examination into the affairs of the Association when ~~he~~ the Commissioner deems it to be ~~prudent and in undertaking such examination he~~ prudent, and as part of the examination the

Commissioner may hold a public ~~hearing pursuant to the provisions of G.S. 58-2-50.~~ hearing. ~~The expenses of such examination shall be borne and paid by the Association.~~ The Association shall pay the expenses of the examination."

Section 15. G.S. 58-46-20(c) reads as rewritten:

"(c) The Commissioner may designate the kinds of property insurance policies on principal residences to be offered by the association, including insurance policies under Article 36 of this Chapter, and the commission rates to be paid to agents or brokers for these policies, if ~~he~~ the Commissioner finds, after a ~~hearing held in accordance with G.S. 58-2-50,~~ hearing, that the public interest requires the designation. The provisions of Chapter 150B of the General Statutes do not apply to any procedure under this subsection, except that G.S. 150B-39 and G.S. 150B-41 shall apply to a hearing under this subsection. Within 30 days after the receipt of notification from the Commissioner of a change in designation ~~pursuant to~~ under this subsection, the association shall submit a revised plan and articles of association for approval in accordance with subsection (b) of this section."

Section 16. G.S. 58-46-30 reads as rewritten:

"**§ 58-46-30. Appeals; judicial review.**

The association shall provide reasonable means, to be approved by the Commissioner, whereby any person or insurer affected by any act or decision of the administrators of the Plan or underwriting association, other than an act or decision relating to the cause or amount of a claimed loss, may be heard in person or by an authorized representative, before the governing board of the association or a designated committee. Any person or insurer aggrieved by any decision of the governing board or designated committee, may be appealed to the Commissioner within 30 days from the date of ~~such~~ the ruling or decision. The Commissioner, after hearing held ~~pursuant to the procedure set forth in G.S. 58-2-50,~~ under rules adopted by the Commissioner, shall issue an order approving or disapproving the act or decision with respect to the matter ~~which~~ that is the subject of appeal. The Commissioner ~~is authorized to~~ may appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ the appeals and a ruling based on ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the ~~Commissioner personally.~~ Commissioner. All persons or insurers or their representatives aggrieved by any order or decision of the Commissioner may appeal as provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than 20 days before each hearing, the appellant shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. ~~Each such hearing shall be recorded and transcribed. The cost of such recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by~~

~~the other party.~~ The procedures governing recordings of hearings and, if necessary, transcripts of recordings, as well as the fees for copies of recordings and transcripts, shall be determined by rules adopted by the Commissioner. Each party shall, on a date determined by the Commissioner or ~~his~~ the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or ~~his~~ the designated hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the designated hearing officer shall then issue an order."

PART III. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION AND RECEIVERSHIPS.

Section 17. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity licensed under Articles 7, 16, 26, 49, 65, or 67 of this Chapter and any employer that has furnished to the Commissioner satisfactory proof of its financial responsibility under G.S. 97-93(a)(2). For purposes of this Article, 'insurer' also includes continuing care retirement ~~centers~~ communities licensed under Article 64 of this Chapter."

Section 18. The title of Article 64 of Chapter 58 of the General Statutes reads as rewritten:

"ARTICLE 64.

~~"Registration, Disclosure, Contract, and Financial Monitoring Requirements for~~ Continuing Care ~~Facilities.~~ Retirement Communities."

Section 19. G.S. 58-64-1 reads as rewritten:

"§ 58-64-1. Definitions.

As used in this Article, unless otherwise specified:

(1) 'Continuing care' means the furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, ~~pursuant to~~ under an agreement effective for the life of the individual or for a period ~~in excess of~~ longer than one year.

(2) 'Entrance fee' means a payment that assures a resident a place in a facility for a term of years or for life.

(3) 'Facility' means the ~~place or places~~ retirement community or communities in which a provider undertakes to provide continuing care to an individual.

(4) 'Health related services' means, at a minimum, nursing home admission or assistance in the activities of daily living, exclusive of the provision of meals or cleaning services.

(5) 'Living unit' means a room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents.

(6) 'Provider' means the promoter, developer, or owner of a ~~continuing care~~ facility, whether a natural person, partnership, or

other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract, or that represents ~~himself~~ himself, herself, or itself as providing continuing care or 'life care.'

(7) 'Resident' means a purchaser of, a nominee of, or a subscriber to, a continuing care contract.

(8) 'Hazardous financial condition' means a provider is insolvent or in eminent danger of becoming insolvent."

Section 20. G.S. 58-64-40(b) reads as rewritten:

"(b) The board of directors or other governing body of a ~~continuing care~~ facility or its designated representative shall hold annual meetings with the residents of the ~~continuing care~~ facility for free discussions of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility and discussions of proposed changes in policies, programs, and services. Residents shall be entitled to at least seven days advance notice of each meeting. An agenda and any materials that will be distributed by the governing body at the meetings shall remain available upon request to residents."

Section 21. G.S. 58-64-80 reads as rewritten:

"**§ 58-64-80. Advisory Committee.**

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

Section 21.1. Article 64 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-64-46. Receiverships; exception for facility beds.**

When the Commissioner has been appointed as a receiver under Article 30 of this Chapter for a provider or facility subject to this Article, and if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that the best interests of the facility or the welfare of persons who have previously contracted with the provider or may contract with the facility may be best served by the addition of adult care home beds, the Department of Human Resources may, notwithstanding any other provision of law, accept and approve the addition of beds for that facility."

PART IV. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 22. G.S. 58-36-1(2) reads as rewritten:

"(2) The Bureau shall provide reasonable means to be approved by the Commissioner whereby any person affected by a rate or loss

costs made by it may be heard in person or by ~~his~~ the person's authorized representative before the governing committee or other proper executive of the Bureau."

Section 23. G.S. 58-36-1(5)c. reads as rewritten:

"c. Failure or refusal by any assigned employer risk to make full disclosure to the Bureau, servicing carrier, or insurer writing a policy of information regarding the employer's true ownership, change of ownership, operations, or payroll, or any other failure to disclose fully any records pertaining to workers' compensation insurance shall be sufficient grounds for ~~the Bureau to authorize~~ the termination of the policy of that employer."

Section 24. G.S. 58-36-10 reads as rewritten:

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

The following standards ~~shall~~ apply to the making and use of ~~rates:~~ rates or loss costs:

(1) Rates or loss costs shall not be excessive, inadequate or unfairly discriminatory.

(2) Due consideration shall be given to actual loss and expense experience within this State for the most recent three-year period for which ~~such~~ that information is available; to prospective loss and expense experience within this State; to the hazards of conflagration and catastrophe; to a reasonable margin for underwriting profit and to contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to investment income earned or realized by insurers from their unearned premium, loss, and loss expense reserve funds generated from business within this State; to past and prospective expenses specially applicable to this State; and to all other relevant factors within this State: Provided, however, that countrywide expense and loss experience and other countrywide data may be considered only where credible North Carolina experience or data is not available.

(3) In the case of fire insurance rates, as are subject to the ratemaking authority of the Bureau, consideration may be given to the experience of such fire insurance business during the most recent five-year period for which ~~such~~ that experience is available. In the case of fire insurance rates that are subject to the ratemaking authority of the Bureau, consideration shall be given to the insurance public protection classifications of rural fire districts based upon standards established by the Commissioner. To the extent credits are provided for proximity to fire hydrants, the Bureau may also provide appropriate credits in public protection

classifications for optional water sources, such as ponds, lakes, or other bodies of water, in accordance with standards and procedures filed with and approved by the Commissioner.

(4) Risks may be grouped by classifications and lines of insurance for establishment of ~~rates~~ rates, loss costs, and base premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans ~~which~~ that establish standards for measuring variations in hazards or expense provisions or both. ~~Such~~ Those standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. The Bureau ~~is directed to~~ shall establish and implement a comprehensive classification rating plan for motor vehicle insurance under its jurisdiction within 90 days of September 1, 1977. No such classification plans shall base any standard or rating plan for private passenger (nonfleet) motor vehicles, in whole or in part, directly or indirectly, upon the age or sex of the persons insured. The Bureau shall at least once every three years make a complete review of the filed classification rates to determine whether they are proper and supported by statistical evidence, and shall at least once every 10 years make a complete review of the territories for nonfleet private passenger motor vehicle insurance to determine whether they are proper and reasonable.

(5) In the case of workers' compensation insurance and employers' liability insurance written in connection therewith, due consideration shall be given to the past and prospective effects of changes in compensation benefits and in legal and medical fees that are provided for in General Statutes Chapter 97."

Section 25. G.S. 58-36-15(a) reads as rewritten:

"(a) The Bureau shall file with the Commissioner copies of the rates, loss costs, classification plans, rating plans and rating systems used by its members. Each rate or loss costs filing shall become effective on the date specified in the filing, but not earlier than 105 days ~~from~~ after the date the filing is received by the Commissioner: Provided that (1) rate or loss costs filings for workers' compensation insurance and employers' liability insurance written in connection therewith shall not become effective earlier than 120 days from the date the filing is received by the Commissioner or on the date ~~as~~ provided ~~under~~ in G.S. 58-36-100, whichever is earlier; and (2) any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the Bureau."

Section 26. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar year the Bureau shall submit to the Commissioner the experience, data, statistics, and information referred to in subsection (c) of this section and required under G.S. 58-36-100 and a residual market rate ~~or~~ and prospective loss costs review based on ~~such~~ those data for

workers' compensation insurance and employers' liability insurance written in connection therewith. Any rate or loss costs increase for ~~such~~ that insurance that is implemented ~~pursuant to~~ under this Article shall become effective solely to ~~such insurance as is written having~~ insurance with an inception date on or after the effective date of the rate or loss costs increase."

Section 27. G.S. 58-36-15(g) reads as rewritten:

"(g) The following information must be included in policy form, rule, and rate or loss costs filings under this Article and under Article 37 of this Chapter:

(1) A detailed list of the rates, loss costs, rules, and policy forms filed, accompanied by a list of those superseded; and

(2) A detailed description, properly referenced, of all changes in policy forms, rules, prospective loss costs, and rates, including the effect of each change."

Section 28. G.S. 58-36-30(a) reads as rewritten:

"(a) ~~No insurer, officer, agent or representative thereof~~ Except as permitted by G.S. 58-36-100 for workers' compensation loss costs filings, no insurer and no officer, agent, or representative of an insurer shall knowingly issue or deliver or knowingly permit the issuance or delivery of any policy of insurance in this State ~~which~~ that does not conform to the rates, rating plans, classifications, schedules, rules and standards made and filed by the Bureau. ~~However, an~~ An insurer may deviate from the rates ~~promulgated~~ adopted by the Bureau ~~provided~~ if the insurer has filed the proposed deviation ~~to be applied both~~ with the Bureau and the Commissioner, ~~and provided the deviation is uniform in its application to all risks in the State of the class to which the deviation is to apply; and provided such deviation is approved by the Commissioner.~~ if the proposed deviation is based on sound actuarial principles, and if the proposed deviation is approved by the Commissioner. ~~The Commissioner shall approve proposed deviations if they do not render the rates excessive, inadequate or unfairly discriminatory. If approved, the deviation may thereafter be amended, subject to the provisions of this subsection.~~ Amendments to deviations are subject to the same requirements as initial filings. ~~The deviation may be terminated~~ An insurer may terminate a deviation only if the deviation has been in effect for a period of six months before the effective date of the termination and the insurer notifies the Commissioner of the termination no later than 15 days before the effective date of the termination."

Section 29. G.S. 58-36-30(c) reads as rewritten:

"(c) ~~Any deviation with respect to workers' compensation and employers' liability insurance written in connection therewith as filed under subsection (a) of this section shall apply uniformly to all classifications.~~ Any approved rate under subsection (b) of this section with respect to workers' compensation and employers' liability insurance written in connection therewith shall be furnished to the Bureau."

Section 30. Effective September 1, 1997, G.S. 58-36-100(a) reads as rewritten:

"(a) ~~Nothing in this section requires the Bureau or its member insurers to refile rates previously implemented before two years after the effective date of this section.~~

~~Any member insurer of the Bureau may continue to use all rates and deviations filed and approved for its use until disapproved, or the insurer makes its own filing to change its rates, either by making an independent filing or by filing a reference filing adoption form adopting the Bureau's prospective loss costs, or modification thereof.~~ Except as provided in ~~subsection~~ subsections (k) and (m) of this section, ~~with the initial prospective loss costs reference filing,~~ the Bureau shall no longer develop or file any minimum premiums, minimum premium formulas, or expense constants. If an insurer wishes to amend minimum premium ~~formulas,~~ formulas or expense constants, it must file the minimum premium rules, formulas, or amounts it proposes to use. A copy of each filing submitted to the Commissioner under subsections (e) and (g) of this section shall also be sent to the Bureau."

Section 31. Effective September 1, 1997, G.S. 58-36-100(b)(1) reads as rewritten:

"(1) 'Expenses'. -- That portion of a rate attributable to acquisition, field supervision, collection expenses, any tax levied by the State or by any political subdivision of the State, licensing costs, fees, and general expenses, as determined by the insurer."

Section 32. Effective September 1, 1997, G.S. 58-36-100(c) reads as rewritten:

"(c) Except as provided in subsection (m) of this section, for workers' compensation and employers' liability insurance written in connection with workers' compensation insurance, the Bureau shall no longer develop or file advisory final rates that contain provisions for expenses (other than loss adjustment expenses) and profit. The Bureau shall instead develop and file for approval with the Commissioner, in accordance with this section, reference filings containing advisory prospective loss costs and the underlying loss data and other supporting statistical and actuarial information for any calculations or assumptions underlying these loss costs. Loss-based ~~assessments, any tax levied by the State or any political subdivision of the State, licensing costs, and fees~~ assessments will be included in prospective loss costs."

Section 32.1. Effective September 1, 1997, G.S. 58-36-100(k) reads as rewritten:

"(k) The Bureau shall file with the Commissioner, for approval, filings containing a revision of rules and supplementary rating information. This includes policy-writing rules, rating plans, classification codes and descriptions, and rules that include factors or relativities, such as ~~employers' liability~~ increased limits ~~factors,~~ factors and related minimum premiums, classification relativities, or similar ~~factors, but excludes minimum premiums.~~ factors. The Bureau may print and distribute manuals of rules and supplementary rating ~~information, excluding minimum premiums.~~ information."

PART V. INSURANCE COMPANY FINANCIAL OPERATIONS.

Section 33. G.S. 58-5-63(a) reads as rewritten:

"(a) All insurance companies making deposits under this Article are entitled to interest on those ~~deposits, which shall remain in the deposit accounts.~~ deposits. The right to interest is subject to a company paying its insurance policy liabilities. If any company fails to pay those liabilities, interest accruing after the failure is payable to

the Commissioner for the payment of those liabilities under subsection (b) of this section."

Section 33.1. G.S. 58-3-81(d) reads as rewritten:

"(d) The minimum reserves for outstanding losses and loss expenses under policies of workers' compensation ~~insurance,~~ insurance in cases involving tabular reserves, except as provided in subsection (e) of this section, shall be computed as follows:

(1) For all such compensation policies where losses were incurred more than three years prior to the date of determination, such reserves shall be the sum of the present values, at three and one-half percent (3 1/2%) interest per annum, of the determined and estimated unpaid losses computed on an individual case basis plus the estimated unpaid loss expenses computed in accordance with subsection (b) of this section.

(2) Where losses were incurred during the three years immediately preceding the date of determination, such reserves shall be the sum of the reserves for each year, which shall be calculated in accordance with any method adopted or approved by the NAIC and shall be not less than the sum of the present values, at three and one-half percent (3 1/2%) interest per annum, of the determined and estimated unpaid losses computed on an individual case basis plus the estimated unpaid loss expenses computed in accordance with subsection (b) of this section."

Section 34. G.S. 58-7-21(a) reads as rewritten:

"(a) As used in this section and in G.S. ~~58-7-26, 58-7-30, and 58-7-31.~~ 58-7-26 and G.S. 58-7-30:

(1) 'Reinsurance' means a transfer of insurance risk from a ceding insurer to an assuming insurer.

(2) 'Insurance risk' means an uncertainty regarding the ultimate amount of any claim payment (underwriting risk) or an uncertainty regarding the timing of the payments (timing risk), or both."

Section 35. G.S. 58-7-31(b)(3) reads as rewritten:

"(3) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement; except that neither offsetting experience refunds against current and prior years' losses under the reinsurance agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the reinsurance agreement upon voluntary termination of in-force reinsurance by the ceding insurer are a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions that allow

the reinsurer to reduce its risk or increase its risk charge under the reinsurance agreement."

Section 36. G.S. 58-7-31(d)(1) reads as rewritten:

"(1) Reinsurance agreements entered into after October 1, 1993, that involve the reinsurance of business issued ~~prior to~~ before the effective date of the reinsurance agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days after its date of execution. Each filing shall include data detailing the ~~final impact~~ financial effect of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this ~~statute~~ section and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Commissioner. The actuary ~~should~~ shall maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that ~~such~~ that work conforms to this ~~statute.~~ section."

Section 37. G.S. 58-7-173(12) reads as rewritten:

"(12) Secured obligations of duly constituted churches and of church-holding companies; and the cost of investments made under this subdivision shall not exceed the lesser of one percent (1%) of the insurer's admitted assets ~~of~~ or five percent (5%) of the insurer's capital and surplus."

Section 38. The catchline of G.S. 58-7-177 reads as rewritten:

"**§ 58-7-177. Investments in ~~subsidiaries and affiliated corporations.~~ subsidiaries.**"

Section 39. G.S. 58-8-5(a)(3) reads as rewritten:

"(3) ~~Said officers shall cause said certificate to be published once a week for two consecutive weeks in a newspaper in Raleigh and in the county where the company's principal office is located, or posted at the courthouse door if no newspaper be published within the county. Said printed or posted notices shall be in such form and of such size as the Commissioner may approve, and in addition to setting forth in full the certificate required in subdivision (2) shall state that application for amending the company's charter in the manner specified has been proposed by the board of directors, and shall also state the time set for a meeting of policyholders thereby called to be held at the principal office of the company to take action on the proposed amendment. A true copy of such notice shall be filed with the Commissioner, and also with that official who performs the functions of Commissioner in each state where the company is licensed to do business. Such publication and filing of notices shall be completed at least 30 days prior to the date set therein~~

~~for the meeting of policyholders and due proof thereof shall be filed with the Commissioner at least 15 days prior to the date of such meeting.~~ If the meeting at which the proposed amendment is to be considered is a special meeting, rather than a regular annual meeting of policyholders, ~~such special~~ that meeting can be called only after the Commissioner has given ~~his~~ approval in ~~writing, and the published notice shall show the fact of such approval;~~ writing;"

Section 40. G.S. 58-8-25 reads as rewritten:

"**§ 58-8-25. Dividends to policyholders.**

(a) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes other than life insurance or workers' compensation insurance and employers' liability insurance in connection therewith, may declare and pay a dividend to policyholders from its ~~surplus,~~ unassigned surplus as reflected in the company's most recent annual or quarterly statement filed with the Commissioner, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period, upon the basis of each general kind of insurance covered by ~~such~~ those policies and by territorial divisions of the location of risks by states, except that in fixing the amount of dividends to be paid on each general kind of insurance, ~~which~~ the dividends shall be uniform in rate and applicable to the majority of risks within ~~such~~ that general kind of insurance, and exceptions may be made as to any class or classes of risk and a different rate or amount of dividends paid on ~~such~~ the class or classes if the conditions applicable to ~~such~~ the class or classes differ substantially from the condition applicable to the kind of insurance as a whole. Every such company shall have an equal rate of dividend for the same term on all policies insuring risks in the same classification. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks.

(b) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes workers' compensation insurance and employers' liability insurance in connection therewith may declare and pay a dividend to policyholders from its ~~surplus,~~ unassigned surplus as reflected in the company's most recent statement filed with the Commissioner under G.S. 58-2-165, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be

paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau, or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks."

Section 41. G.S. 58-9-6(a) reads as rewritten:

"(a) The Commissioner shall issue an intermediary license or an exemption from the license, subject to G.S. 58-9-2(b)(2) or G.S. 58-9-2(c)(3), to any person who has complied with the requirements of this Article. A license issued to a noncorporate entity authorizes all of the members of the entity and any designated employees to act as intermediaries under the license, and those persons shall be named in the application and any supplements. A license issued to a corporation authorizes all of the officers and any designated employees and directors of the corporation to act as intermediaries on behalf of the corporation, and those persons shall be named in the application and any supplements."

Section 42. G.S. 58-9-11(b) reads as rewritten:

"(b) An insurer shall not engage the services of any person to act as a broker on its behalf unless the person is licensed ~~under G.S. 58-9-6.~~ or exempted under this Article. An insurer shall not employ an individual who is employed by a broker with which it transacts business, unless the broker is under common control with the insurer under Article 19 of this Chapter."

Section 43. G.S. 58-9-21(a) reads as rewritten:

"(a) A reinsurer shall not engage the services of any person to act as a manager on its behalf unless the person is licensed ~~under G.S. 58-9-6.~~ or exempted under this Article."

Section 44. G.S. 58-12-2(3) reads as rewritten:

"(3) Domestic insurer. -- Any insurance company organized in this State under ~~Article 7~~ Article 7 or Article 15 of this Chapter."

Section 45. G.S. 58-13-10 reads as rewritten:

"**§ 58-13-10. Scope.**

(a) This Article applies to all domestic insurers and to all kinds of insurance written by those insurers ~~under Articles 1 through 66~~ of this Chapter. Foreign insurers ~~are to~~ shall comply in substance with the requirements and limitations of this section. ~~This Article does not apply to variable contracts for which separate accounts are required to be maintained nor to statutory deposits that are required to be~~

~~maintained by insurance regulatory agencies as a requirement for doing business in such jurisdictions.~~

(b) This Article does not apply to:

(1) Variable contracts for which separate accounts are required to be maintained.

(2) Statutory deposits that are required to be maintained by insurance regulatory agencies as a requirement for doing business.

(3) Real estate authorized under G.S. 58-7-187 and encumbered by a mortgage loan with a first lien."

Section 46. G.S. 58-13-15 reads as rewritten:

"**§ 58-13-15. Definitions.**

As used in this Article:

(1) 'Assets' means all property, real or personal, tangible or intangible, legal or equitable, owned by an insurer.

(2) 'Claimants' means any owners, beneficiaries, assignees, certificate holders, or third-party beneficiaries of any insurance benefit or right arising out of and within the coverage of an insurance policy covered by this Article.

(3) 'Reserve assets' means those assets of an insurer that are authorized investments for policy reserves in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~ this Chapter.

(4) 'Policyholder-related liabilities' means those liabilities that are required to be established by an insurer for all of its outstanding insurance policies in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~ this Chapter."

Section 47. G.S. 58-13-20(b) reads as rewritten:

"(b) The Commissioner ~~has the right to~~ may examine any of ~~such~~ these assets, reinsurance agreements, or deposit arrangements at any time in accordance with ~~his~~ the Commissioner's authority to make examinations of insurers as conferred by other provisions ~~of Articles 1 through 64~~ of this Chapter."

Section 48. G.S. 58-19-5(5) reads as rewritten:

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

Section 49. G.S. 58-19-10(b)(1) reads as rewritten:

"(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts that do not exceed the lesser of ten percent (10%) of ~~such~~ the insurer's admitted assets or fifty percent (50%) of ~~such~~ the insurer's surplus as regards policyholders, provided that after ~~such~~ those investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and

adequate to its financial needs. In calculating the amount of ~~such~~ the investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included: (i) total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of ~~such~~ the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and (ii) all amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;".

PART VI. HANDICAPPED PERSONS.

Section 50. G.S. 168-10 reads as rewritten:

"**§ 168-10. Eliminate discrimination in treatment of handicapped and disabled.**

Each handicapped person shall have the same consideration as any other person for individual accident and health insurance coverage, and no insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes solely on the basis of ~~such~~ the person's handicap, shall deny ~~such~~ coverage or benefits. The availability of ~~such insurance~~ coverage or benefits shall not be denied solely ~~due to~~ because of the ~~handicap, provided, however, that no such insurer shall be prohibited from excluding by waiver or otherwise, any pre-existing conditions from such coverage, and further provided that~~ handicap; however, any such insurer may charge the appropriate premiums or fees for the risk insured on the same basis and conditions as insurance issued to other ~~persons.~~ persons, in accordance with actuarial and underwriting principles prescribed in Chapter 58 of the General Statutes. ~~Nothing contained herein or in any other statute shall restrict or preclude any insurer governed by Chapter 58 of the General Statutes from setting and charging a premium or fee based upon the class or classes of risks and on sound actuarial and underwriting principles as determined by such insurer, or from applying its regular underwriting standards applicable to all classes of risks. The provisions of this section shall apply to both corporations governed by Chapter 58 of the General Statutes.~~"

Section 51. G.S. 168-22(b) reads as rewritten:

"(b) A family care home ~~shall be~~ is deemed a residential use of property for the purposes of determining charges or assessments imposed by political subdivisions or businesses for water, sewer, power, telephone service, cable television, garbage and trash collection, repairs or improvements to roads, streets, and sidewalks, and other services, utilities, and ~~improvements, and for purposes of classification for insurance.~~ improvements."

PART VII. AUTOMOBILE INSURANCE.

Section 52. G.S. 58-36-75(c) is repealed.

Section 53. G.S. 58-36-5(c) reads as rewritten:

"(c) The ~~Bureau, when created,~~ Bureau shall adopt ~~such~~ rules ~~and regulations~~ for its orderly procedure ~~as shall be~~ that are necessary for its maintenance and operation. No ~~such~~ rules ~~and regulations~~ shall discriminate against any type of insurer because of its plan of operation, nor shall any insurer be prevented from returning any unused or unabsorbed premium, deposit, savings or earnings to its policyholders or subscribers. ~~The expense of such Bureau shall be borne by its members by quarterly contributions to be made in advance, such contributions to be made in advance by prorating such expense among the members in accordance with the amount of gross premiums derived from the above lines of insurance in North Carolina during the preceding year and members entering the Bureau since that date to advance an amount to be fixed by the governing committee. After the first fiscal year of operation of the Bureau the~~ The necessary expense of the Bureau shall be advanced by the members in accordance with rules ~~and regulations to be~~ established and adopted by the governing committee. The Bureau ~~shall be empowered to~~ may subscribe for or purchase any necessary service, ~~and~~ employ and fix the salaries of such personnel and assistants as are ~~necessary.~~ necessary, charge reasonable fees for its products and services, and engage in any lawful activities related to the objects, functions, duties, responsibilities, or authority of the Bureau."

Section 53.1. G.S. 58-37-1(7) reads as rewritten:

"(7) 'Motor vehicle insurance' means direct insurance against liability arising out of the ownership, operation, maintenance or use of a motor vehicle for bodily injury including death and property damage and includes medical payments and uninsured and underinsured motorist coverages.

With respect to motor carriers who are subject to the financial responsibility requirements established under the Motor Carrier Act of 1980, the term, 'motor vehicle insurance' includes coverage with respect to environmental restoration. As used in this subsection the term, 'environmental restoration' means restitution for the loss, damage, or destruction of natural resources arising out of the accidental discharge, dispersal, release, or escape into or upon the land, atmosphere, water course, or body of water of any commodity transported by a motor carrier. Environmental restoration includes the cost of removal and the cost of necessary measures taken to minimize or mitigate damage to human health, the natural environment, fish, shellfish, and wildlife."

Section 53.2. G.S. 58-37-35(b)(2) reads as rewritten:

"(2) Additional ceding privileges for motor vehicle insurance shall be provided by the Board of Governors if there is a substantial public demand for a coverage or coverage limit of any component of motor vehicle insurance up to the following:

Bodily injury liability: one hundred thousand dollars ($100,000) each person, three hundred thousand dollars ($300,000) each accident;

Property damage liability: fifty thousand dollars ($50,000) each accident;
Medical payments: two thousand dollars ($2,000) each person;
Underinsured motorist: one ~~hundred thousand~~ million dollars ~~($100,000)~~ ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;
Uninsured motorist: one ~~hundred thousand~~ million dollars ~~($100,000)~~ ($1,000,000) each person and each accident for bodily injury and ~~fifteen~~ fifty thousand dollars ~~($15,000)~~ ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

Section 53.3. G.S. 58-37-35(e) reads as rewritten:

"(e) The Commissioner and member companies shall provide for a Board of ~~Governors within 30 days after May 24, 1973. If any member seat on the initial Board of Governors is not filled in accordance with this Article within such time, then, in that event the Commissioner shall appoint natural persons from any of the classifications specified in subsection (d) of this section to serve the initial term on the Board of Governors. As soon as possible after its selection, the Commissioner shall call for the initial meeting of the Board.~~ Governors. ~~After the~~ The Board of Governors ~~have been selected it~~ shall ~~then~~ elect from its membership a chairman and shall ~~then~~ meet ~~thereafter as often as~~ at the call of the chairman ~~shall require~~ or at the request of ~~three~~ four members of the Board of Governors. The chairman shall retain the right to vote on all issues. Five members of the Board of Governors shall constitute a quorum. The same member may not serve as chairman for more than two consecutive ~~years.~~ years; provided, however, that a member may continue to serve as chairman until a successor chairman is elected and qualified."

Section 53.4. G.S. 58-37-40(e) reads as rewritten:

"(e) Upon approval of the Commissioner of the plan so submitted or promulgation of a plan deemed approved by the Commissioner, all insurance companies licensed to write motor vehicle insurance in this State or any component thereof as a prerequisite to further engaging in writing the insurance shall formally subscribe to and participate in the plan so approved.

The plan of operation shall provide for, among other matters, (i) the establishment of necessary facilities; (ii) the management of the Facility; (iii) the preliminary assessment of all members for initial expenses necessary to commence operations; (iv) the assessment of members if necessary to defray losses and expenses; (v) the distribution of gains to defray losses incurred since September 1, 1977; (vi) the distribution of gains by credit or reduction of recoupment ~~or allocation~~ surcharges to policies subject to recoupment ~~or allocation~~ surcharges pursuant to this Article (the Facility may apportion the distribution of gains among the coverages eligible for cession pursuant to this Article); (vii) the recoupment or allocation of losses sustained by the Facility since September 1, 1977, pursuant to this Article, which losses may be recouped by equitable pro rata assessment of member ~~companies;~~ companies or by way of a surcharge on motor vehicle policies issued by member companies or through the Facility; (viii) the standard amount (one hundred percent (100%) or any

equitable lesser amount) of coverage afforded on eligible risks which a member company may cede to the Facility; and (ix) the procedure by which reinsurance shall be accepted by the Facility. The plan shall further provide that:

(1) Members of the Board of Governors shall receive reimbursement from the Facility for their actual and necessary expenses incurred on Facility business, en route to perform Facility business, and while returning from Facility business plus a per diem allowance of twenty-five dollars ($25.00) a day which may be waived.

(2) In order to obtain a transfer of business to the Facility effective when the binder or policy or renewal thereof first becomes effective, the company must within 30 days of the binding or policy effective date notify the Facility of the identification of the insured, the coverage and limits afforded, classification data, and premium. The Facility shall accept risks at other times on receipt of necessary information, but acceptance shall not be retroactive. The Facility shall accept renewal business after the member on underwriting review elects to again cede the business."

Section 54. G.S. 58-37-40(f) reads as rewritten:

"(f) The plan of operation shall provide that every member shall, following payment of any pro rata assessment, ~~commence~~ begin recoupment of that assessment by way of a surcharge on motor vehicle insurance policies issued by the member or through the Facility until the assessment has been recouped. ~~Such~~ Any surcharge under this subsection or under subsection (e) of this section shall be a percentage of premium adopted by the Board of Governors of the Facility; and the charges determined on the basis of the surcharge shall be combined with and displayed as a part of the applicable premium charges. ~~Provided, however, that recoupment~~ Recoupment of losses sustained by the Facility ~~since September 1, 1977,~~ with respect to nonfleet private passenger motor vehicles may be ~~recouped~~ made only by surcharging nonfleet private passenger motor vehicle insurance policies. ~~policies (i) that are subject to the classification plan promulgated pursuant to G.S. 58-36-65 and (ii) to which one or more driving record points have been assigned pursuant to said plan, subject to the provisions of G.S. 58-36-75.~~ If the amount collected during the period of surcharge exceeds assessments paid by the member to the Facility, the member shall pay over the excess to the Facility on a date specified by the Board of Governors. If the amount collected during the period of surcharge is less than the assessments paid by the member to the Facility, the Facility shall pay the difference to the member. Except as ~~hereinafter provided,~~ otherwise provided in this Article, the amount of recoupment shall not be considered or treated as a rate or premium for any purpose. The Board of Governors shall adopt and implement a plan for compensation of agents of Facility members when recoupment surcharges are imposed; ~~such~~ that compensation shall not exceed the compensation or commission rate normally paid to the agent for the issuance or renewal of the automobile liability policy issued through the North Carolina Reinsurance Facility affected by ~~such surcharge; provided, however, that~~ the surcharge. However, the surcharge ~~provided~~

~~for in this section~~ shall include an amount necessary to recover the amount of the assessment to member companies and the compensation paid by each member, ~~pursuant to~~ under this section, to agents."

Section 55. G.S. 58-37-35(b)(8) reads as rewritten:

"(8) To establish fair and reasonable procedures for the sharing among members of any loss on Facility business ~~which~~ that cannot be recouped ~~pursuant to~~ under G.S. 58-37-40~~(f)~~ (e) ~~or which cannot be recouped or allocated under G.S. 58-37-75,~~ allocated, and other costs, charges, expenses, liabilities, income, property and other assets of the Facility and for assessing or distributing to members their appropriate shares. ~~Such~~ The shares may be based on the member's premiums for voluntary business for the appropriate category of motor vehicle insurance or by any other fair and reasonable method."

Section 56. G.S. 58-37-35(l) reads as rewritten:

"(l) The classifications, rules, rates, rating plans and policy forms used on motor vehicle insurance policies reinsured by the Facility may be made by the Facility or by any licensed or statutory rating organization or bureau on its behalf and shall be filed with the Commissioner. The Board of Governors shall establish a separate subclassification within the Facility for 'clean ~~risks' as herein defined.~~ risks'. For the purpose of this Article, a 'clean risk' ~~shall be~~ is any owner of a nonfleet private passenger motor vehicle as defined in G.S. 58-40-10, if the owner, principal operator, and each licensed operator in the owner's household have two years' driving experience as licensed drivers and if none of the persons has been assigned any Safe Driver Incentive Plan points under Article 36 of this Chapter during the three-year period immediately preceding either (i) the date of application for a motor vehicle insurance policy or (ii) the date of preparation of a renewal of a motor vehicle insurance policy. ~~Such~~ The filings may incorporate by reference any other material on file with the Commissioner. Rates shall be neither excessive, inadequate nor unfairly discriminatory. If the Commissioner finds, after a hearing, that a rate is either excessive, inadequate or unfairly discriminatory, ~~he~~ the Commissioner shall issue an order specifying in what respect it is deficient and stating when, within a reasonable period thereafter, ~~such rate shall be deemed~~ the rate is no longer effective. ~~Said~~ The order is subject to judicial review as set out in Article 2 of this Chapter. Pending judicial review of ~~said~~ the order, the filed classification plan and the filed rates may be used, charged and collected in the same manner as set out in G.S. 58-40-45 of this Chapter. ~~Said~~ The order shall not affect any contract or policy made or issued ~~prior to~~ before the expiration of the period set forth in the order. All rates shall be on an actuarially sound basis and shall be calculated, insofar as is possible, to produce neither a profit nor a loss. However, the rates made by or on behalf of the Facility with respect to 'clean ~~risks', as defined above,~~ risks' shall not exceed the rates charged 'clean risks' who are not reinsured in the Facility. The difference between the actual rate charged and the actuarially sound and self-supporting rates for 'clean risks' reinsured in the Facility may be recouped in similar manner as

assessments ~~pursuant to G.S. 58-37-40(f) or allocated pursuant to G.S. 58-37-75.~~ under G.S. 58-37-40(f). Rates shall not include any factor for underwriting profit on Facility business, but shall provide an allowance for contingencies. There shall be a strong presumption that the rates and premiums for the business of the Facility are neither unreasonable nor excessive."

Section 57. G.S. 58-37-75 is repealed.

PART VIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 58. G.S. 58-50-60 reads as rewritten:

"§ 58-50-60. Rules for precertification practices.

(a) This section applies to all accident and health insurers under Articles 1 through 64 of this Chapter, all third-party administrators and preferred provider arrangements, all entities subject to Articles 65 through 67 of this Chapter, and all self-funded ~~health benefit~~ workers' compensation insurance plans.

(b) The Commissioner shall adopt reasonable rules governing ~~precertification practices and forms~~ utilization review and utilization review organizations ~~affiliated~~ that do business with the entities subject to this section."

Section 59. G.S. 58-50-65(a) reads as rewritten:

"(a) ~~Nothing~~ Except as provided in this subsection, nothing in Articles 50 through 55 of this Chapter ~~shall apply~~ applies to ~~or affect~~ any ~~policy of~~ liability or workers' compensation ~~insurance, except that~~ insurance policy. Except for G.S. 58-50-55(a), the provisions of ~~G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall~~ this Article and Articles 65 and 67 of this Chapter and any administrative rules adopted under those Articles relating to preferred providers and utilization review apply to ~~policies of~~ workers' compensation ~~insurance.~~ insurance policies and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care rules adopted by the Commissioner under this Chapter and managed care rules adopted by the Industrial Commission under G.S. 97-25.2, the Industrial Commission's rules govern. If there is any conflict between managed care provisions in this Chapter and in Chapter 97 of the General Statutes with respect to workers' compensation, the provisions in Chapter 97 govern."

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 60. The phrase "certificate of authority" is deleted and replaced by the word "license" wherever it occurs in each of the following sections of the General Statutes:

G.S. 58-4-15.	Revocation of certificate of authority.
G.S. 58-7-55.	Exceptions to requirements of G.S. 58-7-50.
G.S. 58-7-70.	Effects of redomestication.
G.S. 58-15-5.	Definitions.
G.S. 58-16-35.	Unauthorized Insurers Process Act.
G.S. 58-24-45.	Organization.
G.S. 58-24-145.	Injunction -- Liquidation -- Receivership of domestic society.
G.S. 58-28-5.	Transacting business without certificate of authority prohibited; exceptions.

G.S. 58-28-15.	Validity of acts or contracts of unauthorized company shall not impair obligation of contract as to the company; maintenance of suits; right to defend.
G.S. 58-28-45.	Uniform Unauthorized Insurers Act.
G.S. 58-30-10.	Definitions.
G.S. 58-30-55.	Condition on release from delinquency proceedings.
G.S. 58-30-260.	Conservation of property of foreign or alien insurers found in this State.
G.S. 58-33-132.	Qualifications of instructors.
G.S. 58-41-55.	Penalties; restitution.
G.S. 58-48-35.	Powers and duties of the Association.
G.S. 58-48-45.	Duties and powers of the Commissioner.
G.S. 58-57-80.	Penalties.

PART X. RISK SHARING PLAN SUNSET EXTENSION.

Section 61. G.S. 58-42-55 reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article ~~shall expire~~ expires on July 1, ~~1997.~~ 1999."

PART XI. HEALTH INSURANCE CLARIFYING CHANGES.

Section 62. G.S. 58-50-130(a), as amended by S.L. 1997-259, is amended by adding the following new subdivision:

"(4) Late enrollees may only be excluded from coverage for the greater of 18 months or an 18-month preexisting-condition exclusion; however, if both a period of exclusion from coverage and a preexisting-condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of such period in the health benefit plan currently held by the small employer."

Section 63. G.S. 58-68-40(e)(2), as enacted by S.L. 1997-259, reads as rewritten:

"(2) A self-employed individual as defined in ~~G.S. 58-50-110(21a).~~ G.S. 58-50-110(21a), except as otherwise provided for the basic and standard health care plans under the North Carolina Small Employer Group Health Coverage Reform Act."

Section 63.1. G.S. 58-51-55(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to group health insurance ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

Section 63.2. G.S. 58-65-90(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to subscriber ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

Section 63.3. G.S. 58-67-75(d), as amended by S.L. 1997-259, reads as rewritten:

"(d) Applicability. -- Subsection (b1) of this section applies only to group ~~contracts~~ contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees."

PART XII. COMMERCIAL INSURANCE FORM DOCUMENT RETENTION.

Section 64. G.S. 58-41-50(g) reads as rewritten:

"(g) An insurer subject to this Article may develop and use an individual form or rate as a result of the uniqueness of a particular risk. The form or rate shall be developed, filed, and used in accordance with rules adopted by the Commissioner. Rules adopted by the Commissioner under this section may provide for retention of certain documents and data by insurers instead of insurers filing those records with the Commissioner."

PART XIII. EFFECT OF HEADINGS.

Section 65. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART XIV. EFFECTIVE DATE.

Section 66. Sections 30 through 32 of this act become effective September 1, 1997. Section 61 of this act becomes effective June 30, 1997. Sections 62 and 63 become effective July 1, 1997. Sections 63.1, 63.2, and 63.3 become effective January 1, 1998. The remainder of this act is effective when it becomes law.

MINUTES

HOUSE COMMITTEE ON INSURANCE

August 6, 1997

The House Committee on Insurance met around the Chamber desk of Chairman Jerry Dockham after the Legislative Session on August 6, 1997. A quorum was present and Senate Bill 273 was considered. Representative McComas moved that the bill be given a favorable report. The motion passed.

Representative Jerry C. Dockham, Chairman

Mary H. Moore, Acting Clerk

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 1

SENATE BILL 273

Short Title: Mastectomy/Hospital Stay. (Public)

Sponsors: Senators Forrester; Cochrane, Hoyle, Lucas, and Perdue.

Referred to: Pensions & Retirement and Insurance.

March 3, 1997

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE COVERAGE OF POSTMASTECTOMY INPATIENT CARE UNDER HEALTH INSURANCE PLANS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-171.1. Coverage for postmastectomy inpatient care.**

(a) Every entity providing a health benefit plan that provides coverage for mastectomy, including coverage for postmastectomy inpatient care, shall ensure that the decision whether to discharge the patient following mastectomy is made by the attending physician in consultation with the patient, and shall further ensure that the length of postmastectomy hospital stay is based on the unique characteristics of each patient taking into consideration the health and medical history of the patient.

(b) As used in this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Section 2. This act is effective when it becomes law and applies to health benefit plans issued, renewed, or amended on and after that date.

1997 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Jerry C. Dockham** for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 273 A BILL TO BE ENTITLED AN ACT PERTAINING TO THE COVERAGE OF POSTMASTECTOMY INPATIENT CARE UNDER HEALTH INSURANCE PLANS.

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

HOUSE INSURANCE COMMITTEE

CHAIRMAN

Jerry C. Dockham

Cary D. Allred

Bobby Harold Barbee,

James B. Black

C. Robert Brawley

Nelson Cole

Andrew Thomas Dedmon

W. W. (Dub) Dickson

John R. Gamble, Jr.

