1999

HOUSE HIGHWAY SAFETY COMMITTEE

MINUTES

HIGHWAY SAFETY COMMITTEE

1999 – 2000 SESSION

COMMITTEE CHAIRMEN

Representative Alma Adams
Representative Wayne Goodwin

RESEARCH STAFF

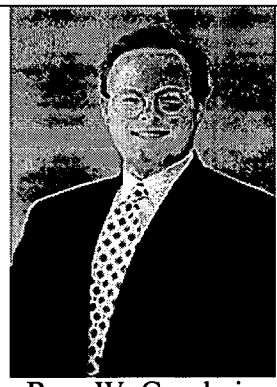
Giles Perry

COMMITTEE ASSISTANTS

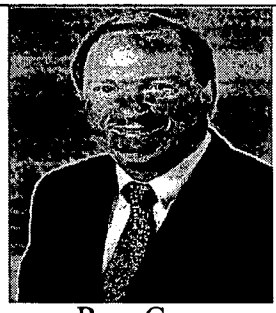
Troy Williams
Kristen Younts

HIGHWAY SAFETY COMMITTEE
1999-2000 BIENNIUM


Rep. Alma Adams
Chair

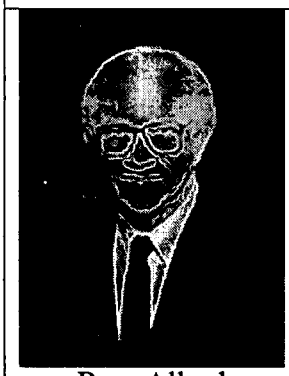

Rep. W. Goodwin
Chair


Rep. Alexander


Rep. Gray

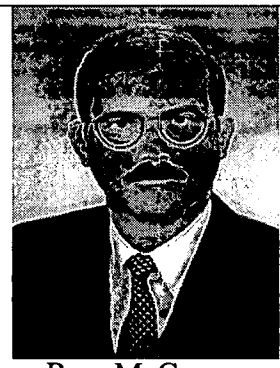

Rep. Mosley


Rep. Dedmon

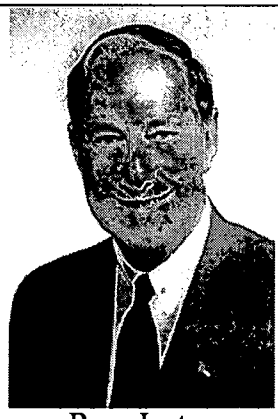

Rep. Allred


Rep. Hurley


Rep. Sexton


Rep. McComas


Rep. Church


Rep. Justus


Rep. C. Wilson

HIGHWAY SAFETY COMMITTEE
1999-00

Member/Clerk	Telephone	Room
Rep. Alma **Adams**, Chair	3-5902	542
Troy Williams		
Rep. Wayne **Goodwin**, Chair	3-4838	502
Kristen Younts		
Rep. Martha **Alexander**	3-7208	2121
Ann Faust		
Rep. Cary **Allred**	3-5607	609
Jean Allred		
Rep. Walter **Church**	3-5805	1311
Joyce Fuller		
Rep. Andy **Dedmon**	3-5732	2213
Donna Abu Harb		
Rep. Lyons **Gray**	3-5820	533
Cindy Brooks		
Rep. Bill **Hurley**	3-5601	2215
Melissa Riddle		
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Carolyn Justus		
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Jayne Walton		
Rep. Jane **Mosley**	3-5781	2221
Gennie Thurlow		
Rep. Wayne **Sexton**	3-5974	506
Debbie Turner		
	3-5903	501

Rep. Connie **Wilson** Paula Covington		
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Rep. Pete **Cunningham** Valerie Rustin	3-5778	541
Rep. Beverly **Earle** Ann Raeford	3-5747	535
Rep. Joe **Hackney** Emily Reynolds	3-5752	2207

Staff		
Giles **Perry**	3-2578	545

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: HIGHWAYS Valid Through 14-JUL-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 57=	ALEXANDER	MOTOR VEHICLE OCCUPANT RESTRAINTS	*H -RE-REF COM ON JUDICI	02-16-99	03-22-99
H 180	CARPENTER J	REPEAL SAFETY INSPECTIONS	HF-REPTD UNFAV	03-01-99	03-24-99
H 898	MCALLISTER	CHILD BICYCLE SAFETY ACT	*S -REF TO COM ON JUDICII	04-01-99	04-20-99
H1054	MOSLEY	ACTIVITY BUSES STOP-RR CROSSINGS	*H -PRES. TO GOV. 07-01	04-15-99	04-21-99
H1054	MOSLEY	ACTIVITY BUSES STOP-RR CROSSINGS	*H -PRES. TO GOV. 07-01	04-22-99	04-27-99
H1203=	BAKER	MOTORCYCLE SAFETY ACT	H -RE-REF COM ON FINANCE	04-15-99	04-21-99

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

ATTENDANCE

HIGHWAY SAFETY

DATES	2/24	3/10	3/17	3/24	4/14	4/21	4/27	5/26							
ADAMS, Alma, Chair		✓	✓	✓	✓	✓	✓	✓							
GOODWIN, Wayne, Chair	✓	✓	✓	✓	✓		✓	✓							
ALEXANDER, Martha	✓	✓	✓		✓	✓	✓	✓							
ALLRED, Cary	✓	✓	✓		✓			✓							
CHURCH, Walter					✓	✓		✓							
DEDMON, Andy		✓	✓	✓											
GRAY, Lyons		✓	✓	✓		✓									
HURLEY, Bill	✓	✓	✓	✓	✓	✓	✓	✓							
JUSTUS, Larry	✓	✓	✓		✓		✓	✓							
McCOMAS, Daniel	✓	✓	✓			✓		✓							
MOSLEY, Jane	✓	✓	✓	✓	✓	✓	✓	✓							
SEXTON, Wayne		✓	✓	✓		✓	✓	✓							
WILSON, Connie		✓	✓					✓							
Ex- Officio															
BADDOUR, Phil			✓												
CUNNINGHAM, Pete	✓		✓	✓											
EARLE, Beverly		✓													
HACKNEY, Joe			✓												

HOUSE COMMITTEE ON HIGHWAY SAFETY
LEGISLATIVE OFFICE BUILDING
Room 415
February 24, 1999

AGENDA

INTRODUCTION AND ORIENTATION

Representative Wayne Goodwin, Chair
Representative Alma Adams, Chair

SPEAKER

Mr. Joe Parker, Director
Governor's Highway Safety Program

ADJOURNMENT

HIGHWAY SAFETY COMMITTEE MEETING
MINUTES FOR FEBRUARY 24, 1999
Room 415 LOB

Committee members in attendance were: Chair, Representative Goodwin, Representatives Alexander, Allred, Hurley, Justus, McComas, Mosley. **Also attending:** Giles Perry (Committee Staff). A visitor registration list is attached and made a part of these minutes.

Narrative/Discussion: Presiding Chair Rep. Goodwin called the meeting to order at approximately 1:05 PM. Rep. Goodwin introduced the pages for the day, staff, and committee assistants. Mr. Joe Parker, Director of The Governor's Highway Safety Program, was introduced as the speaker for the day. Mr. Parker gave a presentation about Highway Safety statistics, programs, and legislation in North Carolina. The complete version of his speech is attached and made a part of these minutes. Handouts given to staff and members were:

(1) Traffic Safety Facts 1997
(2) 1997 NC Traffic Crash Facts
(3) Preliminary 1998 NC Crash Facts
(4) Highway Safety Legislation Issues
(5) Help Save "90 Lives in 99"
(6) List of Standing Committees
(7) FY Summary: Report from Governor's Highway Safety Program
(8) NC Highway Safety Initiative
(9) National Highway Traffic Safety Administration Strategic Plan 1998

Mr. Parker was asked and answered questions from several committee members.

Rep. Goodwin adjourned the meeting at approximately 1:50 PM.

Respectfully submitted,

Rep. Wayne Goodwin
Chairman

Kristen Younts
Committee Assistant

Remarks for Joe Parker
Director
Governor's Highway Safety Program

Introduction

When the Governor's Highway Safety Program was first established in 1967, the mileage death rate in North Carolina was 6.78 deaths per 100 million miles traveled. Today, there are about 1.8 deaths per 100 million miles traveled—despite the fact motorists continue to drive more miles than ever before.