Charlotte A. Gardner

Thomas C. Hardaway

Edwin Mitchell Hardy

Bob Hensley

HOUSE INSURANCE COMMITTEE

RMM

George M. Holmes

John W. Hurley

William (Bill) Ives

Paul Luebke

Danny McComas

George W. Miller

David Miner

Jean R. Preston

Timothy N. Tallent

William L. Wainwright

Thomas Wright

Stephen Wood

PRO TEMPORE

N. Leo Daughtry

MAJORITY Leader

Julia Craven Howard

MAJORITY WHIP

HOUSE INSURANCE COMMITTEE

Joanne W. Bowie

Theresa H. Esposito

H. M. Michaux, Jr.

Carolyn B. Russell

ROLL CALL VOTE

____ ____ = (TOTAL) HB# _____
YES NO SB# _____

HOUSE STANDING COMMITTEE ON INSURANCE

House Subcommittee on _____

YES	NO	MEMBERS	YES	NO	MEMBERS
___	___	(last name)	___	___	
___	___	DOCKHAM	___	___	PRESTON
___	___	ALLRED	___	___	TALLENT
✓	___	BARBEE	___	___	Wainwright
___	___	BLACK	___	___	WRIGHT
✓	___	BRAWLEY	___	___	
___	___	COLE	___	___	
___	___	DEDMON	___	___	
___	___	DICKSON	___	___	
___	___	GAMBLE	___	___	
___	___	GARDNER	___	___	
___	___	HARDAWAY	___	___	
___	___	HARDY	___	___	
___	___	HENSLEY	___	___	
___	___	HOLMES	___	___	
___	___	HURLEY	___	___	
___	___	IVES	___	___	
___	___	LUEBKE			
___	___	McCOMAS	___	___	, CHR
___	___	MILLER	___	___	, CHR
___	___	MINER	___	___	, CHR

12 to 10

___ ___ Daughtry, MAJORITY LEADER

___ ___ WOOD, SPEAKER PRO TEM

___ ___ HOWARD, MAJORITY WHIP

ATTENDANCE

INSURANCE COMMITTEE

DATES	6/18	6/25	7/2	7/7	10/21									
Rep. Jerry C. Dockham	✓	✓	✓	✓	✓									
Rep. Cary D. Allred		✓		✓										
Rep. Bobby H. Barbee	✓	✓	✓	✓										
Rep. James B. Black	✓			✓										
Rep. C. Robert Brawley	✓	✓	✓	✓	✓									
Rep. Nelson Cole	✓	✓	✓	✓	✓									
Rep. Andrew T. Debmon	✓			✓										
Rep. Dub Dickson	✓	✓	✓	✓	✓									
Rep. John R. Gamble, Jr.					✓									
Rep. Charlotte A. Gardner	✓	✓	✓	✓										
Rep. Thomas C. Hardaway	✓		✓	✓										
Rep. Sandy Hardy	✓	✓	✓	✓	✓									
Rep. Bob Hensley	✓		✓	✓	✓									
Rep. Geroge M. Holmes				✓										
Rep. John W. Hurley	✓	✓	✓	✓	✓									
Rep. William Ives	✓	✓	✓	✓										
Rep. Paul Luebke	✓	✓	✓	✓										
Rep. Danny McComas.	✓	✓	✓	✓										
Rep. David Miner			✓	✓										
Rep. Jean R. Preston														
Rep. Timothy N. Tallent														
Rep. William L. Wainwright	✓		✓	✓	✓									
Rep. Thomas Wright	✓	✓	✓		✓									
Rep. Stephen Wood														
Rep. Leo Daughtry														
Rep. Julia C. Howard														

ATTENDANCE

INSURANCE

(Name of Committee)

DATES	4/18	4/25	7/2	7/9	10/21									
Rep. Joni Bowie		✓	✓	✓										
Rep. Theresa H. Esposito				✓										
Rep. Mickey Michaux, Jr.	✓		✓											
Carolyn B. Russell	✓	✓	✓	✓										

MINUTES

INSURANCE COMMITTEE

JUNE 18, 1998

Jerry C. Dockham, Chairman of the Insurance Committee called the meeting to order at 12:00. He introduced the pages and welcomed the members. Members present were: Rep. Jerry C. Dockham, Rep. Bobby H. Barbee, Rep. James Black, Rep. Robert Brawley, Rep. Nelson Cole, Rep. Andrew Debmon, Rep. Dub Dickson, Rep. Charlotte Gardner, Rep. Thomas Hardaway, Rep. Sandy Hardy, Rep. Bob Hensley, Rep. John Hurley, Rep. William Ives, Rep. Paul Luebke, Rep. Danny McComas, Rep. William Wainwright, Rep. Thomas Wright, Rep. Mickey Michaux and Rep. Carolyn Russell. The visitor registration sheet is included and made a part of these minutes. (Attachment 1)

The first bill before the committee was HB-1590- AMEND INSURANCE FINANCE/FEES explained by Rep. McComas. This was a highly technical bill that was summarized by Mr. Bill Hale, Deputy Commissioner of Insurance. Mr. Hale's summary and explanation is enclosed. (See Attachment II) The Proposed Committee Substitute is also enclosed. (See Attachment III) The Committee had a lengthy question and answer session and there were several unanswered questions; therefore, the bill was displaced by Chairman Dockham.

The next bill on the agenda was HB-1588-Revise Insurer Assessments. This was another technical bill that the Department of Insurance wanted to add

that would amend finance and fees. See the memorandum from Linwood Jones which explains the changes requested. Section 1 changed fees charged by the Department of Insurance; Section 2 increased the annual license fee; Sections 3, 4, 5, and 6 make the same increase applicable to risk retention groups; Section 7 amends the current law on the payment of dividends by domestic insurance companies; Section 8 revises the limits on insurance company investments in mortgage loans; Section 9 repeals the provision in GS 59-7-185; Section 10 revises the allowable investments in real estate for insurance companies; Section 11 rewrites the prohibition on insurance companies loaning money to directors, officers, and controlling shareholders; Section 12 removes the current limit on the number of votes that may be cast by a proxy in a mutual insurance company; Section 13 allows a domestic mutual insurance company to convert to a domestic stock insurance company if approved by the Commissioner; Section 14 makes primarily technical changes in the law governing allowable reserves and investments of hospital, medical, and dental service corporations; Section 15 makes this act effective October 1, 1998. (Attachment IV & V) After discussion Representative Dub Dixon made the motion for a favorable report, unfavorable to original bill.

Representative Hurley explained Senate Bill 577 stating that Senate Bill 577 makes several changes to the laws regulating insurance premium financing companies and insurance premium financing agreements, primarily to update and modernize those laws, and exempts charitable annuities from

the insurance laws. Linwood Jones, Counsel for the Insurance Committee further explained the bill. (Attachment VI) There was a great deal of discussion as well as questions that could not be answered; therefore, the Chairman withdrew the bill.

Representative Connie Wilson presented the Proposed House Committee Substitute for Senate Bill 577-AN ACT TO SET THE INSURANCE REGULATORY CHARGE FOR CALENDAR YEAR 1998, TO AMEND JPROVISIONS IN THE INSURANCE LAWS DEALING WITH EXAMINATIONS OF INSURANCE COMPANIES AND AUDITS OF THEIR FINANCIAL STATEMENTS, AND TO CLARIFY THE LAW ON INSURERS' FUNDING AGREEMENT RESERVES. Ed Rossi, Committee Counsel for the House Insurance Committee distributed a memorandum that explained the bill. The bill sets rate used to calculate the insurance regulatory charge; creates additional provisions that permit domestic insurers to maintain records or assets outside NC; provides for the reimbursement of expenses to the Department of Insurance which it conducts examinations; allows the Commissioner to use relevant professional actuarial standards; and allows the Commissioner to adopt auditing requirements that are substantially similar to those set forth in the NAIC model rules. (Attachment VIII, X & XI) The Proposed Committee Substitute for HB-1429 passed favorable to committee substitute; unfavorable to original bill.

Chairman Jerry Dockham adjourned the Insurance Committee Meeting at 1:13 PM.

Jerry C. Dockham, Chairman

Joanna Mills, Clerk

Attachment I

VISITOR REGISTRATION SHEET

INSURANCE COMMITTEE — Name of Committee

JUNE 18, 1998 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Terry Kaplan	
Tommy Harrelson	
Sam Johnson	ATTY
Tom Lowell	NCAICU
Ike Williams	NCACC
Beth Robertson	Johnson Mercer
Jim Ahler	NCACPA
Alan Medlin	Bailey & Dixon LLP
Susan Valaam	Nationwide (is on your side)
Paul Stock	NC Bankers
John Bowdish	Zel Alley P.A
Meredith L. Norris	Lawrence Bewley & Assoc.
Ronnie Finn	Finco Premium Finance Co (Gibsonville, NC)
Michael B Shivar	Sunbelt Premium Finance
James L. Stuart	Stuart Law Firm - NC Self-Insur. Guaranty Assn.
Hugh Tilson	NCHA
Amy Jo Barr	Smith Anderson
Davis Ferrell	Hafer, McNamara, Caldwell, et al
Eugene Faber	CAPIA
Robert Price	Jordan Price Wall Gray & Jones
Robert Pasichal	Young, Moore
Charles D. Watts, Jr.	North Carolina Mutual
R.H. Robinson, Jr.	UNC General Administration
Christian R. Mustard	UNC GA -
	NCALU
	NCDOI

VISITOR REGISTRATION SHEET

INSURANCE COMMITTEE — **JUNE 18, 1998**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Moore & Van Allen
[illegible]	BCBSNC
[illegible]	WCSR/[illegible]
[illegible]	NCIIBA
[illegible]	NCSR

VISITOR REGISTRATION SHEET

INSURANCE COMMITTEE — Name of Committee

JUNE 18, 1998 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ursula Kubal	ACLU
Zack Sayler	Sparks Office
BILL SCOGGIN	NC BAR ASS.
[illegible]	NCFR
[illegible]	Common Sense Foundation
Chris Fitzsimon	Common Sense Foundation
Rebecca Fuller	NCATL
[illegible]	NCATL
[illegible]	ACCAP
Mary Carbonilia	Mecklenburg County
Lad Rubart	CYR
John Madler	Sentencing Commission
Annette Ethridge	Office of the Governor
JUD CLARK	STATE NET
Sheryl Bell	State Net
Mary Timothy	Appalachian State Univ.
Laurie Palmer	Appalachian State Univ.
Ann Christen	NCAWA
Jane P. Gray	DOJ

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

Attachment II

June 18, 1998

TO: House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: H.B. 1590: Insurance Company Fee and Financial Bill

Sections 1 through 7: These repeal a number of miscellaneous fees collected from insurance companies by the Department. The most notable of these is the twenty dollar policy form filing fee, which has caused insurance companies and the Department a lot of trouble to administer. To make up for the revenue lost by these repeals, insurance company license annual renewal fees are increased from $500 to $1,500.

Section 8: Forbids a domestic stock insurance company from declaring dividends to stockholders except from the unassigned surplus of the company.

Section 9: Changes the limitations on investments by domestic companies in mortgage loans by replacing the present rule with a rule restricting investment with any one person or single collateral package to 5% of the insurer's assets and by limiting all such investments to 60% of the assets. If the investments exceed these limits, the insurer must submit a plan to the Commissioner by January 31, 1999, and comply by January 1, 2004.

Section 10: Contains a conforming amendment for the change in Section 8 of the bill.

Section 11: Allows a domestic insurer to acquire, develop, and dispose of income-producing real estate, other than real estate to be used primarily for development of oil or mineral resources, located in United States or Canada.

Section 12: Rewrites the law prohibiting investments in or loans to insurance company officers, directors, or stockholders.

Section 13: Removes the 20-vote limit on proxies in domestic mutual company voting and changes the time for proxies to be exercised from three months to one year.

Section 14: Adds a procedure allowing a domestic mutual insurer to convert to a domestic stock insurer under a plan approved by the Commissioner.

Section 15 : Rewrites the law on investments and reserves by hospital, medical, and dental service corporations.

The bill has an October 1, 1998, effective date.

Attachment III

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 1590

Proposed Committee Substitute
H1590-CSRN-001

THIS IS A DRAFT

Short Title: Amend Insurance Finance/Fees. (Public)

Sponsors:

Referred to: Insurance, if favorable, Finance.

May 28, 1998

A BILL TO BE ENTITLED

AN ACT TO REPEAL POLICY FORM FILING FEES AND HEALTH MAINTENANCE ORGANIZATION ANNUAL REPORT FEES; TO INCREASE CERTAIN COMPANY LICENSE RENEWAL FEES COLLECTED BY THE DEPARTMENT OF INSURANCE; AND TO MAKE NECESSARY CHANGES IN INSURER FINANCE LAWS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-6-5 reads as rewritten:

"**§ 58-6-5. Schedule of fees and charges.**

(a) The Commissioner shall collect and pay into the State treasury fees and charges as follows:

(1) For filing and examining an insurance company application for ~~admission,~~ licensing or for filing and examining a workers' compensation self-insurer's application for licensing, a ~~nonrefundable~~ fee of two hundred fifty dollars ($250.00), to be submitted with ~~such filing; for filing and auditing annual statement, one hundred dollars ($100.00); for filing any other papers required by law, twenty-five dollars ($25.00); for~~

~~each certificate of examination, condition, or qualification of company or association, fifteen dollars ($15.00); for each seal when required, ten dollars ($10.00); for a list of licensed insurance companies, ten dollars ($10.00).~~ the filing.

(2) Repealed by Session Laws 1977, c. 376, s. 2.

(3) ~~The Commissioner shall receive for copy~~ For a copy of any record or paper in ~~his office~~ the Commissioner's office, a charge of fifty cents (50¢) per ~~copy sheet and ten dollars ($10.00) for certifying same, or any fact or data from the records of his office and for the examination and approval of charters of companies, twenty-five dollars ($25.00).~~ sheet.

(4) ~~He shall collect all~~ All other fees and charges due and payable into the ~~State treasury~~ General Fund by any company, association, order, or individual under ~~his Department.~~ this Chapter.

~~(5) The Commissioner shall charge and insurers shall pay, as a prerequisite to receipt and review by the Commissioner of filings of policy forms or rates, a fee of twenty dollars ($20.00) per policy form filed and submitted for approval; a fee of twenty dollars ($20.00) for each property or casualty rate filing submitted; and a fee of twenty dollars ($20.00) for each life, accident, or health rate filing submitted. Payment of the fee shall be made at the time the form or rate filing is submitted. All fees are nonrefundable. If an insurer fails to pay the proper fee at the time of submittal, the Commissioner shall not be required to review the form or rate filed until the insurer remits the proper fee; and any statutory time periods relating to the filing shall be tolled until the insurer remits the proper fee. As used in this subdivision, "insurer" includes an entity subject to Articles 65 through 67 of this Chapter; any rating organization, advisory organization, joint underwriting association, or joint reinsurance organization subject to Articles 1 through 64 of this Chapter; and the North Carolina Rate Bureau and the North Carolina Motor Vehicle Reinsurance Facility. As used in this subdivision, "policy form" includes an application form, a declarations~~

~~page, a policy jacket, a policy or contract of insurance, or an endorsement, rider, or any amendment to a policy form that has already been approved by the Commissioner; provided that an initial policy filing made by an insurer shall constitute one policy form.~~

(6) One hundred dollars ($100.00) per day late charge for any company that fails to file the financial statements required by G.S. 58-2-165 by the required filing date or that fails to make those filings within any extended filing period approved by the Commissioner.

(7) One hundred dollars ($100.00) for filing and examining an application for a third-party administrator license issuance or renewal under G.S. 58-47-215, to be submitted with the filing.

(b) All fees and charges collected by the Commissioner under this Chapter are nonrefundable."

Section 2. G.S. 58-6-7 reads as rewritten:

"**§ 58-6-7. Annual license fees for insurance companies.**

(a) ~~As a condition precedent to doing~~ In order to do business in this State, an insurance company ~~must~~ shall apply for and obtain a license from the Commissioner ~~of Insurance~~ by March 1 of each year. The license shall become effective the following July 1 and shall remain in effect for one year. Except as provided in ~~subsections (b) and (c)~~ subsection (b) of this section, the insurance company shall pay an annual fee for the license as follows:

For each domestic farmer's mutual assessment fire insurance company .....$ 25.00
For each fraternal order 100.00
For each of all other insurance companies, except mutual burial associations taxed under G.S. 105-121.1 .....~~500.00~~ 1,500

The fees levied in this subsection ~~shall be~~ are in addition to those specified in G.S. 58-6-5.

(b) When the paid-in capital stock ~~and/or surplus~~ or surplus, or both of an insurance ~~company~~ company, other than a farmer's mutual assessment company or a fraternal ~~order~~ order, does not exceed one hundred thousand dollars ($100,000), the fee levied in this section shall be ~~one-half~~ one-half the amount ~~above~~ specified.

~~(c) Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange,~~

~~bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars ($100.00) for each such additional classification of business done.~~

(d) Any rating bureau established by action of the General Assembly of North Carolina shall be exempt from the fees ~~above levied.~~ levied in this section."

Section 3. G.S. 58-22-70 reads as rewritten:

"**§ 58-22-70. Registration and renewal fees.**

Every risk retention group and purchasing group that registers with the Commissioner under this Article shall pay the following fees:

Risk retention group registration	$250.00
Purchasing group registration	50.00
Risk retention group renewal	~~500.00~~ 1,500
Purchasing group renewal	50.00

Registration fees ~~are nonrefundable,~~ shall not be ~~prorated,~~ prorated and must be submitted with the application for registration. Renewal fees ~~are nonrefundable,~~ shall not be ~~prorated,~~ prorated and shall be paid on or before January 1 of each year."

Section 4. G.S. 58-27-10 reads as rewritten:

"**§ 58-27-10. Licenses.**

Any domestic land mortgage company, or title insurance company, wishing to do business under the provisions of this Article upon making written application and submitting proof satisfactory to the Commissioner that its business, capital and other qualifications comply with the provisions of this Article, upon paying to the Commissioner, the sum of five hundred dollars ($500.00) as a license fee and all other fees assessed against ~~such~~ the company may be licensed to do business in this State under the provisions of this Article until the first day of the following July, and may have its license renewed for each year thereafter so long as it complies with the provisions of this Article and ~~such~~ rules adopted by the Commissioner. For each ~~such renewal such~~ renewal, the company shall pay to the Commissioner the sum of ~~five hundred dollars ($500.00),~~ one

thousand five hundred dollars ($1,500) and all other fees assessed against ~~such~~ the company and ~~such~~ the renewal shall continue in force and effect until a new license ~~be~~ is issued or specifically refused, unless revoked for good cause. The Commissioner, or any person appointed by ~~him,~~ the Commissioner, ~~shall have the power and authority to make such~~ may adopt rules and regulations and examinations not inconsistent with the provisions of this ~~Article, as may be in his discretion~~ Article that are necessary or proper to enforce the provisions ~~hereof and~~ of this Article and to secure compliance with the terms of this Article. For any examination made hereunder the Commissioner shall charge the land mortgage companies or title insurance companies examined with the actual expense of ~~such~~ the examination."

Section 5. G.S. 58-65-55 reads as rewritten:

"**§ 58-65-55. Issuance of certificate.**

Before issuing any ~~such~~ license or ~~certificate~~ certificate, the Commissioner may ~~make such an~~ conduct any examination or investigation as ~~he~~ the Commissioner deems expedient. The Commissioner shall issue a certificate of authority or license upon the payment of an annual fee of ~~five hundred dollars ($500.00)~~ one thousand five hundred dollars ($1,500) and upon being satisfied ~~on the following points:~~ that:

(1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.

(2) The rates charged and benefits to be provided are fair and reasonable.

(3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and ~~hospital and medical and/or dental~~ for hospital, medical, and dental expenses and ~~such~~ any reserve ~~as~~ the Department deems adequate, as provided hereinafter.

(4) That the amount of money actually available for working capital ~~be~~ is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate."

Section 6. G.S. 58-67-160 reads as rewritten:

"**§ 58-67-160. Fees.**

Every health maintenance organization subject to this Article shall pay to the Commissioner ~~the following fees:~~ a fee of two

hundred fifty dollars ($250.00) for filing an application for a license and a fee of one thousand five hundred dollars ($1,500) for each license renewal.

~~(1) For filing an application for a certificate of authority, two hundred fifty dollars ($250.00); for each renewal thereof, five hundred dollars ($500.00);~~

~~(2) For filing each annual report, one hundred dollars ($100.00).~~"

Section 7. G.S. 58-7-130 reads as rewritten:

"**§ 58-7-130. ~~Payment of dividends impairing financial soundness of company or detrimental to policyholders.~~ Dividends and distributions to stockholders.**

(a) Each domestic insurance company in North Carolina shall be restricted by the Commissioner from the payment of any dividends or other distributions to its stockholders whenever the Commissioner determines from examination of ~~such~~ the company's financial condition that the payment of future dividends or other distributions would cause a hazardous financial condition, impair the financial soundness of the ~~company~~ company, or be detrimental to its ~~policyholders, and such~~ policyholders. Those restrictions shall continue in force until ~~such future date when~~ the Commissioner ~~may specifically permit~~ permits the payment of dividends or other distributions to stockholders by the company through a written authorization. ~~Nothing contained in this section and no action taken by the Commissioner shall in any way restrict the liability of stockholders under G.S. 58-7-125.~~

(b) No domestic stock insurance company shall declare dividends to its stockholders except from the unassigned surplus of the company as reflected in the company's most recent financial statement filed with the Commissioner under G.S. 58-2-165.

(c) The Commissioner shall permit a transfer out of paid-in and contributed surplus to common or preferred capital stock when the Commissioner determines that the transfer is necessary. A transfer shall not be made without the Commissioner's prior approval.

(d) Nothing in this section and no action taken by the Commissioner pursuant to this section or otherwise shall restrict the liabilities of stockholders under G.S. 58-7-125.

(e) Dividends and other distributions paid to stockholders are subject to the requirements and limitations of G.S. 58-19-25(d) and G.S. 58-19-30(c)."

Section 8. G.S. 58-7-170(c) reads as rewritten:

"(c) ~~The cost of investments made by insurers in mortgage loans, authorized by G.S. 58-7-179, with any one person shall not exceed the lesser of five percent (5%) of the insurer's admitted assets or ten percent (10%) of the insurer's capital and surplus. An insurer shall not invest in additional mortgage loans without the Commissioner's consent if the admitted value of all mortgage loans held by the insurer exceeds an aggregate of sixty percent (60%) of the admitted assets of the insurer, if (i) the admitted value of all mortgage pass-through securities permitted by G.S. 58-7-173(17) does not exceed twenty-five percent (25%) of the admitted assets of the insurer and (ii) the admitted value of other mortgage loans permitted by G.S. 58-7-179 does not exceed forty percent (40%) of the admitted assets of the insurer.~~

~~An insurer that, as of October 1, 1993, has mortgage investments that exceed the aggregate limitation specified in this subsection shall submit to the Commissioner no later than January 31, 1994, a plan to bring the amount of mortgage investments into compliance with the limitations by January 1, 2001.~~

The cost of investments made by an insurer in mortgage loans authorized by G.S. 58-7-179 with any one person, or in mortgage pass-through securities and derivatives of mortgage pass-through securities authorized by G.S. 58-7-173(1), (2), (8), or (17), and backed by a single collateral package, shall not exceed five percent (5%) of the insurer's admitted assets. An insurer shall not invest in additional mortgage loans or mortgage pass-through securities and derivatives of mortgage pass-through securities without the Commissioner's consent if the admitted value of all those investments held by the insurer exceeds an aggregate of sixty percent (60%) of the admitted assets of the insurer. Within the aggregate sixty percent (60%) limitation, the admitted value of all mortgage pass-through securities and derivatives of mortgage pass-through securities permitted by G.S. 58-7-173(17) shall not exceed thirty-five percent (35%) of the admitted assets of the insurer. The admitted value of other mortgage loans permitted by G.S. 58-7-179 shall not exceed forty percent (40%) of the admitted assets of the insurer. Mortgage pass-through securities authorized by G.S. 58-7-173(1), (2), or (8) shall only be subject to the single collateral package limitation and the sixty percent (60%) aggregate limitation. No later than January 31, 1999, an insurer that has mortgage investments that exceed the limitations specified in this subsection shall submit to the Commissioner a plan to bring the amount of mortgage investments

into compliance with the specified limitations by January 1, 2004."

Section 9. G.S. 58-7-185(a)(3) is repealed.

Section 10. G.S. 58-7-187(c) reads as rewritten:

"(c) ~~An insurer may acquire and hold real property for investment, subject to the following conditions:~~ An insurer may acquire, improve, develop, manage, lease, mortgage, and dispose of real estate situated in any state of the United States or province of Canada subject to the following limitations and conditions:

(1) The amount shall not exceed in the aggregate the lesser of five percent (5%) of the insurer's admitted assets or fifteen percent (15%) of the insurer's capital and surplus.

(2) The amount in any one property shall not exceed one percent (1%) of the insurer's admitted assets.

(3) The amount in unimproved land shall not exceed one-half of one percent (0.5%) of the insurer's admitted assets.

(4) There shall be no time limit for the disposal of investment real estate.

An insurer may acquire, improve, develop, manage, lease, mortgage, or dispose of real estate pursuant to this section either directly or indirectly through limited partnership interests, general partnership interests where all other partners in the general partnership are subsidiaries of the insurer, limited liability companies, joint ventures, stock of an investment subsidiary, trust certificates, or other similar instruments. The real estate shall be income-producing or to be improved or developed for investment purposes under an existing program, in which case the property shall be deemed to be income-producing. The real estate may be subject to mortgages, liens, or other encumbrances and, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, the amount thereof shall be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with this subsection and G.S. 58-7-187(d). As used in this subsection, 'investment subsidiary' means a subsidiary of an insurer engaged or organized to engage exclusively in real estate investments authorized in this subsection. This subsection does not apply to real estate to be used primarily for mining or development of oil or mineral resources."

Section 11. G.S. 58-7-200(c) reads as rewritten:

"(c) ~~No insurer shall make any direct or indirect loan to any of its directors, officers, or controlling stockholders; nor shall the insurer make any loan to any other person in which the officer, director, or stockholder is substantially interested; nor shall any such director, officer, or stockholder directly or indirectly accept any such loan.~~ Insurers shall not directly or indirectly invest in or lend funds to any of its directors, officers, stockholders, or any other person in which an officer, director, or stockholder is interested substantially. Directors, officers, and stockholders of insurers shall not directly or indirectly accept funds from insurers."

Section 12. G.S. 58-8-10 reads as rewritten:

"**§ 58-8-10. Policyholders are members of mutual companies.**

Every person insured by a mutual insurance company is a member while ~~his~~ that person's policy is in force, entitled to one vote for each policy ~~he~~ that person holds, and must be notified of the time and place of holding ~~its~~ the company's meetings by a written notice or by an imprint upon the back of each policy, receipt, or certificate of renewal, as follows:

The insured is hereby notified that by virtue of this policy ~~he~~ the insured is a member of the ..... insurance company, and that the annual meetings of the company are held at its home office on the ..... day of ....., in each year, at ..... o'clock.

The blanks shall be duly filled in print and are a sufficient notice. A corporation ~~which~~ that becomes a member of ~~such~~ a mutual insurance company may authorize any person to represent ~~it,~~ the corporation; and this representative has all the rights of an individual member. A person holding property in trust may insure it in ~~such~~ a mutual insurance company, and as trustee assume the liability and be entitled to the rights of a ~~member,~~ member; but is not personally liable upon the contract of insurance. Members may vote by proxies, dated and executed within three ~~months,~~ months after receipt, and returned and recorded on the books of the company three days or more before the meeting at which they are to be ~~used; but no person as proxy or otherwise may cast more than 20 votes.~~ used."

Section 13. Article 10 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-10-10. Conversion to stock insurer.**

(a) A domestic mutual insurer may convert to a domestic stock insurer under a plan that is approved in advance by the Commissioner.

(b) The Commissioner shall not approve the plan unless:

(1) It is fair and equitable to the insurer's policyholders.

(2) It is adopted by the insurer's board of directors in accordance with the insurer's bylaws and approved by a vote of not less than two-thirds of the insurer's members voting on it in person, by proxy, or by mail at a meeting called for the purpose of voting on the plan, pursuant to reasonable notice and procedure as approved by the Commissioner. If the company is a life insurer, the right to vote may be limited, as its bylaws provide, to members whose policies are other than term or group policies and have been in effect for more than one year.

(3) Each policyholder's equity in the insurer is determinable under a fair and reasonable formula approved by the Commissioner. The equity shall be based upon the insurer's entire statutory surplus after deducting certificates of contribution, guaranty capital certificates, and similar evidences of indebtedness included in an insurer's statutory surplus.

(4) The policyholders entitled to vote on the plan and participate in the purchase of stock or distribution of assets include all policyholders on the date the plan was adopted by the insurer's board of directors.

(5) The plan provides that each policyholder specified in subdivision (4) of this subsection receives a preemptive right (i) to acquire a proportionate part of all of the proposed capital stock of the insurer or of all of the stock of a corporation affiliated with the insurer within a designated reasonable period as the part is determinable under the plan of conversion; and (ii) to apply toward the purchase of the stock the amount of the policyholder's equity in the insurer under subdivision (3) of this subsection. The plan shall provide for an equitable distribution of fractional interests.

(6) The plan provides for payment to each policyholder of the policyholder's entire equity in the insurer. The payment shall be applied toward the purchase of stock to which the policyholder is entitled

preemptively or to be made in cash, or both. The cash payment shall not exceed fifty percent (50%) of each policyholder's equity. The stock purchased, together with the cash payment, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of the mutual insurer.

(7) Shares are to be offered to policyholders at a price not greater than that of shares to be subsequently offered to others.

(8) The Commissioner finds that the insurer's management has not sought, through reduction of volume of new business written, through policy cancellations, or through any other means, (i) to reduce, limit, or affect the number or identity of the insurer's members entitled to participate in the plan or (ii) to secure for the individuals constituting management any unfair advantage through the plan.

(9) The plan, when completed, provides that the insurer's capital and surplus are not less than the minimum required of a domestic stock insurer transacting the same kinds of insurance, are reasonable in relation to the insurer's outstanding liabilities, and are adequate to meet its financial needs.

(c) With respect to an insurer with a guaranty capital, the conversion plan shall be approved by a vote of not less than two-thirds of the insurer's guaranty capital shareholders and policyholders as provided for in subdivision (b)(2) of this section. The plan may provide for the issuance of stock in exchange for outstanding guaranty capital shares at their redemption value subject to the conditions in subsection (b) of this section.

(d) The Commissioner may schedule a public hearing on the proposed conversion plan.

(e) At the mutual insurer's expense, the Commissioner may retain attorneys, actuaries, economists, accountants, and other experts who are not otherwise a part of the Commissioner's staff and who are reasonably necessary to assist the Commissioner in reviewing proposed conversion plans.

(f) The corporate existence of the mutual company continues in the stock company created under this section. All assets, rights, franchises, and interests of the former mutual insurer in

and to real or personal property are deemed to be transferred to, and vested in, the stock insurer, without any other deed or transfer. The stock insurer simultaneously assumes all of the obligations and liabilities of the former mutual insurer.

(g) No director, officer, or employee of the insurer shall receive:

(1) Any fee, commission, compensation, or other valuable consideration for aiding, promoting, or assisting in the conversion of the mutual insurer to a domestic stock insurer, other than compensation paid to any director, officer, or employee of the insurer in the ordinary course of business; or

(2) Any distribution of the assets, surplus, or capital of the insurer as part of a conversion.

(h) The Commissioner may adopt rules to carry out the provisions of this section."

Section 14. G.S. 58-65-95 reads as rewritten:

"**§ 58-65-95. Investments and reserves.**

(a) No corporation subject to this Article shall invest in any securities other than securities permitted ~~by the laws of this State~~ by Article 7 of this Chapter for the investment of ~~assets of life insurance companies, banks, trust companies, executors, administrators and guardians.~~ assets.

(b) Every ~~such~~ corporation ~~after the first full year of doing business after the passage of this Article and Article 66 of this Chapter~~ subject to this Article shall accumulate and maintain, in addition to proper reserves for current administrative liabilities and whatever reserves are deemed to be adequate and proper by the Commissioner ~~of Insurance~~ for unpaid ~~hospital and/or medical and/or~~ hospital, medical, or dental bills, and unearned membership dues, a special contingent surplus or reserve at the following rates annually of its gross annual collections from membership dues, exclusive of receipts from cost plus plans, until ~~said~~ the reserve ~~shall equal~~ equals an amount that is three times its average monthly expenditures for ~~hospital and/or medical and/or dental~~ claims and administrative and selling expenses:

(1) First $200,000.....4%

(2) Next $200,000.....2%

(3) All above $400,000.....1%

(c) Any ~~such~~ corporation subject to this Article may accumulate and maintain a contingent reserve in excess of the ~~reserve hereinabove provided for,~~ reserve required in subsection

(b) of this section, not to exceed an amount equal to six times the average monthly expenditures for ~~hospital and/or medical and/or dental~~ claims and administrative and selling expenses.

(d) ~~In the event~~ If the Commissioner ~~of Insurance~~ finds that special conditions exist warranting an increase or decrease in the reserves or schedule of ~~reserves, hereinabove provided for, it may be modified by~~ reserves in subsection (b) of this section, the Commissioner ~~of Insurance accordingly,~~ may modify them accordingly. ~~provided~~ Provided, however, when special conditions exist warranting an increase in ~~said~~ the schedule of reserves, ~~said~~ the schedule shall not be increased by the Commissioner ~~of Insurance~~ until a reasonable length of time ~~shall have~~ has elapsed after notice of ~~such~~ the increase."

Section 15. This act becomes effective October 1, 1998, and applies to fees due and payable, reports required, and actions taken on or after that date.

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Legislative Services Office

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Attachment IV

June 18, 1998

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Counsel

RE: House Bill 1590 (Amend Insurance Finance/Fees)

Sections 1 changes the following fees charged by the Department of Insurance:

- The following fees are eliminated: $100 fee for filing and auditing an annual statement; $25 fee for filing other papers; $15 fee for each certificate of examination, condition, or qualification; $10 fee for each seal required; $10 fee for a list of insurers; $10 fee for certifying copies; $25 fee for examining and approving charters; and $20 for each policy form or rate filing.
- The following fees are added: $100 per day late charge for any insurance company that files its required financial statements late; $100 application and renewal fee for third party administrators.
- All fees are nonrefundable.

Section 2 increases the annual license fee for insurance companies (other than farm mutuals and fraternal orders) from $500 to $1,500. This section also eliminates the $100 additional fee that multi-line insurance companies are charged for additional lines of business.

Sections 3, 4, 5, and 6 make the same increase (from $500 to $1,500) applicable to risk retention groups (Sec. 3), title insurance companies (Sec. 4), hospital, medical, and dental service corporations (Sec. 5); and HMOs (Sec. 6). Section 6 also eliminates the $100 fee that each HMO pays to file its annual report.

Section 7 amends the current law on the payment of dividends by domestic insurance companies. The law already prohibits the payment of dividends to stockholders if the payment would financially impair the company or be detrimental to the policyholders. Section 7 extends this standard to "other distributions" of the company to the stockholders and adds a third basis for prohibiting such payments or distributions – the payment or distribution would cause a hazardous financial condition. Section 7 also provides that a domestic insurer can declare dividends only from its unassigned surplus. The Commissioner can approve a transfer from the company's paid-in and contributed surplus if he determines it is necessary.

Section 8 revises the limits on insurance company investments in mortgage loans and mortgage pass-through securities and derivatives of those securities.

Section 9 repeals the provision in GS 59-7-185 that regulates insurance company loans to directors, officers, or controlling stockholders. Another provision in the law, GS 58-7-200(c), prohibits insurance companies from loaning money to its directors, officers, and controlling stockholders. (See Section 11 for changes to GS 58-7-200(c)).

Section 10 revises the allowable investments in real estate for insurance companies, including restricting such holdings to US and Canadian properties and requiring that it be either income-producing or under or soon to be under development or improvement.

Section 11 rewrites the prohibition on insurance companies loaning money to directors, officers, and controlling shareholders. The prohibition is extended to apply to both loans and investments and to all shareholders.

Section 12 removes the current limit on the number of votes that may be cast by a proxy in a mutual insurance company. The current limit is 20 votes.

Section 13 allows a domestic mutual insurance company to convert to a domestic stock insurance company if approved by the Commissioner. In order to approve the conversion, the Commissioner must find that the conversion is fair to the policyholders, has been approved by the board and 2/3 of the members, fairly accounts for each policyholder's equity and provides for payment of that equity to the policyholder (in the form of stock and/or cash, but no more than 50% can be cash), gives policyholders a preemptive right to acquire a proportionate share of the proposed stock of the stock company at a price no greater than what the stock will be offered for later, and provides for adequate capital and surplus to operate as a domestic stock insurer.

The conversion plan must provide for the payment of all policyholders who owned policies as of the date the board of the mutual voted to convert to a stock company. The mutual cannot, through cancellation of policies, reduction of new business, etc., attempt to reduce the number of policyholders eligible to receive a distribution from the mutual upon conversion or attempt to give management an unfair advantage. In addition, no director, officer, or employee of the insurer can receive any financial reward (other than ordinary compensation) for assisting in the conversion.

Section 14 makes primarily technical changes in the law governing allowable reserves and investments of hospital, medical, and dental service corporations.

Section 15 makes this act effective October 1, 1998.

Attachment 5

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 1590

Short Title: Amend Insurance Finance/Fees. (Public)

Sponsors: Representatives Dockham; and Hardaway.

Referred to: Insurance, if favorable, Finance.

May 28, 1998

A BILL TO BE ENTITLED

AN ACT TO REPEAL POLICY FORM FILING FEES AND HEALTH MAINTENANCE ORGANIZATION ANNUAL REPORT FEES; TO INCREASE CERTAIN COMPANY LICENSE RENEWAL FEES COLLECTED BY THE DEPARTMENT OF INSURANCE; AND TO MAKE NECESSARY CHANGES IN INSURER FINANCE LAWS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-6-5 reads as rewritten:

"**§ 58-6-5. Schedule of fees and charges.**

(a) The Commissioner shall collect and pay into the State treasury fees and charges as follows:

(1) For filing and examining an insurance company application for ~~admission,~~ licensing or for filing and examining a workers' compensation self-insurer's application for licensing, a ~~nonrefundable~~ fee of two hundred fifty dollars ($250.00), to be submitted with ~~such filing; for filing and auditing annual statement, one hundred dollars ($100.00); for filing any other papers required by law, twenty-five dollars ($25.00); for each certificate of examination, condition, or qualification of company or association, fifteen dollars ($15.00); for each seal when required, ten dollars ($10.00); for a list of licensed insurance companies, ten dollars ($10.00).~~ the filing.

(2) Repealed by Session Laws 1977, c. 376, s. 2.

(3) ~~The Commissioner shall receive for copy~~ For a copy of any record or paper in ~~his office~~ the Commissioner's office, a charge of fifty cents (50¢) per ~~copy sheet and ten dollars ($10.00) for certifying same, or any fact or data from the records of his office and for the examination and approval of charters of companies, twenty-five dollars ($25.00).~~ sheet.

(4) ~~He shall collect all~~ All other fees and charges due and payable into the ~~State treasury~~ General Fund by any company, association, order, or individual under ~~his Department.~~ this Chapter.

~~(5) The Commissioner shall charge and insurers shall pay, as a prerequisite to receipt and review by the Commissioner of filings of policy forms or rates, a fee of twenty dollars ($20.00) per policy form filed and submitted for approval; a fee of twenty dollars ($20.00) for each property or casualty rate filing submitted; and a fee of twenty dollars ($20.00) for each life, accident, or health rate filing submitted. Payment of the fee shall be made at the time the form or rate filing is submitted. All fees are nonrefundable. If an insurer fails to pay the proper fee at the time of submittal, the Commissioner shall not be required to review the form or rate filed until the insurer remits the proper fee; and any statutory time periods relating to the filing shall be tolled until the insurer remits the proper fee. As used in this subdivision, "insurer" includes an entity subject to Articles 65 through 67 of this Chapter; any rating organization, advisory organization, joint underwriting association, or joint reinsurance organization subject to Articles 1 through 64 of this Chapter; and the North Carolina Rate Bureau and the North Carolina Motor Vehicle Reinsurance Facility. As used in this subdivision, "policy form" includes an application form, a declarations page, a policy jacket, a policy or contract of insurance, or an endorsement, rider, or any amendment to a policy form that has already been approved by the Commissioner; provided that an initial policy filing made by an insurer shall constitute one policy form.~~

(6) One hundred dollars ($100.00) per day late charge for any company that fails to file the financial statements required by G.S. 58-2-165 by the required filing date or that fails to make those filings within any extended filing period approved by the Commissioner.

(7) One hundred dollars ($100.00) for filing and examining an application for a third-party administrator license issuance or renewal under G.S. 58-47-215, to be submitted with the filing.

(b) All fees and charges collected by the Commissioner under this Chapter are nonrefundable."

Section 2. G.S. 58-6-7 reads as rewritten:

"**§ 58-6-7. Annual license fees for insurance companies.**

(a) ~~As a condition precedent to doing~~ In order to do business in this State, an insurance company ~~must~~ shall apply for and obtain a license from the Commissioner ~~of Insurance~~ by March 1 of each year. The license shall become effective the following July 1 and shall remain in effect for one year. Except as provided in ~~subsections (b) and (c)~~ subsection (b) of this section, the insurance company shall pay an annual fee for the license as follows:

For each domestic farmer's mutual assessment fire insurance company ..... $ 25.00
For each fraternal order 100.00
For each of all other insurance companies, except mutual burial associations taxed under G.S. 105-121.1 ..... ~~500.00~~ 1,500

The fees levied in this subsection ~~shall be~~ are in addition to those specified in G.S. 58-6-5.

(b) When the paid-in capital stock ~~and/or surplus~~ or surplus, or both of an insurance ~~company~~ company, other than a farmer's mutual assessment company or a fraternal ~~order~~ order, does not exceed one hundred thousand dollars ($100,000), the fee levied in this section shall be ~~one half~~ one-half the amount ~~above~~ specified.

~~(c) Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars ($100.00) for each such additional classification of business done.~~

(d) Any rating bureau established by action of the General Assembly of North Carolina shall be exempt from the fees ~~above levied.~~ levied in this section."

Section 3. G.S. 58-22-70 reads as rewritten:

"**§ 58-22-70. Registration and renewal fees.**

Every risk retention group and purchasing group that registers with the Commissioner under this Article shall pay the following fees:

Risk retention group registration	$250.00
Purchasing group registration	50.00
Risk retention group renewal	~~500.00~~ 1,500
Purchasing group renewal	50.00

Registration fees ~~are nonrefundable,~~ shall not be ~~prorated,~~ prorated and must be submitted with the application for registration. Renewal fees ~~are nonrefundable,~~ shall not be ~~prorated,~~ prorated and shall be paid on or before January 1 of each year."

Section 4. G.S. 58-27-10 reads as rewritten:

"**§ 58-27-10. Licenses.**

Any domestic land mortgage company, or title insurance company, wishing to do business under the provisions of this Article upon making written application and submitting proof satisfactory to the Commissioner that its business, capital and other qualifications comply with the provisions of this Article, upon paying to the Commissioner, the sum of five hundred dollars ($500.00) as a license fee and all other fees assessed against ~~such~~ the company may be licensed to do business in this State under the provisions of this Article until the first day of the following July, and may have its license renewed for each year thereafter so long as it complies with the provisions of this Article and ~~such~~ rules adopted by the Commissioner. For each ~~such renewal such~~ renewal, the company shall pay to the Commissioner the sum of ~~five hundred dollars ($500.00),~~ one thousand five hundred dollars ($1,500) and all other fees assessed against ~~such~~ the company and ~~such~~ the renewal shall continue in force and effect until a new license ~~be~~ is issued or specifically refused, unless revoked for good cause. The Commissioner, or any person appointed by ~~him,~~ the Commissioner, ~~shall have the power and authority to make such~~ may adopt rules and regulations and examinations not inconsistent with the provisions of this ~~Article, as may be in his discretion~~ Article that are necessary or proper to enforce the provisions ~~hereof and~~ of this Article and to secure compliance with the terms of this Article. For any examination made hereunder the Commissioner shall charge the land mortgage companies or title insurance companies examined with the actual expense of ~~such~~ the examination."

Section 5. G.S. 58-65-55 reads as rewritten:

"**§ 58-65-55. Issuance of certificate.**

Before issuing any ~~such~~ license or ~~certificate~~ certificate, the Commissioner may ~~make such an~~ conduct any examination or investigation as ~~he~~ the Commissioner deems expedient. The Commissioner shall issue a certificate of authority or license upon the payment of an annual fee of ~~five hundred dollars ($500.00)~~ one thousand five hundred dollars ($1,500) and upon being satisfied ~~on the following points:~~ that:

(1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.

(2) The rates charged and benefits to be provided are fair and reasonable.

(3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and ~~hospital and medical and/or dental~~ for hospital, medical, and dental expenses and ~~such~~ any reserve ~~as~~ the Department deems adequate, as provided hereinafter.

(4) That the amount of money actually available for working capital ~~be~~ is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate."

Section 6. G.S. 58-64-30(b) reads as rewritten:

"(b) The annual disclosure statement required to be filed with the Commissioner under this section shall be accompanied by an annual filing fee of ~~one hundred dollars ($100.00).~~ one hundred seventy-five dollars ($175.00)."

Section 7. G.S. 58-67-160 reads as rewritten:

"**§ 58-67-160. Fees.**

Every health maintenance organization subject to this Article shall pay to the Commissioner ~~the following fees:~~ a fee of two hundred fifty dollars ($250.00) for filing an application for a license and a fee of one thousand five hundred dollars ($1,500) for each license renewal.