And as I talk to engineers, law enforcement officers, trauma doctors, legislators, and concerned citizens, I find there is one constant—everyone is concerned about saving lives and prevent injuries on our highways.

In addition to roadway engineering, the strides we've made in recent years can also be attributed to improvements in vehicle crash worthiness and the passage of motor vehicle safety laws such as anti-driving while impaired, child safety seat usage and mandatory seat belt use.

But even these measures have not wiped out traffic deaths. Last year, preliminary numbers show 1,587 people died on the state's highways. That's still far too many North Carolinians dying. The fact is 80 percent of all crashes are not due to poor road conditions or vehicle problems, they are due to driver error. Our mission at the GHSP is to educate the public and change driver behavior by focusing our attention on the issues that will make the greatest impact.

1) Role of federal government in highway safety.

- 1st quarter of the century, highway safety was exclusively the responsibility of state and local governments:

- In 1924 –30 million motorists in the U.S.—22,000 killed—Highway safety was now viewed as a national problem.

- In 1946, President Truman convened the first President's Highway Safety Conference that covered 11 areas including laws, education, and engineering. Most of these were voluntary programs that the federal government had no specific role.

- The year 1954 signaled a significant change in the federal role; President Eisenhower established a permanent President's Committee for Traffic Safety.

- By 1965, there were 49,000 vehicle deaths each year in the United States.

- The Highway Safety Act of 1966 was the first comprehensive federal highway safety legislation enacted. It provided federal funds for safety programs. It also created the Department of Transportation 402 program administered through the National Highway Safety Bureau of the Federal Highway Administration.

- The Governor's Highway Safety Program (GHSP) was created in 1967 by legislation passed by the NC General Assembly, which empowered the Governor to contract with the U.S. Department of Transportation for the purpose of securing funding available through the Highway Safety Act of 1966. This funding provides for the administration of a highway safety program designed to reduce traffic crashes and the resulting deaths, injuries and property damage. The GHSP's mission is to plan and execute a comprehensive highway traffic safety program for North Carolina to reduce the number of fatalities and injuries on the state's roadways.

2) The National Outlook

The National Highway Traffic Safety Administration is an agency of the federal Department of Transportation and one of our partners. It is the federal agency charged with improving highway safety across the nation.

Page 9 and 10 of NHTSA's "Strategic Plan" document give an overview of the state of traffic safety across the nation:

a) Traffic fatalities have declined, but remain at a high level.
b) The traffic fatality rate per 100 million vehicle miles traveled has declined significantly.
c) Since 1988, the number of injuries has increased slightly.
d) Page 10- But the traffic injury rate has declined overall.
e) Alcohol-related traffic fatalities have declined almost 30 percent from 1986 to 1996. Nationally, alcohol-related traffic deaths account for almost 41 percent of all deaths on our nation's roads.
f) Seat belt use nationally has increased. North Carolina now has one of the highest seat belt use rates in the country, thanks to our occupant protection law and outstanding law enforcement.

Another document, "Traffic Safety Facts 1997," gives you an overview of the latest safety numbers. The chart on page 11 shows who is dying on the highways—our youngest and oldest drivers.

3) Highway Safety Partners

The National Highway Traffic Safety Administration is just one of the many partners who are working to save lives on our highways. The list of partners I've given you shows those agencies in North Carolina who are focusing on the different areas affecting safety—the driver (80 percent of all crashes), the roadway (15 percent) and the vehicle (5 percent).

4) **Preliminary 1998 North Carolina Crash Facts**

This sheet shows preliminary crash numbers for 1998. In general:

a) Fatalities are up—good economy, increased speed.
b) Injuries are down.
c) The percentage of alcohol-related crashes has gone down slightly. North Carolina remains about 10 percentage points below the national average.

5) **North Carolina Crash Facts 1997**

This large gray book gives detailed data from 1997 and past years. I encourage you to look through it. For a quick overview turn to:

a) Page 14-Speeding is a continual problem is the most frequent contributing circumstance in crashes.
b) Page 15-You can see how the number of people killed per 100 million vehicle miles traveled as continued to decrease. We're approaching the national average.
c) Page 16-This chart shows how the number of registered vehicle sand the number of miles driven continues to increase in North Carolina.

6) **Highway Safety Legislative Issues**

This chart gives an example of the types of issues facing our state. This chart is neither exhaustive nor authorized. But it gives you an idea of the different highway safety issues that are out there.

7) **GHSI**

As I mentioned earlier, the goal of the Governor's Highway Safety Program is to save lives, prevent injuries on North Carolina highways. One example of our national leadership is the Governor's Highway Safety Initiative. This booklet describes our "Click It or Ticket" and "Booze It & Lose It" programs and how they are models for the nation.

If there is any way our office can be of assistance, please give me a call. My card is available inside your folders.

Traffic Safety Facts 1997

Overview

U.S. Department of Transportation
National Highway Traffic Safety Administration

NHTSA
People Saving People

http://www.nhtsa.dot.gov
DOT HS 808 770

REVISED:
Includes revised data for vehicle miles traveled, licensed drivers, and registered vehicles.

"In 1997, there were an estimated 6,764,000 police-reported traffic crashes, in which 41,967 people were killed and 3,399,000 people were injured; 4,542,000 crashes involved property damage only."

A Public Information Fact Sheet on Motor Vehicle and Traffic Safety Published by the National Highway Traffic Safety Administration's National Center for Statistics and Analysis

Introduction

Motor vehicle travel is the primary means of transportation in the United States, providing an unprecedented degree of mobility. Yet for all its advantages, deaths and injuries resulting from motor vehicle crashes are the leading cause of death for persons of every age from 6 to 27 years old (based on 1994 data). Traffic fatalities account for more than 90 percent of transportation-related fatalities. The mission of the National Highway Traffic Safety Administration is to reduce deaths, injuries, and economic losses from motor vehicle crashes.

Fortunately, much progress has been made in reducing the number of deaths and serious injuries on our nation's highways. In 1997, the fatality rate per 100 million vehicle miles of travel reached a new historic low of 1.6, down from 1.7, the rate since 1992. The 1987 rate was 2.4 per 100 million vehicle miles traveled. A 69 percent safety belt use rate nationwide and a reduction in the rate of alcohol involvement in fatal crashes to 38.6 percent were significant contributions to maintaining this consistently low fatality rate. However, much remains to be done. The economic cost alone of motor vehicle crashes in 1994 was more than $150.5 billion.

In 1997, 41,967 people were killed in the estimated 6,764,000 police-reported motor vehicle traffic crashes, 3,399,000 people were injured, and 4,542,000 crashes involved property damage only.

This overview fact sheet contains statistics on motor vehicle fatalities based on data from the Fatality Analysis Reporting System (FARS). FARS is a census of fatal crashes within the 50 states, the District of Columbia, and Puerto Rico (although Puerto Rico is not included in U.S. totals). Crash and injury statistics are based on data from the General Estimates System (GES). GES is a probability-based sample of police-reported crashes, from 60 locations across the country, from which estimates of national totals for injury and property-damage-only crashes are derived.

Other fact sheets available from the National Center for Statistics and Analysis are *Alcohol*, *Occupant Protection*, *Speeding*, *Children*, *Young Drivers*, *Older Population*, *Pedestrians*, *Pedalcyclists*, *Motorcycles*, *Large Trucks*, *School Buses*, *State Traffic Data*, *State Alcohol Estimates*, and *Rural Crashes*. Detailed data on motor vehicle traffic crashes are published annually in *Traffic Safety Facts: A Compilation of Motor Vehicle Crash Data from the Fatality Analysis Reporting System and the General Estimates System.*

Summary

In 1997, 41,967 people lost their lives in motor vehicle crashes — a decrease of 0.2 percent from 1996.

"An average of 115 persons died each day in motor vehicle crashes in 1997 — one every 13 minutes."

The fatality rate per 100 million vehicle miles of travel in 1997 was 1.6. The injury rate per 100 million vehicle miles of travel in 1997 was 133. The fatality rate per 100,000 population was 15.68 in 1997, a decrease of 1 percent from the 1996 rate of 15.86.