~~(1) For filing an application for a certificate of authority, two hundred fifty dollars ($250.00); for each renewal thereof, five hundred dollars ($500.00);~~

~~(2) For filing each annual report, one hundred dollars ($100.00).~~"

Section 8. G.S. 58-7-130 reads as rewritten:

"**§ 58-7-130. ~~Payment of dividends impairing financial soundness of company or detrimental to policyholders.~~ Dividends and distributions to stockholders.**

(a) Each domestic insurance company in North Carolina shall be restricted by the Commissioner from the payment of any dividends or other distributions to its stockholders whenever the Commissioner determines from examination of ~~such~~ the company's financial condition that the payment of future dividends or other distributions would cause a hazardous financial condition, impair the financial soundness of the ~~company~~ company, or be detrimental to its ~~policyholders, and such~~ policyholders. Those restrictions shall continue in force until ~~such future date when~~ the Commissioner ~~may specifically permit~~ permits the payment of dividends or other distributions to stockholders by the company through a written authorization. ~~Nothing contained in this section and no action taken by the Commissioner shall in any way restrict the liability of stockholders under G.S. 58-7-125.~~

(b) No domestic stock insurance company shall declare dividends to its stockholders except from the unassigned surplus of the company as reflected in the company's most recent financial statement filed with the Commissioner under G.S. 58-2-165.

(c) The Commissioner shall permit a transfer out of paid-in and contributed surplus to common or preferred capital stock when the Commissioner determines that the transfer is necessary. A transfer shall not be made without the Commissioner's prior approval.

(d) Nothing in this section and no action taken by the Commissioner pursuant to this section or otherwise shall restrict the liabilities of stockholders under G.S. 58-7-125.

(e) Dividends and other distributions paid to stockholders are subject to the requirements and limitations of G.S. 58-19-25(d) and G.S. 58-19-30(c)."

Section 9. G.S. 58-7-170(c) reads as rewritten:

"(c) ~~The cost of investments made by insurers in mortgage loans, authorized by G.S. 58-7-179, with any one person shall not exceed the lesser of five percent (5%) of the insurer's admitted assets or ten percent (10%) of the insurer's capital and surplus.~~

~~An insurer shall not invest in additional mortgage loans without the Commissioner's consent if the admitted value of all mortgage loans held by the insurer exceeds an aggregate of sixty percent (60%) of the admitted assets of the insurer, if (i) the admitted value of all mortgage pass-through securities permitted by G.S. 58-7-173(17) does not exceed twenty-five percent (25%) of the admitted assets of the insurer and (ii) the admitted value of other mortgage loans permitted by G.S. 58-7-179 does not exceed forty percent (40%) of the admitted assets of the insurer.~~

~~An insurer that, as of October 1, 1993, has mortgage investments that exceed the aggregate limitation specified in this subsection shall submit to the Commissioner no later than January 31, 1994, a plan to bring the amount of mortgage investments into compliance with the limitations by January 1, 2001.~~

The cost of investments made by an insurer in mortgage loans authorized by G.S. 58-7-179 with any one person, or in mortgage pass-through securities and derivatives of mortgage pass-through securities authorized by G.S. 58-7-173(1), (2), (8), or (17), and backed by a single collateral package, shall not exceed three percent (3%) of the insurer's admitted assets. An insurer shall not invest in additional mortgage loans or mortgage pass-through securities and derivatives of mortgage pass-through securities without the Commissioner's consent if the admitted value of all those investments held by the insurer exceeds an aggregate of sixty percent (60%) of the admitted assets of the insurer. Within the aggregate sixty percent (60%) limitation, the admitted value of all mortgage pass-through securities and derivatives of mortgage pass-through securities permitted by G.S. 58-7-173(17) shall not exceed thirty-five percent (35%) of the admitted assets of the insurer. The admitted value of other mortgage loans permitted by G.S. 58-7-179 shall not exceed forty percent (40%) of the admitted assets of the insurer. Mortgage pass-through securities authorized by G.S. 58-7-173(1), (2), or (8) shall only be subject to the single collateral package limitation and the sixty percent (60%) aggregate limitation. No later than January 31, 1999, an insurer that has mortgage investments that exceed the limitations specified in this subsection shall submit to the Commissioner a plan to bring the amount of mortgage investments into compliance with the specified limitations by January 1, 2004."

Section 10. G.S. 58-7-185(a)(3) is repealed.

Section 11. G.S. 58-7-187(c) reads as rewritten:

"(c) ~~An insurer may acquire and hold real property for investment, subject to the following conditions:~~ An insurer may acquire, improve, develop, manage, lease, mortgage, and dispose of real estate situated in any state of the United States or province of Canada subject to the following limitations and conditions:

(1) The amount shall not exceed in the aggregate the lesser of five percent (5%) of the insurer's admitted assets or fifteen percent (15%) of the insurer's capital and surplus.

(2) The amount in any one property shall not exceed one percent (1%) of the insurer's admitted assets.

(3) The amount in unimproved land shall not exceed one-half of one percent (0.5%) of the insurer's admitted assets.

(4) There shall be no time limit for the disposal of investment real estate.

An insurer may acquire, improve, develop, manage, lease, mortgage, or dispose of real estate pursuant to this section either directly or indirectly through limited partnership interests, general partnership interests where all other partners in the general partnership are subsidiaries of the insurer, limited liability companies, joint ventures, stock of an investment subsidiary, trust certificates, or other similar instruments. The real estate shall be income-producing or to be improved or developed for investment purposes under an existing program, in which case the property shall be deemed to be income-producing. The real estate may be subject to mortgages, liens, or other encumbrances and, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, the amount thereof shall be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with this subsection and G.S. 58-7-187(d). As used in this subsection, 'investment subsidiary' means a subsidiary of an insurer engaged or organized to engage exclusively in real estate investments authorized in this subsection. This subsection does not apply to real estate to be used primarily for mining or development of oil or mineral resources."

Section 12. G.S. 58-7-200(c) reads as rewritten:

"(c) ~~No insurer shall make any direct or indirect loan to any of its directors, officers, or controlling stockholders; nor shall the insurer make any loan to any other person in which the officer, director, or stockholder is substantially interested; nor shall any such director, officer, or stockholder directly or indirectly accept any such loan.~~ Insurers shall not directly or indirectly invest in or lend funds to any of its directors, officers, stockholders, or any other person in which an officer, director, or stockholder is interested substantially. Directors, officers, and stockholders of insurers shall not directly or indirectly accept funds from insurers."

Section 13. G.S. 58-8-10 reads as rewritten:

"**§ 58-8-10. Policyholders are members of mutual companies.**

Every person insured by a mutual insurance company is a member while ~~his~~ that person's policy is in force, entitled to one vote for each policy ~~he~~ that person holds, and must be notified of the time and place of holding ~~its~~ the company's meetings by a written notice or by an imprint upon the back of each policy, receipt, or certificate of renewal, as follows:

The insured is hereby notified that by virtue of this policy ~~he~~ the insured is a member of the ..... insurance company, and that the annual meetings of the company are held at its home office on the ..... day of ....., in each year, at ..... o'clock.

The blanks shall be duly filled in print and are a sufficient notice. A corporation ~~which~~ that becomes a member of ~~such~~ a mutual insurance company may authorize any person to represent ~~it,~~ the corporation; and this representative has all the rights of an individual member. A person holding property in trust may insure it in ~~such~~ a mutual insurance company, and as trustee assume the liability and be entitled to the rights of a ~~member,~~ member; but is not personally liable upon the contract of

insurance. Members may vote by proxies, dated and executed within three ~~months,~~ months after receipt, and returned and recorded on the books of the company three days or more before the meeting at which they are to be ~~used; but no person as proxy or otherwise may cast more than 20 votes.~~ used."

Section 14. Article 10 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-10-10. Conversion to stock insurer.**

(a) A domestic mutual insurer may convert to a domestic stock insurer under a plan that is approved in advance by the Commissioner.

(b) The Commissioner shall not approve the plan unless:

(1) It is fair and equitable to the insurer's policyholders.

(2) It is adopted by the insurer's board of directors in accordance with the insurer's bylaws and approved by a vote of not less than two-thirds of the insurer's members voting on it in person, by proxy, or by mail at a meeting called for the purpose of voting on the plan, pursuant to reasonable notice and procedure as approved by the Commissioner. If the company is a life insurer, the right to vote may be limited, as its bylaws provide, to members whose policies are other than term or group policies and have been in effect for more than one year.

(3) Each policyholder's equity in the insurer is determinable under a fair and reasonable formula approved by the Commissioner. The equity shall be based upon the insurer's entire statutory surplus after deducting certificates of contribution, guaranty capital certificates, and similar evidences of indebtedness included in an insurer's statutory surplus.

(4) The policyholders entitled to vote on the plan and participate in the purchase of stock or distribution of assets include all policyholders on the date the plan was adopted by the insurer's board of directors.

(5) The plan provides that each policyholder specified in subdivision (4) of this subsection receives a preemptive right (i) to acquire a proportionate part of all of the proposed capital stock of the insurer or of all of the stock of a corporation affiliated with the insurer within a designated reasonable period as the part is determinable under the plan of conversion; and (ii) to apply toward the purchase of the stock the amount of the policyholder's equity in the insurer under subdivision (3) of this subsection. The plan shall provide for an equitable distribution of fractional interests.

(6) The plan provides for payment to each policyholder of the policyholder's entire equity in the insurer. The payment shall be applied toward the purchase of stock to which the policyholder is entitled preemptively or to be made in cash, or both. The cash

payment shall not exceed fifty percent (50%) of each policyholder's equity. The stock purchased, together with the cash payment, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of the mutual insurer.

(7) Shares are to be offered to policyholders at a price not greater than that of shares to be subsequently offered to others.

(8) The Commissioner finds that the insurer's management has not sought, through reduction of volume of new business written, through policy cancellations, or through any other means, (i) to reduce, limit, or affect the number or identity of the insurer's members entitled to participate in the plan or (ii) to secure for the individuals constituting management any unfair advantage through the plan.

(9) The plan, when completed, provides that the insurer's capital and surplus are not less than the minimum required of a domestic stock insurer transacting the same kinds of insurance, are reasonable in relation to the insurer's outstanding liabilities, and are adequate to meet its financial needs.

(c) With respect to an insurer with a guaranty capital, the conversion plan shall be approved by a vote of not less than two-thirds of the insurer's guaranty capital shareholders and policyholders as provided for in subdivision (b)(2) of this section. The plan may provide for the issuance of stock in exchange for outstanding guaranty capital shares at their redemption value subject to the conditions in subsection (b) of this section.

(d) The Commissioner may schedule a public hearing on the proposed conversion plan.

(e) At the mutual insurer's expense, the Commissioner may retain attorneys, actuaries, economists, accountants, and other experts who are not otherwise a part of the Commissioner's staff and who are reasonably necessary to assist the Commissioner in reviewing proposed conversion plans.

(f) The corporate existence of the mutual company continues in the stock company created under this section. All assets, rights, franchises, and interests of the former mutual insurer in and to real or personal property are deemed to be transferred to, and vested in, the stock insurer, without any other deed or transfer. The stock insurer simultaneously assumes all of the obligations and liabilities of the former mutual insurer.

(g) No director, officer, or employee of the insurer shall receive:

(1) Any fee, commission, compensation, or other valuable consideration for aiding, promoting, or assisting in the conversion of the mutual insurer to a domestic stock insurer, other than compensation paid to any director, officer, or employee of the insurer in the ordinary course of business; or

(2) Any distribution of the assets, surplus, or capital of the insurer as part of a conversion.

(h) The Commissioner may adopt rules to carry out the provisions of this section."

Section 15. G.S. 58-65-95 reads as rewritten:

"**§ 58-65-95. Investments and reserves.**

(a) Except as provided in subsection (e) of this section, no ~~No~~ corporation subject to this Article shall invest in any securities other than securities permitted ~~by the laws of this State~~ by Article 7 of this Chapter for the investment of ~~assets of life insurance companies, banks, trust companies, executors, administrators and guardians.~~ assets.

(b) Every ~~such~~ corporation ~~after the first full year of doing business after the passage of this Article and Article 66 of this Chapter~~ subject to this Article shall accumulate and maintain, in addition to proper reserves for current administrative liabilities and whatever reserves are deemed to be adequate and proper by the Commissioner ~~of Insurance~~ for unpaid ~~hospital and/or medical and/or~~ hospital, medical, or dental bills, and unearned membership dues, a special contingent surplus or reserve at the following rates annually of its gross annual collections from membership dues, exclusive of receipts from cost plus plans, until ~~said~~ the reserve ~~shall equal~~ equals an amount that is three times its average monthly expenditures for ~~hospital and/or medical and/or dental~~ claims and administrative and selling expenses:

(1) First $200,000 ..... 4%
(2) Next $200,000 ..... 2%
(3) All above $400,000 ..... 1%

(c) Any ~~such~~ corporation subject to this Article may accumulate and maintain a contingent reserve in excess of the ~~reserve hereinabove provided for,~~ reserve required in subsection (b) of this section, not to exceed an amount equal to six times the average monthly expenditures for ~~hospital and/or medical and/or dental~~ claims and administrative and selling expenses.

(d) ~~In the event~~ If the Commissioner ~~of Insurance~~ finds that special conditions exist warranting an increase or decrease in the reserves or schedule of ~~reserves, hereinabove provided for, it may be modified by~~ reserves in subsection (b) of this section, the Commissioner ~~of Insurance accordingly,~~ may modify them accordingly. ~~provided~~ Provided, however, when special conditions exist warranting an increase in ~~said~~ the schedule of reserves, ~~said~~ the schedule shall not be increased by the Commissioner ~~of Insurance~~ until a reasonable length of time ~~shall have~~ has elapsed after notice of ~~such~~ the increase.

(e) The cost of investments made by service corporations in mortgage loans authorized by G.S. 58-7-179, with any one person, shall not exceed the lesser of five percent (5%) of the service corporation's admitted assets of ten percent (10%) of the service corporation's capital and surplus. A service corporation shall not invest in additional mortgage loans without the Commissioner's consent if the admitted value of all additional mortgage loans held by the service corporation exceeds an aggregate of sixty percent (60%) of the admitted assets of the service corporation, if:

(1) The admitted value of all mortgage pass-through securities permitted by G.S. 58-7-173(17) does not exceed twenty-five percent (25%) of the admitted assets of the service corporation; and

(2) The admitted value of other mortgage loans permitted by G.S. 58-7-179 does not exceed forty percent (40%) of the admitted assets of the service corporation.

No later than January 31, 1999, a service corporation that has mortgage investments that exceed the aggregate limitation specified in this subsection as of October 1, 1998, shall submit to the Commissioner a plan to bring the amount of mortgage investments into compliance with the limitations by January 1, 2002."

Section 16. This act becomes effective October 1, 1998, and applies to fees due and payable, reports required, and actions taken on or after that date.

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Attachment VI

June 18, 1998

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Counsel

RE: Senate Bill 577 - Proposed House Committee Susbtitute (Insurance Premium Financing)

Senate Bill 577 makes several changes to the laws regulating insurance premium financing companies and insurance premium financing agreements, primarily to update and modernize those laws, and exempts charitable annuities from the insurance laws.

Insurance premium financing

Section 1 allows premium financing companies to use microfilm , microfiche, and imaging systems, in addition to photographic reproductions, to store records that are required to be kept on file for inspection by the Commissioner. Current law allows only the originals and photographic reproductions.

Section 2 makes several technical and grammatical changes to the law that sets out the required contents of a premium financing agreement and allows the agreement to list any mailing address specified by the insured (in lieu of the insured's residence or place of business).

Section 3 provides that when the insured finances more than one insurance contract under a premium financing agreement, the service charge is computed from the earlier of the date the premium was advanced and the inception date of the insurance contract.

Section 4 provides that the premium financing company or agent can have the agreement delivered to the insured before the due date of the first installment payment. Current law requires the company or agent to deliver it.

Section 5 provides that when the amount of a refund credit for anticipation of payment is less than $5.00, no refund is required to be made. Under current law, this threshold is $1.00. The unrefunded money goes to the escheat fund at the State Treasurer's office.

Section 6 allows the premium financing company to notify the insured of cancellation of its insurance contract (assuming the premium financing company has been authorized to cancel) by mail, personal delivery, e-mail, and fax. Currently, the delivery must be by mail. The premium financing company, in its request to the insurer to cancel the insurance contract, must specify the effective date of cancellation. The insurer must cancel it effective that date. A copy of this request must also be sent to the agent. An insurance policy is considered invalid and void if the agent or premium financing company informs the insurer that the initial down payment for the premium has been dishonored.

Section 6 also requires that the return of unearned premiums from the insurer to the premium financing company when the insurance policy is canceled must be refunded within 30 days of the effective date of the cancellation. If the premium is subject to an audit to determine the final premium amount, the gross unearned premium will be calculated on the deposit premium. The insurer cannot offset the return premiums against other debts that the insured owes the insurer on other policies. If the return premiums credited to the insured exceed what the insured owes by $5.00 or more, the premium finance company must refund the excess to the insured as soon as possible and in any event within 30 days. An unpaid balance owed by the insured after cancellation of his or her policy earns interest at the rate specified in the agreement.

Section 7 rewrites the anti-rebate law for insurance premium financing. The current law prohibits premium financing companies and their employees from offering a rebate or any other kind of inducement to an agent, an agent's employee, or any other person as an inducement to the financing of the premium with that company. The bill restates this prohibition in a different manner.

Charitable Annuities

Many public and private universities, as well as other nonprofit organizations, give annuities to donors in exchange for the donation of stocks, bonds, real estate, or other property. The annuity is paid to the donor until his or her death. The issuance of an annuity in these cases technically requires the university or other organization to be licensed as an insurance company and anyone soliciting donations on behalf of the university or other organization in exchange for an annuity to be licensed as an insurance agent.

Section 8 of the bill amends the law to state that nonprofit organizations that have been active for 5 or more years and public educational institutions are not required to become licensed as insurance companies in order to issue annuities in exchange for charitable donations, nor are their officers, directors, employees, or agents required to

be licensed as insurance agents. However, each such charitable annuity agreement entered into on or after October 1, 1998, must contain a statement disclosing that charitable annuities are not regulated by the State of North Carolina and that they are not backed up by the State or by any insurance guaranty fund.

Effective Date

The insurance premium financing amendments take effect October 1, 1998. The charitable annuity provision takes effect when it becomes law, except that the disclosure statement is required only in new annuity agreements on or after October 1, 1998.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 577
Commerce Committee Substitute Adopted 4/30/97

Proposed House Committee Substitute
S577-CSRN-004

THIS IS A DRAFT

Short Title: Insurance Premium Financing. (Public)

Sponsors:

Referred to:

April 1, 1997

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING INSURANCE PREMIUM FINANCING AND TO EXEMPT CERTAIN CHARITABLE ANNUITIES FROM THE INSURANCE LAWS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-35-30(a) reads as rewritten:

"(a) The licensee shall keep and use in his business ~~such~~ any books, accounts, and records ~~as~~ that will enable the Commissioner to determine whether ~~such~~ the licensee is complying with the provisions of this Article and with the rules and regulations lawfully made by the Commissioner hereunder. Every licensee shall preserve such books, accounts, and records, including cards used in a card system, if any, for at least three years after making the final entry in respect to any insurance premium finance agreement recorded therein; provided, however, the preservation of photographic reproductions thereof or records in ~~photographic~~ photographic, imaging, microfilm, or microfiche form shall constitute compliance with this ~~requirement.~~ requirement by

any licensee. The Commissioner may require of licensees under oath and in the form prescribed by him regular or special reports as he may deem necessary to the proper supervision of licensees under this Article."

Section 2. G.S. 58-35-50 reads as rewritten:

"**§ 58-35-50. Form, contents and execution of insurance premium finance agreements.**

(a) An insurance premium finance agreement shall be in writing, dated, signed by the insured, and the printed portion thereof shall be in at least eight point type. It shall contain the entire agreement of the parties with respect to the insurance contract, the premiums for which are advanced or to be advanced under it, and:

(1) At its top, the words 'INSURANCE PREMIUM FINANCE AGREEMENT' or similar wording in at least 10 point bold type; and the insurance premium finance company license number shall also appear, and:

(2) A notice in at least eight point bold type, reading as follows: 'NOTICE':

a. Do not sign this agreement before you read it.

b. You are entitled to a copy of this agreement.

c. Under the law, you have the right to pay off in advance the full amount due and under certain conditions to obtain a partial refund of the service charge.

(b) An insurance premium finance agreement shall:

(1) Contain the following:

a. The name and place of business of the insurance agent or broker negotiating the related insurance ~~contract,~~ contract;

b. The ~~the~~ name of the insured and either the ~~residence or~~ residence, the place of ~~business~~ business, or any other mailing address of the insured as specified by ~~him,~~ the insured;

c. The ~~the~~ name and place of business of the insurance premium finance company to which installments or other payments are to be ~~made,~~ made;

d. A brief ~~a~~ description of the insurance ~~contract,~~ contract;

e. The ~~the~~ premiums for which are advanced or to be advanced under the ~~agreement,~~ agreement; and

f. The ~~the~~ amount of the premiums for such insurance contract; and

(2) Set forth the following ~~items:~~ items where applicable:

a. The total amount of the premiums;

b. The amount of the down payment;

c. The principal balance, which is the difference between items a and b;

d. The amount of the service charge;

e. The balance, ~~which is the sum of items c and d,~~ payable by the insured, meaning the sum of the amounts stated under items c. and d. of this subdivision.

f. the number of installments required, the amount of each installment expressed in dollars and the due date or period thereof.

(c) The items set forth in subsection (b) of this section need not be stated in the sequence or order ~~set forth above, inapplicable items may be omitted;~~ in which they appear in that subsection, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(d) No insurance premium finance agreement shall be signed by an insured when it contains any blank space to be filled in after it has been signed; however, if the insurance contract, the premiums for which are advanced or to be advanced under the agreement, has not been issued at the time of its signature by the insured and it so provides, the name of the authorized insurer by whom such insurance contract is issued and the policy number and the due date of the first installment may be left blank and later inserted in the original of the agreement after it has been signed by the insured."

Section 3. G.S. 58-35-55(d) reads as rewritten:

"(d) The provisions of subsection (c) of this section apply if the premiums under only one insurance contract are advanced or are to be advanced under an insurance premium finance ~~agreement;~~ agreement. If ~~if~~ premiums under more than one insurance contract are advanced or are to be advanced under an insurance premium finance agreement, the service charge shall be computed from the earlier of the following:

(1) The date that the premium is advanced on behalf of the insured.

(2) The inception date of ~~such~~ the insurance ~~contracts, or from~~ contract.

~~due date of such premiums; however, not more than~~
Only one minimum service charge shall apply to each insurance premium finance agreement."

Section 4. G.S. 58-35-65 reads as rewritten:

"**§ 58-35-65. Delivery of copy of insurance premium finance agreement to insured.**

Before the due date of the first installment payable under an insurance premium finance agreement, the insurance premium finance company holding the agreement or the insurance agent shall ~~deliver~~ cause to be delivered to the insured, or mail to ~~him~~ the insured at ~~his~~ the insured's address as shown in the agreement, a copy of the agreement."

Section 5. G.S. 58-35-80(b) reads as rewritten:

"(b) The amount of any such refund credit shall represent at least as great proportion of the service charge, if any, as the sum of the periodic balances after the month in which prepayment is made bears to the sum of all periodic balances under the schedule of installments in the agreement. Where the amount of the refund credit for anticipation of payment is less than ~~one dollar ($1.00),~~ five dollars ($5.00), no refund need be made. This section does not relieve the premium finance company of its duty to report and deliver these unrefunded monies to the State Treasurer in accordance with G.S. 116B-29(b)."

Section 6. G.S. 58-35-85 reads as rewritten:

"**§ 58-35-85. Procedure for cancellation of insurance contract upon default; return of unearned premiums; collection of cash surrender value.**

When an insurance premium finance agreement contains a power of attorney or other authority enabling the insurance premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be cancelled unless the cancellation is effectuated in accordance with the following provisions:

(1) Not less than 10 days' written notice ~~be mailed~~ is sent by personal delivery, first-class mail, electronic mail, or facsimile transmission to the last known address of the insured or insureds shown on the insurance premium finance agreement of the intent of the insurance premium finance company to cancel his or their insurance contract or contracts unless the defaulted installment payment is received. ~~A notice~~ Notification thereof shall also be ~~sent~~ provided to the insurance agent.

(2) After expiration of the 10-day period, the insurance premium finance company shall send the insurer a request for cancellation specifying the effective date of cancellation and shall ~~mail~~ send ~~a copy of the request for~~ notice of the cancellation to the insured by personal delivery, first-class mail, electronic mail, electronic transmission or facsimile transmission at his last known address as shown on the records of the insurance premium finance ~~agreement.~~ company and to the agent. Upon written request of the insurance company, ~~The~~ the premium finance company shall ~~include~~ furnish a copy of the power of ~~attorney with the request for cancellation if the insurer has not already received a copy of the power of attorney with the application.~~ attorney to the insurance company. The written request shall be sent by mail, personal delivery, electronic mail, or facsimile transmission. The insurer's failure to comply with this request does not invalidate the cancellation.

(3) Upon receipt of a copy of the request for cancellation notice by the insurer, the insurance contract shall be cancelled as of the date specified in the cancellation notice with the same force and effect as if the ~~aforesaid~~ request for cancellation had been submitted by the ~~insured himself,~~ insured, without requiring the return of the insurance contract or contracts.

(4) All statutory, regulatory, and contractual restrictions providing that the insured may not cancel ~~his~~ the insurance contract unless ~~he~~ the insurer first satisfies the restrictions by giving a prescribed notice to a governmental agency, the insurance carrier, an individual, or a person designated to receive the notice for said governmental agency, insurance carrier, or individual shall apply where cancellation is effected under the provisions of this section. If a mortgagee or other loss payee is shown on the insurance contract, the insurer shall notify the mortgagee or loss payee in accordance with G.S. 58-41-15(b).

(4a) If an insurer receives notification from an insurance agent or premium finance company that the initial down payment for the premium being financed has been dishonored by a financial institution or is otherwise unpaid, there is not a valid contract for insurance and the policy will be voided.

(5) Whenever an insurance contract is cancelled in accordance with this section, the insurer shall promptly return whatever gross unearned premiums are due under the contract to the insurance premium finance company effecting the cancellation for the benefit of the insured or ~~insureds.~~ insureds, no later than 30 days after the effective date of cancellation. Whenever the return premium is in excess of the amount due the insurance premium finance company by the insured under the agreement, the excess shall be remitted promptly to the order of the insured, subject to the minimum service charge provided for in this Article. In the event that a premium is subject to an audit to determine the final premium amount, the gross unearned premium shall be calculated upon the deposit premium and the insurer shall return the gross unearned premium to the premium finance company no later than 30 days after the effective date of cancellation.

(6) The provisions of this section relating to request for cancellation by the insurance premium finance company of an insurance contract and the return by an insurer of unearned premiums to the insurance premium finance company, also apply to the surrender by the insurance premium finance company of an insurance contract providing life insurance and the payment by the insurer of the cash value of the contract to the insurance premium finance company, except that the insurer may require the surrender of the insurance contract.

(7) The insurer shall not deduct from any return premiums any amount owed to the insurer for any other indebtedness owed to the insurer by the insured on any policy or policies other than those being financed under the premium finance agreement.

(8) In the event that the crediting of return premiums to the account of the insured results in a surplus

over the amount due from the insured, the premium finance company shall refund the excess to the insured as soon as possible, but in no event later than 30 days of receipt of the return premium, provided that no refund shall be required if it is in an amount less than five dollars ($5.00). This subdivision does not relieve the premium finance company of its duty to report and deliver these unrefunded monies to the State Treasurer in accordance with G.S. 116B-29(b).

(9) In the event that a balance due the premium finance company remains on the account after the cancellation of the agreement, the outstanding balance may earn interest at the rate stated in the agreement until paid in full."

Section 7. G.S. 58-35-40 reads as rewritten:

"**§ 58-35-40. Rebates and inducements prohibited; assignment of insurance premium finance agreements.**

(a) No insurance premium finance ~~company, and no employee of such a~~ company shall pay, allow, or offer to pay or allow ~~in any manner whatsoever~~ payment to an insurance agent ~~or any employee of an insurance agent,~~ or to any other person, ~~or as an inducement to the financing of an insurance policy with the insurance premium finance company or after any such policy has been financed,~~ and no insurance agent or other person shall accept from a company, any rebate whatsoever, either from the service charge for financing specified in the insurance premium finance agreement or ~~otherwise, or~~ otherwise. No insurance premium finance company shall pay, allow, or offer to pay or allow payment to an insurance agent, and no insurance agent shall accept from a company, a rebate as an inducement to the financing of an insurance policy with the company. No insurance premium finance company shall give or offer to give to an insurance agent, and no insurance agent shall accept from a company, any valuable consideration or inducement of any ~~kind~~ kind, directly or indirectly, other than an article of merchandise not exceeding one dollar ($1.00) in value which shall have thereon the advertisement of the insurance premium finance ~~company; but an~~ company. An insurance premium finance company may purchase or otherwise acquire an insurance premium finance agreement ~~provided that it conforms to this Article in all respects,~~ from another insurance premium finance company with recourse against the insurance premium finance company on such terms and conditions as may be mutually agreed upon by the parties, if the agreement

complies with the requirements of this Article. ~~and such terms~~ The terms and conditions of the agreement shall be subject to the approval of the Commissioner.

(b) No filing of the assignment or notice thereof to the insured shall be necessary to the validity of the written assignment of an insurance premium finance agreement as against creditors or subsequent purchases, pledges, or encumbrancers of the assignor.

(c) As used in this section, the term 'insurance premium finance company' includes employees of the company and the term 'insurance agent' includes employees of the insurance agent. The word 'company' means an insurance premium finance company."

Section 8. G.S. 58-3-5 reads as rewritten:

"**§58-3-5. No insurance contracts except under Articles 1 through 64 of this Chapter.**

(a) ~~It~~ Except as provided in subsection (b) of this section, it is unlawful for any company to make any contract of insurance upon or concerning any property or interest or lives in this State, or with any resident thereof, or for any person as insurance agent or insurance broker to make, negotiate, solicit, or in any manner aid in the transaction of such insurance, unless and except as authorized under the provisions of Articles 1 though 64 of this Chapter.

(b) A charitable, religious, benevolent, or educational corporation, not operating for profit and in active operation for at least five years, or a public educational institution may receive a transfer of property contingent upon its agreement to pay an annuity or lump-sum benefit to the transferor or the transferor's nominee without being subject to this Chapter. The annuity agreement must contain the following disclosure clause: 'This annuity is not issued by an insurance company, is not subject to regulation by the State of North Carolina, and is not protected or otherwise guaranteed by any government agency or insurance guaranty fund.'"

Section 9. Sections 1 through 7 of this act become effective October 1, 1998, and apply to premium finance agreements or contracts entered into on or after that date. Section 8 of this act and this section are effective upon becoming law, provided that the disclosure statement required by G.S. 58-3-5(b) is required only in agreements entered into on or after October 1, 1998.

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June 16, 1998

MEMORANDUM

TO: House Insurance Committee

FROM: Ed Rossi, Committee Counsel

RE: Proposed Committee Substitute for HB 1429

This bill sets rate used to calculate the insurance regulatory charge; creates additional provisions that permit domestic insurers to maintain records or assets outside NC; provides for the reimbursement of expenses to the Department of Insurance (DOI) when it conducts examinations; allows the Commissioner to use relevant professional actuarial standards; and allows the Commissioner to adopt auditing requirements that are substantially similar to those set forth in the NAIC model rules.

Section 1.
This section sets the annual insurance regulatory charge for 1998 at 8.75% of an insurance company's premium tax liability. This is the charge that is levied on companies to fund the Insurance Regulatory Fund.

Section 2.
This section amends G.S. § 58-7-50 by adding an additional provision that allows the Commissioner to permit domestic insurers to maintain certain records or assets outside of North Carolina.

Section 3 & 3.1.
This section amends G.S. § 58-2-131(a) by making a technical correction that is required by section 4.

Section 4.
This section amends Article 2 of Chapter 58 of the General Statutes by adding a new section. This new section, G.S. § 58-2-134, adds the requirement that insurers must pay for the actual costs of their examinations. These costs are capped at $100,000 unless:

- the insurer's records are outside of the state the examination occurs outside the state;
- the insurer requests the examination; or
- the examination involves an impaired or insolvent insurer.

Section 5.
This section amends G.S. § 58-7-16(f) by adding a new provision relating to minimum valuation reserves maintained by insurers that issue funding agreements. This new provision allows the Commissioner to use relevant actuarial guidelines, regulations, interpretations, or papers published by the Society of Actuaries or the American Academy of Actuaries when determining minimum valuation reserves.

Section 6.
This section amends G.S. § 58-2-131(d) to allow for insurer examinations every five years. Currently, the statute requires examinations in three year increments.

Section 7.
This section amends G.S. § 58-2-205 by allowing the Commissioner to adopt rules that are substantially similar to the NAIC model rule for annual audited financial reports. This new provision permits the Commissioner to adopt expedited temporary rules under G.S. § 150B-21.1 in order to keep these rules consistent with the NAIC model rule.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H 1

HOUSE BILL 1429*

Short Title: Insurance Reg. Charge/Company Exams. (Public)

Sponsors: Representative C. Wilson.

Referred to: Insurance.

May 25, 1998

A BILL TO BE ENTITLED

AN ACT TO SET THE INSURANCE REGULATORY CHARGE FOR CALENDAR YEAR 1998, TO AMEND PROVISIONS IN THE INSURANCE LAWS DEALING WITH EXAMINATIONS OF INSURANCE COMPANIES AND AUDITS OF THEIR FINANCIAL STATEMENTS, AND TO CLARIFY THE LAW ON INSURERS' FUNDING AGREEMENT RESERVES.

The General Assembly of North Carolina enacts:

Section 1. The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is eight and seventy-five hundredths percent (8.75%) for the 1998 calendar year.

Section 2. G.S. 58-7-50(d) reads as rewritten:

"(d) This section is subject to the exceptions provided in G.S. 58-7-55. The Commissioner may allow a domestic insurer to maintain certain records or assets outside this State."

Section 3. G.S. 58-2-131(k) reads as rewritten:

"(k) ~~When making an examination,~~ For any examination of an insurer, if the Commissioner determines that appropriated resources within the Department are insufficient to conduct or complete the examination properly, the Commissioner may retain attorneys, appraisers, ~~independent~~ actuaries, ~~independent~~ certified public accountants, or other professionals and specialists ~~as examiners.~~ to assist the Commissioner in the examination, the cost of which shall be paid by the insurer pursuant to G.S. 58-2-134."

Section 4. Article 2 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-2-134. Cost of examinations.**

(a) For an examination of records or assets maintained in the State pursuant to G.S. 58-2-131, 58-2-132, or 58-2-133, the insurer shall pay the actual expenses incurred by the Department in conducting the examination. Except as provided in subsection (b) of this section, the amount paid by an insurer for an examination shall not exceed one hundred thousand dollars ($100,000).

(b) An insurer shall reimburse the Department for the actual expenses incurred by the Department in any examination of those records or assets conducted pursuant to G.S. 58-2-131, 58-2-132, or 58-2-133 when:

(1) The insurer maintains part of its records or assets outside this State pursuant to G.S. 58-7-50 or G.S. 58-7-55.

(2) The insurer requests an examination of its records or assets.

(3) The Commissioner examines an insurer that is impaired or insolvent or is unlikely to be able to meet obligations with respect to known or anticipated claims or to pay other obligations in the normal course of business."

Section 5. G.S. 58-7-16(f) reads as rewritten:

"(f) The Commissioner has sole authority to regulate the issuance and sale of funding agreements on behalf of insurers. In addition to the authority in G.S. 58-2-40, the Commissioner may adopt rules relating to:

(1) Standards to be followed in the approval of forms of funding agreements.

(2) Reserves to be maintained by insurers issuing funding agreements.

(3) Accounting and reporting of funds credited under funding agreements.

(4) Disclosure of information to be given to holders and prospective holders of funding agreements.

(5) Qualification and compensation of persons selling funding agreements on behalf of insurers.

In determining minimum valuation reserves to be maintained by insurers issuing funding agreements, the Commissioner may use any relevant actuarial guideline, regulation, interpretation, or paper published by the Society of Actuaries or the American Academy of Actuaries that the Commissioner considers reasonable."

Section 6. G.S. 58-2-131(d) reads as rewritten:

"(d) The Commissioner may conduct an examination of any insurer whenever the Commissioner deems it to be prudent for the protection of policyholders but shall at a minimum conduct ~~an~~ a regular examination of every domestic insurer not less frequently than once every ~~three~~ five years. In scheduling and determining the nature, scope, and frequency of examinations, the Commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the NAIC Examiners' Handbook."

Section 7. G.S. 58-2-205 reads as rewritten:

"**§ 58-2-205. CPA audits of financial statements.**

~~The Commissioner is authorized to adopt rules to provide for audits and opinions of insurers' financial statements by certified public accountants. Such rules shall be in accordance with the NAIC model rule that requires audited financial reports, as amended.~~ (a) The NAIC model rule requiring annual audited financial reports as provided for in the annual statement instructions is incorporated into this section by reference, except as specified in subsections (b) through (g) of this section.

(b) The annual audited financial report shall be filed with the Commissioner on or before May 10 for the previous calendar year. Two copies of this report shall be filed with the Chief Examiner in the Field Audit Section of the Department. An extension of the May 10 filing date may be granted by the Commissioner for a period of up to 45 days. The request for extension must be submitted in writing no sooner than 15 days before the due date.

(c) This requirement applies to all insurers; provided that insurers having direct premiums written in North Carolina of less than two hundred fifty thousand dollars ($250,000) in any year and having fewer than 500 policyholders in North Carolina at the end of any year are exempt from this requirement for that year unless the Commissioner makes a specific finding that compliance is necessary for the Commissioner to carry out the Commissioner's statutory responsibilities.

(d) Certified public accountants that intend to practice pursuant to the provisions of the annual statement instructions shall file a notice to that effect with the Commissioner by October 1 of each year. The Commissioner may reject the filing if the certified public accountant does not meet the requirements. The filing shall contain a statement from the certified public accountant affirming that the certified public accountant is aware of and will comply with the provisions of the annual statement instructions related to the definition, availability, and maintenance of certified public accountant workpapers and evidence of the certified public accountant's expertise in the areas of insurance auditing and insurance accounting. This evidence shall also demonstrate experience in the areas of insurance auditing and insurance accounting for the certified public accountant's staff members who are assigned to the audit.

(e) The certified public accountant may be deemed to be experienced in the areas of insurance auditing and accounting if the office filing with the Department pursuant to this section has existing audit clients in the insurance industry.

(f) The staff assigned to an audit under this section may be considered by the Commissioner to be experienced in the areas of insurance auditing and accounting if they meet the following criteria:

(1) Managerial staff that has been assigned or has had responsibility for audit engagements in the insurance industry in an amount averaging at least thirty percent (30%) of its chargeable time during the last three years.

(2) Nonmanagerial staff that has been assigned or has had responsibility for audit engagements in the insurance industry in an amount averaging at least fifteen percent (15%) of its chargeable

time during the last three years or during the staff members' periods of employment if employed fewer than three years.

(g) An audit performed by a certified public accountant under this section shall be staffed by managerial staff experienced in the areas of insurance auditing and accounting and by a majority or an equal number of nonmanagerial staff experienced in the areas of insurance auditing and accounting.

(h) As used in this section, 'insurance' includes financial services."

Section 8. This act becomes effective July 1, 1998.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

June 18, 1998

TO: House Insurance Committee

FROM: Bill Hale
Deputy Commissioner

SUBJECT: PCS for HB 1429

Section 1: Sets the percentage rate for the insurance regulatory charge in G.S. 58-6-25 for calendar year 1998. This is done by the General Assembly every year.

Section 2: Amends the law that requires every North Carolina insurance company to maintain its records and assets in this State by making it clear that the Commissioner may permit a domestic insurer to maintain a part of its records or assets outside of the State.

Sections 3 and 3.1 are technical. They amend two statutory provisions to include a cross-reference to the new statute section in Section 4 of the bill.

Section 4: Adds a new section to the Examination Law that would provide that the Department of Insurance may bill an insurance company for an examination of its records and assets, up to a maximum billing of $100,000 (unless there is a mutual agreement for a higher amount), in only three situations: (1) When a North Carolina insurer keeps records and assets out of North Carolina and the Department needs to examine those out-of-state records or assets; (2) when an insurer requests an examination (usually this happens when another company wants to acquire or merge with the insurer and the insurer wants an official "stamp of approval" on its financial situation; and (3) when an insurer is financially unstable. The last item is important because intervention by the Department through an examination can keep the insurer from becoming insolvent, thus avoiding a liquidation and assessments by a guaranty fund on all other insurers.

Billing an impaired insurer does not cause further deterioration in the insurer's financial situation.

Section 5: Amends the law that gives the Commissioner authority to regulate the issuance and sale of funding agreements. In determining the appropriate level of reserves to be required by the Commissioner, the Commissioner's actuarial staff has determined that the statute should reference and permit the Commissioner to use relevant guidelines published by the Society of Actuaries or the American Academy of Actuaries, when determined by the Commissioner to be reasonable.

Section 6: Changes the schedule for regular examinations of North Carolina (domestic) insurers from at least once every three years to every five years.

Sections 7 and 8: Amend the law on CPA audits of insurance company financial statements and amend the Administrative Procedure Act to allow the Commissioner to make changes in the existing CPA audit rules under the APA's temporary rulemaking provisions whenever North Carolina needs to keep current with changes in the National Association of Insurance Commissioners Model Rule. The Department needs this flexibility to maintain its accreditation with the NAIC, which is critical for our North Carolina insurance companies. This approach will make any rule changes subject to scrutiny through the permanent rulemaking process, which follows the temporary rulemaking process. It just allows changes to go into effect on a temporary basis before the next session of the General Assembly.

Section 9: This bill has a July 1, 1998, effective date.

MINUTES

INSURANCE COMMITTEE

JUNE 25, 1998

Chairman Jerry Dockham called the meeting to order at 12:00 Noon. He introduced the pages and welcomed the members. Members present were: Rep. Jerry Dockham, Rep. Cary Allred, Rep. Bobby Barbee, Rep. Robert Brawley, Rep. Nelson Cole, Rep. Dub Dixon, Rep. Charlotte Gardner, Rep. Sandy Hardy, Rep. John Hurley, Rep. William Ives, Rep. Paul Luebke, Rep. Danny McComas, Rep. Thomas Wright, Rep. Joni Bowie and Rep. Carolyn Russell. The visitor registration sheet is included and made a part of these minutes. (Attachment I)

Chairman Dockham called on Representative Dennis Reynolds to explain The Committee Substitute for House Bill 1495. Rep. Bobby Barbee made the motion to accept the substitute and it was voted favorably by the Committee Members. Representative Reynolds explained that he has taught classes in computers and is very familiar with electronic medical records. He stated that electronic records are safer than paper records. He then introduced Mr. Holt Anderson, Executive Director of North Carolina Healthcare Information and Communications Alliance, Inc.

Mr. Anderson explained that the purpose of the legislation is to establish rules for when a person's confidential health information may be disclosed and to whom. It defines rules for security to protect confidentiality while information is stored and when it is disclosed to others. It articulates certain rights of patients, including the right to view health information and to suggest corrections or amendments to that information. It requires secure computerized systems that control access and provide audit trails, and integrates state requirements for information systems with those at the federal level. Mr. Holt explained that patients, providers, integrated delivery systems, ancillary service providers, payers, researchers, lawyers, state agencies, and licensing bodies and everyone involved in health care needs this legislation.. "This legislation is first and foremost consumer legislation with a primary focus on the individual patient", said Mr. Anderson. It also provides more privacy protection to patients than is available today in North Carolina. Mr. Anderson gave the members a handout which explains the background, key points and questions and answers. Attachment II and III.

Linwood Jones, Staff Attorney, gave a summary of House Bill 1495. See Attachment IV.

Representative Hurley explained that he has a small amendment which does not take anything away from the bill. Mr. Hurley made the motion to add, "The provisions of G.S. 90-411 shall apply to any request made pursuant to this subsection". Staff explained the amendment and it was passed by the Committee.

Representative Luebke offered an amendment which added the words, "in accordance with federal law," on page 9, line 26. Linwood Jones explained and it was passed.

Representative Brawley made a motion to strike lines 42, 43 and 44 on page 9 and to replace it with the wording "To an employer pursuant to Chapter 97 of the General Statutes." Dr. Levine, DHHS, explained the General Statutes and exactly what changing this wording would mean in regard to the amendment. Representative Cole asked about the availability to medical records while traveling. Dr. Levine explained the profile of medical records on the computer. After much discussion about the privacy element and the reporting of communicable diseases and the "right to know" the motion was made by Representative Brawley for adoption and Representative Dixon moved to have the three amendments rolled into one, with a favorable report and re-referred to Judiciary II. It was given a favorable report by the Insurance Committee. Attachment V

Representative Jerry Dockham adjourned the meeting at 1:00 PM.

Chairman Jerry Dockham

Joanna Mills,

Attachment I

VISITOR REGISTRATION SHEET

INSURANCE COMMITTEE — Name of Committee

Thursday June 25, 1998 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sondra Panico	NCHCFA
[illegible]	WCSR
Wendy Mills	SEANC
Beth Ising	Hunton + Williams
Carrie Aldman	Aetna
JK Culler	NCPP
Wil Edgerton	NCHA/NC
Robert Prom	Jordan Price Wall
Elizabeth Stoar	NCHCA
W. Holt Anderson	NCHCA
Jeff Lipe	Bayer
John Bowdish	Zeb Alley P.A.
Maj Lewis	M A Lewis & Assoc
Karen Gillespie	Bristol-Myers Squibb Co.
Barb Carraven	McKesson Stadleton
[illegible]	PhRMA
[illegible]	Governor's Office
S Watts	National MS Society
Carmen Hooker Buell	Carolinas Health Care System
Vandana Shah	Attorney General's Office
Pat Yancy	APPCNC
[illegible]	NCIAA
Deborah Rich	Aetna
Ron Levine	DHHS
Robert Paschal	Young, Moore

Health Care Information Privacy

Attachment II

BACKGROUND

- The continuing pressures to improve the quality of health care while at the same time dealing with the increasing complexity and cost has led to an acceleration in the use of computers and communications to manage health information. Because of this, the health care industry is experiencing the same explosion in the use of computers and communications as all other industry and government sectors.

- Citizens and health care institutions alike are concerned about maintaining the confidentiality, privacy and security of health information while providing for effective and timely care and improving the practice of medicine through appropriate research.

- Existing statutes and regulations at the federal and state level have not kept pace with the use of information technology and therefore, the public and health care institutions do not know with reasonable certainty what the law allows and requires.

- Patients are reluctant to share sensitive information with health care providers when the rules governing the use of this information are unclear. Similarly, it is difficult to develop software and systems to protect the information when the rules are uncertain.

- The situation demands rules that protect patient privacy while ensuring that providers have legitimate and timely access to information for purposes of care.

- Legislation appears to be the only effective solution to address these concerns.

KEY POINTS

- Establishes rules for when a person's confidential health information may be disclosed and to whom,

- Defines rules for security to protect confidentiality while information is stored and when it is disclosed to others,

- Articulates certain rights of patients, including the right to view health information and to suggest corrections or amendments to that information,

- Requires secure computerized systems that control access and provide audit trails, and

- Integrates state requirements for information systems with those at the federal level.

COMMON QUESTIONS WITH ANSWERS

What is the purpose of the legislation?

The purpose of the legislation is to:

- establish rules for when a person's confidential health information may be disclosed and to whom,
- define rules for security to protect confidentiality while information is stored and when it is disclosed to others,
- articulate certain rights of patients, including the right to view health information and to suggest corrections or amendments to that information,
- require secure computerized systems that control access and provide audit trails, and
- integrate state requirements for information systems with those at the federal level.

Who needs this legislation?

Patients, providers, integrated delivery systems, ancillary service providers, payers, researchers, lawyers, state agencies, and licensing bodies--everyone involved in health care needs this legislation.

How does the legislation protect privacy?

The legislation is first and foremost consumer legislation with a primary focus on the individual patient. It provides more privacy protection to patients than is available today in North Carolina.

A fundamental concern for each citizen is the privacy of individual health care information. Health information is personal and sensitive information such that the inaccurate collection or improper use or release of the information may do significant harm to a patient's interests in privacy, health care, or other interests.

The legislation strives to provide individuals with protections concerning the use, privacy, and confidentiality of their personal health information and to provide a high degree of confidence in health information systems by:

(i) establishing clear and consistent rules, and hence enhancing legal certainty, related to the collection, storage, compilation, disclosure and use of health information;

(ii) assuring that health information is secure, private, and accurate and that such information is not improperly disclosed or modified; and

(iii) limiting access to health information to those with a legitimate, verified need for such information.

The importance of these rules is reinforced by civil damages that arise when these rules are broken.

The legislation also establishes the public policy that a patient's interest in the proper use and

disclosure of the patient's health information survives even when the information is held by persons other than the original health care provider. In this respect the legislation proposes a focus on the utilization of health information that does not identify individual patients.

The legislation ensures patients access to their own health information, enables them to make informed decisions about their health care and provides a mechanism to correct inaccurate or incomplete information about themselves.

The legislation also addresses legitimate privacy interests of health care providers and health care facilities while at the same time accommodating the interests of managed care in a modern health care setting.

The legislation also recognizes that under current North Carolina law others have legitimate needs to collect, use, and disclose health information in different contexts and for different purposes, including providers, integrated delivery systems, ancillary service providers, payers, researchers, lawyers, state agencies and licensing bodies. The legislation balances those needs with the privacy interests of individuals; the emphasis of the legislation is on the establishment and preservation of the privacy of the individual when health information is accessed in ways permitted by law.

Are there similar initiatives going on in the surrounding states?

Some 40 states are working with new legislation in some way.

Why not rely on federal legislation in this area?

It is not clear that federal legislation or regulation in the area of health care confidentiality will become a reality, and, if it does, what form it will take and whether it will preempt more protective state laws. Each of the states that have already proposed or passed legislation in this area has recognized that confidentiality of health information is both a core issue of local concern and, because of the implications for the reduction of health care costs, a significant national issue. These states have opted to act now in order to ensure the protection of the public's health care privacy for the future.

Who may be uncertain or uneasy about this legislation?

Public interest groups and privacy advocates have expressed concerns regarding the security of computerized medical records and the security of transmitting these records over networks. Many of these concerns are alleviated when the advocates understand that the primary purpose of this legislation is to address these very same concerns.

How would the legislation improve care?

The legislation would facilitate the utilization of computerized health information systems by organizing relevant law related to the use of health information so as to minimize the confusion and uncertainty in existing law. In turn, computerized health information systems facilitate timely access by health care providers and others to more complete health information than is now available through paper-based systems, improve the accuracy and integrity of health information, enable quicker response times, provide access to knowledge bases otherwise unavailable, facilitate

medical research and health care quality assurance, and increase opportunities to discover new treatments, methods and drugs.

What is the difference between paper-based systems and electronic systems?

Although the methods of protection vary between physical and electronic forms of information, health care providers and others who handle health care information must deal with both. Designers of health information systems need clearly defined rules to accommodate and facilitate the concerns of privacy and use of health information; consequently, it is impossible to address privacy issues for electronic forms of health information until the law related to privacy issues for all health information, including paper-based information is consolidated and organized. The legislation accomplishes this objective.

What will be the fiscal impact?

The fiscal impact will be different for various groups. The legislation states what must be done, but does not state how it must be done. There is a two year window for implementation. Resources will need to be committed for the education and training of staff but much if not all of this is done currently. Existing systems may require modification to comply with the security and tracking standards. Savings will be realized because the development of complex systems is made much easier with known rules.

Currently costs are being incurred in the normal course of system upgrades and to comply with federal laws. As a result, the incremental impact of the state legislation is less significant.

Some of the costs will be offset by decreased liability due to the organized framework for compliance afforded by the Act. Other costs may be reduced due to the efficiencies of computerized systems over paper systems and due to increases in the quality of care provided. As an example, some insurers are offering discounts on medical malpractice insurance premiums to physicians who maintain electronic records. In this regard, a 1994 Government Accounting Office noted:

> On average, physicians lack access to patient's medical records in 30%+ of all visits.
>
> Hospital medical records typically are 70% incomplete.
>
> On average, physicians spend 38% of their time writing notes by hand in patient's charts.

One 1992 study prepared for the Secretary of the U.S. Department of Health and Human Services indicated that immediate savings from simplified billing alone could be between $4 billion and $10 billion in the United States.

Other significant cost savings arise outside of the administrative arena. Costs are also reduced in areas such as clinical research associated with development and approval of medical devices and beneficial drugs, utilization studies, analysis of public health trends and regulatory review. Also, as noted below, computerized information systems improve the effectiveness of health care delivery, and when this is done, health care costs are reduced.

By working together to adopt standards for systems, North Carolina is reducing the overall cost of implementation and compliance with confidentiality laws and regulations.

What is the Status of Medical Records Under Current North Carolina Law?

Current North Carolina laws and regulations provide, at best, an inconsistent and incomplete treatment of laws and policies related to the subject of health care information in any format, much less that created, stored and transmitted by electronic means. North Carolina law relies heavily on the health care industry to self-regulate through medical ethics principals, licensure and forms of professional review. The system has worked in the past, but many believe that to facilitate the proper use of electronic health information, legislation is needed to provide clearer rules.

Although the privacy of medical information arises in a significant number of settings, North Carolina law currently provides only detailed provisions regulating the privacy of medical information in three settings: health information held by mental health facilities, health information used in the insurance industry, and the prescription practices of pharmacies. Of these three areas, only the laws and regulations regulating pharmacies recognize and address the potential benefits and risks associated with electronic communications, demonstrating that the benefits and risks associated with health information can be controlled through appropriate treatment in the law.

North Carolina laws and regulations affecting health information generally were drafted before health information was commonly stored in electronic form. Yet today most forms of health information are stored in an electronic form, including mental health records, communicable disease information, as well as physicians notes and claims information. Without significant changes in North Carolina law, it will be very difficult for the health care industry to respond in a consistent manner to protect the privacy of patients' health information.

While voluminous, incomplete, and sometimes conflicting in nature, current North Carolina law concerning privacy of health information also negatively impacts the ability of the health care industry to address adequately the technological issues associated with developing confidence in the privacy of health care information and making it difficult to achieve the benefits of the technology. The uncertainty created by current North Carolina law increases the costs and risks associated with utilizing computerized health information, and hampers the investment commitments necessary to develop and implement appropriate systems in North Carolina.

The legislation is a response to this inconsistent statutory and regulatory framework and is designed to comprehensively protect patient records in today's information age.

Attachment III

Protecting the Patient's Right to Privacy in Health Care

The proposed health care privacy legislation in North Carolina

House Bill 1495

Senate Bill 1288

Utilizing Technology to Improve Health Care

- Technology has a tremendous potential for improving health care delivery to patients and reducing costs, but ...
- Implementing electronic health information requires more than technical expertise
- It requires ***strong*** privacy protections

Why Protect Patient Privacy?

- Inappropriate collection, use, or disclosure of personal information can be devastating
- Professional ethics requires confidentiality
- Breaches can lead to significant liability
- Protection of privacy is essential to acceptance of technology

What's Wrong With What We Have Now?

- Current laws are inconsistent and incomplete
- Few patient rights protections exist
- Many laws ignore information created, stored, and transmitted electronically
- Lack of consistency makes it difficult to uniformly protect privacy

Why Not Wait for Federal Legislation?

- Federal framework has been established by Kennedy-Kassebaum (HIPAA)
- It provides very little helpful substance now
- Detailed regulations on this issue may not be forthcoming for many months
- The shift to electronic information is underway without adequate guidance in place

Why Not Wait for Federal Legislation?

- With guidance, the benefits of information technology can be realized sooner - -
- Reduced risk to patients and providers
- Improved patient care via complete records
- Record of disclosures and amendments
- Reduction of costs through elimination of paper and enabling secure use of electronic commerce
- Influence the direction of federal legislation

What has been the Process?

- NCHICA initiated dialogue among "stakeholders" in the health care industry (1995)
- Research begun and work groups established (2-96)
- Drafts of "model legislation" created that reflected key needs for guidance (1996-1997)
- Drafts circulated initially to NCHICA members, and later to anyone interested
- Process was wide open; all comments were considered, and most were incorporated

Process -- Industry and Patient Representatives Contacted

- Professional associations including: NCHIMA, NC Medical Society, NC Nurses Assn, NC Health Care Facilities Assn, NC Psychiatric Assn and NC Psychological Assn, NCHA, NC Assn of Health Plans
- State agencies, academic medical centers, integrated delivery systems, HMOs
- ACLU, Alliance for the Mentally Ill, AIDS/HIV interest groups and other patient advocates
- Technology, pharmaceutical and research organizations
- Health care lobbyists and lots of lawyers

Process -- Legal Research

Looked to:

- Accreditation standards
- Industry guidelines
- Codes of professional ethics

Process -- Legal Research

Pulled "best of the best" from:

- North Carolina statutes and regulations
- Other states' laws
- Model acts
- Federal law -- pending, enacted and "leaked" drafts

Process -- Converging on a Workable Model

- Effort made to accommodate all interests
- Initial result was a very complete - but unwieldy and complicated draft
- "Surgery" left only essentials necessary to establish sound base
- Goal is to establish basic privacy protections and to continue discussions regarding more challenging issues

Fundamental Principles

- Provide **clear legal framework** for handling personal medical information, **whether paper or electronic**
- Establish **basic privacy protections**
- Information is to be used only for the **purpose** for which it was gathered
- Encourage compliance through **sanctions**
- Create **safe harbors** from liability

Fundamental Principles

- **Preserve existing law** except to eliminate inconsistencies
- Reflect industry practice and **legitimate uses** of information
- Take into account **developing federal and industry standards**
- Avoid creating new bureaucracies

What Does the Bill Do?

Establishes rules to serve patient interests in:

- Privacy
- Controlling most disclosures of personal information
- Access to and amendment of medical information

What Does the Bill Do?

- Clarifies rules for subpoenas, court orders and other "compulsory" disclosures
- Authorizes providers to communicate information necessary for patient's care, unless patient objects
- Enables a custodian to perform internal audits (such as peer review, quality assessment, planning) appropriate to its business purposes

What Does the Bill Do?

- Eliminates "quill pen" laws
- Facilitates "electronic signatures"
- Authorizes NC to establish standards in accord with emerging federal and industry standards, guidelines and requirements

Nuts and Bolts - How It Works

Patient's Rights:

- To examine and copy *Section 132A-2-1(a)*
- Request amendment *Section 132A-2-2*
- Confidentiality *Section 132A-2-3*

Nuts and Bolts

Basic Confidentiality Requirements:

- **Custodian** maintains confidentiality of identifying health information, and discloses only as authorized ***Section 132A-2-3(a)***
- **Recipient** can use or redisclose only for the purpose and under authority of original disclosure or specifically authorized by law ***Section 132A-2-3(c)***

Nuts and Bolts

Basic Confidentiality Requirements:

- Applies to custodian's employees, agents and contractors *Section 132A-2-3(d)*
- Prohibits linking non-identifying information to identify an individual unless authorized *Section 132A-2-3(e) and (f)*

Nuts and Bolts

Record of Disclosure and Revision:

- Custodian shall establish policies for recording the creation, revision or disclosure of identifying health information *Section 132A-3-4(a)*
- Limited access by others to record of disclosures and revisions *Section 132A-3-4*
- Patient can have access to record of disclosures and revisions (with important exceptions) *Section 132A-2-1(b) and (c)*

Nuts and Bolts

Limited Disclosures:

- Disclosure of non-identifying information preferred *Section 132A-3-2(a)*
- Disclosing party obligated to disclose only the identifying information it believes is necessary to provide care for purpose requested *Section 132A-2-3(h)*
- Patient can authorize more *Section 132A-2-3(h)*
- Court order can authorize more *Section 132A-2-3(h)*

Nuts and Bolts – How It Works

Disclosures without Patient Authorization:

- Currently provided for in current statutes or through customary practice
- Proposed bill does not attempt to broaden disclosure of identifying information beyond what is permissible today
- Application of technology will make it easier to protect these types of disclosures

Nuts and Bolts

Disclosures Without Patient Authorization:

- To a referring provider, if patient does not object *Section 132A-3-2(c)(1)*
- To provide care to patient if within group or network *Section 132A-3-2(c)(2)*

Nuts and Bolts

Disclosures Without Patient Authorization (Cont.):

- To provide care in case of immediate threat to patient's health *Section 132A-3-2(c)(3)*
- To a family member or person known to have a close personal relationship with a patient incapable of consenting, if disclosure is necessary to avoid serious jeopardy to patient's health *Section 132A-3-2(c)(4)*

Nuts and Bolts

Disclosures Without Patient Authorization (Cont.):

- Although **no duty** to disclose, disclosure may be made:
  - To protect against serious and imminent danger
  - To protect against violent felony or violent misdemeanor *Section 132A-3-2(5)*

Nuts and Bolts

Disclosures Without Patient Authorization (Cont.):

- To disclosing custodian to verify accuracy of information *Section 132A-3-2(c)(6)*
- To health oversight agency for audits *Section 132A-3-2(c)(7)*
- For custodian's internal audit *Section 132A-3-2(c)(8)*

Nuts and Bolts

Disclosures Without Patient Authorization (Cont.):

- To agents, employees, custodians if necessary to patient care or to perform administrative services *Section 132A-3-2(c)(9)*
- To a health researcher for health research "if not prohibited by state or federal law" *Section 132A-3-2(10)*

Nuts and Bolts

Disclosures Without Patient Authorization (Cont.):

- To a provider to confirm or compare treatment *Section 132A-3-2(c)(11)*
- To the custodian's successor in interest *Section 132A-3-2(c)(12)*
- To a payer when necessary for audit of services already provided *Section 132A-3-2(c)(13)*
- Mandated disclosures laws retained (e.g.Child abuse, gunshot wounds)

Nuts and Bolts

Subpoena:

- Access for legal purposes requires:
  - Patient authorization *Section 132A-3-3(b)(1)*
  - Authorization from deceased patient's representative *Section 132A-3-3(b)(2)*
    or
  - Court order *Section 132A-3-3(b)(4)*

Nuts and Bolts

Custodian Responsibilities:

- Policies and safeguards to protect security, confidentiality, accuracy and integrity of information *Section 132A-3-4*
- Internal punishment for violation *Section 132A-3-4(a)(1)*
- Training for those with access to identifying information *Section 132A-3-4(a)(3)*

Nuts and Bolts

Custodian Responsibilities:

- Limiting disclosure to information needed to accomplish purpose ***Section 132A-3-4(a)(5)***
- Record of disclosure not required for: ***Section 132A-3-4(b)***
  - on-going health care unless communicated electronically ***Section 132A-3-4(b)(1)***
  - oral disclosures to patient or to family if patient lacks capacity to authorize ***Section 132A-3-4(b)(2)***

Patient Information Locator

- Points to location of health records ***Section 132A-1-2(l)***
- Enables access to complete patient record for health care if authorized
- Custodian may participate in locator ***Section 132A-3-5(a)***
- Not a database of clinical information
- Does not include "sensitive" information, unless authorized ***Section 132A-3-5(b)***

Liability

- Provides safe harbors for compliance with law ***Section 132A-4-1***
- Authorizes NC to establish standards in accord with emerging federal and industry standards, guidelines, and requirements ***Section 132A-4-1 (6)***

Liability

- Provides civil liability for violations (including negligence, action, injunction) ***Section 132A-4-2***
- No new criminal liability
- Criminal liability under computer crimes law and statutes governing mental health facilities not affected

Electronic Medical Records and Signatures:

- Paper records no longer required ***Section 132A-3-6***
- Electronic authentication authorized ***Section 132A-3-7***
- Disclosure of individual's secure code not allowed ***Section 132A-3-7(b)***
  (i.e. no PostIt notes with password)

Conflicting Laws

Mental Health & Substance Abuse

- Does not apply to mental health information governed by chapter 122C:
  - Patient's examination and copying
  - Disclosures without consent
  - Other provisions do apply
- Does not affect federal law regarding substance abuse records

Conflicting Laws

Health Insurance

- Does not apply to insurance information governed by chapter 58, article 39:
  - Patient's examination and copying
  - Request for amendment
  - Authorization for disclosure
  - Custodian responsibilities
  - Civil remedies
  - Other provisions apply

Conflicting Laws

Communicable Diseases

- Does not apply to communicable disease information governed by chapter 130A:
  - Disclosures without consent
  - Other provisions apply

Issues Needing Additional Consideration in Future Bill(s)

- Criminal penalties
- Reproductive status
- Health Research
- Consistency of application across the healthcare community (payers, providers, self-insured employers, government, and research organizations)

Thank you !

Questions ???

Editorials


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MODERN HEALTHCARE
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"HEY, COOL! NOW LET'S SEE WHAT KIND OF SECURITY MEDICAL RECORDS HAVE!!"

Attachment IV

TO: Members, House Insurance Committee
FROM: Linda Attarian, Staff Attorney
RE: **Summary of House Bill 1495 -- Health Care Information Privacy Act**
DATE: June 25, 1998

Statute Section & Page/Line Number	Bill Summary
132A-1-1, Page 1, lines 13-23, page 2 lines 1-10	**Purpose:** To facilitate the benefits of electronic information and to establish a clear legislative policy to ensure the accuracy, security, integrity and reliability of health information.
132A-1-2, Page 2, lines 13-44	**Definitions:** The following terms are defined: Audit, Custodian,
Page 3, lines 1-24	Directory information, Electronic, Electronic agent, Electronic record, Electronic signatures,
Page 4, lines 24-44, Page 5, lines1-15	Facility, Health care, Health information,
Page 5, lines 16-44, Page 6, lnes 1-13	Health oversight agency, Health research, Identifying health information, Identifying provider information,
Page 6, lines 14-44	Master person index, Medical record, Patient, Payer, Person, Provider, Sign.
132A-2-1(a), Page 6, lines 4-8	**Patient's privacy interests:** Establishes patient's right of access to examine and copy the patient's own health information.
132A-2-2(a), Page 6, lines 22-24	Establishes procedure to request to amend information the patient believes is inaccurate or incomplete.
132A-2-3(a) Page 6, lines 34-36	Places a duty to maintain the confidentiality of identifying health information upon the custodian of that information, and the custodian's employees, and agents.
132A-2-3(e) & (f) Page 7, lines 1-8	Provides protections against linking non-identifying information to identify the patient or provider.
132A-2-3(c) Page 6, lines 39-41	Prohibits unauthorized use by the recipient of disclosed identifying health information.
132A-2-3(h) Page 7, lines 17-22	The recipient may use or redisclose identifying information **only** for the purpose and under the authority of the original disclosure.
132A-3-1(a), Page 7, lines 33-38	**Authorization to disclose health information:** Prohibits custodian from disclosing identifying health information without patient's authorization, unless disclosure is otherwise authorized by law.
132A-3-1(b) Page 7, lines 39-41	Requires the custodian to keep a patient's authorization to disclose with the patient's health information.
Page 7, lines 42-44, Page 8, lines 1-6	Establishes the minimum requirements for a patient's authorization to disclose to be valid.
132A-3-1-(d) & (e) Page 8, lines 18-22	Provides that the patient may revoke or amend authorization, except to the extent custodian has relied upon it. Authorization is effective for time specified by the patient or if not specified, one year.

	Rules of disclosure and use of health information:
132A-3-2(a) Page 8, lines 24-28	Obligates disclosing party to make a reasonable effort to disclose or use **non-identifying** health information whenever sufficient to achieve the purpose of the disclosure.
132A-3-2 (b) Page 8, lines 29-32	Requires mandatory disclosures as currently required by law (to law enforcement, to report suspected abuse, pursuant to a court order).
	When disclosure is allowed without consent:
132A-3-2(c) Page 8, lines 33-43, Page 9, lines 1-44	Sets forth circumstances in which identifying health information may be disclosed, including:

132A-3-2 (c)(1) & (c)(2)
Pages 8, lines 35-43,
Page 9, lines 1-2
	* to provide health care to the patient:
	  * to a provider currently caring for the patient
	  * to a referring provider (if the patient does not object);
	  * to another provider in the same group practice or provider network.

132A-3-2(c)(3) Page 9, lines 3-4	* to provide care in case of an immediate threat to the patient's health;
132A-3-2(c)(4)&(c)(5) Page 9, lines 5-15	* to protect against serious and imminent danger; * to protect against violent felony or misdemeanor;
132A-3-2(c)(6) Page 9, line 16	* to the custodian that originally reported the information to verify the accuracy of the information;
132A-3-2(c)(7) Page 9, lines 17-18	* to a health oversight agency for audit functions;
132A-3-2(c)(9) Page 9, lines 21-25	* to agents, employees of the custodian if necessary to patient care or to perform administrative services;
132A-3-2(c)(10) Page 9, lines 26-27	* to a health researcher for health research if permitted by federal or State law;
132A-3-2(c)(8) Page 9, lines 19-20	* for custodian's internal audit;
132A-3-2(c)(14) Page 9, lines 35-41	* directory information;
132A-3-2(c)(13) Page 9, lines 33-34	* to a group policyholder when necessary for audit of a service already provided;
132A-3-2(c)(11) Page 9, lines 28-29	* to a provider to confirm or compare treatment;
132A-3-2(c)(12) Page 9, lines 30-32	* to a custodian's successor in interest (e.g., Executor or Administrator of Estate)
	Subpoenas, search warrants, discovery requests, and court orders:
132A-3-3(a) Page 10, lines 2-9	Provides that identifying health information is to be treated as if the information were medical records.
132A-3-3(b) Page 10, lines 10-33	Access to health information for legal purposes requires: * patient authorization * authorization from deceased patient's representative **or** * a court order.

	Custodian responsibilities:
132A-3-4(a) Page 10, lines 39-44	* Requires custodians to develop policies and safeguards to protect the confidentiality, security, accuracy, and integrity of health information;
132A-3-4(a)(3) Page 11, lines 7-8	* training of employees having access to identifying health information;
132A-3-4(a)(1) Page 11, lines 1-3	* internal punishment for violation;
132A-3-4(a)(5) Page 11, lines 13-15	* limiting disclosure to information needed to accomplish purpose;
132A-3-4(a)(4) Page 11, lines 10-12	* audit trails showing disclosure (except disclosures made for the purpose of providing ongoing health care to the patient unless communicated electronically, or oral disclosures to a patient or to family members if the patient lacks mental capacity).
132A-3-5 Page 11, lines 23-43	**Patient Information Locator:** Permits the creation by a custodian of an index that: * points to the location of medical records held by the custodian; * enables access to complete patient record for health care if authorized; * custodian may participate in locator; * does not include "sensitive" information, unless authorized.
132A-3-6 Page 12, lines 1-7	**Electronic medical records:** Allows a custodian to maintain and preserve health information solely in electronic form, (paper records are no longer required).
132A-3-7 Page 12, lines 9-19	**Electronic signatures:** Provides that electronic authentication of individuals, entities and associated health information is authorized. Prohibits the disclosure of an individual's security code (password).
132A-4-1, Pages 12, lines 23-44, Page 13,lines 1-34	**Safe harbors (from liability):** Provides safe harbor for compliance with standards.
132A-4-2 Page 13, lines 36-44, Page 14, lines 1-2	**Civil remedies:** Provides civil liability for violation of the law, including negligence action and injunctions. Criminal liability under computer crimes law and statutes governing mental health facilities are not affected.
132A-4-3(a) Pages 14, lines 4-14	**Conflict of existing laws:** Does not preempt disclosure obligations imposed by federal health care payment programs.
132A-4-3(a) Page 14, lines 4-14	Does not preempt State and federal law compelling or prohibiting disclosure. (Does not affect federal law regarding substance abuse).
132A-4-3(a) Page 14, lines 4-14	To the extent the provisions of this Chapter conflict with existing State law the provisions of this Chapter will control unless: * the other State law is specifically exempted ; OR * the State law governs the nondisclosure of identifying health information held by a health oversight agency for the purposes of peer review, professional review, or other professional disciplinary or corrective action.

132A-4-3(b) Page 14, lines 15-19	**Conflict of existing laws, continued:** The following provisions do not apply to insurance information governed by Article 39 of Chapter 58: * patient's examination and copying * request for amendment * authorization requirement for disclosure * custodian responsibilities * civil remedies All other provisions apply.
132A-4-3(c) Page 14, lines 20-21	**Conflict of existing laws, continued** The following provisions do not apply to mental health information governed by Chapter 122C: * patient's examination and copying * disclosures without consent [132A-3-2(c)] All other provisions apply.
132A-4-3(d) Page 14, lines 22-24	The Chapter does not apply to disclosures governed by Chapter 130A to protect the public's health.
132A-4-3(e) Page 14, lines 25-29	Does not apply to a telecommunications common carrier or an enhanced service provider if they are certified and subject to regulation under Chapter 62 of the General Statutes (Public Utilities) or by the Federal Communications Commission.
132A-4-4 Page 14, lines 33-34	**Rules of construction:** This Chapter is to be construed as NOT requiring the disclosure of trade secrets or other confidential commercial information.
132A-4-4 Page 14,lines 35-38	**Effective dates:** The act will become effective July 1, 1999, except that G.S. 132A-3-3 (subpoenas, court etc.), 132A-3-5 (master patient index), 132A-3-6 (electronic and paper records), and 132 (authentication of persons and information by electronic signatures), are effective when t becomes law.

Attachment K

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 1495*
Proposed Committee Substitute H1495-PCS7487-RM

Short Title: Health Care Information Privacy. (Public)

Sponsors:

Referred to:

May 25, 1998

A BILL TO BE ENTITLED

AN ACT TO PROTECT THE PRIVACY OF HEALTH INFORMATION, AS RECOMMENDED BY THE JOINT LEGISLATIVE HEALTH CARE OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

Section 1. The General Statutes are amended by adding a new Chapter to read:

"Chapter 132A.

"Health Information Privacy Act.

"ARTICLE 1.

"Legislative Findings and Definitions.

"**§ 132A-1-1. Legislative findings.**

(a) The General Assembly finds that health information is personal and sensitive information which, if inaccurately collected, documented, or improperly used or released may cause significant harm to a patient's interests in privacy and health care. Benefits of electronic health information include:

(1) Facilitating timely, authorized communications of more complete health information that is now available through paper-based systems;

(2) Improving the accuracy, integrity, and security of health information;

(3) Providing access to medical knowledge bases;

(4) Enhancing efficiencies of health care; and

(5) Facilitating health care research and health care quality improvement.

(b) The General Assembly finds that it is in the public interest to establish legislative policies and guidelines to ensure that health information is:

(1) Secure, private, accurate, and reliable;

(2) Properly disclosed or modified; and

(3) Accessible only to those with a legitimate need for the information.

(c) Certain types of information, such as information about HIV infection, AIDS, mental health, or substance abuse, are so highly sensitive that more strict requirements for disclosure are needed.

"**§ 132A-1-2. Definitions.**

As used in this Chapter, unless the context otherwise requires:

(1) 'Audit' means an assessment, communication evaluation, analysis determination, investigation, or prosecution of a custodian, provider, or facility, to identify, determine, evaluate, or monitor practices, services, or products concerning the applicability of, compliance with, or availability of:

a. Legal, fiscal, quality assurance, quality control, risk management, utilization review, medical, professional, or scientific standards or practices, or aspects of performance or potential liability relating to:

1. The delivery of or payment for present or future health care, health care services, health care products, or health care equipment;

2. Health care fraud or fraudulent claims regarding health care, health care services or equipment, or related activities and items;

3. Security of health information; and

4. Coordination of or planning for present or future services among providers or facilities;

b. Requirements for and oversight of licensing and professional discipline, accreditation, credentialing, or certification, including peer review; or

c. Future health care services or health care products provided by the custodian, provider, or facility to, or case management related to, a patient currently or previously served by the custodian, provider, or facility.

(2) 'Custodian' means any person operating in a business, professional, or governmental capacity that collects, creates, receives, obtains, maintains, uses, analyzes, or transmits identifying health information, including a college, employer, facility, payer, health oversight agency, health researcher, penal institution, provider, public health authority, school, State agency, third-party administrator, or university.

(3) 'Directory information' means the following information concerning a patient who is an inpatient or outpatient or who is currently receiving emergency health care in a health care facility:
a. The presence of the patient at the facility, including room, bed number, or telephone number;
b. Date of admission; and
c. The patient's health status whether 'critical', 'poor', 'fair', 'good', 'excellent', or a term denoting a similar condition.

(4) 'Electronic' means electrical, digital, magnetic, optical, electromagnetic, or other form of technology that entails capabilities similar to these technologies.

(5) 'Electronic agent' means a computer program or other electronic or automated means used, selected, or programmed by a person to initiate or respond to electronic records or performances in whole or in part without review by an individual.

(6) 'Electronic record' means a record created, stored, generated, received, or communicated by electronic means such as computer equipment or programs, electronic data interchange, electronic voice mail, facsimile, telex, telecopying, scanning, and similar technologies.

(7) 'Electronic signatures' means any signatures in electronic form, attached to or logically associated with an electronic record, executed or adopted by a person or the person's electronic agent with an intent to sign the electronic record.

(8) 'Facility' means any place where health care is regularly provided by a provider.

(9) 'Health care' means:
a. Preventive, diagnostic, therapeutic, rehabilitative, maintenance, investigational, experimental, cosmetic, reconstructive, or palliative care, including assistance with disease or symptom management and maintenance, counseling, service, laboratory test, or procedure:
1. With respect to the physical or mental condition of a patient; or
2. Affecting the structure or function of the human body or any part of the human body including the banking of blood, sperm, ova, organs, or any other tissue.
b. Any sale or dispensing of a drug, device, durable or disposable goods or equipment, or other health care related item to a patient, or for the use of a patient pursuant to a prescription, a purpose specified in a. of this subdivision.

(10) 'Health information' means any data, information, or orders, including advance directives, documents granting anatomical gifts, biological samples from the human body from which information

can be drawn, films, videotapes, consent forms, genetic sequences, digitized images, sound recordings, and demographic information recorded or stored in any form that:

a. Relates to a specific patient's past, present, or future health care or condition, including the patient's individual cells and their components or personal and family medical history;

b. Was created or obtained by a custodian in connection with health care diagnosis, treatment, screening, counseling, intake, or discharge of a patient or related to the application for, or enrollment of, a patient in a reimbursement plan, or for insurance use; or

c. Was obtained by or from a provider, a facility, a patient, a member of the patient's family, or any other person about a patient and in connection with a patient's health care.

(11) 'Health oversight agency' means a public agency or other person that receives a disclosure of, uses, maintains, or discloses health information while acting in the capacity of a person authorized by law or recognized by a government agency to perform or oversee the performance of an audit.

(12) 'Health research' means scientific, actuarial, survey, or statistical research based upon health information, including clinical investigations governed by the Code of Federal Regulations, Chapter I of Title 21. Health research does not include disclosure of health information for purposes of providing health care, peer review, audit functions, or reporting to State and federal authorities.

(13) 'Identifying health information' means a collection of health information that includes the name, address, social security number, unique identifier established by State or federal law, likenesses or other information which readily identifies a patient's personal identity, could be used or manipulated to identify a patient by foreseeable method with reasonable accuracy and speed, or could be linked or matched by a foreseeable method to any other information in order to identify a patient. Identifying health information includes information stored in a master person index authorized by G.S. 132A-3-5. Health information shall not be considered identifying health information solely based on the inclusion in a collection of health information of a code assigned to a patient by a custodian if that code does not consist of or contain symbols that could be used to readily identify a patient with reasonable accuracy and speed from sources external to the custodian.

(14) 'Identifying provider information' means the collection of health information that includes the name, address, social security number, medical billing number, employer identification number, likenesses, or other information by which the identity of a health care provider can readily be determined with reasonable accuracy and speed, or could be linked or matched by a foreseeable method to any other information in order to identify a provider. The term does not include a unique identification code assigned to a provider by a custodian and used and disclosed only internally to the custodian if that code does not consist of or contain symbols that could be used to identify readily a health care provider with reasonable accuracy and speed from sources external to the custodian.

(15) 'Master person index' means an index indicating the existence and general location of medical records of patients held by a custodian to facilitate the request for the information under circumstances permitted by this Chapter.

(16) 'Medical record' means identifying health information which is maintained in a health information collection, storage, and retrieval system of the custodian in the usual course of health care in accordance with applicable standards of practice.

(17) 'Patient' means an individual who is requesting, receives, or has received health care, or another person legally empowered to authorize the disclosure of a patient's identifying health information to the extent necessary to effect the terms or purposes of the individual's grant of authority.

(18) 'Payer' means a person acting in a business capacity who undertakes to furnish health insurance, disability insurance, life insurance, workers' compensation insurance, or otherwise to pay for all or some of health care services rendered to the patient.

(19) 'Person' means an individual, government, governmental subdivision, agency or authority, association, corporation, firm, limited liability company, partnership, society, estate, trust, joint venture, or any other legal entity.

(20) 'Provider' means:

a. A person licensed, certified, registered, or otherwise authorized by State or federal law to provide health care in the ordinary course of business or practice of profession;

b. A State or federal program that directly provides health care; or

c. A student training to provide health care acting under the supervision of a provider described in a. of this subdivision.

(21) 'Sign' means the execution or adoption of a signature by a person or the person's electronic agent.

"ARTICLE 2.

"Patient Interests.

"§ 132A-2-1. Patient's examination and copying of health information.

(a) Upon a written request from a patient to examine or copy the patient's medical record, a custodian who is a provider or facility shall, within a reasonable time of the receipt of the request, at the custodian's option, make the patient's medical record available for examination during regular business hours or provide a copy to the patient.

(b) If, in the professional judgment of the provider, it would be injurious to the mental or physical health of the patient who is the subject of the health information or in violation of the provider's professional ethical responsibilities to disclose, pursuant to subsection (a) of this section, certain identifying health information to the patient; the provider is not required to provide the information to the patient, but shall upon written request of the patient disclose the information to another provider designated by the patient.

(c) A patient shall not have a right of access to health information compiled and used by a custodian solely for purposes of audit, peer review, or other administrative functions, to information protected by an evidentiary privilege of a person other than the patient, or information collected about the patient for or during a clinical trial monitored by an institutional review board when such trial is not complete.

"§ 132A-2-2. Request for amendment.

(a) A patient or provider treating a patient may request that a facility or provider amend identifying health information in a patient's medical record maintained by the provider or facility.

(b) Upon a request for an amendment, the custodian shall either amend the medical record or inform the patient or provider in writing of the reasons for refusal to amend the medical record. If the custodian refuses to amend the record, the patient or provider shall be entitled to add a statement about the disagreement to the disputed identifying health information.

(c) When amending a medical record, the custodian shall add the amending information to the patient's identifying health information without affecting the original information.

"§ 132A-2-3. Health information confidentiality; public records.

(a) A custodian shall maintain, as confidential, identifying health information. Disclosures of identifying health information may be made only as authorized by this Chapter.

(b) Unless otherwise provided by this section or by other law, identifying health information is not a public record.

(c) No recipient of identifying health information shall use or redisclose identifying health information except for the purpose and authority under which the disclosure was made, or as otherwise authorized in this Chapter.

(d) A custodian's employees, agents, and contractors shall be subject to this Chapter to the same extent as the custodian.

(e) No person shall use health information that is not identifying health information for the purpose of identifying an individual patient unless the person is authorized under this Chapter to receive disclosures of the information as identifying health information.

(f) No person shall use health information that is not identifying provider information for the purpose of identifying an individual provider unless the person is authorized under this Chapter to receive disclosures of the information as identifying provider information.

(g) The records established pursuant to G.S. 132A-3-4(a)(4) may only be disclosed as follows:

(1) To a patient, subject to G.S. 132A-2-1(c);

(2) To a custodian for audit functions, except for records recording peer review functions;

(3) To health oversight agencies to the extent these records relate to the performance of authorized audit function; or

(4) By order pursuant to G.S. 132A-3-3(b)(4).

(h) When practicable, disclosures of identifying health information shall be limited only to information which the disclosing party reasonably believes is necessary to accomplish the purpose of the disclosure, except to the extent that disclosure is authorized by a patient or compelled by G.S. 132A-3-2(b) or G.S. 132A-3-3(b)(4), in which case all information so authorized or compelled to be disclosed shall be disclosed.

(i) A disclosing custodian may in good faith rely upon representations made by a requesting person pursuant to this Chapter as to the authority and purpose for which a disclosure is being sought. A requesting person is in violation of this Chapter for misrepresenting the authority and purpose for which a disclosure is being sought, for seeking a disclosure for a purpose that is not authorized by this Chapter, or for seeking a disclosure for a purpose that is authorized by this Chapter but that does not apply to the role, position, or authority of the requesting person.

"ARTICLE 3.

"Health Information Communications.

"§ 132A-3-1. Authorization to disclose health information.

(a) Except for disclosures otherwise authorized by this Chapter, a custodian may disclose a patient's identifying health information only with authorization of the patient. A custodian shall not condition coverage or treatment of a patient based on the patient's refusal to authorize disclosures not permitted by this Chapter, except when this disclosure is essential to the health and safety of the provider or to the patient's treatment, coverage, or payment.

(b) A custodian shall retain a patient's authorization to disclose identifying health information with the patient's health information. A patient's authorization, to be valid, shall have the following:

(1) The patient's identity;

(2) A dated written or electronic signature of the patient;

(3) A description of the health information to be disclosed;

(4) The name or title of a person or either (i) the description of a group to whom the information is to be disclosed or (ii) the description of the class of persons to whom the information is to be disclosed; and

(5) A statement of the purposes for which the information is to be used.

(c) A patient's authorization to disclose identifying health information may also include any of the following:

(1) Any limitation on the scope of disclosure that may be made by the recipient in carrying out the authorized purpose for which the disclosure is requested;

(2) An acknowledgment from the patient that the patient understands that the authorization is valid for the time period stated unless revoked; or

(3) Any other information believed by the custodian to be needed to facilitate the authorization or to inform the patient as to the patient's rights with respect to the authorization.

(d) A patient may revoke or amend an authorization at any time, except to the extent that the custodian has acted in reliance on the authorization.

(e) An authorization under subsection (b) of this section shall remain effective for the time specified by the patient in the authorization. If no time is specified, an authorization shall remain effective for one year.

"**§ 132A-3-2. Disclosures and uses of health information.**

(a) When a disclosure authorized pursuant to this section, other than as authorized by the patient or mandated by other law, may be accomplished without undue burden by disclosing health information that is not identifying health information, a custodian shall in good faith use reasonable efforts to disclose only health information that is not identifying health information.

(b) A custodian shall disclose identifying health information to federal, State, or local law enforcement authorities or to other federal or State authorities only as provided in G.S. 132A-3-3 or pursuant to mandatory disclosure obligations as otherwise provided by State or federal law.

(c) A custodian may disclose identifying health information about a patient without the patient's authorization if the disclosure is to be to the patient or:

(1) To a provider currently providing authorized health care to a patient or to a referring provider who continues to provide authorized health care to a patient if the information is necessary to provide health care to the patient, and the patient does not object to the disclosure. This subdivision shall not impose on the custodian a duty to inquire of or inform the patient of the disclosure either before or after the disclosure is made;

(2) To another provider in the same group practice or provider network, or to a custodian under contract with the group practice

or provider network, for the purpose of providing patient health care within the practice or network;

(3) To a provider with a need for information to treat a condition that poses an immediate threat to a patient's health;

(4) Unless otherwise limited by G.S. 90-21.4, to a member of a patient's immediate family, a legal guardian of a patient, or to a person with whom the patient is known to have a close personal relationship, when the attending provider reasonably believes that notification is necessary to avoid serious jeopardy to the health of a patient and the patient lacks the capacity to authorize the disclosure;

(5) Necessary because in a provider's opinion, a person is in serious and imminent danger or a person is likely to commit a violent felony or violent misdemeanor. This subdivision shall not impose a duty upon the provider to disclose health information;

(6) To a custodian that originally disclosed the information;

(7) To a health oversight agency performing authorized audit functions;

(8) To perform internal audit functions within a custodian's organization;

(9) To agents, employees, and contractors of a custodian for the purpose of:

a. Providing health care to a patient; or

b. Performing administrative services for or on behalf of a custodian;

(10) If not prohibited by federal or State law, to a health researcher for health research;

(11) To a provider to confirm a past method or outcome of a course of treatment performed by the provider;

(12) To a successor in interest of a custodian that is or was a provider, facility, or payer for the patient whose information is being disclosed;

(13) To a payer for the purpose of conducting an audit of provider's operation or service related to services billed or care provided; and

(14) Directory information, unless the patient has instructed the custodian not to make the disclosure or unless the disclosure of the location of the patient would reveal that the patient may be receiving mental health or substance abuse treatment. This subdivision shall not impose on the custodian a duty to inquire of or inform the patient of the disclosure either before or after the disclosure is made.

None of the limitations prescribed in this section shall relieve any person of any mandatory disclosure obligation concerning health information as otherwise prescribed by law.

"**§ 132A-3-3. Subpoenas, search warrants, requests for discovery, and court orders.**

(a) The provisions of G.S. 1A-1, Rule 45(c), shall apply to all identifying health information authorized to be disclosed under subdivisions (1) and (2) of subsection (b) of this section as if this information were hospital medical records. If this authorization is refused or is not obtainable, the requesting party must obtain an order as provided in subdivision (4) of subsection (b) of this section requiring disclosure before identifying health information may be released by the custodian for use in discovery, a hearing, or a trial except when this information is to be disclosed pursuant to subdivision (3) of subsection (b) of this section.