An average of 115 persons died each day in motor vehicle crashes in 1997 — one every 13 minutes.

Motor vehicle crashes are the leading cause of death for every age from 6 through 27 years old.

Vehicle occupants accounted for 85 percent of traffic fatalities in 1997. The remaining 15 percent were pedestrians, pedalcyclists, and other nonoccupants.

Table 1. Motor Vehicle Occupants and Nonoccupants Killed and Injured, 1987-1997

Year	Occupants							Nonoccupants				Total
	Passenger Cars	Light Trucks	Large Trucks	Motor-cycles	Buses	Other/ Unknown	Total	Pedestrian	Pedalcyclist	Other	Total	
Killed												
1987	25,132	8,058	852	4,036	51	436	*38,565*	6,745	948	132	*7,825*	**46,390**
1988	25,808	8,306	911	3,662	54	429	*39,170*	6,870	911	136	*7,917*	**47,087**
1989	25,063	8,551	858	3,141	50	424	*38,087*	6,556	832	107	*7,495*	**45,582**
1990	24,092	8,601	705	3,244	32	460	*37,134*	6,482	859	124	*7,465*	**44,599**
1991	22,385	8,391	661	2,806	31	466	*34,740*	5,801	843	124	*6,768*	**41,508**
1992	21,387	8,098	585	2,395	28	387	*32,880*	5,549	723	98	*6,370*	**39,250**
1993	21,566	8,511	605	2,449	18	425	*33,574*	5,649	816	111	*6,576*	**40,150**
1994	21,997	8,904	670	2,320	18	409	*34,318*	5,489	802	107	*6,398*	**40,716**
1995	22,423	9,568	648	2,227	33	392	*35,291*	5,584	833	109	*6,526*	**41,817**
1996	22,505	9,932	621	2,161	21	455	*35,695*	5,449	765	154	*6,368*	**42,065**
1997	21,989	10,224	717	2,106	17	640	*35,693*	5,307	813	154	*6,274*	**41,967**
Injured												
1988	2,585,000	478,000	37,000	105,000	15,000	4,000	*3,224,000*	110,000	75,000	8,000	*192,000*	**3,416,000**
1989	2,431,000	511,000	43,000	83,000	15,000	5,000	*3,088,000*	112,000	73,000	11,000	*196,000*	**3,284,000**
1990	2,376,000	505,000	42,000	84,000	33,000	4,000	*3,044,000*	105,000	75,000	7,000	*187,000*	**3,231,000**
1991	2,235,000	563,000	28,000	80,000	21,000	4,000	*2,931,000*	88,000	67,000	11,000	*166,000*	**3,097,000**
1992	2,232,000	545,000	34,000	65,000	20,000	12,000	*2,908,000*	89,000	63,000	10,000	*162,000*	**3,070,000**
1993	2,265,000	601,000	32,000	59,000	17,000	4,000	*2,978,000*	94,000	68,000	9,000	*171,000*	**3,149,000**
1994	2,364,000	631,000	30,000	57,000	16,000	4,000	*3,102,000*	92,000	62,000	9,000	*164,000*	**3,266,000**
1995	2,469,000	722,000	30,000	57,000	19,000	4,000	*3,303,000*	86,000	67,000	10,000	*162,000*	**3,465,000**
1996	2,478,000	768,000	33,000	56,000	20,000	4,000	*3,360,000*	82,000	59,000	11,000	*151,000*	**3,511,000**
1997	2,378,000	768,000	31,000	54,000	17,000	5,000	*3,253,000*	77,000	58,000	11,000	*146,000*	**3,399,000**

* Includes 2 fatalities of unknown person type.

Table 2. Persons Killed and Injured and Fatality and Injury Rates, 1987-1997

Killed									
Year	Killed	Resident Population (Thousands)	Fatality Rate per 100,000 Population	Licensed Drivers (Thousands)	Fatality Rate per 100,000 Licensed Drivers	Registered Motor Vehicles (Thousands)	Fatality Rate per 100,000 Registered Vehicles	Vehicle Miles Traveled (Billions)	Fatality Rate per 100 Million VMT
1987	46,390	242,289	19.15	161,816	28.67	172,750	26.85	1,921	2.4
1988	47,087	244,499	19.26	162,854	28.91	177,455	26.53	2,026	2.3
1989	45,582	246,819	18.47	165,554	27.53	181,165	25.16	2,096	2.2
1990	44,599	249,440	17.88	167,015	26.70	184,275	24.20	2,144	2.1
1991	41,508	252,124	16.46	168,995	24.56	186,370	22.27	2,172	1.9
1992	39,250	255,002	15.39	173,125	22.67	184,938	21.22	2,247	1.7
1993	40,150	257,753	15.58	173,149	23.19	188,350	21.32	2,296	1.7
1994	40,716	260,292	15.64	175,403	23.21	192,497	21.15	2,358	1.7
1995	41,817	262,761	15.91	176,628	23.68	197,065	21.22	2,423	1.7
1996	42,065	265,179	15.86	179,539	23.43	201,626	20.86	2,486	1.7
1997	41,967	267,636	15.68	*	*	*	*	2,560	1.6

Injured									
Year	Injured	Resident Population (Thousands)	Injury Rate per 100,000 Population	Licensed Drivers (Thousands)	Injury Rate per 100,000 Licensed Drivers	Registered Motor Vehicles (Thousands)	Injury Rate per 100,000 Registered Vehicles	Vehicle Miles Traveled (Billions)	Injury Rate per 100 Million VMT
1988	3,416,000	244,499	1,397	162,854	2,098	177,455	1,925	2,026	169
1989	3,284,000	246,819	1,330	165,554	1,984	181,165	1,813	2,096	157
1990	3,231,000	249,440	1,295	167,015	1,934	184,275	1,753	2,144	151
1991	3,097,000	252,124	1,228	168,995	1,833	186,370	1,662	2,172	143
1992	3,070,000	255,002	1,204	173,125	1,773	184,938	1,660	2,247	137
1993	3,149,000	257,753	1,222	173,149	1,819	188,350	1,672	2,296	137
1994	3,266,000	260,292	1,255	175,403	1,862	192,497	1,697	2,358	139
1995	3,465,000	262,761	1,319	176,628	1,962	197,065	1,758	2,423	143
1996	3,511,000	265,179	1,324	179,539	1,956	201,626	1,741	2,486	141
1997	3,399,000	267,636	1,270	*	*	*	*	2,560	133

*Data not available.

Sources: Vehicle Miles of Travel and Licensed Drivers — Federal Highway Administration; Registered Vehicles — R.L. Polk & Co. and Federal Highway Administration; Population — U.S. Bureau of the Census.

"NHTSA estimates that 10,750 lives were saved in 1997 by the use of safety belts."

Occupant Protection

In 1997, 49 states and the District of Columbia had safety belt use laws in effect. Use rates vary widely from state to state, reflecting factors such as differences in public attitudes, enforcement practices, legal provisions, and public information and education programs.

From 1975 through 1997, it is estimated that safety belts saved 100,998 lives, including 10,750 lives saved in 1997. If *ALL* passenger vehicle occupants over age 4 wore safety belts, 20,351 lives (that is, an additional 9,601) could have been saved in 1997.

In 1997, it is estimated that 312 children under age 5 were saved as a result of child restraint use. An estimated 3,894 lives were saved by child restraints from 1975 through 1997.

Children in rear-facing child seats should not be placed in the front seat of cars equipped with passenger-side air bags. The impact of a deploying air bag striking a rear-facing child seat could result in injury to the child. NHTSA also recommends that children 12 and under sit in the rear seat away from the force of a deploying air bag.

In 1997, 44 percent of passenger car occupants and 49 percent of light truck occupants involved in fatal crashes were unrestrained.

In fatal crashes, 73 percent of passenger car occupants who were totally ejected from the vehicle were killed. Safety belts are effective in preventing total ejections: only 1 percent of the occupants reported to have been using restraints were totally ejected, compared with 20 percent of the unrestrained occupants.