(b) A patient's medical record or other health information shall be disclosed by a custodian pursuant to a civil, criminal, or administrative subpoena, search warrant, or request for discovery in any federal or State judicial or administrative investigation or proceeding only if:

(1) The patient, or the patient's attorney, acting with the consent of the patient, has authorized the disclosure in writing;

(2) The patient is deceased and the disclosure is authorized in writing by the executor or administrator of the patient's estate, or, if the estate is unadministered, by the next of kin;

(3) The information disclosed is to be used in the patient's involuntary commitment, adjudication of incompetency, or guardianship proceeding;

(4) A federal or State court or an administrative agency having subpoena power over the custodian and having jurisdiction of a matter in which the health information may be relevant, orders the disclosure as necessary for the proper administration of justice or health oversight as required by law, in which case, unless an original is compelled, a copy of the medical record shall suffice; or

(5) The information is disclosed to a presiding judge or designee by a presiding judge pursuant to G.S. 1A-1, Rule 45, for purposes of determining use of identifying health information in discovery or at trial. This information shall not be open for inspection or copying by any person, including the parties to a case, until the order has been entered and then only in accordance with the order.

(c) Nothing in this section shall be construed to waive the privilege between a patient and a provider or to require any communications privileged under law to be disclosed, unless a patient's authorization or court order pursuant to subdivision (4) of subsection (b) of this section is obtained.

"**§ 132A-3-4. Responsibilities of custodians as to disclosures.**

(a) Custodians shall adopt and implement technical, contractual, and physical policies and safeguards to effect the requirements of this Chapter and shall undertake to carry out these policies and safeguards to protect against reasonably anticipated threats to the confidentiality, security, accuracy, and integrity of health information maintained, used, or disclosed by the custodian. These policies and safeguards shall include:

(1) Providing for internal disciplinary and corrective measures for violations of the custodian's policy for implementing the requirements of this Chapter;
(2) Requiring that each employee, agent, or contractor having access to identifying health information sign a statement agreeing to comply with the policies and safeguards adopted by the custodian;
(3) Providing periodic training of employees, agents, and contractors having access to identifying health information as to their obligations and liabilities under this Chapter;
(4) Maintaining a record of the creation, revision, or disclosure of identifying health information, including without limitation to whom an authorized disclosure is made; and
(5) Limiting, to the extent practicable, the disclosure to that which is legitimately needed to be known in order to perform authorized functions.

(b) A custodian need not maintain a record of:
(1) Access or disclosures made pursuant to G.S. 132A-3-2(c)(1), (2), (9), or (14) unless the information is maintained as an electronic record; or
(2) Oral disclosures made to a patient or made pursuant to G.S. 132A-3-2(c)(1), (2), (4), or (9)a.

"**§ 132A-3-5. Master person index.**

(a) A custodian may maintain or participate in and use, directly or through a contractor, a master person index. A custodian utilizing a master person index shall disclose or permit access to the index only to a custodian who has entered into a written agreement requiring protection of confidentiality of health information as required in this Chapter with the disclosing custodian. A master person index may utilize a unique identifier to identify patients and custodians.

(b) Notwithstanding subsection (a) of this section, the existence of the following medical records shall not be disclosed in a master person index unless the requesting party has authority under State or federal law to receive a disclosure of the information:
(1) Confidential information as defined in G.S. 122C-3(9);
(2) Information and records regulated by G.S. 130A-143; and
(3) Identifying health information that is otherwise maintained by a health care provider or health care facility and is identified by the provider as being related to a patient's evaluation, diagnosis, or treatment of HIV infection, AIDS, substance abuse, or mental health condition.

(c) Access to an entry in a master person index indicating the existence of identifying health information shall not be permitted except to the extent that the disclosure of the information sought is authorized pursuant to G.S. 132A-3-1, 132A-3-2, or 132A-3-3.

"**§ 132A-3-6. Electronic and other medical records.**

Notwithstanding any other State law, if a custodian maintains and preserves health information or signatures utilizing electronic, optical, or other technology and media, a custodian shall not be required to maintain a separate paper copy of the health information or signatures. However, if a person receiving a disclosure requests the disclosure in a paper form, the custodian shall not refuse to provide the requested information in a paper form, unless another medium is required by State or federal law.

"§ 132A-3-7. Authentication of persons and information; electronic signatures.

(a) When used in connection with health information, health care delivery, or transactions involving health care, health care services, equipment, or supplies, or payments therefor, electronic signatures shall have the same legal effect as written signatures. Other authentication techniques recognized as having comparable or superior reliability to written or electronic signatures shall be acceptable for identification of any individual, entity, or health information associated with an individual or entity.

(b) All individuals authorized by a custodian to authenticate health information utilizing an authentication technique requiring a secure code shall sign an agreement with the custodian to the effect that only the individual will use or permit access to the code assigned to the individual.

"ARTICLE 4.

"General Provisions.

"§ 132A-4-1. Safe harbors.

(a) Notwithstanding any other provision of this Chapter, no custodian or employee, agent, or contractor of a custodian shall be liable for actions authorized to be taken under this Chapter when the custodian or employee, agent, or contractor of the custodian:

(1) Acted in good faith and in reliance upon health information disclosed consistent with this Chapter;

(2) Disclosed health information in good faith and in reliance upon a request for disclosure when the request identified a purpose for which disclosure is authorized under this Chapter;

(3) Disclosed health information as authorized by this Chapter, and the transmission of the information was interrupted, or an error in the transmission otherwise was caused, by a common carrier or enhanced service provider while facilitating the disclosure;

(4) Disclosed identifying health information in good faith reliance on an authorization provided by this Chapter;

(5) Is protected by a statutory immunity related to identifying health information; or

(6) Acted in good faith and in reliance upon recommendations, guidelines, or specifications implemented by the custodian that address the subject matter of this Chapter and that are designed to protect patients from the damages complained of, in whole or in part, and which recommendations, guidelines, or specifications are:

a. Adopted by the United States Secretary of Health and Human Services; or

b. To the extent not preempted by or inconsistent with recommendations, guidelines, or specifications authorized by subdivision (1) of subsection (a) of this section, recommendations, guidelines, or specifications recommended by the following organizations as model standards or specifications if adopted by the Office of State Planning or the Department of Health and Human Services pursuant to the rule-making procedures of the Administrative Procedures Act, Chapter 150B of the General Statutes, which agency may rely on the temporary rule-making procedures to utilize technology on a timely basis:

1. The National Committee on Vital and Health Statistics;
2. The National Uniform Billing Committee;
3. The National Uniform Claim Committee;
4. The North Carolina Health Care Information and Communications Alliance, Inc.;
5. The Workgroup for Electronic Data Interchange; or
6. Other public purpose organizations created under section 501(c) of the Internal Revenue Code and certified by Executive Order of the Governor as having the technical capability and breadth of representation in the health care community to address the subject matter of this Chapter in the public interest.

(b) Until the time that these recommendations, specifications, or guidelines are adopted as set forth in sub-subdivision b. of subdivision (6) of subsection (a) of this section, the recommendations, guidelines, or specifications recommended by the organizations set forth in this sub-subdivision as model standards or specifications shall constitute prima facie evidence of an appropriate standard of care that may be relied on by a custodian.

"§ 132A-4-2. Civil remedies.

(a) Subject to G.S. 132A-4-1 and Chapter 1D of the General Statutes, a custodian or an employee, agent, or contractor of a custodian shall be subject to civil liability for damages incurred by a person with respect to the patient's identifying health information to the extent that these damages arise out of the intentional or negligent act or omission of a custodian in violation of the requirements of this Chapter.

(b) If a patient believes that a custodian, employee, agent, or contractor of a custodian has failed to comply with its obligations under this Chapter with respect to the patient's identifying health information, a patient may apply to a court of competent jurisdiction for appropriate equitable relief.

(c) Any agreement purporting to limit the liability arising from violations of this Chapter, other than pursuant to a settlement agreement, is void.

"**§ 132A-4-3. Conflicting laws.**

(a) This Chapter does not restrict a custodian from complying with obligations imposed by federal health care payment programs, federal law, or State law compelling disclosure. This Chapter shall not apply if and to the extent portions of it may be preempted by the Employee Retirement Income Security Act of 1974. To the extent the provisions of this Chapter conflict with other State law, the provisions of this Chapter shall control unless the other State law specifically states that it is an exception to a specific provision of this Chapter or unless this Chapter conflicts with another State statute governing the nondisclosure of identifying health information held by a health oversight agency for the purposes of peer review, professional review, or other professional disciplinary or corrective action. In these two cases, that other statute shall control.

(b) G.S. 132A-2-1, 132A-2-2, 132A-3-4(a)(4), and 132A-4-2 shall not apply to disclosures of identifying health information regulated by Article 39 of Chapter 58 of the General Statutes. Health information regulated by Article 39 of Chapter 58 of the General Statutes may also be disclosed as permitted by that Article or G.S. 132A-3-1 and G.S. 132A-3-2(b) and (c).

(c) G.S. 132A-2-1 and G.S. 132A-3-2(c) shall not apply to disclosures of identifying health information regulated by Chapter 122C of the General Statutes.

(d) G.S. 132A-3-2(c) shall not apply to disclosures of identifying health information regulated by G.S. 130A-143 when a custodian is acting pursuant to that section. This Chapter does not prohibit disclosures of identifying health information that are authorized or required by Chapter 130A for the protection of the public's health.

(e) This Chapter does not apply to a telecommunications common carrier or an enhanced service provider if they are certified or subject to regulation:

(1) Under Chapter 62 of the General Statutes; or

(2) By the Federal Communications Commission pursuant to federal law.

(f) Except as provided in G.S. 132A-2-3(e) and (f), this Chapter does not regulate the disclosure of health information that is not identifying health information.

"**§ 132A-4-4. Rules of construction.**

Except as otherwise required by law, this Chapter does not require the disclosure of trade secrets or other commercial information."

Section 2. This act becomes effective July 1, 2000, except that G.S. 132A-3-3, 132A-3-5, 132A-3-6, and 132A-3-7 become effective when this act becomes law. Custodians who comply with this act prior to its effective date may rely on G.S. 132A-4-1 as to causes of action that accrue after their compliance.

HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **JERRY DOCKHAM** for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1495 A BILL TO BE ENTITLED AN ACT TO PROTECT THE PRIVACY OF HEALTH INFORMATION, AS RECOMMENDED BY THE JOINT LEGISLATIVE HEALTH CARE OVERSIGHT COMMITTEE.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☒ With a favorable report as to committee substitute bill (#), ☐ ~~which changes the title,~~ unfavorable as to original bill (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on Judiciary II

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

PLEASE PRESS HARD - 5 COPIES

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 1

H. B. No. 1495 DATE 6-25-98

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

moves to amend the bill on page 6, line 8

( ) WHICH CHANGES THE TITLE

by inserting at the end of that line the following sentence:

"The provisions of G.S. 90-411 shall apply to any request made pursuant to this subsection."

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

MINUTES

INSURANCE COMMITTEE MEETING

JULY 2, 1998

The House Committee on Insurance met in Room 643 of the Legislative Office Building on July 2, 1998 at 12:00 p. m. Chairman Dockham presided. Members present were: Representatives Barbee, Brawley, Cole, Dickson, Gardner, Hardaway, Hardy, Hensley, Hurley, Ives, Luebke, McComas, Miller, Minor, Wainwright, Wright, Bowie, Esposito, and Russell. A list of visitors attending is attached, Attachment I.

Chairman Dockham called the meeting to order at 12:00 p.m.; thanked everyone for being present and introduced the pages to the committee. He also informed the committee that there would be no vote on this bill today; however this meeting would be devoted to explanation of the bill and a question and answer session.

Linda Attarian, Staff Attorney, explained House Bill 1455-A BILL TO BE ENTITLED AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING. General Provisions: 1. Contains general declarations of legislative intent including: PSOs require different regulatory oversight to protect the public than do HMOs and insurance companies. 2. Appoints the Department of Health and Human Resources as the State agency to regulate PSOs. 3. Codifies Medicare requirement that a PSO must be State licensed as a risk-bearing entity or otherwise be certified by the federal government prior to operation a health care plan for Medicare beneficiaries enrolled in the Medicare+Choice program. See Attachments II and III.

William Hale, Deputy Commissioner of the Insurance Department shared his concerns and the Department's position in regard to HB-1455. He said the Department's position is that PSOs engaged only in Medicare+Choice business should continue to be regulated by the Department of Insurance and that the proposed regulatory structure in H.B. 1455 represents a duplication of current State efforts. Some of the reasons for this position are: 1. Current state law already provides for the licenser of Medicare+Choice PSOs. 2. Special treatment of Medicare+Choice-only PSOs is not warranted based on the fact that they will only engage in Medicare programs and therefore are not engaged in insurance.

3. Special licenser of Medicure+Choice-only PSOs is not warranted based on the fact that they are PSOs or based on the guidance provided in federal law.

Mr. Hale said that H.B. 1455 would have the Department of Health and Human Services (DHHS) apply and enforce the Department of Insurance's standards for HMOs and managed care plans to PSOs. He also said that H.B. 1455 would have the Department of Insurance review the financial information that a PSO submits to DHHS and advise DHHS on whether the PSO meets the solvency standards in DHHS' laws. The Department of Insurance strongly feels that it should have full regulatory authority over Medicare+Choice PSOs, or no involvement at all.

Finally, Mr. Hale said, if no changes are made to North Carolina law, any PSO that applied for an HMO license but was refused because of an inability to meet existing solvency standards would be eligible to apply to HCFA for a waiver of it s licensure requirement. Therefore, North Carolina law would not be an impediment to any PSO's ability to participate in the Medicare+Choice program. The General Assembly could amend the HMO Act to include special solvency standards for Medicare+Choice PSOs if the General Assembly wants to eliminate the need for any PSO to request a waiver of HCFA's licensing requirement. See Attachment IV.

After a lengthly discussion and numerous questions asked by members of the Insurance Committee concerning this bill, Chairman Dockham stated that there would be further discussion of the bill at the next meeting on July 9.

Chairman Jerry C. Dockham

Joanna Mills, Clerk

Attachment I

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

JULY 2, 1998 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Ramsey	NCSOS
Robert Pierce	Jordan Price Wall Gray & Jones
Hubb Tilson	NCHA
TOM STUCES	SMITH HELMS MULLISS & MOORE
[illegible]	NCSOS
Henry A Landsberger	AARP
Adam Searing	NCHAC
Bob Fitzgerald	DHHS/DFS
Steve Keene	NCMS
Kathy Daley	NCHA
Lucia Peel	NCMS
Amy Jo Baum	Smith Anderson
Tommy Watts II	Carolinas HealthCare System
Sandy Sands	WCSR
Roger Bone	Bone & Assoc.
Mary Wunderlich	Pappas Consulting
Paul Mahony	NC ASSN Health Plans
[illegible]	NCAHP
Susan Valauri	Nationwide
Cissy Parker	Bone & Associates
Joanne Schoen	N.C. Nurses Association
Ed Duncan	WCSR/Allegheny
Sandy Sands	WCSR/ "
Ralph E. Cloud	NCALH
John Bowditch	Zeb Alley P.A.
Jerry Kaplan	
Barbara Morales Burke	NCDOI

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

JULY 2, 1998 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marcus Smith	NC Society of Anesthesiologists
Joyce Peters	JP Assoc/MAMSI
Stephanie Manning	NC Assoc. of Realtors

Attachment II

TO: Members of the House Insurance Committee
FROM: Linda Attarian, Staff Attorney
RE: **HB 1455 -- PSO Medicare Licensing (PCS-8355-RN)**
DATE: July 2, 1998

Bill Summary

G.S. 131E-275 Page 1 and Page 2, lines 1-16.	**General Provisions:** • Contains general declarations of legislative intent, including: PSOs require different regulatory oversight to protect the public than do HMOs and insurance companies. • Appoints the Department of Health and Human Resources as the State agency to regulate PSOs. • Codifies Medicare requirement that a PSO must be State licensed as a risk -bearing entity or otherwise be certified by the federal government prior to operating a health care plan for Medicare beneficiaries enrolled in the Medicare+Choice program.
G.S. 131E-276 Page 2, line 17 to page 4, line 23.	**Definitions** • The section generally incorporates federal definitions into the State PSO licensure law to meet Medicare contract requirements. These include financial terms and such terms as "provider", "substantial proportion of services", "affiliated provider", etc.. However, the following do not mirror federal law: * "Parent of a sponsoring provider" means the entity that owns, controls, or directs the management policies of the sponsoring provider or that has the power to appoint a controlling number of the sponsoring provider's governing board. * The definition of provider sponsored organization" includes a requirement that at least 50% of a PSO's governing body must be composed of licensed physicians (licensed in any state), and also includes a provision designed to ensure the ability of a tax-exempt hospital to retain control over the distribution of the PSO's assets so as to protect the hospital's tax-exempt status.
G.S. 131E-277 Page 4, line 24.	**Directly or indirectly share substantial financial risk** • Under federal law, the PSO must demonstrate to the Health Care Financing Administration's (HCFA's) satisfaction that it apportions a significant part of the financial risk of the PSO enterprise to each affiliated provider. This section outlines 5 mechanisms that will constitute "substantial" financial risk-sharing arrangements. Four of the five are incorporated into the bill from federal law.
G.S. 131E-278 Page 5, line 8.	**Applicability of other laws.** • Exempts licensed PSOs, their plan contracts, provider contracts, and other arrangements related to the delivery of health care services by the PSOs, or by their health care providers when operating through these PSOs, from regulation by the Department of Insurance.
G.S. 131E-279 Page 5, line 15.	**Licensure Approval** • Appoints the Department of Health and Human Services as the state licensing agency for PSOs. • Subsection (a) provides that any PSO contracting with Medicare+Choice pursuant to a federal waiver shall be deemed as licensed under this Article for the duration of the waiver.

	Continued: • Subsection (c) includes a specific time line and procedures for the processing of applications for State PSO license. The time line is different than the corresponding provisions in the State's HMO Act. If the State fails to process a substantially complete application within 90 days, the Department must immediately issue a license to the PSO. • Subsection (d) describes when an application is deemed substantially complete so that the federal waiver time line can begin at a clearly defined time. • Subsection (e) allows federal standards to supersede State standards if federal standards are more favorable to the PSO or if State standards are otherwise preempted by federal law. Note: The State standards incorporated into this bill mirror current available federal standards.
G.S. 131E-280 Page 6, line 15.	**Requirements for Applicants** • Describes the information PSOs and their sponsoring providers must provide in the licensing application. The section generally tracks State statutory requirements for applicants for a certificate of authority to establish and operate a HMO, [G.S. 58-67-10(c)], and the federal law where applicable.
G.S. 131E-281 Page 8, line 18.	**Additional Information** • Describes additional information (generally relating to consumer protection guarantees) PSOs and their sponsoring providers must provide in the licensing application. The section tracks State HMO requirements. [G.S. 58-67-11]. • Department may promulgate rules exempting any of the requirements listed in this section . (Similar authority is given to DOI).

S. 131E-282
Page 8, line 40.
	Issuance of License
	• Describes the financial standards which PSOs must meet in order to receive a license. These standards mirror federal law.
	  • Requires initial net worth of $1.5 million, reduced to $1.0 million if the PSO demonstrates that it has a sufficient administrative infrastructure in place. A lower (unspecified) amount may be set (by the Department) if the PSO operates primarily in rural areas.
	  • At least $750,000 of net worth must be in cash or cash equivalents. A portion of intangible value may be included in the net worth calculation.
	• The PSO must demonstrate that it has a sufficient cash flow to meet its obligations as they become due. (See G.S. 131E-288).
	• The PSO must submit a financial plan that shows it can cover the first 12 months of operation of the Medicare contract. (See detailed explanation below).

G.S. 131E-283 Page 10, line 8.	**Financial Plan** • The elements which must be included within the financial plan mirror federal law and include: 1) detailed marketing plan 2) statements of revenue and expenses on an accrual basis 3) cash flow statements 4) balance sheets 5) assumptions in support of the plan. • Statements about funding for projected losses for the entire period to break-even must also be included. The following components related to the funding of projected losses do not mirror federal standards. . • An irrevocable, clean, unconditional letter of credit may be used in place of cash or cash equivalents resources available to meet projected losses.

	Continued: • Also describes the extent to which guarantees may be included as an acceptable resource to meet projected losses. • The Department has the discretion to approve the use of lines of credit, capital contributions, and other legally binding contracts it finds to be reliable. • The Department may consider factors such as the financial condition of the guarantor and the accuracy of the financial plan and may, in its discretion, may require other methods or timing of funding projected losses (This provision is not found in the federal law).
G.S. 131E-284 Page 11, line 16.	**Modifications** • Describes the filing requirements for licensed PSOs when there are modifications to the PSO's initial application. The section is almost identical to State HMO requirements. [G.S. 58-67-10(d)(1)].
G.S. 131E-285 Page 11, line 35.	**Deposits** • Requires PSOs to make a deposit of $100,000. *(NC HMO Act requires a $500,000 deposit)*. The deposit will be included as part of the calculation of the PSO's net worth. This section mirror federal standards. The use of the deposit be restricted to help assure continuation of services or pay costs associated with receivership or liquidation in the event of insolvency.
G.S. 131E-286 Page 11, line 43.	**Ongoing Financial Standards** • Establishes an "equal to the greater of" test for determining ongoing net worth requirements which a PSO must meet once it is licensed and begins operations. This section mirrors federal standards. • On an ongoing basis, PSOs are required to have a minimum net worth in the greater amount of: (a) $1 million in cash or cash equivalents; (*NC HMO Act requires $1million*); or (b) 2% of premiums on first $150 million and 1% thereafter; (c) an amount equal to three months uncovered health care expenditures; or (d) a specified percentage of annual health care expenditures. • In calculating minimum net worth, a certain percentage of the PSO's intangible assets may be admitted. • The Department has discretion to lower the financial threshold for PSOs operating primarily in rural areas. • Requires an ongoing minimum net worth in cash or cash equivalents of either $750,000 or 40% of minimum net worth. *(NC HMO Act = $1 million).* • A lower amount may be allowed for PSOs operating primarily in rural areas. • This section incorporates federal law.

G.S. 131E-287 Page 13, line 2.	**Reporting** • Requires PSOs to file quarterly reports on financial information relating to PSO solvency until break-even, then annually if the PSO has a net operating surplus, or as often as monthly if the PSO continues to operate without a net operating surplus. • Requires PSOs to report to the Secretary (unless preempted by federal law, or other wise mandated by the Medicare program) data relating to: grievances; enrollment history; provider satisfaction; utilization, quality, availability, and accessibility of health care services; provider networks; plan performance compared to plan targets; network sufficiency; etc. This provision is identical to the current State law applicable to managed health care plans. • Requires PSOs to disclose (unless preempted by federal law, or other wise mandated by the Medicare program) its policies related to coverage, utilization review, restrictions on prescription drugs, experimental treatment, etc. This provision is identical to the current State law applicable to managed health care plans.
G.S. 131E-288 Page 16, line 31.	**Liquidity.** • Requires each PSO to have sufficient cash flow to meet its obligations as they become due and provides for remedies in the event the PSO is unable to pay its obligations as they become due. This section incorporates federal law.
G.S. 131E-289 Page 17, line 16.	**Minimum of net worth that must be in cash or cash equivalents** • Requires an ongoing minimum net worth in cash or cash equivalents of either $750,000 or 40% of minimum net worth. *(NC HMO Act = $1 million).* • A lower amount may be allowed for PSOs operating primarily in rural areas. • This section incorporates federal law.
G.S. 131E-290 Page 17 line 27.	**Prohibited Practice** • Prohibits PSOs and their sponsoring providers, not otherwise licensed under Chapter 58 to describe themselves as being in the insurance casualty, or surety business. • Prohibits PSOs from discriminating with respect to participation or reimbursement among providers acting within the scope of there practice solely on the basis of the provider's license or certification. Thus, the PSO must contract with any willing provider as long as that provider's scope of practice includes a covered service. This provision expands upon a similar provision applicable to HMOs that offer a Point of Service Plan, in that PSOs will be required to contract with any willing provider.
G.S. 131E-291 Page 17, line 26	**Collaboration with local health departments** Requires PSOs and their sponsoring providers to collaborate with local health departments in health promotion and disease prevention. Corresponds to an identical provision applicable to HMOs.
G.S. 131E-292 Page 18, line 1.	**Coverage Requirements** • PSOs are required to meet the coverage requirements of their Medicare contract. • If Medicare allows PSOs or their participating providers to object on moral or religious grounds to providing items or services to a Medicare beneficiary, the PSO/provider may make such objection, including advanced directives. This provision is not in the State HMO Act nor in the federal law.

G.S. 131E-293 Page 18, line 5.	**Reimbursement Rates** • Rates under PSO's Medicare contracts are governed by the terms of the contract.
G.S. 131E-294 Page 18, line 19..	**Consumer Protection and Quality Standards** • Applies to PSOs the same standards and requirements that the Department of Insurance applies to health maintenance organizations under Chapter 58 with respect to: 1. consumer protection and quality management programs, 2. utilization review procedures, 3. unfair or deceptive trade practices, 4. antidiscrimination, 5. provider accessibility and availability, 6. and network provider credentialing. 7. Data reporting and disclosures to consumers
G.S. 131E-295 Page 18, line 34.	**Powers of Insurers and Medical Service Providers** • Permits an insurer or a hospital or medical service corporation to contract with a PSO to provide insurance against the cost of care and to provide coverage in the event of the failure of the PSO or its sponsoring providers to meet its obligations.
G.S. 131E-296 Page 19, line 3.	**Examinations** • Allows (does not require) the Department to perform examinations of PSOs at least once every three (3) years or more often as it deems necessary for the protection of the interests of the people of this State. This section tracks the HMO Act. (G.S. 58-67-100.).
G.S. 131E-297 Page 19, line 9.	**Hazardous Financial Conditions** • Authorizes the Department to take one or more of eight specified actions if it believes that the PSO is in a hazardous financial condition. • Permits the Department to adopt rules to set uniform standards and criteria for early warning for financial problems and to set standards for evaluating the financial condition of any PSO if the standards do not provide sufficient early warning of hazardous conditions of PSOs.
G.S. 131E-298 Page 19, line 36.	**Protection Against Insolvency** • Requires that each PSO maintains at all times an adequate plan for protection against insolvency acceptable to the Department. • Describes the elements of an acceptable plan of protection in order to avoid insolvency. This section tracks the HMO Act. (G.S. 58-67-110).
G.S. 131E-299 Page 20, line 21.	**Hold Harmless Agreements or Special Deposits** • Requires that PSO's include in their contracts with participating providers the requirement that the provider hold the Medicare subscriber or beneficiary harmless if the PSO fails to pay the provider. This provision tracks the HMO Act. (G.S. 58-67-115).

	Continued: • If there is no participating provider contract, then the PSO must keep special deposits in cash or cash equivalents or through reinsurance in uncovered health care expenditures reach a specified threshold. This provision tracks the HMO Act • The Department may allow the PSO to make withdraws from the deposit under certain circumstances. This provision is not in the HMO Act. • The Department may waive or reduce requirements. Tracks the HMO Act.
G.S. 131E-300 Page 21,line 44.	**Continuation of Benefits** • Requires each PSO to have a plan, in the event of insolvency, for continuing benefits for the duration of the contract period for which premiums have been paid and for the continuation of benefits to beneficiaries who are confined in an inpatient facility until their discharge or expiration of benefits. This section tracks the HMO Act. (G.S. 58-67-120).
G.S. 131E-301 Page 22, line 21.	**In the Event of Insolvency** • All providers which were sponsoring providers of an insolvent PSO within the previous 12 months are required to offer all beneficiaries enrolled with the insolvent PSO covered services without charge for thirty (30) days. • In addition, requires the Department to allocate the insolvent PSO's contracts to other PSOs operating in the area and to allocate the insolvent PSO's beneficiaries who are unable to obtain other coverage.
G.S. 131E-302 Page 23, line 6.	**Replacement Coverage** • Requires immediate coverage of beneficiaries by carriers providing replacement coverage within a period of 60 days of discontinuance of prior PSO contract or policy providing and without reducing benefits otherwise available under the prior PSO contract or policy. This section tracks HMO Act. (G.S. 58-67-130).
G.S. 131E-303 Page 23, line 22.	**Incurred But Not Reported Claims** • Requires PSOs to make estimates of their liability for incurred by not reported claims. This section tracks HMO Act. (G.S. 58-67-135).
G.S. 131E-304 Page 23, line 31.	**Suspension or Revocation of License** • Permits the Department to suspend, revoke, or refuse to renew a PSO license in certain events. This section tracks the HMO Act. (G.S. 58-67-140)
G.S. 131E-305 Page 24, line 29.	**Administrative Procedures** • Requires the Department to notify PSOs if their applications are denied or if their licenses are revoked or suspended and provides them with rights to a hearing on the denial, suspension or revocation. This section tracks the HMO Act. (G.S. 58-67-155).
G.S. 131E-306 Page 24, line [illegible].	**Department of Insurance** • Permits the Department to request that the Department of Insurance evaluate a PSO's compliance with any or all of the solvency standards. • Even so, the Department retains final authority to license PSOs

G.S. 131E-307 Page 25, line 1.	**Penalties and Enforcement** • Imposes penalties (Class 1 misdemeanor) if the provisions of this Article are violated or threatened to be violated • Authorizes the Department to institute proceedings for cease and desist orders or injunctive relief. • Authorizes the Department to institute a proceeding in the Superior Court of Wake County to obtain injunctive or other appropriate relief. This section tracks the HMO Act. (G.S. 58-67-165)
G.S. 131E-308 Page 25, line 44.	**Statutory Construction and Relationship to Other Laws** • Provides that, unless specified, insurance laws and provisions of hospital or medical service corporation laws are not be applicable to any provider sponsored organization granted a license under this Article or to its sponsoring providers when operating under such a license. • Licensed PSOs are not deemed to be practicing medicine or dentistry. • PSO solicitation shall not be construed to violate professional prohibitions on solicitation. • This section tracks the HMO Act. (G.S. 58-67-170).
G.S. 131E-309 Page 26, line 21.	**Filings and Reports are Public Documents** • Exempts PSO and sponsoring provider trade secrets and competitively sensitive information from public record rules. This section tracks the HMO Act. (G.S. 58-67-175).
G.S. 131E-310 Page 26 line 26.	**Confidentiality of Medical Information** • Medical information given to PSO or its providers is confidential, but may be released under limited circumstances specified in statute. This section tracks the HMO Act. (G.S. 58-67-180).
G.S. 131E-311 Page 26, line 39.	**Conflicts and Severability** • The provisions of the PSO Act prevail when there is a conflict with other provisions of Chapter 131E of the General Statutes. • Requires the Department to process PSO applications in the absence of promulgated regulations. • Severs any section of the Article which is determined to be invalid. This provision tracks the HMO Act. (G.S. 58-67-185).
G.S. 131E-312 Page 27, line 4.	**Regulations** • The Article is self-implementing • The Department may promulgate rules and regulations no later than 6 months after the enactment of the bill.
G.S. 131E-313 Page 26, line 40	**Utilization Review and Grievances** • Provides that State law pertaining to utilization review and grievances shall apply to PSOs and that the Department of Insurance shall have the authority to regulate compliance under this section.

Sections 2 and 3 of the bill. Page 27-29.	**Conforming changes to current law.**
Section 4. Page 29, line 6.	**Effective Date** The act is effective when it becomes law.

Attachment II

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 1455*
Proposed Committee Substitute H1455-PCS8355-RN

Short Title: PSO Medicare Licensing. (Public)

Sponsors:

Referred to:

May 25, 1998

A BILL TO BE ENTITLED

AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING.

The General Assembly of North Carolina enacts:

Section 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"ARTICLE 17.

"Provider Sponsored Organization Licensing.

"**§ 131E-275. General provisions.**

(a) The General Assembly acknowledges that section 1855, et seq., of the federal Social Security Act permits provider sponsored organizations that are organized and licensed under State law as risk-bearing entities, or that are otherwise certified as such by the federal government, to be eligible to offer Medicare health insurance or health benefits coverage in each state in which the provider sponsored organization offers a Medicare+Choice plan. The General Assembly declares that provider sponsored organizations are beneficial to North Carolina citizens who are Medicare beneficiaries and should be encouraged, subject to appropriate regulation by the Department of Health and Human Services. The General Assembly further declares that, because provider sponsored organizations provide health care directly and assume responsibility for the provision of health care services to Medicare beneficiaries under the requirements of the federal Medicare program, they require different regulatory oversight to protect the public than health maintenance organizations and insurance companies. The General Assembly further declares that

the organizers and operators of provider sponsored organizations which are licensed under the terms of this Article as risk-bearing entities authorized to contract directly with the federal Medicare+Choice program shall not be subject to Chapter 58 of the General Statutes or the insurance laws of this State, unless otherwise specified in this Article.

It is the intent of the General Assembly to encourage innovative methods by which sponsoring providers can directly or indirectly share substantial financial risk in the PSO in any lawful manner.

(b) As set forth in this Article, the Department of Health and Human Services shall be the agency of the State authorized to license provider sponsored organizations to contract with Medicare to provide health care services to Medicare beneficiaries and to engage in the other related activities described in this Article.

(c) Each provider sponsored organization shall obtain a license from the Department or shall otherwise be certified by the federal government prior to establishing, maintaining, and operating a health care plan in this State for Medicare+Choice beneficiaries.

"§ 131E-276. Definitions.

As used in this Article, unless the context clearly implies otherwise, the following definitions apply:

(1) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries of the Medicare+Choice program who are enrolled with the provider sponsored organization (PSO) under the terms of a contract between the PSO and the Medicare program.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina.

(3) 'Current assets' means cash, marketable securities, accounts receivable, and other current items that will be converted into cash within 12 months.

(4) 'Current liabilities' means accounts payable and other accrued liabilities, including payroll, claims, and taxes that will need to be paid within 12 months.

(5) 'Current ratio' means the ratio of current assets divided by current liabilities calculated at the end of any accounting period.

(6) 'Department' means the Department of Health and Human Services.

(7) 'Emergency services' shall have the same meaning as for that term defined in G.S. 58-50-61(a)(5).

(8) 'Health care delivery assets' means any tangible asset that is part of a PSO operation, including hospitals, medical facilities, and their ancillary equipment, and any property that may reasonably be required for the PSO's principal office or for any purposes that may be necessary in the transaction of the business of the PSO.

(9) 'Health plan contract' or 'Medicare contract' means a PSO's direct contract with the United States Department of Health and Human Services under section 1857 of the federal Social Security Act.

(10) 'Out-of-network services' means health care items or services that are covered services under a PSO's Medicare contract and that are provided to beneficiaries by health care providers that are not participating providers in the PSO's network of health care providers.

(11) 'Parent of a sponsoring provider' means the public or private entity that owns or controls a controlling interest in the sponsoring provider or that has the power to appoint a controlling number of the governing board of a sponsoring provider or that has the power to direct the management policy and decisions of the sponsoring provider.

(12) 'Provider' or 'health care provider' means: (i) any individual that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; (ii) any entity that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; or (iii) any entity that is owned or controlled entirely by individuals or entities described in subparts (i) or (ii) of this definition.

(13) 'Provider sponsored organization' or 'PSO' means a public or private entity domiciled in this State, including a business corporation, a nonprofit corporation, a partnership, a limited liability company, a professional limited liability company, a professional corporation, a sole proprietorship, a public hospital, a hospital authority, a hospital district, or a body politic: (i) that is established, organized, and operated by sponsoring providers; (ii) in which physicians licensed pursuant to Article 1 of Chapter 90 of the General Statutes or to the laws of any state of the United States comprise no less than fifty percent (50%) of the governing board or body, unless otherwise prohibited by law; and (iii) that provides a substantial proportion of the services under each Medicare contract directly through the sponsoring provider. The requirement in subpart (ii) of this definition shall not preclude a PSO that includes a tax-exempt hospital from adopting a bylaw provision that provides a veto for the tax-exempt hospital over actions of the PSO necessary to maintain the hospital's tax-exempt status. A PSO shall not be out of compliance with the requirement in subpart (ii) due to temporary vacancies on its governing board or body.

(14) 'Secretary' means the Secretary of the Department of Health and Human Services.

(15) 'Sponsoring providers' of a PSO means the health care provider domiciled in this State that assumes, or group of affiliated health care providers that directly or indirectly shares, substantial financial risk in the PSO and that has at least a majority financial interest in the PSO.

(16) 'Substantial proportion of the services' means at least seventy percent (70%), or sixty percent (60%) for PSOs whose beneficiaries reside primarily in rural areas, of the annual health care expenditures.

(17) A health care provider is affiliated with another provider if through contract, ownership, or otherwise, when: (i) one provider directly controls, is controlled by, or is under common control with the other provider; (ii) each provider participates in a lawful combination under which they share substantial financial risk for the organization's operation; (iii) both providers are part of a controlled group of corporations as defined under section 1563 of the Internal Revenue Code of 1986; or (iv) both providers are part of an affiliated service group under section 414 of this Code. Control is presumed if one party directly or indirectly owns, controls, or holds the power to vote, or proxies for, at least fifty-one percent (51%) of the voting or governance rights of another.

"§ 131E-277. Direct or indirect sharing of substantial financial risk.

In order for sponsoring providers to directly or indirectly share substantial financial risk in the PSO, the PSO shall do one or more of the following:

(1) Provide services under its Medicare contract at a capitated rate;

(2) Provide designated services or classes of services under its Medicare contract for a predetermined percentage of premium or revenue from the Medicare program;

(3) Use significant financial incentives for its sponsoring providers, as a group to achieve specified cost-containment and utilization management goals either by:

a. Withholding from all sponsoring providers a substantial amount of the compensation due to them, with distribution of that amount to the sponsoring providers based on performance of all sponsoring providers in meeting the cost-containment goals of the network as a whole; or

b. Establishing overall cost or utilization targets for the PSO, with the sponsoring providers subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; or

(4) Agree to provide a complex or extended course of treatment that requires the substantial coordination of care by sponsoring

providers in different specialties offering a complementary mix of services, for a fixed, predetermined payment, when the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's treatment or other factors; or

(5) Agree to any other arrangement that the Department determines to provide for the sharing of substantial financial risk by the sponsoring providers.

"**§ 131E-278. Applicability of other laws.**

Unless otherwise required by federal law, provider sponsored organizations licensed pursuant to the terms of this Article are exempt from all regulation under Chapter 58 of the General Statutes. Plan contracts, provider contracts, and other arrangements related to the provision of covered services by these licensed networks or by health care providers of these PSOs when operating through these PSOs shall likewise be exempt from regulation under Chapter 58 of the General Statutes.

"**§ 131E-279. Approval.**

(a) Unless otherwise required by federal law, the Department shall be the agency of the State that shall license provider sponsored organizations that seek to contract with the federal government to provide health care services directly to Medicare beneficiaries under the Medicare+Choice program.

(b) Provider sponsored organizations which have been granted a waiver pursuant to 42 U.S.C. § 1395w-25(a)(2) and which otherwise meet the requirements of the PSO's Medicare contract shall be deemed by the State to be licensed under this Article for so long as the waiver or Medicare contract remains in effect. The foregoing shall not limit the Department's authority to regulate such PSOs and their respective sponsoring providers and affiliated providers as may be permitted in 42 U.S.C. § 1395w-25(a)(2)(G) or the PSO's Medicare contract.

(c) The Department shall license a PSO as a risk-bearing entity eligible to offer health benefits coverage in this State to Medicare beneficiaries if the PSO complies with the requirements of this Article. This license shall be granted or denied by the Department not longer than 90 days after the receipt of a substantially complete application for licensing. Within 45 days after the Department receives an application for licensing, the Department shall either notify the applicant that the application is substantially complete, or clearly and accurately specify in writing to the applicant all additional specific information required by the applicant to make the application a substantially completed application. This agency response shall set forth a date and time for a meeting within 30 days after it is sent to the applicant, at which a representative of the Department will explain with particularity the additional information required by the Department in the response to make the application substantially complete. The Department shall be bound by the response unless the Secretary determines that it must be modified in order to meet the purposes of this Article. The Secretary shall not delegate the authority to modify the response. If an applicant provides the additional information set forth in the response, the application shall be considered substantially complete. If the Department has not acted on an application within 90 days after it is deemed

substantially complete, the Department shall immediately issue a license to the applicant, and the applicant shall be considered to have been licensed by the Department. Any reapplication which corrects the deficiencies which were specified by the Department in the response shall be approved by the Department.

(d) For purposes of determining, under 42 U.S.C. § 1395w-25(a)(2)(B), or any successor thereof, the date of receipt by the State of a substantially complete application, the date the Department receives the applicant's written response to the agency response or an earlier date considered by the Department shall be considered to be that date. The foregoing shall not limit the Department's authority to consider an application not substantially complete under subsection (c) of this section if the applicant's response to the response does not provide substantially the information specified in the response.

(e) A license shall be denied only after the Department complies with the requirements of G.S. 131E-305.

"§ 131E-280. Applicants for license.

Each application for licensing as a provider sponsored organization authorized to do business in North Carolina shall be certified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Department, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant and each sponsoring organization that holds greater than a five percent (5%) interest in the PSO, such as the articles of incorporation, articles of organization, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the respective bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant and each sponsoring provider which holds greater than a five percent (5%) interest in the PSO;

(3) Copies of the document evidencing the arrangements between the applicant and each sponsoring provider that create the relationships and obligations described in G.S. 131E-276(17);

(4) A list of the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant and of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO, respectively, including all members of the respective boards of directors, boards of trustees, executive committees, or other governing boards or committees, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(5) A copy of any contract form made or to be made between any class of providers and the PSO and a copy of any contract form made or to be made between third-party administrators, marketing

consultants, or persons listed in subdivision (3) of this subsection and the PSO;

(6) A statement generally describing the provider sponsored organization, its sponsoring providers, its health care plan or plans, facilities, and personnel;

(7) A copy of the hospital license of each sponsoring provider that is a hospital, a copy of the license to practice medicine of each sponsoring provider or owner of a sponsoring provider that is a licensed physician, and a copy of the health care service or facility license held by any other licensed sponsoring provider;

(8) Financial statements showing the applicant's assets, liabilities, sources of financial support, and the financial statements of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO showing the sponsoring provider's assets, liabilities, and sources of support. If the applicant's or any such sponsoring provider's financial affairs are audited by independent certified public accountants, a copy of the applicant's or sponsoring provider's most recent regular certified financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article;

(9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-297, 131E-298, and 131E-299 are guaranteed by one or more guarantors:

a. Documentation that each guarantor meets the following requirements:

1. The guarantor is a legal entity authorized to conduct business in North Carolina.

2. The guarantor is not under federal bankruptcy or State receivership or rehabilitation proceedings.

3. The guarantor has a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the PSO's guarantee.

b. Financial statements showing each guarantor's assets, liabilities, and source of financial support.

c. If a guarantor's financial affairs are audited by independent certified public accountants, a copy of the guarantor's most recent regular audited financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article.

d. The guarantee document, including a statement of the financial obligation covered by the guarantee, an agreement

to unconditionally fulfill the financial obligations covered by the guarantee, an agreement not to subordinate the guarantee to any other claim on the resources of the guarantor and a declaration that the guarantor must act on a timely basis to satisfy the financial obligations covered by the guarantee;

(10) A financial plan, satisfactory to the Department, covering the first 12 months of operation under the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the financial plan projects losses, the financial plan must cover the period through 12 months beyond the projected breakeven;

(11) A statement reasonably describing the geographic area or areas to be served;

(12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 131E-298; and

(13) Any other information the Department may require to make the determinations required in G.S. 131E-282.

"**§ 131E-281. Additional information.**

(a) In addition to the information filed under G.S. 131E-280, each application shall include a description of the following:

(1) The program to be used to evaluate whether the applicant's network of sponsoring providers and contracted providers is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay;

(2) The program used to evaluate whether the sponsoring providers provide a substantial portion of services under each Medicare contract of the PSO;

(3) The program to be used for verifying provider credentials;

(4) The utilization review program for the review and control of health care services provided or paid for by the applicant;

(5) The quality management program to assure quality of care and health care services managed and provided through the health care plan; and

(6) The applicant's network of sponsoring providers and contracted providers and evidence of the ability of that network to provide all health care services other than out-of-network services and emergency services to the applicant's prospective beneficiaries.

(b) The Department may promulgate rules and regulations exempting from the filing requirements of subsection (a) of this section those items it deems unnecessary.

"**§ 131E-282. Issuance of license.**

(a) Before issuing a PSO license, the Department may make an examination or investigation as it deems expedient. The Department shall issue a license after receipt of a substantially complete application and upon satisfaction of the following requirements:

(1) The applicant is duly organized as a provider sponsored organization as defined by this Article.