Table 3. Restraint Use Rates for Passenger Car Occupants in Fatal Crashes, 1987 and 1997

Type of Occupant	Restraint Use Rate (Percent)	
	1987	1997
Drivers	36	60
Passengers		
Front Seat	34	58
Rear Seat	25	40
5 Years Old and Over	28	49
4 Years Old and Under	49	68
All Passengers	30	50
All Occupants	33	56

"Alcohol-related traffic fatalities fell to 16,189 in 1997 — 39 percent of all traffic fatalities for the year."

Alcohol

In 1997 there were 16,189 fatalities in alcohol-related crashes. This is a 6 percent decrease compared to 1996, and it represents an average of one alcohol-related fatality every 32 minutes.

The 16,189 alcohol-related fatalities in 1997 (38.6 percent of total traffic fatalities for the year) represent a 32 percent reduction from the 23,641 alcohol-related fatalities reported in 1987 (51.0 percent of the total).

NHTSA estimates that alcohol was involved in 38.5 percent of fatal crashes and in 7.0 percent of all crashes in 1997.

In 1997, 30.3 percent of all traffic fatalities occurred in crashes in which at least one driver or nonoccupant had a blood alcohol concentration (BAC) of 0.10 grams per deciliter (g/dl) or greater.

All states and the District of Columbia now have 21-year-old minimum drinking age laws. NHTSA estimates that these laws have reduced traffic fatalities involving drivers 18 to 20 years old by 13 percent and have saved an estimated 17,359 lives since 1975. In 1997, an estimated 846 lives were saved by minimum drinking age laws.

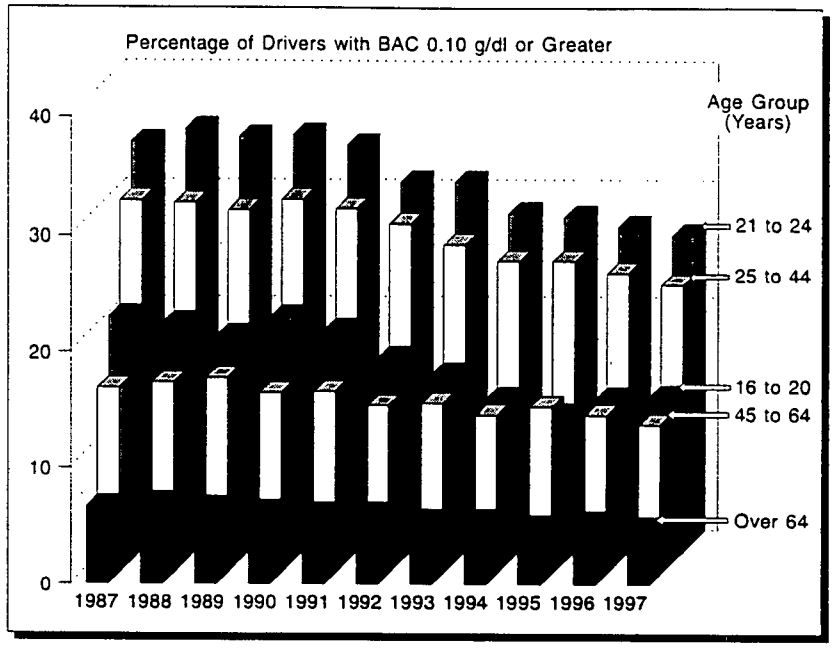
Approximately 1.5 million drivers were arrested in 1996 for driving under the influence of alcohol or narcotics. This is an arrest rate of 1 for every 122 licensed drivers in the United States (1997 data not yet available).

About 3 in every 10 Americans will be involved in an alcohol-related crash at some time in their lives.

From 1987 to 1997, intoxication rates (BAC of 0.10 g/dl or greater) decreased for drivers of all age groups involved in fatal crashes.

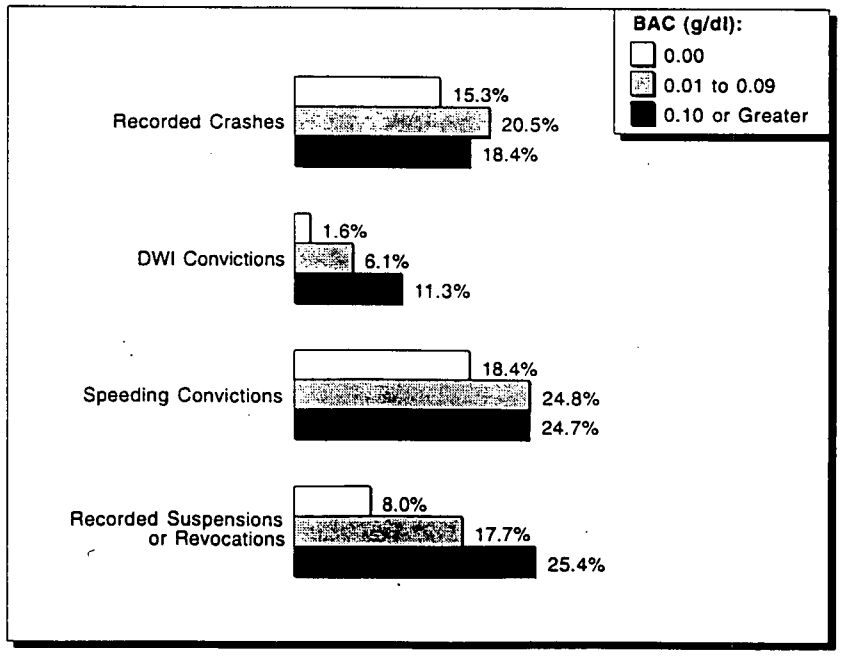
"From 1987 to 1997, intoxication rates decreased for drivers of all age groups involved in fatal crashes."

Figure 1. Intoxicated Drivers in Fatal Crashes by Age Group, 1987-1997



Intoxication rates for drivers in fatal crashes in 1997 were 27.9 percent for motorcycles, 20.2 percent for light trucks, 18.2 percent for passenger cars, and 1.1 percent for large trucks.

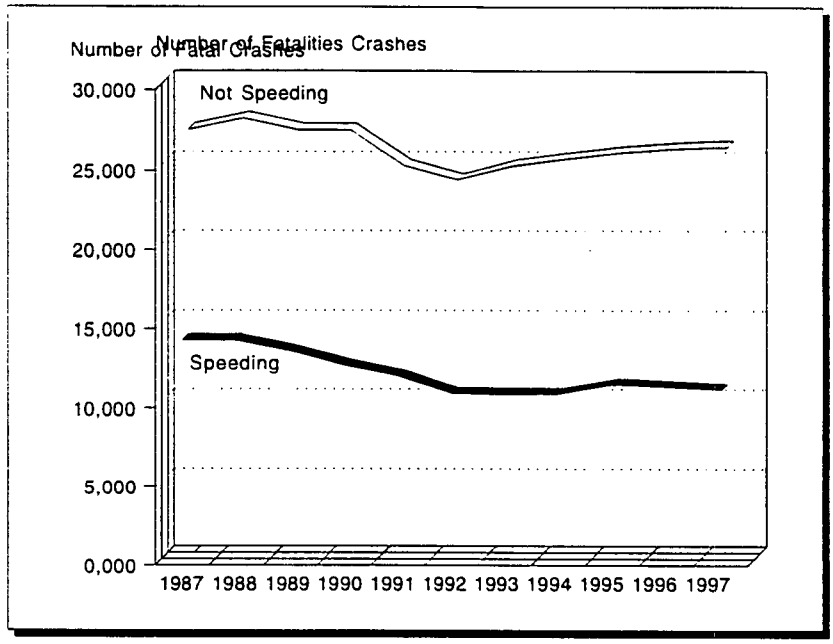
Figure 2. Previous Driving Records of Drivers Killed in Traffic Crashes, by Blood Alcohol Concentration, 1997



Speeding

Speeding — exceeding the posted speed limit or driving too fast for conditions — is one of the most prevalent factors contributing to traffic crashes. The economic cost to society of speeding-related crashes is estimated by NHTSA to be $28.9 billion per year. In 1997, speeding was a contributing factor in 30 percent of all fatal crashes, and 13,036 lives were lost in speeding-related crashes.

Figure 3. Fatal Crashes by Speeding Status, 1987-1997



"The economic cost of speeding-related crashes is estimated to be $28.9 billion each year."

In 1997, 626,000 people received minor injuries in speeding-related crashes. An additional 75,000 people received moderate injuries, and 41,000 received critical injuries in speeding-related crashes (based on methodology from *The Economic Cost of Motor Vehicle Crashes 1994*, NHTSA).

In 1997, 86 percent of speeding-related fatalities occurred on roads that were not Interstate highways.

For drivers involved in fatal crashes, young males are the most likely to be speeding. The proportion of all crashes that are speeding-related decreases with increasing driver age. In 1997, 37 percent of the male drivers 15 to 20 years old who were involved in fatal crashes were speeding at the time of the crash.

Alcohol and speeding are clearly a deadly combination. Speeding involvement is prevalent for drivers involved in alcohol-related crashes. In 1997, 43 percent of the **intoxicated** drivers (BAC = 0.10 or higher) involved in fatal crashes were speeding, compared with only 14 percent of the **sober** drivers (BAC = 0.00) involved in fatal crashes.

"In 1997, 37 percent of male drivers 15 to 20 years old involved in fatal crashes were speeding."

Figure 4. Speeding Drivers in Fatal Crashes by Age and Sex, 1997

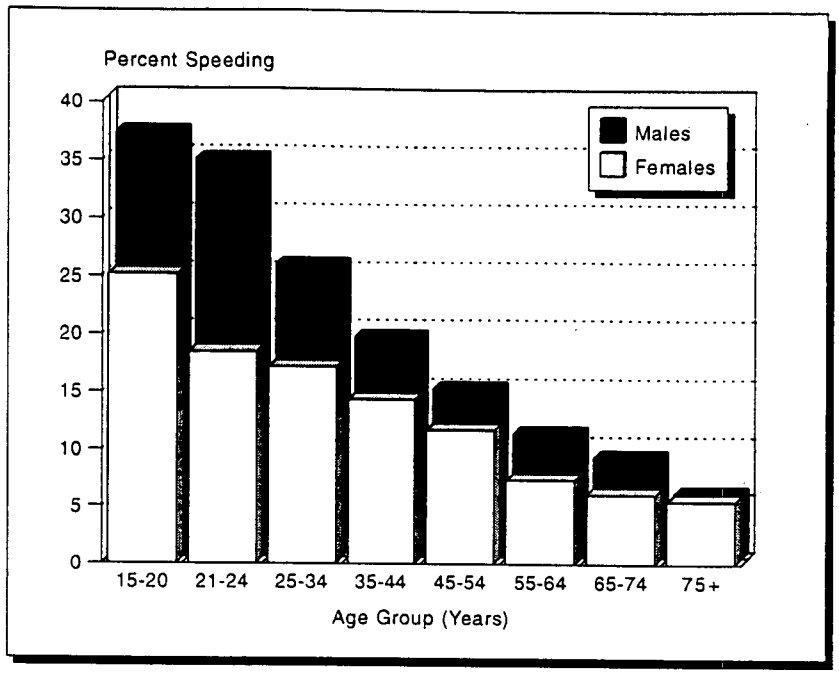
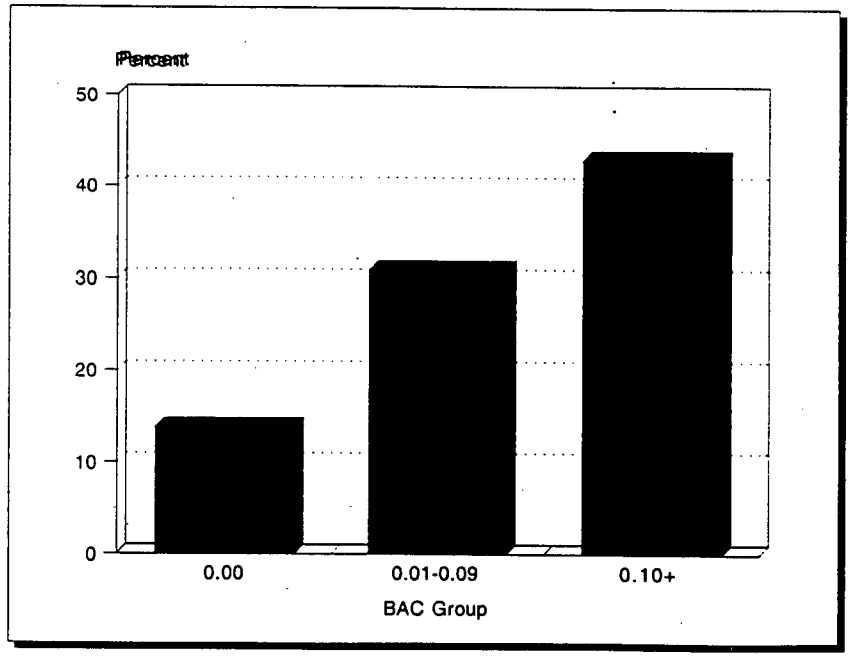


Figure 5. Percentage of All Drivers Involved in Fatal Crashes That Were Speeding, by BAC Level, 1997



Motorcycles

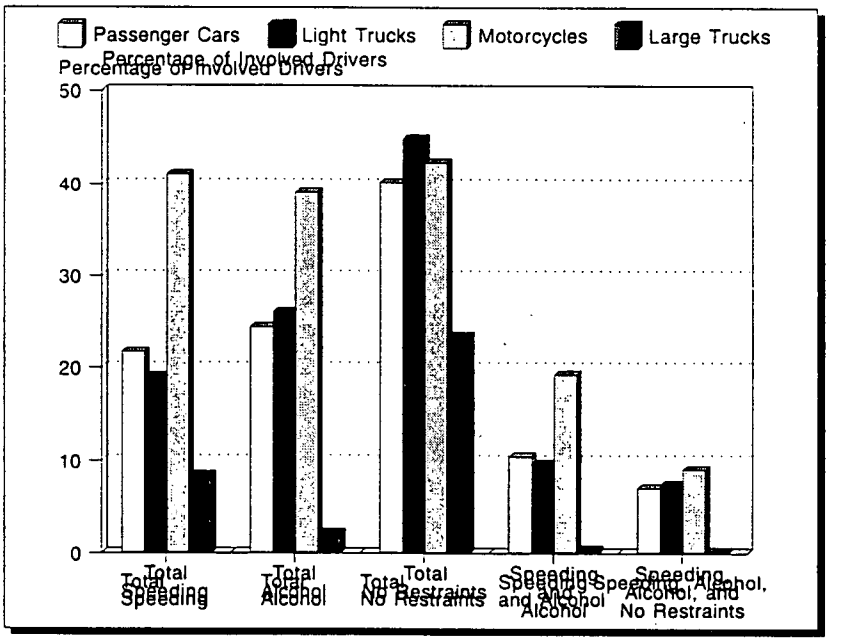
The 2,106 motorcyclist fatalities in 1997 accounted for 5 percent of all traffic fatalities for the year. An additional 54,000 motorcycle occupants were injured.

Per vehicle mile traveled, motorcyclists were about 15 times as likely as passenger car occupants to die in a motor vehicle traffic crash and about 3 times as likely to be injured.

In 1997, 41 percent of all motorcycle drivers involved in fatal crashes were speeding. The percentage of speeding involvement in fatal crashes was approximately twice as high for motorcyclists as for drivers of passenger cars or light trucks, and the percentage of alcohol involvement was more than 50 percent higher for motorcyclists.

"Speeding involvement for motorcyclists in fatal crashes was twice as high as for car and light truck drivers."

Figure 6. Speeding, Alcohol Involvement, and Failure To Use Restraints Among Drivers Involved in Fatal Crashes by Vehicle Type, 1997



In 1997, 43 percent of fatally injured motorcycle operators and 51 percent of fatally injured passengers were not wearing helmets at the time of the crash.

Nearly one out of five motorcycle operators (18 percent) involved in fatal crashes in 1997 were operating the vehicle with an invalid license at the time of the collision.

Motorcycle operators involved in fatal crashes in 1997 had higher intoxication rates (BAC of 0.10 g/dl or greater) than any other type of motor vehicle driver. The intoxication rate for motorcycle operators involved in fatal crashes was 27.9 percent.

NHTSA estimates that helmets saved the lives of 486 motorcyclists in 1997. If all motorcyclists had worn helmets, an additional 266 lives could have been saved.