(2) The PSO has initially a minimum net worth of one million five hundred thousand dollars ($1,500,000). In the event the PSO submits a financial plan that demonstrates that the PSO does not have to create but has or has available to it an administrative infrastructure that shall reduce the PSO's start-up costs, the Department may lower the initial minimum net worth required to one million dollars ($1,000,000) or to any lower amount as determined by the Department if the PSO operates primarily in rural areas.

(3) The PSO shall have at least seven hundred fifty thousand dollars ($750,000) in cash or equivalents on its balance sheet, except that the Department may permit a PSO operating primarily in rural areas to have a lesser amount held in cash or equivalents on its balance sheets.

(4) The applicant submits a financial plan satisfactory to the Department which covers the first 12 months of operation of the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the plan projects losses, the financial plan shall cover the period through 12 months beyond projected breakeven.

(5) The Department determines that the applicant has sufficient cash flow to meet its obligations as they become due. In making that determination, the Department shall consider the following:

a. The timeliness of payment;

b. The extent to which the current ratio is maintained at one to one, or whether there is a change in the current ratio over a period of time; and

c. The availability of outside financial resources.

(b) In calculating the net worth of a PSO, the Department shall admit the following:

(1) One hundred percent (100%) of the book value of health care delivery assets on the balance sheet of the applicant.

(2) One hundred percent (100%) of the value of cash and cash equivalents on the balance sheet of the applicant.

(3) If at least one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents, then one hundred percent (100%) of the book value of the PSO's intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents or if the Department has used its discretion to reduce the initial net worth requirement below one million five hundred thousand dollars ($1,500,000), then the Department shall admit one

hundred percent (100%) of the book value of intangible assets of the PSO up to ten percent (10%) of the minimum net worth amount required.

(4) Standard accounting principles treatment shall be given to other assets of the PSO not used in the delivery of health care for the purposes of meeting the minimum net worth requirement.

(5) Deferred acquisition costs shall not be admitted.

"§ 131E-283. Financial plan.

(a) The financial plan shall include the following:

(1) A detailed marketing plan;

(2) Statements of revenue and expense on an accrual basis;

(3) Cash flow statements;

(4) Balance sheets; and

(5) The assumptions and justifications in support of the financial plan.

(b) In the financial plan, the PSO shall demonstrate that it has the resources available to meet the projected losses for the entire period to breakeven. Except for the use of guaranties as provided in subsection (c) of this section, letters of credit as provided in subsection (e) of this section, and other means as provided in subsection (f) of this section, the resources must be assets on the balance sheet of the PSO in a form that is either cash or convertible to cash in a timely manner, pursuant to the financial plan.

(c) Guaranties shall be acceptable as a resource to meet projected losses, under the following conditions:

(1) For the first year of the PSO's operation of the PSO's Medicare contract, the guarantor must provide the PSO with cash or cash equivalents to fund the projected losses, as follows:

a. Prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;

b. Prior to the beginning of the second quarter, in the amount of the projected losses through the end of the third quarter; and

c. Prior to the beginning of the third quarter, in the amount of the projected losses through the end of the fourth quarter.

(2) If the guarantor provides the cash or cash equivalents to the PSO in a timely manner on the above schedule, this funding shall be considered in compliance with the guarantor's commitment to the PSO. In the third quarter, the PSO shall notify the Department if the PSO intends to reduce the period of funding of projected losses. The Department shall notify the PSO within 60 days of receiving the PSO's notice if the reduction is not acceptable.

(3) If the above guaranty requirements are not met, the Department may take appropriate action, such as requiring funding of projected losses through means other than a guaranty. The Department retains discretion which shall be reasonably exercised to require

other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(d) The Department may modify the conditions in subsection (c) of this section in order to clarify the acceptability of guaranty arrangements.

(e) An irrevocable, clean, unconditional letter of credit may be used as an acceptable resource to fund projected losses in place of cash or cash equivalents if satisfactory to the Department.

(f) If approved by the Department, based on appropriate standards promulgated by the Department, PSOs may use the following to fund projected losses for periods after the first year: lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability.

(g) The exceptions in subsections (c), (d), and (e) of this section may be used in an appropriate combination or sequence.

"**§ 131E-284. Modifications.**

(a) A provider sponsored organization shall file a notice describing any significant change in the information required by the Department under G.S. 131E-280. Such notice shall be filed with the Department prior to the change. If the Department does not disapprove within 90 days after the filing, this modification shall be considered approved. Changes subject to the terms of this section include expansion of service area, addition or deletion of sponsoring providers, changes in provider contract forms, and group contract forms when the distribution of risk is significantly changed, and any other changes that the Department describes in properly adopted rules. Every PSO shall report to the Department for the Department's information material changes in the network of sponsoring providers and affiliated providers of services to beneficiaries enrolled with the PSO, the addition or deletion of any Medicare contracts of the PSO or any other information the Department may require. This information shall be filed with the Department within 15 days after implementation of the reported changes. Every PSO shall file with the Department all subsequent changes in the information or forms that are required by this Article to be filed with the Department.

(b) The Department may adopt rules exempting from the filing requirements of subsection (a) of this section those items it considers unnecessary.

"**§ 131E-285. Deposits.**

(a) At the time of application, the Department shall require a deposit of one hundred thousand dollars ($100,000) in cash or securities or a combination thereof for all provider sponsored organizations. The deposits shall be included in the calculations of a PSO's or applicant's net worth.

(b) All deposits required by this section shall be restricted to use in the event of insolvency to help assume continuation of services or pay costs associated with receivership or liquidation.

"**§ 131E-286. Ongoing financial standards - net worth.**

(a) Beginning the first day of operation of the PSO and except as otherwise provided in subsection (d) of this section, every PSO shall maintain a minimum net worth equal to the greatest of the following amounts:

(1) One million dollars ($1,000,000);

(2) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Department on the first one hundred fifty million dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);

(3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the Department;

(4) An amount equal to the sum of:

a. Eight percent (8%) of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers as reported on the most recent financial statement filed with the Department; and

b. Four percent (4%) of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and

c. Zero percent (0%) of annual health care expenditures paid on a capitated basis to affiliated providers regardless of downstream arrangements from the affiliated provider.

(b) In calculating net worth, liabilities shall not include fully subordinated debt or subordinated liabilities. For purposes of this provision, subordinated liabilities are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors.

(c) In calculating net worth for purposes of this section, the items described in G.S. 131E-282(b) shall be admitted, except as follows:

(1) For intangible assets, if at least the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to ten percent (10%) of the minimum net worth amount required; and

(2) Deferred acquisition costs shall not be admitted.

(d) The Department may lower the minimum ongoing net worth threshold, and the amount held in cash or cash equivalents for PSOs that operate primarily in rural areas.

(e) During the start-up phase of the PSO, the pre-break-even financial plan requirements shall apply. After the point of break-even, the financial plan requirement shall address cash needs and the financing required for the next three years.

(f) If a PSO, or the legal entity of which the PSO is a component, did not earn a net operating surplus during the most recent fiscal year, the PSO shall submit a financial plan, satisfactory to the Department, meeting all of the requirements established for the initial financial plan.

"**§ 131E-287. Reporting.**

(a) The PSO shall file with the Department financial information relating to PSO solvency standards described in this Article, according to the following schedule:

(1) On a quarterly basis until break-even; and

(2) On an annual basis after break-even, if the PSO has a net operating surplus; or

(3) On a quarterly or monthly basis, as specified by the Department, after break-even, if the PSO does not have a net operating surplus.

(b) To the extent not preempted by federal law or otherwise mandated by the Medicare program, the PSO shall annually, on or before the first day of March of each year, file in the office of the Secretary the following information for the previous calendar year:

(1) The number of and reasons for grievances received from Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every PSO shall file with the Department, as part of its annual grievance report, a certificate of compliance stating that the PSO has established and follows, for its Medicare contract, grievance procedures that comply with G.S. 131E-314.

(2) The number of Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract who terminated their enrollment with the PSO for any reason.

(3) The number of provider contracts between the PSO and network providers for the provision of covered services to Medicare beneficiaries that were terminated and reasons for termination. This information shall include the number of providers leaving the PSO network and the number of new providers in the network.

The report shall show voluntary and involuntary terminations separately.

(4) Data relating to the utilization, quality, availability, and accessibility of service. The report shall include the following:

a. Information on the PSO's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the PSO's methodology under its Medicare+Choice program for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in PSO Medicare+Choice program enrollees will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the PSO's provider network; and an evaluation of actual plan performance against performance targets.

b. The PSO's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.

c. Information on the PSO's program under its Medicare+Choice program to determine the level of provider network accessibility necessary to serve its Medicare enrollees. This information shall include the PSO's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.

2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual Medicare + Choice plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the PSO's methods and standards for determining whether in-network services are reasonably available and accessible to a Medicare enrollee for the purpose of determining whether such enrollee should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the PSO's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, Medicare + Choice plan performance, and network provider performance.

f. A summary of the PSO's utilization review program activities for the previous calendar year under its Medicare + Choice program. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of Medicare enrollees. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 131E-314.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Department.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(c) Disclosure Requirements. -- To the extent not otherwise prohibited by federal law or under the terms of the PSO's Medicare contract, each PSO shall provide the following applicable information to Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract and bonafide prospective enrollees upon request:

(1) The evidence of coverage under the Medicare+Choice plan provided by the PSO to Medicare beneficiaries under the terms of the PSO's Medicare contract;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective enrollee. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The procedures and medically based criteria under the PSO's Medicare contract for determining whether a specified procedure, test, or treatment is experimental.

(d) Effective January 1, 1999, PSOs shall make the reports that are required under subsection (b) of this section and that have been filed with the Department available on their business premises and shall provide any Medicare beneficiary enrolled with the PSO access to them upon request, unless otherwise prohibited by federal law or under the terms of the PSO's Medicare contract.

(e) Every PSO licensed under this Article shall annually on or before the first day of March of each year, file in the office of the Secretary a sworn statement verified by at least two of the principal officers of the PSO showing its condition on the thirty-first day of December, then next preceding; which shall be in such form as the Secretary shall prescribe. In case the PSO fails to file the annual statement as herein required, the Secretary is authorized to suspend the license issued to the PSO until the statement shall be properly filed.

"**§ 131E-288. Liquidity.**

(a) Each PSO shall have sufficient cash flow to meet its obligations as they become due. In determining the ability of a PSO to meet this requirement, the Department shall consider the following:

(1) The timeliness of payment;

(2) The extent to which the current ratio is maintained at one to one or whether there is a change in the current ratio over a period of time; and

(3) The availability of outside financial resources.

(b) The following corresponding remedies apply:

(1) If the PSO fails to pay obligations as they become due, the Department shall require the PSO to initiate corrective action to pay all overdue obligations.

(2) The Department may require the PSO to initiate corrective action if either of the following is evident: (i) the current ratio declines significantly; or (ii) there is a continued downward trend in the current ratio. The corrective action may include a change in the distribution of assets, a reduction of liabilities, or alternative arrangements to secure additional funding requirements to restore the current ratio to one to one.

(3) If there is a change in the availability of the outside resources, the Department shall require the PSO to obtain funding from alternative financial resources.

(c) Nothing in the foregoing liquidity requirements shall be interpreted to require the PSO to maintain a current ratio of one to one if the PSO can demonstrate to the Department that it is able to pay its obligations as they become due and the current ratio maintained by the PSO has neither declined significantly nor is on a continued downward trend.

"§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.

(a) Except as otherwise provided in subsection (b) of this section, each PSO shall, on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of the greater of:

(1) Seven hundred fifty thousand dollars ($750,000) cash or cash equivalents; or

(2) Forty percent (40%) of the minimum net worth required.

(b) The Department may lower the threshold for minimum net worth held in cash or cash equivalents by PSOs that operate primarily in rural areas.

(c) Cash or cash equivalents held to meet the net worth requirement shall be current assets of the PSO.

"§ 131E-290. Prohibited practice.

(a) No provider sponsored organization or sponsoring provider, unless licensed as an insurer under Chapter 58 of the General Statutes may use in its name, contracts, or literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

(b) No provider sponsored organization or sponsoring provider shall engage in any activity or conduct which is prohibited by the terms of the PSO's Medicare contract.

(c) Unless otherwise preempted by federal law or mandated by the Medicare program, a PSO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of that license or certification. This subsection does not preclude a PSO from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

"**§ 131E-291. Collaboration with local health departments.**

A provider sponsored organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health.

"**§ 131E-292. Coverage.**

(a) Provider sponsored organizations subject to this Article shall provide coverage for the medically appropriate and necessary services specified under the PSO's Medicare contract.

(b) In the event a PSO's Medicare contract or federal law, regulations, or rules governing coverage by the PSO of items or services to Medicare beneficiaries permits a PSO, sponsoring provider, or participating provider to object on moral or religious grounds to providing an item or service to Medicare beneficiaries, it is the policy of this State to permit this objection and allow the participating provider to refuse to provide the item or service.

"**§ 131E-293. Rates.**

Rates charged by provider sponsored organizations to the Medicare program and charges by PSOs and sponsoring providers for items or services to beneficiaries shall be governed by the terms of the PSO's Medicare contract.

"**§ 131E-294. Consumer protection and quality standards.**

(a) Unless otherwise preempted by federal law or mandated by the Medicare program, the Department shall apply to provider sponsored organizations the same standards and requirements that the Department of Insurance applies to health maintenance organizations under Chapter 58 of the General Statutes with respect to the following consumer protection and quality matters:

(1) Quality management programs (11 NCAC 20.0500, et seq.);
(2) Utilization review procedures (G.S. 58-67-61 and G.S. 58-67-62);
(3) Unfair or deceptive trade practices (Article 63 of Chapter 58 of the General Statutes);
(4) Antidiscrimination (G.S. 58-3-25(b) and (c), 58-3-120; 58-63-15(7), and 58-67-75);
(5) Provider accessibility and availability (11 NCAC 20.0300, et seq.);
(6) Network provider credentialing (11 NCAC 20.0400, et seq.); and
(7) Data reporting requirements under G.S. 58-67-50(e).

"**§ 131E-295. Powers of insurers and medical service corporations.**

Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 67 of Chapter 58 of the General Statutes, an insurer or a hospital or medical service corporation may contract with a provider sponsored organization to provide insurance or similar protection against the cost of care provided through provider sponsored organizations and their sponsoring providers to beneficiaries and to provide coverage in the event of the failure of the provider sponsored organization or its sponsoring providers to meet its obligations under the PSO's Medicare contract. The beneficiaries of a provider sponsored organization constitute a permissible group under these laws. Among other things, under these contracts, the insurer or hospital or medical service

corporation may make benefit payments to provider sponsored organizations for health care services rendered by providers pursuant to the health care plan.

"§ 131E-296. Examinations.

The Department may make an examination of the affairs of any provider sponsored organization and the contracts, agreements, or other arrangements pursuant to its health care plan as often as the Department considers necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

"§ 131E-297. Hazardous financial condition.

(a) Whenever the financial condition of any provider sponsored organization indicates a condition such that the continued operation of the provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, then the Department may order the provider sponsored organization to take any action that may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

(1) To reduce the total amount of present and potential liability for benefits by reinsurance;

(2) To reduce the volume of new business being accepted;

(3) To reduce the expenses by specified methods;

(4) To suspend or limit the writing of new business for a period of time;

(5) To require an increase to the provider sponsored organization's net worth by contribution;

(6) To add or delete sponsoring providers;

(7) To increase the amount of payments from the PSO which sponsoring providers agree to forego; or

(8) To require additional guaranties from sponsoring providers or from parents of sponsoring providers.

(b) If the Department determines that the standards in G.S. 131E-286, 131E-288, and 131E-289 do not provide sufficient early warning that the continued operation of any provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, the Department may adopt rules to set uniform standards and criteria for such an early warning and to set standards for evaluating the financial condition of any provider sponsored organization, which standards shall be consistent with the purposes expressed in subsection (a) of this section.

"§ 131E-298. Protection against insolvency.

(a) The Department shall require deposits in accordance with the provisions of G.S. 131E-285.

(b) If a provider sponsored organization fails to comply with the net worth requirements of G.S. 131E-286, the Department may take appropriate action to assure that the continued operation of the provider sponsored organization will not be hazardous to the beneficiaries enrolled with the PSO.

(c) Every provider sponsored organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Department. In determining the adequacy of such a plan, the Department shall consider:

(1) A reinsurance agreement preapproved by the Department covering excess loss, stop-loss, or catastrophies. The agreement shall provide that the Department will be notified no less than 60 days prior to cancellation or reduction of coverage;

(2) A conversion policy or policies that will be offered by an insurer to the beneficiaries in the event of the provider sponsored organization's insolvency;

(3) Legally binding unconditional guaranties by adequately capitalized sponsoring provider or adequately capitalized sponsoring corporations of sponsoring providers;

(4) Legally binding obligations of sponsoring providers to forego payment for items or services provided by the sponsoring provider in order to avoid the financial insolvency of the PSO;

(5) Legally binding obligations of sponsoring providers or parents of sponsoring providers to make capital infusions to the PSO; and

(6) Any other arrangements offering protection against insolvency that the Department may require.

"**§ 131E-299. Hold harmless agreements or special deposit.**

(a) Unless the PSO maintains a special deposit in accordance with subsection (b) of this section, each contract between every PSO and a participating provider of health care services shall be in writing and shall set forth that in the event the PSO fails to pay for health care services as set forth in the contract, the Medicare subscriber or beneficiary shall not be liable to the provider for any sums owed by the PSO. No other provisions of these contracts shall, under any circumstances, change the effect of this provision. No participating provider or agent, trustee, or assignee thereof may maintain any action at law against a subscriber or beneficiary to collect sums owed by the PSO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the PSO shall maintain a special deposit in cash or cash equivalent as follows:

(1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures the PSO shall either:

a. Place an uncovered expenditures insolvency deposit with the Department, or with any organization or trustee acceptable to the Department through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Department. This deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the PSO's outstanding liability for uncovered expenditures for enrollees, including incurred but not reported claims, and shall be calculated as of the first

day of the month and maintained for the remainder of the month. If a PSO is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section; or

b. Maintain adequate insurance or a guaranty arrangement approved in writing by the Department, to pay for any loss to beneficiaries claiming reimbursement due to the insolvency of the PSO. The Department shall approve a guaranty arrangement if the guarantying organization is a sponsoring provider, has been operating for at least 10 years and has a net worth, including organization-related land, buildings, and equipment of at least fifty million dollars ($50,000,000), unless the Department finds that the approval of this guaranty may be financially hazardous to beneficiaries.

(2) The deposit required under sub-subdivision a. of subdivision (1) of this subsection is an admitted asset of the PSO in the determination of net worth. All income from these deposits or trust accounts shall be assets of the PSO and may be withdrawn from the deposit or account quarterly with the approval of the Department;

(3) A PSO that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this subsection is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the Department;

(4) The deposit required under sub-subdivision a. of subdivision (1) of this section is in trust and may be used only as provided under this section. The Department may use the deposit of an insolvent PSO for administrative costs associated with administering the deposit and payment of claims of enrollees of the PSO.

(c) Whenever the reimbursements described in this section exceed ten percent (10%) of the PSO's total costs for health care services over the immediately preceding six months, the PSO shall file a written report with the Department containing the information necessary to determine compliance with sub-subdivision a. of subdivision (1) of subsection (b) of this section no later than 30 business days from the first day of the month. Upon an adequate showing by the PSO that the requirements of this section should be waived or reduced, the Department may waive or reduce these requirements to an amount it deems sufficient to protect beneficiaries of the PSO consistent with the intent and purpose of this Article.

"§ 131E-300. Continuation of benefits.

The Department shall require that each PSO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to beneficiaries who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Department may require:

(1) Insurance to cover the expenses to be paid for benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PSO's insolvency for which premium payment has been made and until the beneficiaries' discharge from inpatient facilities;

(3) Insolvency reserves as the Department may require;

(4) Letters of credit acceptable to the Department;

(5) Additional guaranties from a sponsoring provider of the PSO or from the parent of a sponsoring provider;

(6) Legally binding obligations of sponsoring providers to forego payment from the PSO for services provided to beneficiaries in order to avoid the insolvency of the PSO; and

(7) Any other arrangements to assure that benefits are continued as specified.

"§ 131E-301. Insolvency.

(a) In the event of an insolvency of a PSO upon order of the Department, all providers that were sponsoring providers of the PSO within the previous 12 months from the order of the Department shall, for 30 days after the order, offer all beneficiaries enrolled with the insolvent PSO covered services without charge other than for any applicable co-payments, deductibles, or coinsurance permitted to be charged to beneficiaries under the PSO's Medicare contract.

(b) If the Department determines that the sponsoring providers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the beneficiaries of the insolvent PSO, then, in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall allocate the insolvent PSO's contracts for these groups among all other PSOs that operate within a portion of the insolvent PSO's service area, taking into consideration the health care delivery resources of each PSO. Each PSO to which beneficiaries are so allocated by the Department shall offer such group or groups that PSO's existing coverage that is most similar to each beneficiary's coverage with the insolvent PSO at rates determined in accordance with the successor PSO's existing rating methodology.

(c) Taking into consideration the health care delivery resources of each such PSO, then in the event the Health Care Financing Administration of the U.S. Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall also allocate among all PSOs that operate within a portion of the insolvent PSO's service area the insolvent PSO's beneficiaries who are unable to

obtain other coverage. Each PSO to which beneficiaries are so allocated by the Department shall offer such beneficiaries that PSO's existing coverage for individual or conversion coverage as determined by the beneficiary's type of coverage in the insolvent PSO at rates determined in accordance with the successor PSO's Medicare contract.

"§ 131E-302. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior PSO contract or policy providing these hospital, medical, or surgical expense or service benefits, shall immediately cover all beneficiaries who were validly covered under the previous PSO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those beneficiaries validly covered under the prior carrier's contract on the date of discontinuance.

"§ 131E-303. Incurred but not reported claims.

(a) Every PSO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such PSO is or may be liable; and to provide for the expense of adjustment or settlement of such claims.

(b) These liabilities shall be computed in accordance with rules adopted by the Department upon reasonable consideration of the ascertained experience and character of the PSO.

"§ 131E-304. Suspension or revocation of license.

(a) The Department may suspend, revoke, or refuse to renew a PSO license if the Department finds that the PSO:

(1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 131E-280, unless amendments to these submissions have been filed with and approved by the Department;

(2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with Medicare or Medicaid program requirements as applicable;

(3) No longer maintains the financial reserve specified in G.S. 131E-286 or is no longer financially responsible and may reasonably be

expected to be unable to meet its obligations to beneficiaries or prospective beneficiaries;

(4) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the PSO or with any order issued by the Department after notice and opportunity for a hearing;

(5) Has knowingly made to the Department any false statement or report;

(6) Has sponsoring providers that fail to provide a substantial proportion of the services under any health plan during any 12-month period;

(7) Has itself or through any person on its behalf advertised or merchandised its items or services in an untrue, misrepresentative, misleading, or unfair manner;

(8) If continuing to operate would be hazardous to beneficiaries; or

(9) Has otherwise substantially failed to comply with this Article.

(b) A license shall be suspended or revoked only after compliance with G.S. 131E-305.

(c) When a PSO license is suspended, the PSO shall not, during the suspension, enroll any additional beneficiaries and shall not engage in any advertising or solicitation.

(d) When a PSO license is revoked, the PSO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the PSO. The PSO shall engage in no advertising or solicitation. The Department may, by written order, permit any further operation of the PSO that the Department may find to be in the best interest of beneficiaries, to the end that beneficiaries will be afforded the greatest practical opportunity to obtain continuing health care coverage.

"§ 131E-305. Administrative procedures.

(a) When the Department has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, it shall notify the provider sponsored organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

(b) After this hearing, or upon the failure of the provider sponsored organization to appear at this hearing, the Department shall take the action it considers advisable or make written findings that shall be mailed to the provider sponsored organization. The action of the Department shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Department in whole or in part.

(c) The provisions of Chapter 150B of the General Statutes apply to proceedings under this section to the extent that they are not in conflict with subsections (a) and (b) of this section.

"§ 131E-306. Department of Insurance.

At the request of the Department, the Department of Insurance shall evaluate a PSO's compliance with any or all of the solvency requirements set forth in this Article. Upon this request, the Department of Insurance shall undertake the evaluation in accordance with this Article and regulations adopted pursuant to it and shall report its evaluation to the Department in a timely manner. The Department of Insurance may collect from the applicant or PSO subject to the evaluation a fee not to exceed the fee that the Department of Insurance would be entitled to impose on a health maintenance organization for undergoing a similar evaluation. Nothing in this section limits the Department's final authority to license PSOs in accordance with this Article.

"§ 131E-307. Penalties and enforcement.

(a) The provisions of G.S. 58-2-70, modified to replace the word 'Commissioner' by the word 'Department', applies to this Article. The Department may, in addition to or in lieu of suspending or revoking a license under G.S. 131E-304, proceed under G.S. 58-2-70, as so modified, provided that the provider sponsored organization has a reasonable time within which to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Any person who violates this Article shall be guilty of a Class 1 misdemeanor.

(c) If the Department shall for any reason have cause to believe that any violation of this Article has occurred or is threatened, the Department may give notice to the provider sponsored organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Department may deem appropriate under the circumstances.

(d) The Department may issue an order directing a provider sponsored organization or a representative of a provider sponsored organization to cease and desist from engaging in any act or practice in violation of the provisions of this Article.

Within 30 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Article have occurred. These hearings shall be conducted pursuant to Chapter 150B of the General Statutes, and judicial review shall be available as provided by this Chapter.

(e) In the case of any violation of the provisions of this Article, if the Department elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the Department may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County.

"§ 131E-308. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this Article, provisions of the insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any provider sponsored organization granted a license under this Article or to its sponsoring providers when operating under such a license. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its provider sponsored organization activities authorized and regulated pursuant to this Article.

(b) Solicitation of beneficiaries by a provider sponsored organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals or health care providers.

(c) Any provider sponsored organization licensed under this Article shall not be considered to be a provider of medicine or dentistry and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine and dentistry; provided, however, that this exemption does not apply to individual providers under contract with or employed by the provider sponsored organization or sponsoring providers or to the sponsoring providers.

(d) Except as otherwise limited by this Article, a PSO may organize in the same manner and may exercise the same prerogatives, powers and privileges as other entities that are organized and existing under the same laws as the PSO.

"§ 131E-309. Filings and reports as public documents.

Except for information that constitutes a bona fide trade secret, proprietary information or competitively sensitive information of a sponsoring provider or parent of a sponsoring provider, all applications, filings, and reports required under this Article shall be treated as public documents.

"§ 131E-310. Confidentiality of medical information.

Any data or information pertaining to the diagnosis, treatment, or health of any beneficiary or applicant obtained from the person or from any provider by any provider sponsored organization or by any provider acting pursuant to its provider contract with a provider sponsored organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Article; or upon the express consent of the beneficiary or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the provider sponsored organization wherein such data or information is pertinent. A provider sponsored organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the provider sponsored organization is entitled to claim.

"§ 131E-311. Conflicts; severability.

To the extent that the provisions of this Article may be in conflict with any other provision of this Chapter, the provisions of this Article shall prevail and apply with respect to provider sponsored organizations. Notwithstanding the absence of adopted rules, the Department shall continue to process applications for provider sponsored organization licenses as described in this Article. If any section, term, or provision of

this Article shall be adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Article, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"§ 131E-312. Regulations.

This Article shall be self-implementing. No later than six months after the date of enactment of this Article, the Department may adopt rules consistent with this Article to authorize and regulate provider sponsored organizations to contract directly with the federal Medicare program to provide health care services to the beneficiaries of such programs. The Department shall issue permanent rules and, may issue temporary rules, to the extent these rules may be necessary. The Department shall limit its regulation of provider sponsored organizations to the licensing and regulating of these organizations as risk bearing entities contracting directly with the Medicare program and to the consumer protection and quality standards as provided in G.S. 131E-294, and shall not regulate any matters described in 42 U.S.C. § 1395W-26(b)(3), or any successor thereof.

"§ 131E-313. Utilization review and grievances.

Unless otherwise preempted by federal law or mandated by the Medicare program, the provisions of G.S. 58-50-61 and G.S. 58-50-62 apply to a PSO licensed under this Article as if the PSO was an 'insurer' under those sections, except that the Department rather than the Commissioner of Insurance shall regulate a PSO's compliance with those sections."

Section 2. G.S. 58-67-10(b) reads as rewritten:

"(b) (1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, a provider sponsored organization or other organization certified, qualified, or otherwise approved by the Department of

Health and Human Services pursuant to Article 17 of Chapter 131E of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

(4) Except as provided in paragraphs (1), (2), (3), and (3a) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article."

Section 3. G.S. 90-21.22A reads as rewritten:

"**§ 90-21.22A. Medical review committees.**

(a) As used in this section, "medical review committee" means a committee composed of health care providers licensed under this Chapter that is formed for the purpose of evaluating the quality of, cost of, or necessity for health care services, including provider credentialing. "Medical review committee" does not mean a medical review committee established under G.S. 131E-95.

(b) A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(c) The proceedings of a medical review committee, the records and materials it produces, and the materials it considers shall be confidential and not considered public records within the meaning of ~~G.S. 132-1~~ G.S. 132-1, 131E-309, or ~~G.S.~~ 58-2-100; and shall not be subject to discovery or introduction into evidence in any civil action against a provider of health care services who directly provides services and is licensed under this ~~Chapter or~~ Chapter, a PSO licensed under Article 17 of Chapter 131E of the General Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General Statutes or that is owned or operated by the State, which civil action results from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. A member of the committee may testify in a civil action but cannot be asked about his or her testimony before the committee or any opinions formed as a result of the committee hearings.

(d) This section applies to a medical review committee, including a medical review committee appointed by one of the entities licensed under Articles 1 through 67 of Chapter 58 of the General Statutes.

(e) Subsection (c) of this section does not apply to proceedings initiated under ~~G.S. 58-50-61 or G.S. 58-50-62.~~ G.S. 58-50-61, 58-50-62, or 131E-313."

Section 4. This act is effective when it becomes law.

Cole

Hardaway Wainwright Ives

BRAWLY

Attachment IV

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

July 2, 1998

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 1455 – Medicare+Choice Provider Sponsored Organizations (PSOs)

The Department's position is that PSOs engaged only in Medicare+Choice business should continue to be regulated by the Department of Insurance and that the proposed regulatory structure in H.B. 1455 represents a duplication of current State efforts. Some of the reasons for this position are outlined below:

Current state law already provides for the licensure of Medicare+Choice PSOs. The HMO Act applies to any entity, including a PSO, that provides health care services on a prepaid basis. Federal laws and regulations and Health Care Financing Administration's (HCFA) requirements call for all Medicare+Choice carriers to hold a state license as a "risk bearing entity". This requirement, along with the lack of any language preempting state regulation, is an indication that all Medicare+Choice carriers are to be licensed under state law. Therefore, a PSO engaged in Medicare+Choice business is and will continue to be subject to The HMO Act absent any new state laws that establish separate licensing for PSOs.

Special treatment of Medicare+Choice-only PSOs is not warranted based on the fact that they will only engage in Medicare programs and therefore are not engaged in insurance. All indications from HCFA are that all Medicare+Choice carriers are to be treated the same as all state-licensed insurance carriers, with the exception of benefit requirements, coverage determinations, and non-discrimination of providers. (These exceptions, which are effectuated through federal preemption of state law, apply to all Medicare+Choice carriers, not just PSOs.) This approach, along with the requirement for state licensure, indicates that the creation of special or separate state regulation of any entity based on the fact that it is engaged only in Medicare+Choice business is not consistent with the intent of federal law or HCFA.

Special licensure of Medicare+Choice-only PSOs is not warranted based on the fact that they are PSOs or based on the guidance provided in federal law. The only case where federal law and regulations provide for differential treatment of PSOs is in PSO

Medicare+Choice business may request that HCFA waive its requirement for a state license if: the state does not act upon an application within 90 days; the state's solvency requirements for licensing differ from federally established solvency standards; or the state applies additional requirements to PSOs that do not apply to other carriers engaged in Medicare+Choice business. Therefore, the argument that state regulation of PSOs engaged in Medicare+Choice business should be special or separate from state regulation of all other carriers engaged in Medicare+Choice business is not consistent with the approach taken in federal laws and regulations.

Additional concerns about the proposed legislation (H.B. 1455) follow:

H.B. 1455 would have the Department of Health and Human Services (DHHS) apply and enforce the Department of Insurance's standards for HMOs and managed care plans to PSOs. It is doubtful that any additional benefit would be provided to consumers by having DHHS perform this function for one type of health plan while Department of Insurance performs the same function all other types of health plans. Furthermore, a bifurcated regulatory system is likely to result in differences in the way each agency interprets, applies, and enforces the same laws, simply because of the fact that different individuals and organizations will be trying to so the same job.

H.B. 1455 would have the Department of Insurance review the financial information that a PSO submits to DHHS and advise DHHS on whether the PSO meets the solvency standards in DHHS' laws. Although the Department of Insurance would have some level of responsibility of solvency regulation, it would not have authority over the PSO. The Department of Insurance strongly feels that it should have full regulatory authority over Medicare+Choice PSOs, or no involvement at all.

Finally, if no changes are made to North Carolina law, any PSO that applied for an HMO license but was refused because of an inability to meet existing solvency standards would be eligible to apply to HCFA for a waiver of its licensure requirement. Therefore, current North Carolina law would not be an impediment to any PSO's ability to participate in the Medicare+Choice program. The General Assembly could amend the HMO Act to include special solvency standards for Medicare+Choice PSOs if the General Assembly wants to eliminate the need for any PSO to request a waiver of HCFA's licensing requirement.

MINUTES

INSURANCE COMMITTEE

October 21, 1998

The House Committee on Insurance met at Chairman Dockham's desk in the House Chamber. Members present were: Representative Brawley, Cole, Dickson, Barefoot, Hardy, Hensley, Hurley, Wainwright, and Wright.

Chairman Dockham called the meeting to order. He handed out a list of the House Bills that remain in the Insurance Committee and asked for a motion to postpone them indefinitely. Representative Dub Dixon made the motion and it passed unanimously.

The meeting was adjourned.

Chairman Jerry C. Dockham

Joanna Mills, Clerk

1998 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham** for the Committee on **INSURANCE**.

HB 276 REDUCE TAX ON NONPRESCRIPTION DRUGS

HB 291 AUTOPSY/FAMILY NOTICE

HB 350 GENETIC INFO/NO DISCRIMINATION

HB 358 OB-GYN ACCESS/MEDICAID RECIPIENTS

HB 405 ELIMINATE MEDICAID PRESCRIPTION LIMIT

HB 421 RESPIRATORY CARE PRACTICE ACT

HB 436 STATE HEALTH PLAN SUBSTANTIVE

HB 541 IMPROVE HMO SERVICES

HB 562 DIRECT PAYMENT/SUBSTANCE ABUSE PROFESSIONALS

HB 563 MENTAL HEALTH PARITY

HB 796 PRESCRIPTION DRUGS/COMPETITION

HB 803 HEALTH INSURANCE/RISK POOL

HB 914 BONE MASS MEASUREMENT/COVERAGE

HB 923 WINDSTORM DEDUCTIBLES

HB 1020 INSURANCE SETTLEMENTS

HB 1058 HEALTH CARE FACILITIES/ANY WILLING PROVIDER

HB 1162 CERTIFICATE OF NEED MODIFICATIONS

HB 1399 NO INSURANCE POINTS/15 MPH OVER LIMIT

HB 1476 AMEND PHARMACY PRACTICE ACT

HB 1569 EXPAND INSURANCE REGULATORY CHARGE

HB 1588 REVISE INSURER ASSESSMENTS

HB 1590 AMEND INSURANCE FINANCE/FEES

X With an indefinite postponement report.

MINUTES

HOUSE COMMITTEE ON INSURANCE

JULY 7, 1998

The House Committee on Insurance met in room 643 of the Legislative Office Building on July 7, 1998 at 11:50 p.m. Chairman Dockham presided. Members present were: Representative Allred, Barbee, Black, Brawley, Cole, Debmon, Dickson, Gardner, Hardaway, Hardy, Hensley, Holmes, Hurley, Ives, Luebke, McComas, Miller, Miner, Wainwright, Bowie, Esposito, and Russell. The visitor registration list is made a part of the minutes.

Chairman Dockham stated that discussion of HB-1455- AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING would continue. The bill was considered by the Insurance Committee on July 2, 1998. Representative Cansler explained his bill and answered questions from members of the committee. He called on Mr. Bob Fitzgerald, Deputy Commissioner of Health and Human Services, to answer the concerns about having this agency in the Department of Insurance verses the Department of Health and Human Services.

Representative Brawley's proposed substitute (PCS1578), which would have put this agency under the Department of Insurance, failed by a show of hands, 12 to 10. His proposed committee substitute is included in and made a part of the minutes.

Representative Russell presented a committee substitute (PCS8355)to amend the bill on page 3, line 44, by adding the following sentence: This subdivision applies only if a hospital licensed under Chapter 131E or Chapter 122C of the General Statues is the sponsoring provider or a member of the group of affiliated health care providers that comprises the sponsoring provider. Also, on page 2, line 16, by adding the following sentence: "Nothing in this Article shall be construed to authorize a provider sponsored organization to establish, maintain, or operate a health care plan other than exclusively for Medicare+Choice beneficiaries. On page 25, line 1, by deleting the word "shall" and

inserting the word "may". The Committee amended it and asked that the amendments be incorporated into this committee substitute.

House Bill 1455 passed with a favorable report as to committee substitute bill and unfavorable as to original bill. This bill was later referred to the Insurance Sub Committee on Health for further consideration.

There being no further discussion, Chairman Dockham adjourned the meeting.

Representative Jerry C. Dockham
Chairman

Joanna Mills
Clerk

Attachments

1998 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Jerry C. Dockham** for the Committee on **INSURANCE.**

☑ Committee Substitute for
H.B. 1455 A BILL TO BE ENTITLED AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐ .

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on ☐ Appropriations ☐ Finance ☐

☑ With a favorable report as to committee substitute bill (#_____), ☐ ~~which changes the title,~~ unfavorable as to original bill (~~Committee Substitute Bill #_____~~), ~~(and recommendation that the committee substitute bill #_____ be re-referred to the Committee on _____.)~~

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ And having received a unanimous vote in committee, is placed on the Consent Calendar. (PUBLIC BILLS ONLY)

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

4/24/97

VISITOR REGISTRATION SHEET

INSURANCE COMMITTEE — Name of Committee

JULY 7, 1998 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCAUS
[illegible]	NCDOT
[illegible]	"
Barbara Morales Bourke	"
Lucia Peel	NCMS
[illegible]	[illegible]
Paul Lawler	Lawler Consulting
Elizabeth Tillman	w/ Rep. Charlotte Gardner
Suzanne Jones	Representative Esposito's intern
George Ivey	Johnson & Johnson
[illegible]	BCBSNC
William Riddick	DOR
Tommy Watts	CMS
Donna Mackinnon	Fiscal Research
David Knight	NC Sierra Club
Chris Heagerty	Energy Coalition
Deborah Ross	ACLU

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 1455*
Proposed Committee Substitute H1455-PCS1590-RN

Short Title: PSO Medicare Licensing. (Public)

Sponsors:

Referred to:

May 25, 1998

A BILL TO BE ENTITLED

AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING.

The General Assembly of North Carolina enacts:

Section 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"ARTICLE 17.

"Provider Sponsored Organization Licensing.

"**§ 131E-275. General provisions.**

(a) The General Assembly acknowledges that section 1855, et seq., of the federal Social Security Act permits provider sponsored organizations that are organized and licensed under State law as risk-bearing entities, or that are otherwise certified as such by the federal government, to be eligible to offer Medicare health insurance or health benefits coverage in each state in which the provider sponsored organization offers a Medicare+Choice plan. The General Assembly declares that provider sponsored organizations are beneficial to North Carolina citizens who are Medicare beneficiaries and should be encouraged, subject to appropriate regulation by the Department of Health and Human Services. The General Assembly further declares that, because provider sponsored organizations provide health care directly and assume responsibility for the provision of health care services to Medicare beneficiaries under the requirements of the federal Medicare program, they require different regulatory oversight to protect the public than health maintenance organizations and insurance companies. The General Assembly further declares that

the organizers and operators of provider sponsored organizations which are licensed under the terms of this Article as risk-bearing entities authorized to contract directly with the federal Medicare+Choice program shall not be subject to Chapter 58 of the General Statutes or the insurance laws of this State, unless otherwise specified in this Article.

It is the intent of the General Assembly to encourage innovative methods by which sponsoring providers can directly or indirectly share substantial financial risk in the PSO in any lawful manner.

(b) As set forth in this Article, the Department of Health and Human Services shall be the agency of the State authorized to license provider sponsored organizations to contract with Medicare to provide health care services to Medicare beneficiaries and to engage in the other related activities described in this Article.

(c) Each provider sponsored organization shall obtain a license from the Department or shall otherwise be certified by the federal government prior to establishing, maintaining, and operating a health care plan in this State for Medicare+Choice beneficiaries. Nothing in this Article shall be construed to authorize a provider sponsored organization to establish, maintain, or operate a health care plan other than exclusively for Medicare+Choice beneficiaries.

"§131E-276. Definitions.

As used in this Article, unless the context clearly implies otherwise, the following definitions apply:

(1) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries of the Medicare+Choice program who are enrolled with the provider sponsored organization (PSO) under the terms of a contract between the PSO and the Medicare program.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina.

(3) 'Current assets' means cash, marketable securities, accounts receivable, and other current items that will be converted into cash within 12 months.

(4) 'Current liabilities' means accounts payable and other accrued liabilities, including payroll, claims, and taxes that will need to be paid within 12 months.

(5) 'Current ratio' means the ratio of current assets divided by current liabilities calculated at the end of any accounting period.

(6) 'Department' means the Department of Health and Human Services.

(7) 'Emergency services' shall have the same meaning as for that term defined in G.S. 58-50-61(a)(5).

(8) 'Health care delivery assets' means any tangible asset that is part of a PSO operation, including hospitals, medical facilities, and their ancillary equipment, and any property that may reasonably be required for the PSO's principal office or for any purposes that may be necessary in the transaction of the business of the PSO.

(9) 'Health plan contract' or 'Medicare contract' means a PSO's direct contract with the United States Department of Health and Human Services under section 1857 of the federal Social Security Act.

(10) 'Out-of-network services' means health care items or services that are covered services under a PSO's Medicare contract and that are provided to beneficiaries by health care providers that are not participating providers in the PSO's network of health care providers.

(11) 'Parent of a sponsoring provider' means the public or private entity that owns or controls a controlling interest in the sponsoring provider or that has the power to appoint a controlling number of the governing board of a sponsoring provider or that has the power to direct the management policy and decisions of the sponsoring provider.

(12) 'Provider' or 'health care provider' means: (i) any individual that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; (ii) any entity that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; or (iii) any entity that is owned or controlled entirely by individuals or entities described in subparts (i) or (ii) of this definition.

(13) 'Provider sponsored organization' or 'PSO' means a public or private entity domiciled in this State, including a business corporation, a nonprofit corporation, a partnership, a limited liability company, a professional limited liability company, a professional corporation, a sole proprietorship, a public hospital, a hospital authority, a hospital district, or a body politic: (i) that is established, organized, and operated by sponsoring providers; (ii) in which physicians licensed pursuant to Article 1 of Chapter 90 of the General Statutes or to the laws of any state of the United States comprise no less than fifty percent (50%) of the governing board or body, unless otherwise prohibited by law; and (iii) that provides a substantial proportion of the services under each Medicare contract directly through the sponsoring provider. The requirement in subpart (ii) of this definition shall not preclude a PSO that includes a tax-exempt hospital from adopting a bylaw provision that provides a veto for the tax-exempt hospital over actions of the PSO necessary to maintain the hospital's tax-exempt status. A PSO shall not be out of compliance with the requirement in subpart (ii) due to temporary vacancies on its governing board or body. This subdivision applies only if a

hospital licensed under Chapter 131E or Chapter 122C of the General Statutes is the sponsoring provider or a member of the group of affiliated health care providers that comprises the sponsoring provider.

(14) 'Secretary' means the Secretary of the Department of Health and Human Services.

(15) 'Sponsoring providers' of a PSO means the health care provider domiciled in this State that assumes, or group of affiliated health care providers that directly or indirectly shares, substantial financial risk in the PSO and that has at least a majority financial interest in the PSO.

(16) 'Substantial proportion of the services' means at least seventy percent (70%), or sixty percent (60%) for PSOs whose beneficiaries reside primarily in rural areas, of the annual health care expenditures.