"Per vehicle mile, motorcyclists were about 15 times as likely as passenger car occupants to die in a traffic crash."

Large Trucks

In 1997, 11 percent (4,777) of all the motor vehicle traffic fatalities reported involved heavy trucks (gross vehicle weight rating greater than 26,000 pounds), and 2 percent (639) involved medium trucks (gross vehicle weight rating 10,000 to 26,000 pounds).

Of the fatalities that resulted from crashes involving large trucks (gross vehicle weight rating greater than 10,000 pounds), 78 percent were occupants of another vehicle, 8 percent were nonoccupants, and 13 percent were occupants of a large truck.

Large trucks accounted for 8 percent of all vehicles involved in fatal crashes and 4 percent of all vehicles involved in injury and property-damage-only crashes in 1997.

More than three-quarters (78 percent) of the large trucks involved in fatal crashes in 1997 collided with another motor vehicle in transport.

Only 1.1 percent of the drivers of large trucks involved in fatal crashes in 1997 were intoxicated, compared with 18.2 percent for passenger cars, 20.2 percent for light trucks, and 27.9 percent for motorcycles.

"One out of eight traffic fatalities in 1997 resulted from a collision involving a large truck."

Table 4. Fatalities and Injuries in Crashes Involving Large Trucks, 1997

Type of Fatality	Number	Percentage of Total
Occupants of Large Trucks	717	13
Single-Vehicle Crashes	*496*	*9*
Multiple-Vehicle Crashes	*221*	*4*
Occupants of Other Vehicles in Crashes Involving Large Trucks	4,189	78
Nonoccupants (Pedestrians, Pedalcyclists, etc.)	449	8
Total	**5,355**	**100**
Type of Injury	**Number**	**Percentage of Total**
Occupants of Large Trucks	31,000	24
Single-Vehicle Crashes	*14,000*	*11*
Multiple-Vehicle Crashes	*17,000*	*13*
Occupants of Other Vehicles in Crashes Involving Large Trucks	99,000	75
Nonoccupants (Pedestrians, Pedalcyclists, etc.)	2,000	2
Total	**133,000**	**100**

Cars, Light Trucks, and Vans

In 1997, 32,213 occupants of passenger vehicles were killed in traffic crashes and an additional 3,146,000 were injured, accounting for 90 percent of all occupant fatalities (passenger cars 62 percent, light trucks and vans 29 percent) and 97 percent of all occupants injured (passenger cars 73 percent, light trucks and vans 24 percent).

Occupant fatalities in single-vehicle crashes accounted for 39 percent of all motor vehicle fatalities in 1997. Occupant fatalities in multiple-vehicle crashes accounted for 46 percent of all fatalities, and the remaining 15 percent were nonoccupant fatalities (pedestrians, pedalcyclists, etc.).

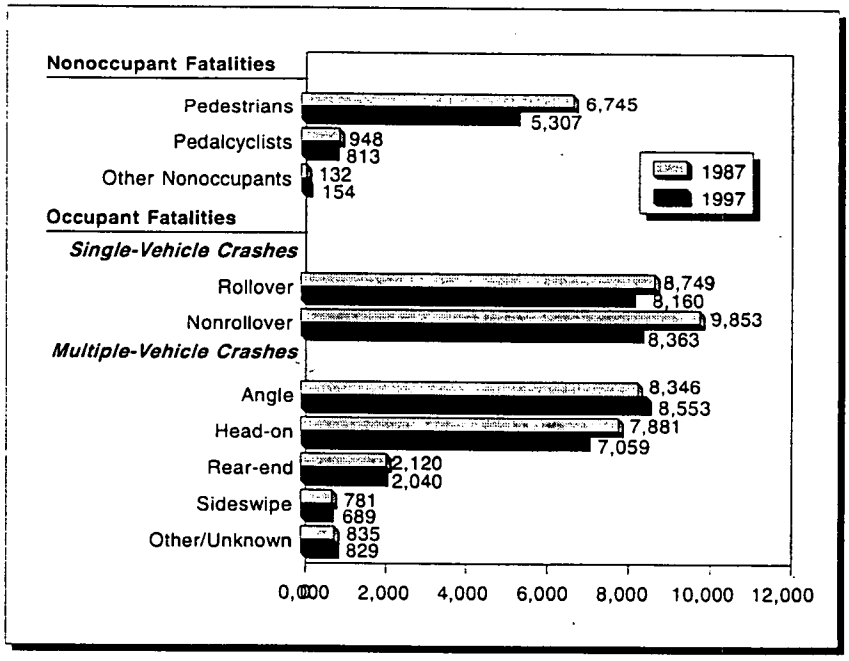
"Ejection from the vehicle accounted for 26 percent of all passenger vehicle occupant fatalities."

Among passenger vehicles involved in fatal crashes, 60 percent of the occupant fatalities in 1997 occurred in frontal impacts.

Ejection from the vehicle accounted for 26 percent of all passenger vehicle occupant fatalities. The ejection rate for occupants of light trucks in fatal crashes was twice the rate for passenger car occupants.

Utility vehicles had the highest rollover involvement rate of any vehicle type in fatal crashes — 36 percent, as compared with 24 percent for pickups, 20 percent for vans, and 15 percent for passenger cars.

Figure 7. Fatalities in Traffic Crashes, 1987 and 1997



"Nearly two-thirds of the passenger vehicle occupants killed in traffic crashes in 1997 were unrestrained."

Utility vehicles also had the highest rollover rate in injury crashes — 9 percent, compared with 7 percent for pickups, 3 percent for vans, and 3 percent for passenger cars.

Nearly two-thirds (63 percent) of the passenger vehicle occupants killed in traffic crashes in 1997 were unrestrained.

The intoxication rate for drivers of light trucks involved in fatal crashes (20.2 percent) is higher than that for passenger car drivers (18.2 percent).

Driver Age

There are more than 24 million people age 70 years and older in the United States. In 1997, this age group made up 9 percent of the total U.S. resident population, compared with 8 percent in 1987. From 1987 to 1997, this older segment of the population grew 2.1 times as fast as the total population.

In 1997, 175,000 older individuals were injured in traffic crashes, accounting for 5 percent of all the people injured in traffic crashes during the year. These older individuals made up 14 percent of all traffic fatalities, 13 percent of all vehicle occupant fatalities, and 17 percent of all pedestrian fatalities.

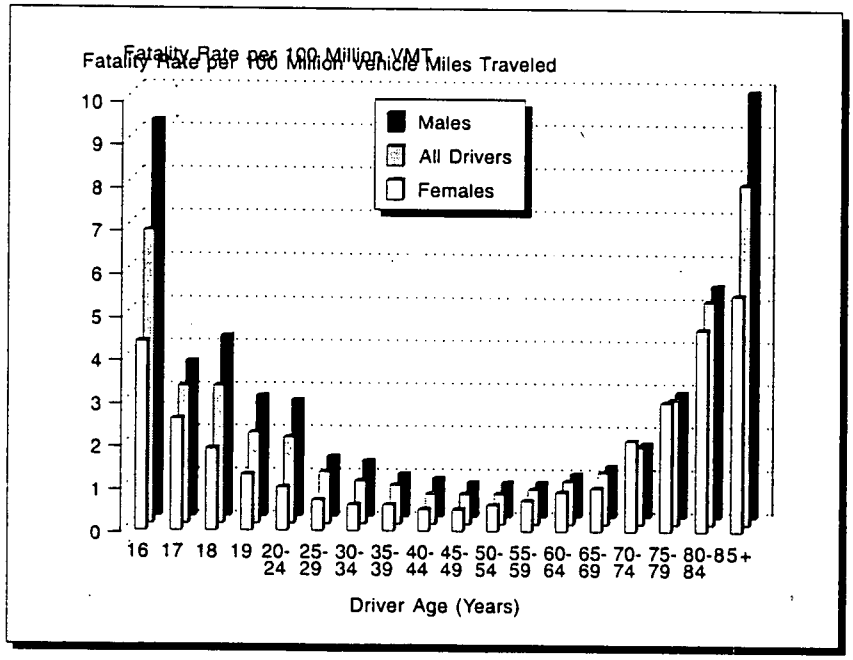
Older drivers involved in fatal crashes in 1997 had the lowest intoxication rate (3.8 percent) of all adult drivers.

In two-vehicle fatal crashes involving an older driver and a younger driver, the vehicle driven by the older person was almost 3 times as likely to be the one that was struck (55 percent and 20 percent, respectively). In 44 percent of these crashes, both vehicles were proceeding straight at the time of the collision. In 28 percent, the older driver was turning left — 7 times as often as the younger driver.

When driver fatality rates are calculated on the basis of estimated annual travel, the highest rates are found among the youngest and oldest drivers. Compared with the fatality rate for drivers 25 through 69 years old, the rate for teenage drivers is about 4 times as high, and the rate for drivers in the oldest group is 9 times as high.

"In 1997, older people made up 9 percent of the resident population but accounted for 14 percent of all traffic fatalities and 17 percent of all pedestrian fatalities."

Figure 8. Driver Fatality Rates by Age and Sex, 1996



Young female drivers, under age 50, have a lower fatality rate than their male counterparts, on a per mile driven basis, while the rate is essentially the same for both male and female drivers over 50 years of age, with the exception of the oldest group (Figure 8).

Youth

In 1997, 16- to 24-year-olds represented 23 percent of all traffic fatalities, compared with 8 percent for ages 1 to 15, 44 percent for ages 25 to 54, and 25 percent for ages 55 and over.

On a per population basis, drivers under the age of 25 had the highest rate of involvement in fatal crashes of any age group.

The intoxication rate for 16- to 20-year-old drivers involved in fatal crashes in 1997 was 14.3 percent. The highest intoxication rates were for drivers 21 to 24 and 25 to 34 years old (26.3 percent and 23.8 percent, respectively).

"Males accounted for 66 percent of all traffic fatalities, 69 percent of all pedestrian fatalities, and 88 percent of all pedalcyclist fatalities in 1997."

Nearly one-third of all children between the ages of 5 and 9 years who were killed in motor vehicle traffic crashes were pedestrians. One-fifth of the traffic fatalities under age 16 were pedestrians.

Passenger vehicle occupants 10 to 24 years old involved in fatal crashes had the lowest restraint use rate (44 percent), and those over age 65 had the highest rate (67 percent).

Male/Female Fatal Crash Involvement

In 1997, the fatal crash involvement rate per 100,000 population was almost 3 times as high for male drivers as for females. However, the population-based rates do not account for the actual on-road exposure, which is greater for males, or the percentage of the population that has driver licenses, also greater for males (see Figure 8).

Males accounted for 66 percent of all traffic fatalities, 69 percent of all pedestrian fatalities, and 88 percent of all pedalcyclist fatalities in 1997.

The intoxication rate for male drivers involved in fatal crashes was 20.3 percent, compared with 10.3 percent for female drivers.

Among female drivers of passenger vehicles involved in fatal crashes in 1997, 32 percent were unrestrained at the time of the collision, compared with 46 percent of male drivers in fatal crashes.

"Pedestrian fatalities in 1997 were 21 percent lower than in 1987."

Pedestrians

In 1997, 77,000 pedestrians were injured and 5,307 were killed in traffic crashes in the United States, representing 2 percent of all the people injured in traffic crashes and 13 percent of all traffic fatalities.

On average, a pedestrian is killed in a motor vehicle crash every 99 minutes, and one is injured every 7 minutes.

Alcohol involvement — either for the driver or the pedestrian — was reported in 45 percent of the traffic crashes that resulted in pedestrian fatalities. Of the pedestrians involved, 29.5 percent were intoxicated. The intoxication rate for the drivers involved was only 12.5 percent. In 5.3 percent of the crashes, both the driver and the pedestrian were intoxicated.

Pedalcyclists

In 1997, 813 pedalcyclists were killed and an additional 58,000 were injured in traffic crashes. Pedalcyclists made up 2 percent of all traffic fatalities and 2 percent of all the people injured in traffic crashes during the year.

Most of the pedalcyclists injured or killed in 1997 were males (82 percent and 88 percent, respectively), and most were between the ages of 5 and 44 years (88 percent and 76 percent, respectively).

Almost one-third (30 percent) of the pedalcyclists killed in traffic crashes in 1997 were between 5 and 15 years old.

"Almost one-third of the pedalcyclists killed in traffic crashes in 1997 were between 5 and 15 years old."

Table 5. Nonoccupant Traffic Fatalities, 1987-1997

Year	Pedestrian	Pedalcyclist	Other	Total
1987	6,745	948	132	7,825
1988	6,870	911	136	7,917
1989	6,556	832	107	7,495
1990	6,482	859	124	7,465
1991	5,801	843	124	6,768
1992	5,549	723	98	6,370
1993	5,649	816	111	6,576
1994	5,489	802	107	6,398
1995	5,584	833	109	6,526
1996	5,449	765	154	6,368
1997	5,307	813	154	6,274

For more information:

Information on traffic safety is available from the National Center for Statistics and Analysis, NRD-31, 400 Seventh Street, S.W., Washington, D.C. 20590. Telephone inquiries should be addressed to Ms. Louann Hall at 1-800-934-8517. FAX messages should be sent to (202) 366-7078. General information on highway traffic safety can be accessed by Internet users at http://www.nhtsa.dot.gov/people/ncsa. To report a safety-related problem or to inquire about motor vehicle safety information, contact the Auto Safety Hotline at 1-800-424-9393.

Preliminary 1998 North Carolina Crash Facts

	1998	1997
Fatalities	1,587	1,483
Injuries	150,048	152,289
Total crashes	211,175	210,666
Fatal crashes	1,424	1,290
***Alcohol-related fatalities**	463	462
***Percent alcohol-related fatalities**	29%	31.2%
***Alcohol-related injuries**	10,594	11,472
***Percent alcohol-related injuries**	7.1%	7.5%
***Alcohol-related fatal crashes**	413	403
***Alcohol-related injury crashes**	6,529	7,013
Drivers killed	900	812
Passengers killed	370	401
Motorcyclists killed	80	61
Bicyclists killed	41	31
Pedestrians killed	196	178

**Note: December numbers have not been finalized so alcohol-related numbers for 1998 are not complete.*

Source: NC Department of Transportation, Division of Motor Vehicles, Traffic Records Section

2/24/99

Highway Safety Legislation Issues

Issues raised at December 17 meeting on the agenda of:

Issue	Dept. of Transportation	Governor's Highway Safety Commission	Division of Motor Vehicles	Governor's Task Force on DWI	Crime Control & Public Safety	Dept. of Insurance
Strengthen Seat Belt Laws	X	X			X	X
Strengthen Child Restraint Laws	X	X			X	X
Underage Drinking	X	X		X		
Increase Fines on DWLR		X		X		
SBI Lab Funding		X		X		
Increasing Citation Fines		X			X	
Increasing Statewide Camera Enforcement	X	X			X	
Bicycle Helmet	X	X			X	X
Judge/DA Training		X				
Out of State Motorist (No magistrate needed)		X			X	
Points/Raise Fines for Speeding in Work Zone	X	X			X	
Hire Additional State Troopers		X		X	X	
Expand Motor Assistance Patrol	X				X	
DMV-Reduce Rest Area Patrols	X		X			
TEA-21 Sanctions Open Container	X	X		X		
TEA-21 Sanctions Repeat O[redacted]er	X	X		X		

Help Save "90 Lives In '99"

Thousands of lives have been saved and thousands of injuries prevented, since North Carolina's seat belt and child passenger safety laws went into effect in October 1985. But more must be done to protect drivers and passengers from death and devastating injury. Legislation requiring all occupants in all seating positions using age-appropriate passenger restraint will ***save 90 lives in 1999*** and every year there after.

1999 Proposed Legislation Will Include The Following:

- Assess two (2) driver license points (not insurance points) for a driver's failure to use a seat belt and/or failure to ensure that passengers under age 16 are properly restrained.
- Require occupants in all seating positions to be restrained at all times.
- Raise age from under 4 years old to under 5 years old or less than 60 lbs. for mandatory use of a child restraint system.
- Require child restraint system to be placed in the back seat, if the back seat will accommodate a child restraint system.