(17) A health care provider is affiliated with another provider if through contract, ownership, or otherwise, when: (i) one provider directly controls, is controlled by, or is under common control with the other provider; (ii) each provider participates in a lawful combination under which they share substantial financial risk for the organization's operation; (iii) both providers are part of a controlled group of corporations as defined under section 1563 of the Internal Revenue Code of 1986; or (iv) both providers are part of an affiliated service group under section 414 of this Code. Control is presumed if one party directly or indirectly owns, controls, or holds the power to vote, or proxies for, at least fifty-one percent (51%) of the voting or governance rights of another.

"§ 131E-277. Direct or indirect sharing of substantial financial risk.

In order for sponsoring providers to directly or indirectly share substantial financial risk in the PSO, the PSO shall do one or more of the following:

(1) Provide services under its Medicare contract at a capitated rate;

(2) Provide designated services or classes of services under its Medicare contract for a predetermined percentage of premium or revenue from the Medicare program;

(3) Use significant financial incentives for its sponsoring providers, as a group to achieve specified cost-containment and utilization management goals either by:

a. Withholding from all sponsoring providers a substantial amount of the compensation due to them, with distribution of that amount to the sponsoring providers based on performance of all sponsoring providers in meeting the cost-containment goals of the network as a whole; or

b. Establishing overall cost or utilization targets for the PSO, with the sponsoring providers subject to subsequent

substantial financial rewards or penalties based on group performance in meeting the targets; or

(4) Agree to provide a complex or extended course of treatment that requires the substantial coordination of care by sponsoring providers in different specialties offering a complementary mix of services, for a fixed, predetermined payment, when the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's treatment or other factors; or

(5) Agree to any other arrangement that the Department determines to provide for the sharing of substantial financial risk by the sponsoring providers.

"**§ 131E-278. Applicability of other laws.**

Unless otherwise required by federal law, provider sponsored organizations licensed pursuant to the terms of this Article are exempt from all regulation under Chapter 58 of the General Statutes. Plan contracts, provider contracts, and other arrangements related to the provision of covered services by these licensed networks or by health care providers of these PSOs when operating through these PSOs shall likewise be exempt from regulation under Chapter 58 of the General Statutes.

"**§ 131E-279. Approval.**

(a) Unless otherwise required by federal law, the Department shall be the agency of the State that shall license provider sponsored organizations that seek to contract with the federal government to provide health care services directly to Medicare beneficiaries under the Medicare+Choice program.

(b) Provider sponsored organizations which have been granted a waiver pursuant to 42 U.S.C. § 1395w-25(a)(2) and which otherwise meet the requirements of the PSO's Medicare contract shall be deemed by the State to be licensed under this Article for so long as the waiver or Medicare contract remains in effect. The foregoing shall not limit the Department's authority to regulate such PSOs and their respective sponsoring providers and affiliated providers as may be permitted in 42 U.S.C. § 1395w-25(a)(2)(G) or the PSO's Medicare contract.

(c) The Department shall license a PSO as a risk-bearing entity eligible to offer health benefits coverage in this State to Medicare beneficiaries if the PSO complies with the requirements of this Article. This license shall be granted or denied by the Department not longer than 90 days after the receipt of a substantially complete application for licensing. Within 45 days after the Department receives an application for licensing, the Department shall either notify the applicant that the application is substantially complete, or clearly and accurately specify in writing to the applicant all additional specific information required by the applicant to make the application a substantially completed application. This agency response shall set forth a date and time for a meeting within 30 days after it is sent to the applicant, at which a representative of the Department will explain with particularity the additional information required by the Department in the response to make the application substantially complete. The Department shall be bound by the response unless the Secretary determines that it must be modified in order to meet the

purposes of this Article. The Secretary shall not delegate the authority to modify the response. If an applicant provides the additional information set forth in the response, the application shall be considered substantially complete. If the Department has not acted on an application within 90 days after it is deemed substantially complete, the Department shall immediately issue a license to the applicant, and the applicant shall be considered to have been licensed by the Department. Any reapplication which corrects the deficiencies which were specified by the Department in the response shall be approved by the Department.

(d) For purposes of determining, under 42 U.S.C. § 1395w-25(a)(2)(B), or any successor thereof, the date of receipt by the State of a substantially complete application, the date the Department receives the applicant's written response to the agency response or an earlier date considered by the Department shall be considered to be that date. The foregoing shall not limit the Department's authority to consider an application not substantially complete under subsection (c) of this section if the applicant's response to the response does not provide substantially the information specified in the response.

(e) A license shall be denied only after the Department complies with the requirements of G.S. 131E-305.

"**§ 131E-280. Applicants for license.**

Each application for licensing as a provider sponsored organization authorized to do business in North Carolina shall be certified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Department, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant and each sponsoring organization that holds greater than a five percent (5%) interest in the PSO, such as the articles of incorporation, articles of organization, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the respective bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant and each sponsoring provider which holds greater than a five percent (5%) interest in the PSO;

(3) Copies of the document evidencing the arrangements between the applicant and each sponsoring provider that create the relationships and obligations described in G.S. 131E-276(17);

(4) A list of the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant and of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO, respectively, including all members of the respective boards of directors, boards of trustees, executive committees, or other governing boards or committees, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(5) A copy of any contract form made or to be made between any class of providers and the PSO and a copy of any contract form made or to be made between third-party administrators, marketing consultants, or persons listed in subdivision (3) of this subsection and the PSO;

(6) A statement generally describing the provider sponsored organization, its sponsoring providers, its health care plan or plans, facilities, and personnel;

(7) A copy of the hospital license of each sponsoring provider that is a hospital, a copy of the license to practice medicine of each sponsoring provider or owner of a sponsoring provider that is a licensed physician, and a copy of the health care service or facility license held by any other licensed sponsoring provider;

(8) Financial statements showing the applicant's assets, liabilities, sources of financial support, and the financial statements of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO showing the sponsoring provider's assets, liabilities, and sources of support. If the applicant's or any such sponsoring provider's financial affairs are audited by independent certified public accountants, a copy of the applicant's or sponsoring provider's most recent regular certified financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article;

(9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-297, 131E-298, and 131E-299 are guaranteed by one or more guarantors:

a. Documentation that each guarantor meets the following requirements:

1. The guarantor is a legal entity authorized to conduct business in North Carolina.

2. The guarantor is not under federal bankruptcy or State receivership or rehabilitation proceedings.

3. The guarantor has a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the PSO's guarantee.

b. Financial statements showing each guarantor's assets, liabilities, and source of financial support.

c. If a guarantor's financial affairs are audited by independent certified public accountants, a copy of the guarantor's most recent regular audited financial statement shall be considered to satisfy this requirement unless the Department

directs that additional or more recent financial information is required for the proper administration of this Article.

d. The guarantee document, including a statement of the financial obligation covered by the guarantee, an agreement to unconditionally fulfill the financial obligations covered by the guarantee, an agreement not to subordinate the guarantee to any other claim on the resources of the guarantor and a declaration that the guarantor must act on a timely basis to satisfy the financial obligations covered by the guarantee;

(10) A financial plan, satisfactory to the Department, covering the first 12 months of operation under the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the financial plan projects losses, the financial plan must cover the period through 12 months beyond the projected breakeven;

(11) A statement reasonably describing the geographic area or areas to be served;

(12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 131E-298; and

(13) Any other information the Department may require to make the determinations required in G.S. 131E-282.

"**§ 131E-281. Additional information.**

(a) In addition to the information filed under G.S. 131E-280, each application shall include a description of the following:

(1) The program to be used to evaluate whether the applicant's network of sponsoring providers and contracted providers is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay;

(2) The program used to evaluate whether the sponsoring providers provide a substantial portion of services under each Medicare contract of the PSO;

(3) The program to be used for verifying provider credentials;

(4) The utilization review program for the review and control of health care services provided or paid for by the applicant;

(5) The quality management program to assure quality of care and health care services managed and provided through the health care plan; and

(6) The applicant's network of sponsoring providers and contracted providers and evidence of the ability of that network to provide all health care services other than out-of-network services and emergency services to the applicant's prospective beneficiaries.

(b) The Department may promulgate rules and regulations exempting from the filing requirements of subsection (a) of this section those items it deems unnecessary.

"**§ 131E-282. Issuance of license.**

(a) Before issuing a PSO license, the Department may make an examination or investigation as it deems expedient. The Department shall issue a license after receipt of a substantially complete application and upon satisfaction of the following requirements:

(1) The applicant is duly organized as a provider sponsored organization as defined by this Article.

(2) The PSO has initially a minimum net worth of one million five hundred thousand dollars ($1,500,000). In the event the PSO submits a financial plan that demonstrates that the PSO does not have to create but has or has available to it an administrative infrastructure that shall reduce the PSO's start-up costs, the Department may lower the initial minimum net worth required to one million dollars ($1,000,000) or to any lower amount as determined by the Department if the PSO operates primarily in rural areas.

(3) The PSO shall have at least seven hundred fifty thousand dollars ($750,000) in cash or equivalents on its balance sheet, except that the Department may permit a PSO operating primarily in rural areas to have a lesser amount held in cash or equivalents on its balance sheets.

(4) The applicant submits a financial plan satisfactory to the Department which covers the first 12 months of operation of the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the plan projects losses, the financial plan shall cover the period through 12 months beyond projected breakeven.

(5) The Department determines that the applicant has sufficient cash flow to meet its obligations as they become due. In making that determination, the Department shall consider the following:

a. The timeliness of payment;

b. The extent to which the current ratio is maintained at one to one, or whether there is a change in the current ratio over a period of time; and

c. The availability of outside financial resources.

(b) In calculating the net worth of a PSO, the Department shall admit the following:

(1) One hundred percent (100%) of the book value of health care delivery assets on the balance sheet of the applicant.

(2) One hundred percent (100%) of the value of cash and cash equivalents on the balance sheet of the applicant.

(3) If at least one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents, then one hundred percent (100%) of the book value of the PSO's intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than one million dollars ($1,000,000) of

the initial minimum net worth requirement is met by cash or cash equivalents or if the Department has used its discretion to reduce the initial net worth requirement below one million five hundred thousand dollars ($1,500,000), then the Department shall admit one hundred percent (100%) of the book value of intangible assets of the PSO up to ten percent (10%) of the minimum net worth amount required.

(4) Standard accounting principles treatment shall be given to other assets of the PSO not used in the delivery of health care for the purposes of meeting the minimum net worth requirement.

(5) Deferred acquisition costs shall not be admitted.

"**§ 131E-283. Financial plan.**

(a) The financial plan shall include the following:

(1) A detailed marketing plan;

(2) Statements of revenue and expense on an accrual basis;

(3) Cash flow statements;

(4) Balance sheets; and

(5) The assumptions and justifications in support of the financial plan.

(b) In the financial plan, the PSO shall demonstrate that it has the resources available to meet the projected losses for the entire period to breakeven. Except for the use of guaranties as provided in subsection (c) of this section, letters of credit as provided in subsection (e) of this section, and other means as provided in subsection (f) of this section, the resources must be assets on the balance sheet of the PSO in a form that is either cash or convertible to cash in a timely manner, pursuant to the financial plan.

(c) Guaranties shall be acceptable as a resource to meet projected losses, under the following conditions:

(1) For the first year of the PSO's operation of the PSO's Medicare contract, the guarantor must provide the PSO with cash or cash equivalents to fund the projected losses, as follows:

a. Prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;

b. Prior to the beginning of the second quarter, in the amount of the projected losses through the end of the third quarter; and

c. Prior to the beginning of the third quarter, in the amount of the projected losses through the end of the fourth quarter.

(2) If the guarantor provides the cash or cash equivalents to the PSO in a timely manner on the above schedule, this funding shall be considered in compliance with the guarantor's commitment to the PSO. In the third quarter, the PSO shall notify the Department if the PSO intends to reduce the period of funding of projected losses. The Department shall notify the PSO within 60 days of receiving the PSO's notice if the reduction is not acceptable.

(3) If the above guaranty requirements are not met, the Department may take appropriate action, such as requiring funding of projected losses through means other than a guaranty. The Department retains discretion which shall be reasonably exercised to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(d) The Department may modify the conditions in subsection (c) of this section in order to clarify the acceptability of guaranty arrangements.

(e) An irrevocable, clean, unconditional letter of credit may be used as an acceptable resource to fund projected losses in place of cash or cash equivalents if satisfactory to the Department.

(f) If approved by the Department, based on appropriate standards promulgated by the Department, PSOs may use the following to fund projected losses for periods after the first year: lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability.

(g) The exceptions in subsections (c), (d), and (e) of this section may be used in an appropriate combination or sequence.

"**§ 131E-284. Modifications.**

(a) A provider sponsored organization shall file a notice describing any significant change in the information required by the Department under G.S. 131E-280. Such notice shall be filed with the Department prior to the change. If the Department does not disapprove within 90 days after the filing, this modification shall be considered approved. Changes subject to the terms of this section include expansion of service area, addition or deletion of sponsoring providers, changes in provider contract forms, and group contract forms when the distribution of risk is significantly changed, and any other changes that the Department describes in properly adopted rules. Every PSO shall report to the Department for the Department's information material changes in the network of sponsoring providers and affiliated providers of services to beneficiaries enrolled with the PSO, the addition or deletion of any Medicare contracts of the PSO or any other information the Department may require. This information shall be filed with the Department within 15 days after implementation of the reported changes. Every PSO shall file with the Department all subsequent changes in the information or forms that are required by this Article to be filed with the Department.

(b) The Department may adopt rules exempting from the filing requirements of subsection (a) of this section those items it considers unnecessary.

"**§ 131E-285. Deposits.**

(a) At the time of application, the Department shall require a deposit of one hundred thousand dollars ($100,000) in cash or securities or a combination thereof for all provider sponsored organizations. The deposits shall be included in the calculations of a PSO's or applicant's net worth.

(b) All deposits required by this section shall be restricted to use in the event of insolvency to help assume continuation of services or pay costs associated with receivership or liquidation.

"§ 131E-286. Ongoing financial standards - net worth.

(a) Beginning the first day of operation of the PSO and except as otherwise provided in subsection (d) of this section, every PSO shall maintain a minimum net worth equal to the greatest of the following amounts:

(1) One million dollars ($1,000,000);

(2) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Department on the first one hundred fifty million dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);

(3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the Department;

(4) An amount equal to the sum of:

a. Eight percent (8%) of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers as reported on the most recent financial statement filed with the Department; and

b. Four percent (4%) of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and

c. Zero percent (0%) of annual health care expenditures paid on a capitated basis to affiliated providers regardless of downstream arrangements from the affiliated provider.

(b) In calculating net worth, liabilities shall not include fully subordinated debt or subordinated liabilities. For purposes of this provision, subordinated liabilities are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors.

(c) In calculating net worth for purposes of this section, the items described in G.S. 131E-282(b) shall be admitted, except as follows:

(1) For intangible assets, if at least the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to

ten percent (10%) of the minimum net worth amount required; and

(2) Deferred acquisition costs shall not be admitted.

(d) The Department may lower the minimum ongoing net worth threshold, and the amount held in cash or cash equivalents for PSOs that operate primarily in rural areas.

(e) During the start-up phase of the PSO, the pre-break-even financial plan requirements shall apply. After the point of break-even, the financial plan requirement shall address cash needs and the financing required for the next three years.

(f) If a PSO, or the legal entity of which the PSO is a component, did not earn a net operating surplus during the most recent fiscal year, the PSO shall submit a financial plan, satisfactory to the Department, meeting all of the requirements established for the initial financial plan.

"**§ 131E-287. Reporting.**

(a) The PSO shall file with the Department financial information relating to PSO solvency standards described in this Article, according to the following schedule:

(1) On a quarterly basis until break-even; and

(2) On an annual basis after break-even, if the PSO has a net operating surplus; or

(3) On a quarterly or monthly basis, as specified by the Department, after break-even, if the PSO does not have a net operating surplus.

(b) To the extent not preempted by federal law or otherwise mandated by the Medicare program, the PSO shall annually, on or before the first day of March of each year, file in the office of the Secretary the following information for the previous calendar year:

(1) The number of and reasons for grievances received from Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every PSO shall file with the Department, as part of its annual grievance report, a certificate of compliance stating that the PSO has established and follows, for its Medicare contract, grievance procedures that comply with G.S. 131E-314.

(2) The number of Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract who terminated their enrollment with the PSO for any reason.

(3) The number of provider contracts between the PSO and network providers for the provision of covered services to Medicare

beneficiaries that were terminated and reasons for termination. This information shall include the number of providers leaving the PSO network and the number of new providers in the network. The report shall show voluntary and involuntary terminations separately.

(4) Data relating to the utilization, quality, availability, and accessibility of service. The report shall include the following:

a. Information on the PSO's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the PSO's methodology under its Medicare+Choice program for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in PSO Medicare+Choice program enrollees will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the PSO's provider network; and an evaluation of actual plan performance against performance targets.

b. The PSO's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.

c. Information on the PSO's program under its Medicare+Choice program to determine the level of provider network accessibility necessary to serve its Medicare enrollees. This information shall include the PSO's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.

2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual Medicare+Choice plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the PSO's methods and standards for determining whether in-network services are reasonably available and accessible to a Medicare enrollee for the purpose of determining whether such enrollee should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the PSO's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, Medicare+Choice plan performance, and network provider performance.

f. A summary of the PSO's utilization review program activities for the previous calendar year under its Medicare+Choice program. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of Medicare enrollees. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 131E-314.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Department.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(c) Disclosure Requirements. -- To the extent not otherwise prohibited by federal law or under the terms of the PSO's Medicare contract, each PSO shall provide the

following applicable information to Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract and bonafide prospective enrollees upon request:

(1) The evidence of coverage under the Medicare+Choice plan provided by the PSO to Medicare beneficiaries under the terms of the PSO's Medicare contract;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective enrollee. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The procedures and medically based criteria under the PSO's Medicare contract for determining whether a specified procedure, test, or treatment is experimental.

(d) Effective January 1, 1999, PSOs shall make the reports that are required under subsection (b) of this section and that have been filed with the Department available on their business premises and shall provide any Medicare beneficiary enrolled with the PSO access to them upon request, unless otherwise prohibited by federal law or under the terms of the PSO's Medicare contract.

(e) Every PSO licensed under this Article shall annually on or before the first day of March of each year, file in the office of the Secretary a sworn statement verified by at least two of the principal officers of the PSO showing its condition on the thirty-first day of December, then next preceding; which shall be in such form as the Secretary shall prescribe. In case the PSO fails to file the annual statement as herein required, the Secretary is authorized to suspend the license issued to the PSO until the statement shall be properly filed.

"§ 131E-288. Liquidity.

(a) Each PSO shall have sufficient cash flow to meet its obligations as they become due. In determining the ability of a PSO to meet this requirement, the Department shall consider the following:

(1) The timeliness of payment;

(2) The extent to which the current ratio is maintained at one to one or whether there is a change in the current ratio over a period of time; and

(3) The availability of outside financial resources.

(b) The following corresponding remedies apply:

(1) If the PSO fails to pay obligations as they become due, the Department shall require the PSO to initiate corrective action to pay all overdue obligations.

(2) The Department may require the PSO to initiate corrective action if either of the following is evident: (i) the current ratio declines significantly; or (ii) there is a continued downward trend in the current ratio. The corrective action may include a change in the distribution of assets, a reduction of liabilities, or alternative arrangements to secure additional funding requirements to restore the current ratio to one to one.

(3) If there is a change in the availability of the outside resources, the Department shall require the PSO to obtain funding from alternative financial resources.

(c) Nothing in the foregoing liquidity requirements shall be interpreted to require the PSO to maintain a current ratio of one to one if the PSO can demonstrate to the Department that it is able to pay its obligations as they become due and the current ratio maintained by the PSO has neither declined significantly nor is on a continued downward trend.

"§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.

(a) Except as otherwise provided in subsection (b) of this section, each PSO shall, on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of the greater of:

(1) Seven hundred fifty thousand dollars ($750,000) cash or cash equivalents; or

(2) Forty percent (40%) of the minimum net worth required.

(b) The Department may lower the threshold for minimum net worth held in cash or cash equivalents by PSOs that operate primarily in rural areas.

(c) Cash or cash equivalents held to meet the net worth requirement shall be current assets of the PSO.

"§ 131E-290. Prohibited practice.

(a) No provider sponsored organization or sponsoring provider, unless licensed as an insurer under Chapter 58 of the General Statutes may use in its name, contracts, or literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

(b) No provider sponsored organization or sponsoring provider shall engage in any activity or conduct which is prohibited by the terms of the PSO's Medicare contract.

(c) Unless otherwise preempted by federal law or mandated by the Medicare program, a PSO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of that license or certification. This subsection does not preclude a PSO from including providers

only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

"§ 131E-291. Collaboration with local health departments.

A provider sponsored organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health.

"§ 131E-292. Coverage.

(a) Provider sponsored organizations subject to this Article shall provide coverage for the medically appropriate and necessary services specified under the PSO's Medicare contract.

(b) In the event a PSO's Medicare contract or federal law, regulations, or rules governing coverage by the PSO of items or services to Medicare beneficiaries permits a PSO, sponsoring provider, or participating provider to object on moral or religious grounds to providing an item or service to Medicare beneficiaries, it is the policy of this State to permit this objection and allow the participating provider to refuse to provide the item or service.

"§ 131E-293. Rates.

Rates charged by provider sponsored organizations to the Medicare program and charges by PSOs and sponsoring providers for items or services to beneficiaries shall be governed by the terms of the PSO's Medicare contract.

"§ 131E-294. Consumer protection and quality standards.

(a) Unless otherwise preempted by federal law or mandated by the Medicare program, the Department shall apply to provider sponsored organizations the same standards and requirements that the Department of Insurance applies to health maintenance organizations under Chapter 58 of the General Statutes with respect to the following consumer protection and quality matters:

(1) Quality management programs (11 NCAC 20.0500, et seq.);
(2) Utilization review procedures (G.S. 58-67-61 and G.S. 58-67-62);
(3) Unfair or deceptive trade practices (Article 63 of Chapter 58 of the General Statutes);
(4) Antidiscrimination (G.S. 58-3-25(b) and (c), 58-3-120; 58-63-15(7), and 58-67-75);
(5) Provider accessibility and availability (11 NCAC 20.0300, et seq.);
(6) Network provider credentialing (11 NCAC 20.0400, et seq.); and
(7) Data reporting requirements under G.S. 58-67-50(e).

"§ 131E-295. Powers of insurers and medical service corporations.

Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 67 of Chapter 58 of the General Statutes, an insurer or a hospital or medical service corporation may contract with a provider sponsored organization to provide insurance or similar protection against the cost of care provided through provider sponsored organizations and their sponsoring providers to beneficiaries and to provide coverage in the event of the failure of the provider sponsored organization or its sponsoring providers to meet its

obligations under the PSO's Medicare contract. The beneficiaries of a provider sponsored organization constitute a permissible group under these laws. Among other things, under these contracts, the insurer or hospital or medical service corporation may make benefit payments to provider sponsored organizations for health care services rendered by providers pursuant to the health care plan.

"**§ 131E-296. Examinations.**

The Department may make an examination of the affairs of any provider sponsored organization and the contracts, agreements, or other arrangements pursuant to its health care plan as often as the Department considers necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

"**§ 131E-297. Hazardous financial condition.**

(a) Whenever the financial condition of any provider sponsored organization indicates a condition such that the continued operation of the provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, then the Department may order the provider sponsored organization to take any action that may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

(1) To reduce the total amount of present and potential liability for benefits by reinsurance;

(2) To reduce the volume of new business being accepted;

(3) To reduce the expenses by specified methods;

(4) To suspend or limit the writing of new business for a period of time;

(5) To require an increase to the provider sponsored organization's net worth by contribution;

(6) To add or delete sponsoring providers;

(7) To increase the amount of payments from the PSO which sponsoring providers agree to forego; or

(8) To require additional guaranties from sponsoring providers or from parents of sponsoring providers.

(b) If the Department determines that the standards in G.S. 131E-286, 131E-288, and 131E-289 do not provide sufficient early warning that the continued operation of any provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, the Department may adopt rules to set uniform standards and criteria for such an early warning and to set standards for evaluating the financial condition of any provider sponsored organization, which standards shall be consistent with the purposes expressed in subsection (a) of this section.

"**§ 131E-298. Protection against insolvency.**

(a) The Department shall require deposits in accordance with the provisions of G.S. 131E-285.

(b) If a provider sponsored organization fails to comply with the net worth requirements of G.S. 131E-286, the Department may take appropriate action to assure

that the continued operation of the provider sponsored organization will not be hazardous to the beneficiaries enrolled with the PSO.

(c) Every provider sponsored organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Department. In determining the adequacy of such a plan, the Department shall consider:

(1) A reinsurance agreement preapproved by the Department covering excess loss, stop-loss, or catastrophies. The agreement shall provide that the Department will be notified no less than 60 days prior to cancellation or reduction of coverage;

(2) A conversion policy or policies that will be offered by an insurer to the beneficiaries in the event of the provider sponsored organization's insolvency;

(3) Legally binding unconditional guaranties by adequately capitalized sponsoring provider or adequately capitalized sponsoring corporations of sponsoring providers;

(4) Legally binding obligations of sponsoring providers to forego payment for items or services provided by the sponsoring provider in order to avoid the financial insolvency of the PSO;

(5) Legally binding obligations of sponsoring providers or parents of sponsoring providers to make capital infusions to the PSO; and

(6) Any other arrangements offering protection against insolvency that the Department may require.

"§ 131E-299. Hold harmless agreements or special deposit.

(a) Unless the PSO maintains a special deposit in accordance with subsection (b) of this section, each contract between every PSO and a participating provider of health care services shall be in writing and shall set forth that in the event the PSO fails to pay for health care services as set forth in the contract, the Medicare subscriber or beneficiary shall not be liable to the provider for any sums owed by the PSO. No other provisions of these contracts shall, under any circumstances, change the effect of this provision. No participating provider or agent, trustee, or assignee thereof may maintain any action at law against a subscriber or beneficiary to collect sums owed by the PSO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the PSO shall maintain a special deposit in cash or cash equivalent as follows:

(1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures the PSO shall either:

a. Place an uncovered expenditures insolvency deposit with the Department, or with any organization or trustee acceptable to the Department through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Department. This deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the PSO's outstanding liability for

uncovered expenditures for enrollees, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a PSO is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section; or

b. Maintain adequate insurance or a guaranty arrangement approved in writing by the Department, to pay for any loss to beneficiaries claiming reimbursement due to the insolvency of the PSO. The Department shall approve a guaranty arrangement if the guarantying organization is a sponsoring provider, has been operating for at least 10 years and has a net worth, including organization-related land, buildings, and equipment of at least fifty million dollars ($50,000,000), unless the Department finds that the approval of this guaranty may be financially hazardous to beneficiaries.

(2) The deposit required under sub-subdivision a. of subdivision (1) of this subsection is an admitted asset of the PSO in the determination of net worth. All income from these deposits or trust accounts shall be assets of the PSO and may be withdrawn from the deposit or account quarterly with the approval of the Department;

(3) A PSO that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this subsection is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the Department;

(4) The deposit required under sub-subdivision a. of subdivision (1) of this section is in trust and may be used only as provided under this section. The Department may use the deposit of an insolvent PSO for administrative costs associated with administering the deposit and payment of claims of enrollees of the PSO.

(c) Whenever the reimbursements described in this section exceed ten percent (10%) of the PSO's total costs for health care services over the immediately preceding six months, the PSO shall file a written report with the Department containing the information necessary to determine compliance with sub-subdivision a. of subdivision (1) of subsection (b) of this section no later than 30 business days from the first day of the month. Upon an adequate showing by the PSO that the requirements of this section should be waived or reduced, the Department may waive

or reduce these requirements to an amount it deems sufficient to protect beneficiaries of the PSO consistent with the intent and purpose of this Article.

"§ 131E-300. Continuation of benefits.

The Department shall require that each PSO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to beneficiaries who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Department may require:

(1) Insurance to cover the expenses to be paid for benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PSO's insolvency for which premium payment has been made and until the beneficiaries' discharge from inpatient facilities;

(3) Insolvency reserves as the Department may require;

(4) Letters of credit acceptable to the Department;

(5) Additional guaranties from a sponsoring provider of the PSO or from the parent of a sponsoring provider;

(6) Legally binding obligations of sponsoring providers to forego payment from the PSO for services provided to beneficiaries in order to avoid the insolvency of the PSO; and

(7) Any other arrangements to assure that benefits are continued as specified.

"§ 131E-301. Insolvency.

(a) In the event of an insolvency of a PSO upon order of the Department, all providers that were sponsoring providers of the PSO within the previous 12 months from the order of the Department shall, for 30 days after the order, offer all beneficiaries enrolled with the insolvent PSO covered services without charge other than for any applicable co-payments, deductibles, or coinsurance permitted to be charged to beneficiaries under the PSO's Medicare contract.

(b) If the Department determines that the sponsoring providers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the beneficiaries of the insolvent PSO, then, in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall allocate the insolvent PSO's contracts for these groups among all other PSOs that operate within a portion of the insolvent PSO's service area, taking into consideration the health care delivery resources of each PSO. Each PSO to which beneficiaries are so allocated by the Department shall offer such group or groups that PSO's existing coverage that is most similar to each beneficiary's coverage with the insolvent PSO at rates determined in accordance with the successor PSO's existing rating methodology.

(c) Taking into consideration the health care delivery resources of each such PSO, then in the event the Health Care Financing Administration of the U.S. Department

of Health and Human Services fails to make such allocations in a timely manner, the Department shall also allocate among all PSOs that operate within a portion of the insolvent PSO's service area the insolvent PSO's beneficiaries who are unable to obtain other coverage. Each PSO to which beneficiaries are so allocated by the Department shall offer such beneficiaries that PSO's existing coverage for individual or conversion coverage as determined by the beneficiary's type of coverage in the insolvent PSO at rates determined in accordance with the successor PSO's Medicare contract.

"§ 131E-302. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior PSO contract or policy providing these hospital, medical, or surgical expense or service benefits, shall immediately cover all beneficiaries who were validly covered under the previous PSO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those beneficiaries validly covered under the prior carrier's contract on the date of discontinuance.

"§ 131E-303. Incurred but not reported claims.

(a) Every PSO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such PSO is or may be liable; and to provide for the expense of adjustment or settlement of such claims.

(b) These liabilities shall be computed in accordance with rules adopted by the Department upon reasonable consideration of the ascertained experience and character of the PSO.

"§ 131E-304. Suspension or revocation of license.

(a) The Department may suspend, revoke, or refuse to renew a PSO license if the Department finds that the PSO:

(1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 131E-280, unless amendments to these submissions have been filed with and approved by the Department;

(2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with Medicare or Medicaid program requirements as applicable;

(3) No longer maintains the financial reserve specified in G.S. 131E-286 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to beneficiaries or prospective beneficiaries;

(4) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the PSO or with any order issued by the Department after notice and opportunity for a hearing;

(5) Has knowingly made to the Department any false statement or report;

(6) Has sponsoring providers that fail to provide a substantial proportion of the services under any health plan during any 12-month period;

(7) Has itself or through any person on its behalf advertised or merchandised its items or services in an untrue, misrepresentative, misleading, or unfair manner;

(8) If continuing to operate would be hazardous to beneficiaries; or

(9) Has otherwise substantially failed to comply with this Article.

(b) A license shall be suspended or revoked only after compliance with G.S. 131E-305.

(c) When a PSO license is suspended, the PSO shall not, during the suspension, enroll any additional beneficiaries and shall not engage in any advertising or solicitation.

(d) When a PSO license is revoked, the PSO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the PSO. The PSO shall engage in no advertising or solicitation. The Department may, by written order, permit any further operation of the PSO that the Department may find to be in the best interest of beneficiaries, to the end that beneficiaries will be afforded the greatest practical opportunity to obtain continuing health care coverage.

"§ 131E-305. Administrative procedures.

(a) When the Department has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, it shall notify the provider sponsored organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

(b) After this hearing, or upon the failure of the provider sponsored organization to appear at this hearing, the Department shall take the action it considers advisable or make written findings that shall be mailed to the provider sponsored organization. The action of the Department shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Department in whole or in part.

(c) The provisions of Chapter 150B of the General Statutes apply to proceedings under this section to the extent that they are not in conflict with subsections (a) and (b) of this section.

"**§ 131E-306. Department of Insurance.**

At the request of the Department, the Department of Insurance may evaluate a PSO's compliance with any or all of the solvency requirements set forth in this Article. Upon this request, the Department of Insurance shall undertake the evaluation in accordance with this Article and regulations adopted pursuant to it and shall report its evaluation to the Department in a timely manner. The Department of Insurance may collect from the applicant or PSO subject to the evaluation a fee not to exceed the fee that the Department of Insurance would be entitled to impose on a health maintenance organization for undergoing a similar evaluation. Nothing in this section limits the Department's final authority to license PSOs in accordance with this Article.

"**§ 131E-307. Penalties and enforcement.**

(a) The provisions of G.S. 58-2-70, modified to replace the word 'Commissioner' by the word 'Department', applies to this Article. The Department may, in addition to or in lieu of suspending or revoking a license under G.S. 131E-304, proceed under G.S. 58-2-70, as so modified, provided that the provider sponsored organization has a reasonable time within which to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Any person who violates this Article shall be guilty of a Class 1 misdemeanor.

(c) If the Department shall for any reason have cause to believe that any violation of this Article has occurred or is threatened, the Department may give notice to the provider sponsored organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Department may deem appropriate under the circumstances.

(d) The Department may issue an order directing a provider sponsored organization or a representative of a provider sponsored organization to cease and desist from engaging in any act or practice in violation of the provisions of this Article.

Within 30 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Article have occurred. These hearings shall be conducted pursuant to Chapter 150B of the General Statutes, and judicial review shall be available as provided by this Chapter.

(e) In the case of any violation of the provisions of this Article, if the Department elects not to issue a cease and desist order, or in the event of noncompliance with a

cease and desist order issued pursuant to subsection (d) of this section, the Department may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County.

"§ 131E-308. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this Article, provisions of the insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any provider sponsored organization granted a license under this Article or to its sponsoring providers when operating under such a license. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its provider sponsored organization activities authorized and regulated pursuant to this Article.

(b) Solicitation of beneficiaries by a provider sponsored organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals or health care providers.

(c) Any provider sponsored organization licensed under this Article shall not be considered to be a provider of medicine or dentistry and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine and dentistry; provided, however, that this exemption does not apply to individual providers under contract with or employed by the provider sponsored organization or sponsoring providers or to the sponsoring providers.

(d) Except as otherwise limited by this Article, a PSO may organize in the same manner and may exercise the same prerogatives, powers and privileges as other entities that are organized and existing under the same laws as the PSO.

"§ 131E-309. Filings and reports as public documents.

Except for information that constitutes a bona fide trade secret, proprietary information or competitively sensitive information of a sponsoring provider or parent of a sponsoring provider, all applications, filings, and reports required under this Article shall be treated as public documents.

"§ 131E-310. Confidentiality of medical information.

Any data or information pertaining to the diagnosis, treatment, or health of any beneficiary or applicant obtained from the person or from any provider by any provider sponsored organization or by any provider acting pursuant to its provider contract with a provider sponsored organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Article; or upon the express consent of the beneficiary or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the provider sponsored organization wherein such data or information is pertinent. A provider sponsored organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the provider sponsored organization is entitled to claim.

"§ 131E-311. Conflicts; severability.

To the extent that the provisions of this Article may be in conflict with any other provision of this Chapter, the provisions of this Article shall prevail and apply with respect to provider sponsored organizations. Notwithstanding the absence of adopted rules, the Department shall continue to process applications for provider sponsored organization licenses as described in this Article. If any section, term, or provision of this Article shall be adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Article, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"**§ 131E-312. Regulations.**

This Article shall be self-implementing. No later than six months after the date of enactment of this Article, the Department may adopt rules consistent with this Article to authorize and regulate provider sponsored organizations to contract directly with the federal Medicare program to provide health care services to the beneficiaries of such programs. The Department shall issue permanent rules and, may issue temporary rules, to the extent these rules may be necessary. The Department shall limit its regulation of provider sponsored organizations to the licensing and regulating of these organizations as risk bearing entities contracting directly with the Medicare program and to the consumer protection and quality standards as provided in G.S. 131E-294, and shall not regulate any matters described in 42 U.S.C. § 1395W-26(b)(3), or any successor thereof.

"**§ 131E-313. Utilization review and grievances.**

Unless otherwise preempted by federal law or mandated by the Medicare program, the provisions of G.S. 58-50-61 and G.S. 58-50-62 apply to a PSO licensed under this Article as if the PSO was an 'insurer' under those sections, except that the Department rather than the Commissioner of Insurance shall regulate a PSO's compliance with those sections."

Section 2. G.S. 58-67-10(b) reads as rewritten:

"(b) (1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, a provider sponsored organization or other organization certified, qualified, or otherwise approved by the Department of Health and Human Services pursuant to Article 17 of Chapter 131E of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

(4) Except as provided in paragraphs (1), (2), (3), and (3a) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article."

Section 3. G.S. 90-21.22A reads as rewritten:

"**§ 90-21.22A. Medical review committees.**

(a) As used in this section, "medical review committee" means a committee composed of health care providers licensed under this Chapter that is formed for the purpose of evaluating the quality of, cost of, or necessity for health care services, including provider credentialing. "Medical review committee" does not mean a medical review committee established under G.S. 131E-95.

(b) A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(c) The proceedings of a medical review committee, the records and materials it produces, and the materials it considers shall be confidential and not considered public records within the meaning of ~~G.S. 132-1~~ G.S. 132-1, 131E-309, or ~~G.S.~~ 58-2-100; and shall not be subject to discovery or introduction into evidence in any civil action against a provider of health care services who directly provides services and is licensed under this ~~Chapter or~~ Chapter, a PSO licensed under Article 17 of Chapter 131E of the General Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General Statutes or that is owned or operated by the State, which civil action results from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not

immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. A member of the committee may testify in a civil action but cannot be asked about his or her testimony before the committee or any opinions formed as a result of the committee hearings.

(d) This section applies to a medical review committee, including a medical review committee appointed by one of the entities licensed under Articles 1 through 67 of Chapter 58 of the General Statutes.

(e) Subsection (c) of this section does not apply to proceedings initiated under ~~G.S. 58-50-61 or G.S. 58-50-62.~~ G.S. 58-50-61, 58-50-62, or 131E-313."

Section 3.1. Nothing in this act shall obligate the General Assembly to appropriate funds to implement this act.

Section 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 1455*
Proposed Committee Substitute H1455-PCS8355-RN

Short Title: PSO Medicare Licensing. (Public)

Sponsors:

Referred to:

May 25, 1998

A BILL TO BE ENTITLED

AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING.

The General Assembly of North Carolina enacts:

Section 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"ARTICLE 17.

"Provider Sponsored Organization Licensing.

"**§ 131E-275. General provisions.**

(a) The General Assembly acknowledges that section 1855, et seq., of the federal Social Security Act permits provider sponsored organizations that are organized and licensed under State law as risk-bearing entities, or that are otherwise certified as such by the federal government, to be eligible to offer Medicare health insurance or health benefits coverage in each state in which the provider sponsored organization offers a Medicare+Choice plan. The General Assembly declares that provider sponsored organizations are beneficial to North Carolina citizens who are Medicare beneficiaries and should be encouraged, subject to appropriate regulation by the Department of Health and Human Services. The General Assembly further declares that, because provider sponsored organizations provide health care directly and assume responsibility for the provision of health care services to Medicare beneficiaries under the requirements of the federal Medicare program, they require different regulatory oversight to protect the public than health maintenance organizations and insurance companies. The General Assembly further declares that

the organizers and operators of provider sponsored organizations which are licensed under the terms of this Article as risk-bearing entities authorized to contract directly with the federal Medicare+Choice program shall not be subject to Chapter 58 of the General Statutes or the insurance laws of this State, unless otherwise specified in this Article.

It is the intent of the General Assembly to encourage innovative methods by which sponsoring providers can directly or indirectly share substantial financial risk in the PSO in any lawful manner.

(b) As set forth in this Article, the Department of Health and Human Services shall be the agency of the State authorized to license provider sponsored organizations to contract with Medicare to provide health care services to Medicare beneficiaries and to engage in the other related activities described in this Article.

(c) Each provider sponsored organization shall obtain a license from the Department or shall otherwise be certified by the federal government prior to establishing, maintaining, and operating a health care plan in this State for Medicare+Choice beneficiaries.

"**§ 131E-276. Definitions.**

As used in this Article, unless the context clearly implies otherwise, the following definitions apply:

(1) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries of the Medicare+Choice program who are enrolled with the provider sponsored organization (PSO) under the terms of a contract between the PSO and the Medicare program.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina.

(3) 'Current assets' means cash, marketable securities, accounts receivable, and other current items that will be converted into cash within 12 months.

(4) 'Current liabilities' means accounts payable and other accrued liabilities, including payroll, claims, and taxes that will need to be paid within 12 months.

(5) 'Current ratio' means the ratio of current assets divided by current liabilities calculated at the end of any accounting period.

(6) 'Department' means the Department of Health and Human Services.

(7) 'Emergency services' shall have the same meaning as for that term defined in G.S. 58-50-61(a)(5).

(8) 'Health care delivery assets' means any tangible asset that is part of a PSO operation, including hospitals, medical facilities, and their ancillary equipment, and any property that may reasonably be required for the PSO's principal office or for any purposes that may be necessary in the transaction of the business of the PSO.

(9) 'Health plan contract' or 'Medicare contract' means a PSO's direct contract with the United States Department of Health and Human Services under section 1857 of the federal Social Security Act.

(10) 'Out-of-network services' means health care items or services that are covered services under a PSO's Medicare contract and that are provided to beneficiaries by health care providers that are not participating providers in the PSO's network of health care providers.

(11) 'Parent of a sponsoring provider' means the public or private entity that owns or controls a controlling interest in the sponsoring provider or that has the power to appoint a controlling number of the governing board of a sponsoring provider or that has the power to direct the management policy and decisions of the sponsoring provider.

(12) 'Provider' or 'health care provider' means: (i) any individual that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; (ii) any entity that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; or (iii) any entity that is owned or controlled entirely by individuals or entities described in subparts (i) or (ii) of this definition.

(13) 'Provider sponsored organization' or 'PSO' means a public or private entity domiciled in this State, including a business corporation, a nonprofit corporation, a partnership, a limited liability company, a professional limited liability company, a professional corporation, a sole proprietorship, a public hospital, a hospital authority, a hospital district, or a body politic: (i) that is established, organized, and operated by sponsoring providers; (ii) in which physicians licensed pursuant to Article 1 of Chapter 90 of the General Statutes or to the laws of any state of the United States comprise no less than fifty percent (50%) of the governing board or body, unless otherwise prohibited by law; and (iii) that provides a substantial proportion of the services under each Medicare contract directly through the sponsoring provider. The requirement in subpart (ii) of this definition shall not preclude a PSO that includes a tax-exempt hospital from adopting a bylaw provision that provides a veto for the tax-exempt hospital over actions of the PSO necessary to maintain the hospital's tax-exempt status. A PSO shall not be out of compliance with the requirement in subpart (ii) due to temporary vacancies on its governing board or body.

(14) 'Secretary' means the Secretary of the Department of Health and Human Services.

(15) 'Sponsoring providers' of a PSO means the health care provider domiciled in this State that assumes, or group of affiliated health care providers that directly or indirectly shares, substantial financial risk in the PSO and that has at least a majority financial interest in the PSO.

(16) 'Substantial proportion of the services' means at least seventy percent (70%), or sixty percent (60%) for PSOs whose beneficiaries reside primarily in rural areas, of the annual health care expenditures.

(17) A health care provider is affiliated with another provider if through contract, ownership, or otherwise, when: (i) one provider directly controls, is controlled by, or is under common control with the other provider; (ii) each provider participates in a lawful combination under which they share substantial financial risk for the organization's operation; (iii) both providers are part of a controlled group of corporations as defined under section 1563 of the Internal Revenue Code of 1986; or (iv) both providers are part of an affiliated service group under section 414 of this Code. Control is presumed if one party directly or indirectly owns, controls, or holds the power to vote, or proxies for, at least fifty-one percent (51%) of the voting or governance rights of another.

"§ 131E-277. Direct or indirect sharing of substantial financial risk.

In order for sponsoring providers to directly or indirectly share substantial financial risk in the PSO, the PSO shall do one or more of the following:

(1) Provide services under its Medicare contract at a capitated rate;

(2) Provide designated services or classes of services under its Medicare contract for a predetermined percentage of premium or revenue from the Medicare program;

(3) Use significant financial incentives for its sponsoring providers, as a group to achieve specified cost-containment and utilization management goals either by:

a. Withholding from all sponsoring providers a substantial amount of the compensation due to them, with distribution of that amount to the sponsoring providers based on performance of all sponsoring providers in meeting the cost-containment goals of the network as a whole; or

b. Establishing overall cost or utilization targets for the PSO, with the sponsoring providers subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; or

(4) Agree to provide a complex or extended course of treatment that requires the substantial coordination of care by sponsoring

providers in different specialties offering a complementary mix of services, for a fixed, predetermined payment, when the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's treatment or other factors; or

(5) Agree to any other arrangement that the Department determines to provide for the sharing of substantial financial risk by the sponsoring providers.

"**§ 131E-278. Applicability of other laws.**

Unless otherwise required by federal law, provider sponsored organizations licensed pursuant to the terms of this Article are exempt from all regulation under Chapter 58 of the General Statutes. Plan contracts, provider contracts, and other arrangements related to the provision of covered services by these licensed networks or by health care providers of these PSOs when operating through these PSOs shall likewise be exempt from regulation under Chapter 58 of the General Statutes.

"**§ 131E-279. Approval.**

(a) Unless otherwise required by federal law, the Department shall be the agency of the State that shall license provider sponsored organizations that seek to contract with the federal government to provide health care services directly to Medicare beneficiaries under the Medicare+Choice program.

(b) Provider sponsored organizations which have been granted a waiver pursuant to 42 U.S.C. § 1395w-25(a)(2) and which otherwise meet the requirements of the PSO's Medicare contract shall be deemed by the State to be licensed under this Article for so long as the waiver or Medicare contract remains in effect. The foregoing shall not limit the Department's authority to regulate such PSOs and their respective sponsoring providers and affiliated providers as may be permitted in 42 U.S.C. § 1395w-25(a)(2)(G) or the PSO's Medicare contract.

(c) The Department shall license a PSO as a risk-bearing entity eligible to offer health benefits coverage in this State to Medicare beneficiaries if the PSO complies with the requirements of this Article. This license shall be granted or denied by the Department not longer than 90 days after the receipt of a substantially complete application for licensing. Within 45 days after the Department receives an application for licensing, the Department shall either notify the applicant that the application is substantially complete, or clearly and accurately specify in writing to the applicant all additional specific information required by the applicant to make the application a substantially completed application. This agency response shall set forth a date and time for a meeting within 30 days after it is sent to the applicant, at which a representative of the Department will explain with particularity the additional information required by the Department in the response to make the application substantially complete. The Department shall be bound by the response unless the Secretary determines that it must be modified in order to meet the purposes of this Article. The Secretary shall not delegate the authority to modify the response. If an applicant provides the additional information set forth in the response, the application shall be considered substantially complete. If the Department has not acted on an application within 90 days after it is deemed

substantially complete, the Department shall immediately issue a license to the applicant, and the applicant shall be considered to have been licensed by the Department. Any reapplication which corrects the deficiencies which were specified by the Department in the response shall be approved by the Department.

(d) For purposes of determining, under 42 U.S.C. § 1395w-25(a)(2)(B), or any successor thereof, the date of receipt by the State of a substantially complete application, the date the Department receives the applicant's written response to the agency response or an earlier date considered by the Department shall be considered to be that date. The foregoing shall not limit the Department's authority to consider an application not substantially complete under subsection (c) of this section if the applicant's response to the response does not provide substantially the information specified in the response.

(e) A license shall be denied only after the Department complies with the requirements of G.S. 131E-305.

"**§ 131E-280. Applicants for license.**

Each application for licensing as a provider sponsored organization authorized to do business in North Carolina shall be certified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Department, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant and each sponsoring organization that holds greater than a five percent (5%) interest in the PSO, such as the articles of incorporation, articles of organization, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the respective bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant and each sponsoring provider which holds greater than a five percent (5%) interest in the PSO;

(3) Copies of the document evidencing the arrangements between the applicant and each sponsoring provider that create the relationships and obligations described in G.S. 131E-276(17);

(4) A list of the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant and of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO, respectively, including all members of the respective boards of directors, boards of trustees, executive committees, or other governing boards or committees, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(5) A copy of any contract form made or to be made between any class of providers and the PSO and a copy of any contract form made or to be made between third-party administrators, marketing

consultants, or persons listed in subdivision (3) of this subsection and the PSO;

(6) A statement generally describing the provider sponsored organization, its sponsoring providers, its health care plan or plans, facilities, and personnel;

(7) A copy of the hospital license of each sponsoring provider that is a hospital, a copy of the license to practice medicine of each sponsoring provider or owner of a sponsoring provider that is a licensed physician, and a copy of the health care service or facility license held by any other licensed sponsoring provider;

(8) Financial statements showing the applicant's assets, liabilities, sources of financial support, and the financial statements of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO showing the sponsoring provider's assets, liabilities, and sources of support. If the applicant's or any such sponsoring provider's financial affairs are audited by independent certified public accountants, a copy of the applicant's or sponsoring provider's most recent regular certified financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article;

(9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-297, 131E-298, and 131E-299 are guaranteed by one or more guarantors:

a. Documentation that each guarantor meets the following requirements:

1. The guarantor is a legal entity authorized to conduct business in North Carolina.

2. The guarantor is not under federal bankruptcy or State receivership or rehabilitation proceedings.

3. The guarantor has a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the PSO's guarantee.

b. Financial statements showing each guarantor's assets, liabilities, and source of financial support.

c. If a guarantor's financial affairs are audited by independent certified public accountants, a copy of the guarantor's most recent regular audited financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article.

d. The guarantee document, including a statement of the financial obligation covered by the guarantee, an agreement

to unconditionally fulfill the financial obligations covered by the guarantee, an agreement not to subordinate the guarantee to any other claim on the resources of the guarantor and a declaration that the guarantor must act on a timely basis to satisfy the financial obligations covered by the guarantee;

(10) A financial plan, satisfactory to the Department, covering the first 12 months of operation under the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the financial plan projects losses, the financial plan must cover the period through 12 months beyond the projected breakeven;

(11) A statement reasonably describing the geographic area or areas to be served;

(12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 131E-298; and

(13) Any other information the Department may require to make the determinations required in G.S. 131E-282.

"§ 131E-281. Additional information.

(a) In addition to the information filed under G.S. 131E-280, each application shall include a description of the following:

(1) The program to be used to evaluate whether the applicant's network of sponsoring providers and contracted providers is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay;

(2) The program used to evaluate whether the sponsoring providers provide a substantial portion of services under each Medicare contract of the PSO;

(3) The program to be used for verifying provider credentials;

(4) The utilization review program for the review and control of health care services provided or paid for by the applicant;

(5) The quality management program to assure quality of care and health care services managed and provided through the health care plan; and

(6) The applicant's network of sponsoring providers and contracted providers and evidence of the ability of that network to provide all health care services other than out-of-network services and emergency services to the applicant's prospective beneficiaries.

(b) The Department may promulgate rules and regulations exempting from the filing requirements of subsection (a) of this section those items it deems unnecessary.

"§ 131E-282. Issuance of license.

(a) Before issuing a PSO license, the Department may make an examination or investigation as it deems expedient. The Department shall issue a license after receipt of a substantially complete application and upon satisfaction of the following requirements:

(1) The applicant is duly organized as a provider sponsored organization as defined by this Article.

(2) The PSO has initially a minimum net worth of one million five hundred thousand dollars ($1,500,000). In the event the PSO submits a financial plan that demonstrates that the PSO does not have to create but has or has available to it an administrative infrastructure that shall reduce the PSO's start-up costs, the Department may lower the initial minimum net worth required to one million dollars ($1,000,000) or to any lower amount as determined by the Department if the PSO operates primarily in rural areas.

(3) The PSO shall have at least seven hundred fifty thousand dollars ($750,000) in cash or equivalents on its balance sheet, except that the Department may permit a PSO operating primarily in rural areas to have a lesser amount held in cash or equivalents on its balance sheets.

(4) The applicant submits a financial plan satisfactory to the Department which covers the first 12 months of operation of the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the plan projects losses, the financial plan shall cover the period through 12 months beyond projected breakeven.

(5) The Department determines that the applicant has sufficient cash flow to meet its obligations as they become due. In making that determination, the Department shall consider the following:

a. The timeliness of payment;

b. The extent to which the current ratio is maintained at one to one, or whether there is a change in the current ratio over a period of time; and

c. The availability of outside financial resources.

(b) In calculating the net worth of a PSO, the Department shall admit the following:

(1) One hundred percent (100%) of the book value of health care delivery assets on the balance sheet of the applicant.

(2) One hundred percent (100%) of the value of cash and cash equivalents on the balance sheet of the applicant.

(3) If at least one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents, then one hundred percent (100%) of the book value of the PSO's intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents or if the Department has used its discretion to reduce the initial net worth requirement below one million five hundred thousand dollars ($1,500,000), then the Department shall admit one

hundred percent (100%) of the book value of intangible assets of the PSO up to ten percent (10%) of the minimum net worth amount required.

(4) Standard accounting principles treatment shall be given to other assets of the PSO not used in the delivery of health care for the purposes of meeting the minimum net worth requirement.

(5) Deferred acquisition costs shall not be admitted.

"**§ 131E-283. Financial plan.**

(a) The financial plan shall include the following:

(1) A detailed marketing plan;

(2) Statements of revenue and expense on an accrual basis;

(3) Cash flow statements;

(4) Balance sheets; and

(5) The assumptions and justifications in support of the financial plan.

(b) In the financial plan, the PSO shall demonstrate that it has the resources available to meet the projected losses for the entire period to breakeven. Except for the use of guaranties as provided in subsection (c) of this section, letters of credit as provided in subsection (e) of this section, and other means as provided in subsection (f) of this section, the resources must be assets on the balance sheet of the PSO in a form that is either cash or convertible to cash in a timely manner, pursuant to the financial plan.

(c) Guaranties shall be acceptable as a resource to meet projected losses, under the following conditions:

(1) For the first year of the PSO's operation of the PSO's Medicare contract, the guarantor must provide the PSO with cash or cash equivalents to fund the projected losses, as follows:

a. Prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;

b. Prior to the beginning of the second quarter, in the amount of the projected losses through the end of the third quarter; and

c. Prior to the beginning of the third quarter, in the amount of the projected losses through the end of the fourth quarter.

(2) If the guarantor provides the cash or cash equivalents to the PSO in a timely manner on the above schedule, this funding shall be considered in compliance with the guarantor's commitment to the PSO. In the third quarter, the PSO shall notify the Department if the PSO intends to reduce the period of funding of projected losses. The Department shall notify the PSO within 60 days of receiving the PSO's notice if the reduction is not acceptable.

(3) If the above guaranty requirements are not met, the Department may take appropriate action, such as requiring funding of projected losses through means other than a guaranty. The Department retains discretion which shall be reasonably exercised to require

other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(d) The Department may modify the conditions in subsection (c) of this section in order to clarify the acceptability of guaranty arrangements.

(e) An irrevocable, clean, unconditional letter of credit may be used as an acceptable resource to fund projected losses in place of cash or cash equivalents if satisfactory to the Department.

(f) If approved by the Department, based on appropriate standards promulgated by the Department, PSOs may use the following to fund projected losses for periods after the first year: lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability.

(g) The exceptions in subsections (c), (d), and (e) of this section may be used in an appropriate combination or sequence.

"§ 131E-284. Modifications.

(a) A provider sponsored organization shall file a notice describing any significant change in the information required by the Department under G.S. 131E-280. Such notice shall be filed with the Department prior to the change. If the Department does not disapprove within 90 days after the filing, this modification shall be considered approved. Changes subject to the terms of this section include expansion of service area, addition or deletion of sponsoring providers, changes in provider contract forms, and group contract forms when the distribution of risk is significantly changed, and any other changes that the Department describes in properly adopted rules. Every PSO shall report to the Department for the Department's information material changes in the network of sponsoring providers and affiliated providers of services to beneficiaries enrolled with the PSO, the addition or deletion of any Medicare contracts of the PSO or any other information the Department may require. This information shall be filed with the Department within 15 days after implementation of the reported changes. Every PSO shall file with the Department all subsequent changes in the information or forms that are required by this Article to be filed with the Department.

(b) The Department may adopt rules exempting from the filing requirements of subsection (a) of this section those items it considers unnecessary.

"§ 131E-285. Deposits.

(a) At the time of application, the Department shall require a deposit of one hundred thousand dollars ($100,000) in cash or securities or a combination thereof for all provider sponsored organizations. The deposits shall be included in the calculations of a PSO's or applicant's net worth.

(b) All deposits required by this section shall be restricted to use in the event of insolvency to help assume continuation of services or pay costs associated with receivership or liquidation.

"§ 131E-286. Ongoing financial standards - net worth.

(a) Beginning the first day of operation of the PSO and except as otherwise provided in subsection (d) of this section, every PSO shall maintain a minimum net worth equal to the greatest of the following amounts:

(1) One million dollars ($1,000,000);

(2) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Department on the first one hundred fifty million dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);

(3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the Department;

(4) An amount equal to the sum of:

a. Eight percent (8%) of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers as reported on the most recent financial statement filed with the Department; and

b. Four percent (4%) of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and

c. Zero percent (0%) of annual health care expenditures paid on a capitated basis to affiliated providers regardless of downstream arrangements from the affiliated provider.

(b) In calculating net worth, liabilities shall not include fully subordinated debt or subordinated liabilities. For purposes of this provision, subordinated liabilities are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors.

(c) In calculating net worth for purposes of this section, the items described in G.S. 131E-282(b) shall be admitted, except as follows:

(1) For intangible assets, if at least the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to ten percent (10%) of the minimum net worth amount required; and

(2) Deferred acquisition costs shall not be admitted.

(d) The Department may lower the minimum ongoing net worth threshold, and the amount held in cash or cash equivalents for PSOs that operate primarily in rural areas.

(e) During the start-up phase of the PSO, the pre-break-even financial plan requirements shall apply. After the point of break-even, the financial plan requirement shall address cash needs and the financing required for the next three years.

(f) If a PSO, or the legal entity of which the PSO is a component, did not earn a net operating surplus during the most recent fiscal year, the PSO shall submit a financial plan, satisfactory to the Department, meeting all of the requirements established for the initial financial plan.

"**§ 131E-287. Reporting.**

(a) The PSO shall file with the Department financial information relating to PSO solvency standards described in this Article, according to the following schedule:

(1) On a quarterly basis until break-even; and

(2) On an annual basis after break-even, if the PSO has a net operating surplus; or

(3) On a quarterly or monthly basis, as specified by the Department, after break-even, if the PSO does not have a net operating surplus.

(b) To the extent not preempted by federal law or otherwise mandated by the Medicare program, the PSO shall annually, on or before the first day of March of each year, file in the office of the Secretary the following information for the previous calendar year:

(1) The number of and reasons for grievances received from Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every PSO shall file with the Department, as part of its annual grievance report, a certificate of compliance stating that the PSO has established and follows, for its Medicare contract, grievance procedures that comply with G.S. 131E-314.

(2) The number of Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract who terminated their enrollment with the PSO for any reason.

(3) The number of provider contracts between the PSO and network providers for the provision of covered services to Medicare beneficiaries that were terminated and reasons for termination. This information shall include the number of providers leaving the PSO network and the number of new providers in the network.

The report shall show voluntary and involuntary terminations separately.

(4) Data relating to the utilization, quality, availability, and accessibility of service. The report shall include the following:

a. Information on the PSO's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the PSO's methodology under its Medicare+Choice program for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in PSO Medicare+Choice program enrollees will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the PSO's provider network; and an evaluation of actual plan performance against performance targets.

b. The PSO's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.

c. Information on the PSO's program under its Medicare+Choice program to determine the level of provider network accessibility necessary to serve its Medicare enrollees. This information shall include the PSO's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.

2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual Medicare+Choice plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the PSO's methods and standards for determining whether in-network services are reasonably available and accessible to a Medicare enrollee for the purpose of determining whether such enrollee should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the PSO's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, Medicare+Choice plan performance, and network provider performance.

f. A summary of the PSO's utilization review program activities for the previous calendar year under its Medicare+Choice program. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of Medicare enrollees. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 131E-314.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Department.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(c) Disclosure Requirements. -- To the extent not otherwise prohibited by federal law or under the terms of the PSO's Medicare contract, each PSO shall provide the following applicable information to Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract and bonafide prospective enrollees upon request:

(1) The evidence of coverage under the Medicare+Choice plan provided by the PSO to Medicare beneficiaries under the terms of the PSO's Medicare contract;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective enrollee. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The procedures and medically based criteria under the PSO's Medicare contract for determining whether a specified procedure, test, or treatment is experimental.

(d) Effective January 1, 1999, PSOs shall make the reports that are required under subsection (b) of this section and that have been filed with the Department available on their business premises and shall provide any Medicare beneficiary enrolled with the PSO access to them upon request, unless otherwise prohibited by federal law or under the terms of the PSO's Medicare contract.

(e) Every PSO licensed under this Article shall annually on or before the first day of March of each year, file in the office of the Secretary a sworn statement verified by at least two of the principal officers of the PSO showing its condition on the thirty-first day of December, then next preceding; which shall be in such form as the Secretary shall prescribe. In case the PSO fails to file the annual statement as herein required, the Secretary is authorized to suspend the license issued to the PSO until the statement shall be properly filed.

"§ 131E-288. Liquidity.

(a) Each PSO shall have sufficient cash flow to meet its obligations as they become due. In determining the ability of a PSO to meet this requirement, the Department shall consider the following:

(1) The timeliness of payment;

(2) The extent to which the current ratio is maintained at one to one or whether there is a change in the current ratio over a period of time; and

(3) The availability of outside financial resources.

(b) The following corresponding remedies apply:

(1) If the PSO fails to pay obligations as they become due, the Department shall require the PSO to initiate corrective action to pay all overdue obligations.

(2) The Department may require the PSO to initiate corrective action if either of the following is evident: (i) the current ratio declines significantly; or (ii) there is a continued downward trend in the current ratio. The corrective action may include a change in the distribution of assets, a reduction of liabilities, or alternative arrangements to secure additional funding requirements to restore the current ratio to one to one.

(3) If there is a change in the availability of the outside resources, the Department shall require the PSO to obtain funding from alternative financial resources.

(c) Nothing in the foregoing liquidity requirements shall be interpreted to require the PSO to maintain a current ratio of one to one if the PSO can demonstrate to the Department that it is able to pay its obligations as they become due and the current ratio maintained by the PSO has neither declined significantly nor is on a continued downward trend.

"§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.

(a) Except as otherwise provided in subsection (b) of this section, each PSO shall, on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of the greater of:

(1) Seven hundred fifty thousand dollars ($750,000) cash or cash equivalents; or

(2) Forty percent (40%) of the minimum net worth required.

(b) The Department may lower the threshold for minimum net worth held in cash or cash equivalents by PSOs that operate primarily in rural areas.

(c) Cash or cash equivalents held to meet the net worth requirement shall be current assets of the PSO.

"§ 131E-290. Prohibited practice.

(a) No provider sponsored organization or sponsoring provider, unless licensed as an insurer under Chapter 58 of the General Statutes may use in its name, contracts, or literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

(b) No provider sponsored organization or sponsoring provider shall engage in any activity or conduct which is prohibited by the terms of the PSO's Medicare contract.

(c) Unless otherwise preempted by federal law or mandated by the Medicare program, a PSO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of that license or certification. This subsection does not preclude a PSO from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

"**§ 131E-291. Collaboration with local health departments.**

A provider sponsored organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health.

"**§ 131E-292. Coverage.**

(a) Provider sponsored organizations subject to this Article shall provide coverage for the medically appropriate and necessary services specified under the PSO's Medicare contract.

(b) In the event a PSO's Medicare contract or federal law, regulations, or rules governing coverage by the PSO of items or services to Medicare beneficiaries permits a PSO, sponsoring provider, or participating provider to object on moral or religious grounds to providing an item or service to Medicare beneficiaries, it is the policy of this State to permit this objection and allow the participating provider to refuse to provide the item or service.

"**§ 131E-293. Rates.**

Rates charged by provider sponsored organizations to the Medicare program and charges by PSOs and sponsoring providers for items or services to beneficiaries shall be governed by the terms of the PSO's Medicare contract.

"**§ 131E-294. Consumer protection and quality standards.**

(a) Unless otherwise preempted by federal law or mandated by the Medicare program, the Department shall apply to provider sponsored organizations the same standards and requirements that the Department of Insurance applies to health maintenance organizations under Chapter 58 of the General Statutes with respect to the following consumer protection and quality matters:

(1) Quality management programs (11 NCAC 20.0500, et seq.);
(2) Utilization review procedures (G.S. 58-67-61 and G.S. 58-67-62);
(3) Unfair or deceptive trade practices (Article 63 of Chapter 58 of the General Statutes);
(4) Antidiscrimination (G.S. 58-3-25(b) and (c), 58-3-120; 58-63-15(7), and 58-67-75);
(5) Provider accessibility and availability (11 NCAC 20.0300, et seq.);
(6) Network provider credentialing (11 NCAC 20.0400, et seq.); and
(7) Data reporting requirements under G.S. 58-67-50(e).

"**§ 131E-295. Powers of insurers and medical service corporations.**

Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 67 of Chapter 58 of the General Statutes, an insurer or a hospital or medical service corporation may contract with a provider sponsored organization to provide insurance or similar protection against the cost of care provided through provider sponsored organizations and their sponsoring providers to beneficiaries and to provide coverage in the event of the failure of the provider sponsored organization or its sponsoring providers to meet its obligations under the PSO's Medicare contract. The beneficiaries of a provider sponsored organization constitute a permissible group under these laws. Among other things, under these contracts, the insurer or hospital or medical service

corporation may make benefit payments to provider sponsored organizations for health care services rendered by providers pursuant to the health care plan.

"**§ 131E-296. Examinations.**

The Department may make an examination of the affairs of any provider sponsored organization and the contracts, agreements, or other arrangements pursuant to its health care plan as often as the Department considers necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

"**§ 131E-297. Hazardous financial condition.**

(a) Whenever the financial condition of any provider sponsored organization indicates a condition such that the continued operation of the provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, then the Department may order the provider sponsored organization to take any action that may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

(1) To reduce the total amount of present and potential liability for benefits by reinsurance;

(2) To reduce the volume of new business being accepted;

(3) To reduce the expenses by specified methods;

(4) To suspend or limit the writing of new business for a period of time;

(5) To require an increase to the provider sponsored organization's net worth by contribution;

(6) To add or delete sponsoring providers;

(7) To increase the amount of payments from the PSO which sponsoring providers agree to forego; or

(8) To require additional guaranties from sponsoring providers or from parents of sponsoring providers.

(b) If the Department determines that the standards in G.S. 131E-286, 131E-288, and 131E-289 do not provide sufficient early warning that the continued operation of any provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, the Department may adopt rules to set uniform standards and criteria for such an early warning and to set standards for evaluating the financial condition of any provider sponsored organization, which standards shall be consistent with the purposes expressed in subsection (a) of this section.

"**§ 131E-298. Protection against insolvency.**

(a) The Department shall require deposits in accordance with the provisions of G.S. 131E-285.

(b) If a provider sponsored organization fails to comply with the net worth requirements of G.S. 131E-286, the Department may take appropriate action to assure that the continued operation of the provider sponsored organization will not be hazardous to the beneficiaries enrolled with the PSO.

(c) Every provider sponsored organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Department. In determining the adequacy of such a plan, the Department shall consider:

(1) A reinsurance agreement preapproved by the Department covering excess loss, stop-loss, or catastrophies. The agreement shall provide that the Department will be notified no less than 60 days prior to cancellation or reduction of coverage;

(2) A conversion policy or policies that will be offered by an insurer to the beneficiaries in the event of the provider sponsored organization's insolvency;

(3) Legally binding unconditional guaranties by adequately capitalized sponsoring provider or adequately capitalized sponsoring corporations of sponsoring providers;

(4) Legally binding obligations of sponsoring providers to forego payment for items or services provided by the sponsoring provider in order to avoid the financial insolvency of the PSO;

(5) Legally binding obligations of sponsoring providers or parents of sponsoring providers to make capital infusions to the PSO; and

(6) Any other arrangements offering protection against insolvency that the Department may require.

"§ 131E-299. Hold harmless agreements or special deposit.

(a) Unless the PSO maintains a special deposit in accordance with subsection (b) of this section, each contract between every PSO and a participating provider of health care services shall be in writing and shall set forth that in the event the PSO fails to pay for health care services as set forth in the contract, the Medicare subscriber or beneficiary shall not be liable to the provider for any sums owed by the PSO. No other provisions of these contracts shall, under any circumstances, change the effect of this provision. No participating provider or agent, trustee, or assignee thereof may maintain any action at law against a subscriber or beneficiary to collect sums owed by the PSO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the PSO shall maintain a special deposit in cash or cash equivalent as follows:

(1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures the PSO shall either:

a. Place an uncovered expenditures insolvency deposit with the Department, or with any organization or trustee acceptable to the Department through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Department. This deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the PSO's outstanding liability for uncovered expenditures for enrollees, including incurred but not reported claims, and shall be calculated as of the first

day of the month and maintained for the remainder of the month. If a PSO is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section; or

b. Maintain adequate insurance or a guaranty arrangement approved in writing by the Department, to pay for any loss to beneficiaries claiming reimbursement due to the insolvency of the PSO. The Department shall approve a guaranty arrangement if the guarantying organization is a sponsoring provider, has been operating for at least 10 years and has a net worth, including organization-related land, buildings, and equipment of at least fifty million dollars ($50,000,000), unless the Department finds that the approval of this guaranty may be financially hazardous to beneficiaries.

(2) The deposit required under sub-subdivision a. of subdivision (1) of this subsection is an admitted asset of the PSO in the determination of net worth. All income from these deposits or trust accounts shall be assets of the PSO and may be withdrawn from the deposit or account quarterly with the approval of the Department;

(3) A PSO that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this subsection is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the Department;

(4) The deposit required under sub-subdivision a. of subdivision (1) of this section is in trust and may be used only as provided under this section. The Department may use the deposit of an insolvent PSO for administrative costs associated with administering the deposit and payment of claims of enrollees of the PSO.

(c) Whenever the reimbursements described in this section exceed ten percent (10%) of the PSO's total costs for health care services over the immediately preceding six months, the PSO shall file a written report with the Department containing the information necessary to determine compliance with sub-subdivision a. of subdivision (1) of subsection (b) of this section no later than 30 business days from the first day of the month. Upon an adequate showing by the PSO that the requirements of this section should be waived or reduced, the Department may waive or reduce these requirements to an amount it deems sufficient to protect beneficiaries of the PSO consistent with the intent and purpose of this Article.

"§ 131E-300. Continuation of benefits.

The Department shall require that each PSO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to beneficiaries who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Department may require:

(1) Insurance to cover the expenses to be paid for benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PSO's insolvency for which premium payment has been made and until the beneficiaries' discharge from inpatient facilities;

(3) Insolvency reserves as the Department may require;

(4) Letters of credit acceptable to the Department;

(5) Additional guaranties from a sponsoring provider of the PSO or from the parent of a sponsoring provider;

(6) Legally binding obligations of sponsoring providers to forego payment from the PSO for services provided to beneficiaries in order to avoid the insolvency of the PSO; and

(7) Any other arrangements to assure that benefits are continued as specified.

"**§ 131E-301. Insolvency.**

(a) In the event of an insolvency of a PSO upon order of the Department, all providers that were sponsoring providers of the PSO within the previous 12 months from the order of the Department shall, for 30 days after the order, offer all beneficiaries enrolled with the insolvent PSO covered services without charge other than for any applicable co-payments, deductibles, or coinsurance permitted to be charged to beneficiaries under the PSO's Medicare contract.

(b) If the Department determines that the sponsoring providers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the beneficiaries of the insolvent PSO, then, in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall allocate the insolvent PSO's contracts for these groups among all other PSOs that operate within a portion of the insolvent PSO's service area, taking into consideration the health care delivery resources of each PSO. Each PSO to which beneficiaries are so allocated by the Department shall offer such group or groups that PSO's existing coverage that is most similar to each beneficiary's coverage with the insolvent PSO at rates determined in accordance with the successor PSO's existing rating methodology.

(c) Taking into consideration the health care delivery resources of each such PSO, then in the event the Health Care Financing Administration of the U.S. Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall also allocate among all PSOs that operate within a portion of the insolvent PSO's service area the insolvent PSO's beneficiaries who are unable to

obtain other coverage. Each PSO to which beneficiaries are so allocated by the Department shall offer such beneficiaries that PSO's existing coverage for individual or conversion coverage as determined by the beneficiary's type of coverage in the insolvent PSO at rates determined in accordance with the successor PSO's Medicare contract.

"§ 131E-302. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior PSO contract or policy providing these hospital, medical, or surgical expense or service benefits, shall immediately cover all beneficiaries who were validly covered under the previous PSO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those beneficiaries validly covered under the prior carrier's contract on the date of discontinuance.

"§ 131E-303. Incurred but not reported claims.

(a) Every PSO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such PSO is or may be liable; and to provide for the expense of adjustment or settlement of such claims.

(b) These liabilities shall be computed in accordance with rules adopted by the Department upon reasonable consideration of the ascertained experience and character of the PSO.

"§ 131E-304. Suspension or revocation of license.

(a) The Department may suspend, revoke, or refuse to renew a PSO license if the Department finds that the PSO:

(1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 131E-280, unless amendments to these submissions have been filed with and approved by the Department;

(2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with Medicare or Medicaid program requirements as applicable;

(3) No longer maintains the financial reserve specified in G.S. 131E-286 or is no longer financially responsible and may reasonably be

expected to be unable to meet its obligations to beneficiaries or prospective beneficiaries;

(4) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the PSO or with any order issued by the Department after notice and opportunity for a hearing;

(5) Has knowingly made to the Department any false statement or report;

(6) Has sponsoring providers that fail to provide a substantial proportion of the services under any health plan during any 12-month period;

(7) Has itself or through any person on its behalf advertised or merchandised its items or services in an untrue, misrepresentative, misleading, or unfair manner;

(8) If continuing to operate would be hazardous to beneficiaries; or

(9) Has otherwise substantially failed to comply with this Article.

(b) A license shall be suspended or revoked only after compliance with G.S. 131E-305.

(c) When a PSO license is suspended, the PSO shall not, during the suspension, enroll any additional beneficiaries and shall not engage in any advertising or solicitation.

(d) When a PSO license is revoked, the PSO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the PSO. The PSO shall engage in no advertising or solicitation. The Department may, by written order, permit any further operation of the PSO that the Department may find to be in the best interest of beneficiaries, to the end that beneficiaries will be afforded the greatest practical opportunity to obtain continuing health care coverage.

"§ 131E-305. Administrative procedures.

(a) When the Department has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, it shall notify the provider sponsored organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

(b) After this hearing, or upon the failure of the provider sponsored organization to appear at this hearing, the Department shall take the action it considers advisable or make written findings that shall be mailed to the provider sponsored organization. The action of the Department shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Department in whole or in part.

(c) The provisions of Chapter 150B of the General Statutes apply to proceedings under this section to the extent that they are not in conflict with subsections (a) and (b) of this section.

"§ 131E-306. Department of Insurance.

At the request of the Department, the Department of Insurance shall evaluate a PSO's compliance with any or all of the solvency requirements set forth in this Article. Upon this request, the Department of Insurance shall undertake the evaluation in accordance with this Article and regulations adopted pursuant to it and shall report its evaluation to the Department in a timely manner. The Department of Insurance may collect from the applicant or PSO subject to the evaluation a fee not to exceed the fee that the Department of Insurance would be entitled to impose on a health maintenance organization for undergoing a similar evaluation. Nothing in this section limits the Department's final authority to license PSOs in accordance with this Article.

"§ 131E-307. Penalties and enforcement.

(a) The provisions of G.S. 58-2-70, modified to replace the word 'Commissioner' by the word 'Department', applies to this Article. The Department may, in addition to or in lieu of suspending or revoking a license under G.S. 131E-304, proceed under G.S. 58-2-70, as so modified, provided that the provider sponsored organization has a reasonable time within which to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Any person who violates this Article shall be guilty of a Class 1 misdemeanor.

(c) If the Department shall for any reason have cause to believe that any violation of this Article has occurred or is threatened, the Department may give notice to the provider sponsored organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Department may deem appropriate under the circumstances.

(d) The Department may issue an order directing a provider sponsored organization or a representative of a provider sponsored organization to cease and desist from engaging in any act or practice in violation of the provisions of this Article.

Within 30 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Article have occurred. These hearings shall be conducted pursuant to Chapter 150B of the General Statutes, and judicial review shall be available as provided by this Chapter.

(e) In the case of any violation of the provisions of this Article, if the Department elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the Department may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County.

"§ 131E-308. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this Article, provisions of the insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any provider sponsored organization granted a license under this Article or to its sponsoring providers when operating under such a license. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its provider sponsored organization activities authorized and regulated pursuant to this Article.

(b) Solicitation of beneficiaries by a provider sponsored organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals or health care providers.

(c) Any provider sponsored organization licensed under this Article shall not be considered to be a provider of medicine or dentistry and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine and dentistry; provided, however, that this exemption does not apply to individual providers under contract with or employed by the provider sponsored organization or sponsoring providers or to the sponsoring providers.

(d) Except as otherwise limited by this Article, a PSO may organize in the same manner and may exercise the same prerogatives, powers and privileges as other entities that are organized and existing under the same laws as the PSO.

"§ 131E-309. Filings and reports as public documents.

Except for information that constitutes a bona fide trade secret, proprietary information or competitively sensitive information of a sponsoring provider or parent of a sponsoring provider, all applications, filings, and reports required under this Article shall be treated as public documents.

"§ 131E-310. Confidentiality of medical information.

Any data or information pertaining to the diagnosis, treatment, or health of any beneficiary or applicant obtained from the person or from any provider by any provider sponsored organization or by any provider acting pursuant to its provider contract with a provider sponsored organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Article; or upon the express consent of the beneficiary or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the provider sponsored organization wherein such data or information is pertinent. A provider sponsored organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the provider sponsored organization is entitled to claim.

"§ 131E-311. Conflicts; severability.

To the extent that the provisions of this Article may be in conflict with any other provision of this Chapter, the provisions of this Article shall prevail and apply with respect to provider sponsored organizations. Notwithstanding the absence of adopted rules, the Department shall continue to process applications for provider sponsored organization licenses as described in this Article. If any section, term, or provision of

this Article shall be adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Article, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"**§ 131E-312. Regulations.**

This Article shall be self-implementing. No later than six months after the date of enactment of this Article, the Department may adopt rules consistent with this Article to authorize and regulate provider sponsored organizations to contract directly with the federal Medicare program to provide health care services to the beneficiaries of such programs. The Department shall issue permanent rules and, may issue temporary rules, to the extent these rules may be necessary. The Department shall limit its regulation of provider sponsored organizations to the licensing and regulating of these organizations as risk bearing entities contracting directly with the Medicare program and to the consumer protection and quality standards as provided in G.S. 131E-294, and shall not regulate any matters described in 42 U.S.C. § 1395W-26(b)(3), or any successor thereof.

"**§ 131E-313. Utilization review and grievances.**

Unless otherwise preempted by federal law or mandated by the Medicare program, the provisions of G.S. 58-50-61 and G.S. 58-50-62 apply to a PSO licensed under this Article as if the PSO was an 'insurer' under those sections, except that the Department rather than the Commissioner of Insurance shall regulate a PSO's compliance with those sections."

Section 2. G.S. 58-67-10(b) reads as rewritten:

"(b) (1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, a provider sponsored organization or other organization certified, qualified, or otherwise approved by the Department of

Health and Human Services pursuant to Article 17 of Chapter 131E of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

(4) Except as provided in paragraphs (1), (2), (3), and (3a) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article."

Section 3. G.S. 90-21.22A reads as rewritten:

"**§ 90-21.22A. Medical review committees.**

(a) As used in this section, "medical review committee" means a committee composed of health care providers licensed under this Chapter that is formed for the purpose of evaluating the quality of, cost of, or necessity for health care services, including provider credentialing. "Medical review committee" does not mean a medical review committee established under G.S. 131E-95.

(b) A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(c) The proceedings of a medical review committee, the records and materials it produces, and the materials it considers shall be confidential and not considered public records within the meaning of ~~G.S. 132-1~~ G.S. 132-1, 131E-309, or ~~G.S.~~ 58-2-100; and shall not be subject to discovery or introduction into evidence in any civil action against a provider of health care services who directly provides services and is licensed under this ~~Chapter or~~ Chapter, a PSO licensed under Article 17 of Chapter 131E of the General Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General Statutes or that is owned or operated by the State, which civil action results from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. A member of the committee may testify in a civil action but cannot be asked about his or her testimony before the committee or any opinions formed as a result of the committee hearings.

(d) This section applies to a medical review committee, including a medical review committee appointed by one of the entities licensed under Articles 1 through 67 of Chapter 58 of the General Statutes.

(e) Subsection (c) of this section does not apply to proceedings initiated under ~~G.S. 58-50-61 or G.S. 58-50-62.~~ G.S. 58-50-61, 58-50-62, or 131E-313."

Section 4. This act is effective when it becomes law.

REFERRAL FORM

NORTH CAROLINA HOUSE OF REPRESENTATIVES
ASSIGNMENT OF BILLS TO SUBCOMMITTEE

COMMITTEE: **INSURANCE**

CHAIRMAN: **Representative JERRY C. DOCKHAM**

DATE: **JULY 9, 1998**

Bill Number (Indicate **H** or **S**): H-1455

Short Title: A BILL TO BE INTITLED AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING

Assigned to Subcommittee on: **Health**

Re-Assigned to Subcommittee on:

Bill Number (Indicate **H** or **S**):

Short Title:

Assigned to Subcommittee on:

Re-Assigned to Subcommittee on:

Bill Number (Indicate **H** or **S**):

Short Title:

Assigned to Subcommittee on:

Re-Assigned to Subcommittee on:

Bill Number (Indicate **H** or **S**):

Short Title:

Assigned to Subcommittee on:

Re-Assigned to Subcommittee on:

Bill Number (Indicate **H** or **S**):

Short Title:

Assigned to Subcommittee on:

Re-Assigned to Subcommittee on:

Bill Number (Indicate **H** or **S**):

Short Title:

Assigned to Subcommittee on:

Re-Assigned to Subcommittee on:

Bill Number (Indicate **H** or **S**):

Short Title:

Assigned to Subcommittee on:

Re-Assigned to Subcommittee on:

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1455

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

H1455-ARN-002

Date_____,1998

Comm. Sub. [X]
Amends Title [ ]
Draft Edition H1455-PCS8355-RN

Representative _____

moves to amend the bill on page 3, line 44, by adding the following sentence:

This subdivision applies only if a hospital licensed under Chapter 131E or Chapter 122C of the General Statutes is the sponsoring provider or a member of the group of affiliated health care providers that comprises the sponsoring provider.";

and on page 2, line 16, by adding the following sentence:

"Nothing in this Article shall be construed to authorize a provider sponsored organization to establish, maintain, or operate a health care plan other than exclusively for Medicare+Choice beneficiaries.;

and on page 25, line 1, by deleting the word "shall" and inserting the word "may".

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE

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

DAY & DATE: **TUESDAY, JULY 7, 1998**

TIME: **IMMEDIATELY AFTER SESSION**

LOCATION: **643 LOB**

The following bills will be considered (Bill # & Short Title):
HB-1455-PSO MEDICARE LICENSING

Respectfully,

Representative JERRY C. DOCKHAM
Chairman

I hereby certify this notice was filed by the committee clerk at the following offices at **1:45** on **JULY 2, 1998**.

___Principal Clerk
___Reading Clerk - House Chamber

JOANNA MILLS (Committee Clerk)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE

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

DAY & DATE: **THURSDAY, JULY 2, 1998**

TIME: **12:00 NOON**

LOCATION: **ROOM 643 LOB**

The following bills will be considered (Bill # & Short Title):
HB-1455 PSO Medicare Licensing
Rep. Cansler

Respectfully,

Representative Jerry C. Dockham
Chairman

I hereby certify this notice was filed by the committee clerk at the following offices at **11:40 AM** on **June 29, 1998.**

___Principal Clerk
___Reading Clerk - House Chamber

Joanna Mills (Committee Clerk)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR

BILL SPONSOR: **Rep. Lanier Cansler**

OFFICE: **419A- LOB**

DATE: **June 29, 1998**

The House Committee on **INSURANCE** will meet as follows:

DAY & DATE: **THURSDAY, JULY 2, 1998**

TIME: **12:00 NOON**

LOCATION: **643 LOB**

Your Bill (or Bills) will be discussed at this time:
HB-1455- PSO-MEDICARE LICENSING

We would like to have you attend this meeting.

Representatives JERRY C. DOCKHAM
Co-Chairs

(Committee Clerk)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE

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

DAY & DATE: **JUNE 25, 1998**

TIME: **12:00 NOON**

LOCATION: **ROOM 643 LOB**

The following bills will be considered (Bill # & Short Title):
HB- 1495 Health Care Information Privacy
Rep. Reynolds

HB- 1455 PSO Medicare Licensing
Rep. Cansler

Respectfully,

Representative Jerry C. Dockham
Chairman

I hereby certify this notice was filed by the committee clerk at the following offices at **3:15** on **June, 1998**.

___Principal Clerk
___Reading Clerk - House Chamber

Joanna Mills (Committee Clerk)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR

BILL SPONSOR: **Rep. Cansler**

OFFICE: **419A**

DATE: **June 18, 1998**

The House Committee on **INSURANCE** will meet as follows:

DAY & DATE: **THURSDAY, JUNE 25, 1998**

TIME: **12:00 NOON**

LOCATION: **643 LOB**

Your Bill (or Bills) will be discussed at this time:
HB-1455- PSO-Medicare Licensing- **Note: Your Bill will be on the calendar to be read if time permits. We are hearing HB-1495 Rep. Reynolds bill first and this will more than likely take the full hour.**
Rep. Cansler

We would like to have you attend this meeting.

Representative Jerry C. Dockham
Chairman

Joanna Mills (Committee Clerk)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR

BILL SPONSOR: **Rep. Dennis Reynolds**

OFFICE: **533**

DATE: **June 18, 1998**

The House Committee on **INSURANCE** will meet as follows:

DAY & DATE: **THURSDAY, JUNE 25, 1998**

TIME: **12:00 NOON**

LOCATION: **ROOM 643 LOB**

Your Bill (or Bills) will be discussed at this time:
HB- 1495- HEALTH CARE INFORMATION PRIVACY

We would like to have you attend this meeting.

Representative JERRY C. DOCKHAM
Chairman

JOANNA MILLS (Committee Clerk)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR

BILL SPONSOR: **Rep. Connie Wilson**

OFFICE: **529 LOB**

DATE: **June 11, 1998**

The House Committee on **Insurance** will meet as follows:

DAY & DATE: **Thursday, June 18, 1998**

TIME: **12 o'clock Noon**

LOCATION: **643 LOB**

Your Bill (or Bills) will be discussed at this time:
HB-1429- Insurance Reg. Change/Company Exams

We would like to have you attend this meeting.

Representative Jerry C. Dockham
Chairman

Joanna Mills (Committee Clerk)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR

BILL SPONSOR: **Rep. Jerry C. Dockham**

OFFICE: **1106 Legislative Bldg.**

DATE: **June 11, 1998**

The House Committee on **Insurance** will meet as follows:

DAY & DATE: **Thursday, June 18, 1998**

TIME: **12 o'clock Noon**

LOCATION: **643 LOB**

Your Bill (or Bills) will be discussed at this time:
HB-1590- Amend Insurance Finance/Fees
HB-1588- Revise Insurer Assesments

We would like to have you attend this meeting.

Representative Jerry C. Dockham
Chairman

Joanna Mills (Committee Clerk)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
NOTIFICATION TO BILL SPONSOR

BILL SPONSOR: **Senator Reeves**

OFFICE: **2111**

DATE: **June 11, 1998**

The House Committee on **Insurance** will meet as follows:

DAY & DATE: **Thursday, June 18, 1998**

TIME: **12 o'clock Noon**

LOCATION: **643 LOB**

Your Bill (or Bills) will be discussed at this time:
SB-577- Insurance Premium financing

We would like to have you attend this meeting.

Representative Jerry C. Dockham
Chairman

Joanna Mills (Committee Clerk)

Box 17

1. 1997 House Insurance – Health
2. 1998 House Insurance – Health
3. 1997 House Judiciary I
4. 1998 House Judiciary I
5. 1997 House Judiciary II (cont'd. to Box 18)