Benefits In Strengthening Occupant Restraint Laws:

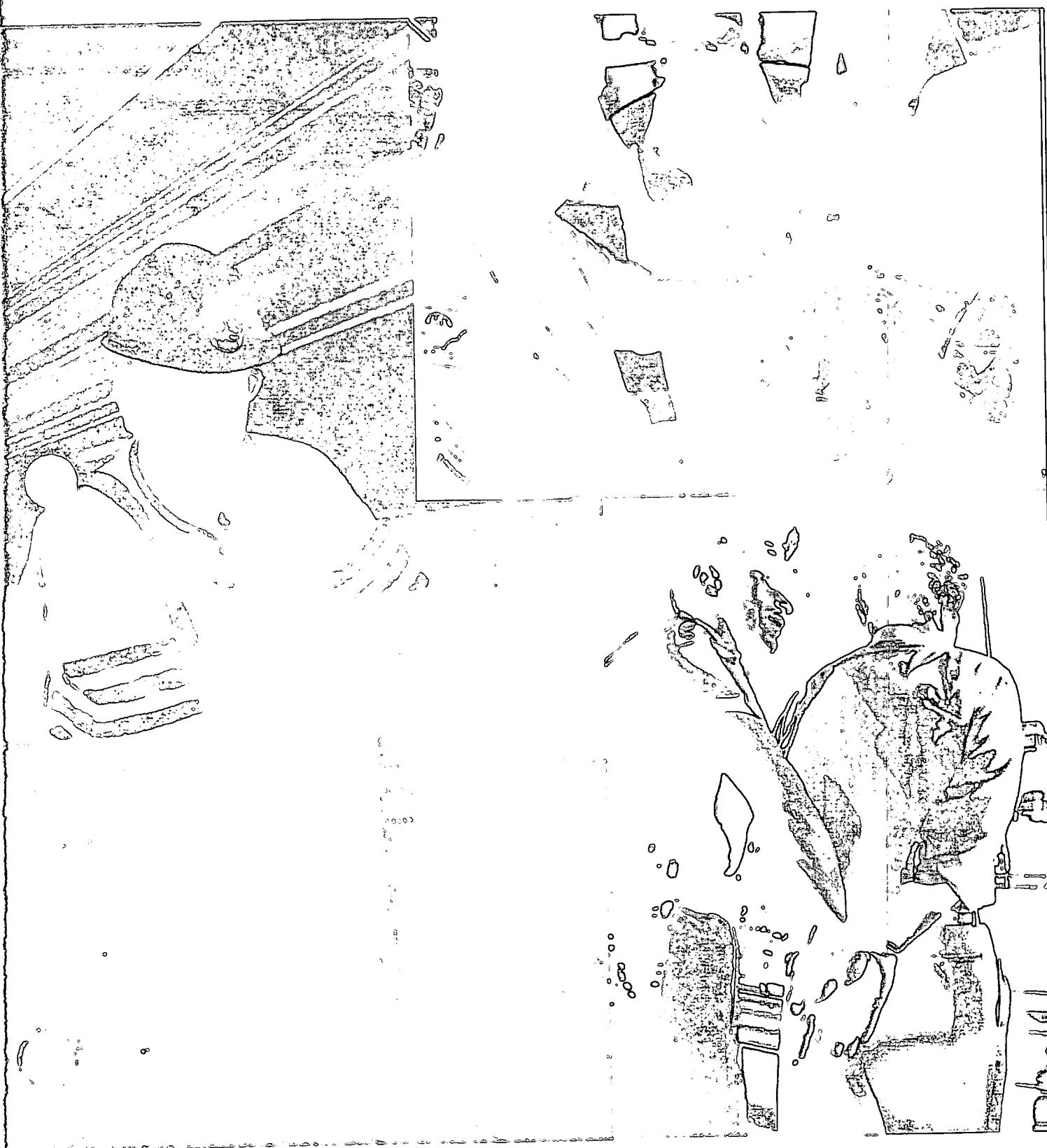
- Surveys of North Carolina belt nonusers indicate that they would respond to driver license points.
- Increasing seat belt use from 80% to 90% should lead to an estimated 90 lives saved and 800 serious injuries prevented per year in North Carolina.
- Belt nonusers in North Carolina are more often involved in high risk behaviors such as drinking and driving, are less likely to have health care coverage, and are up to 35% more likely to be involved in crashes.
- When a driver is buckled, restraint use for children under age 12 is 95%; for an unbuckled driver child restraint use drops by more than half to 44%.
- Increasing seat belt use from 80% to 90% should lead to an additional annual cost savings for direct medical and emergency services of $1.338,000 for fatalities and $15,290,000 for serious injuries.
- Increasing coverage to include all rear seat occupants to be buckled up would save an estimated four lives and prevent 32 serious injuries per year in North Carolina.

Standing Committees

DRIVER	VEHICLE	ROADWAY	DATA
AAA Carolinas	DCC&PS	Associated General Contractors of America	DCC&PS
AARP	DCC&PS / Division of Emergency Management	DCC&PS / Division of Emergency Management	DCC&PS / Division of the Highway Patrol
Administrative Office of the Courts	DCC&PS / Division of the Highway Patrol	DOH / Highway Design	DMV / Collision Reports and General Services
DCC&PS	DMV / Collision Reports and General Services	DOH / Maintenance Unit	DMV / Enforcement
DCC&PS / Division of Alcohol Law Enforcement	DMV / Commissioner's Office	DOH / Program Development	DMV / School Bus and Traffic Safety
DCC&PS / Division of Emergency Management	DMV / Enforcement Section	DOT / Ferry Division	DOH / Traffic Engineering
DCC&PS / Division of the Highway Patrol	DMV / School Bus and Traffic Safety Section	DOH / Traffic Engineering	DOI
Department of Public Instruction	DOH / Traffic Engineering	Eastern Band of Cherokee Indians	Governor's Highway Safety Program
Division of Facilities Services / EMS	DOI	FHWA / Office of Motor Carriers	Medical Database Commission
DMV / Collision Reports and General Services	FHWA / Office of Motor Carriers	Governor's Highway Safety Program	NC DEHNR
DMV / Commissioner's Office	Governor's Highway Safety Program	ITRE	UNC HSRC
DMV / Enforcement Section	Independent Insurance Agents of NC	ITRE / Technology Transfer Program	
DMV / School Bus and Traffic Safety Section	ITRE	League of Municipalities	
DOI	ITRE / Technology Transfer Program	National Park Service	
DOT / Bicycle and Pedestrian Program	League of Municipalities	NC Association of County Commissioners	
DOH / Traffic Engineering	NC Association of County Commissioners	NC Commission on Indian Affairs	
Eastern Band of Cherokee Indians	NC Auto Dealers Association	NC Trucking Association	
Governor's Highway Safety Program	NC Trucking Association	Norfolk Southern Corporation	
Independent Insurance Agents of NC	Office of Attorney General	Office of Attorney General	
ITRE	State Bureau of Investigation	Operation Lifesaver	
League of Municipalities	UNC HSRC	UNC HSRC	
MADD	US Air Force (Seymour Johnson AFB)	US Air Force (Seymour Johnson AFB)	
National Park Service	US Army (Fort Bragg)	US Army (Fort Bragg)	
NC Association of Broadcasters	US Coast Guard Support Center	US Coast Guard Support Center	
NC Association of County Commissioners	US Marine Corps (Camp Lejeune)	US Marine Corps (Camp Lejeune)	
NC Commission on Indian Affairs	US Marine Corps (Cherry Point)	US Marine Corps (Cherry Point)	
NC DEHNR			
NC Motorcycle Safety Education Program		Alamance Co. MPO	
NC Trucking Association		Bessemer City MPO	
Office of Attorney General		City of Charlotte MPO	
SADD		City of Goldsboro MPO	
Safety and Health Council of North Carolina		City of Winston Salem MPO	
State Bureau of Investigation		Western Piedmont COG MPO	
UNC HSRC			
US Air Force (Seymour Johnson AFB)			
US Army (Fort Bragg)			
US Coast Guard Support Center			
US Marine Corps (Camp Lejeune)			
US Marine Corps (Cherry Point)			
Alamance Co. MPO			
Bessemer City MPO			
City of Charlotte MPO			
City of Goldsboro MPO			
City of Winston Salem MPO			
Western Piedmont COG MPO			

FY 1998 Summary:

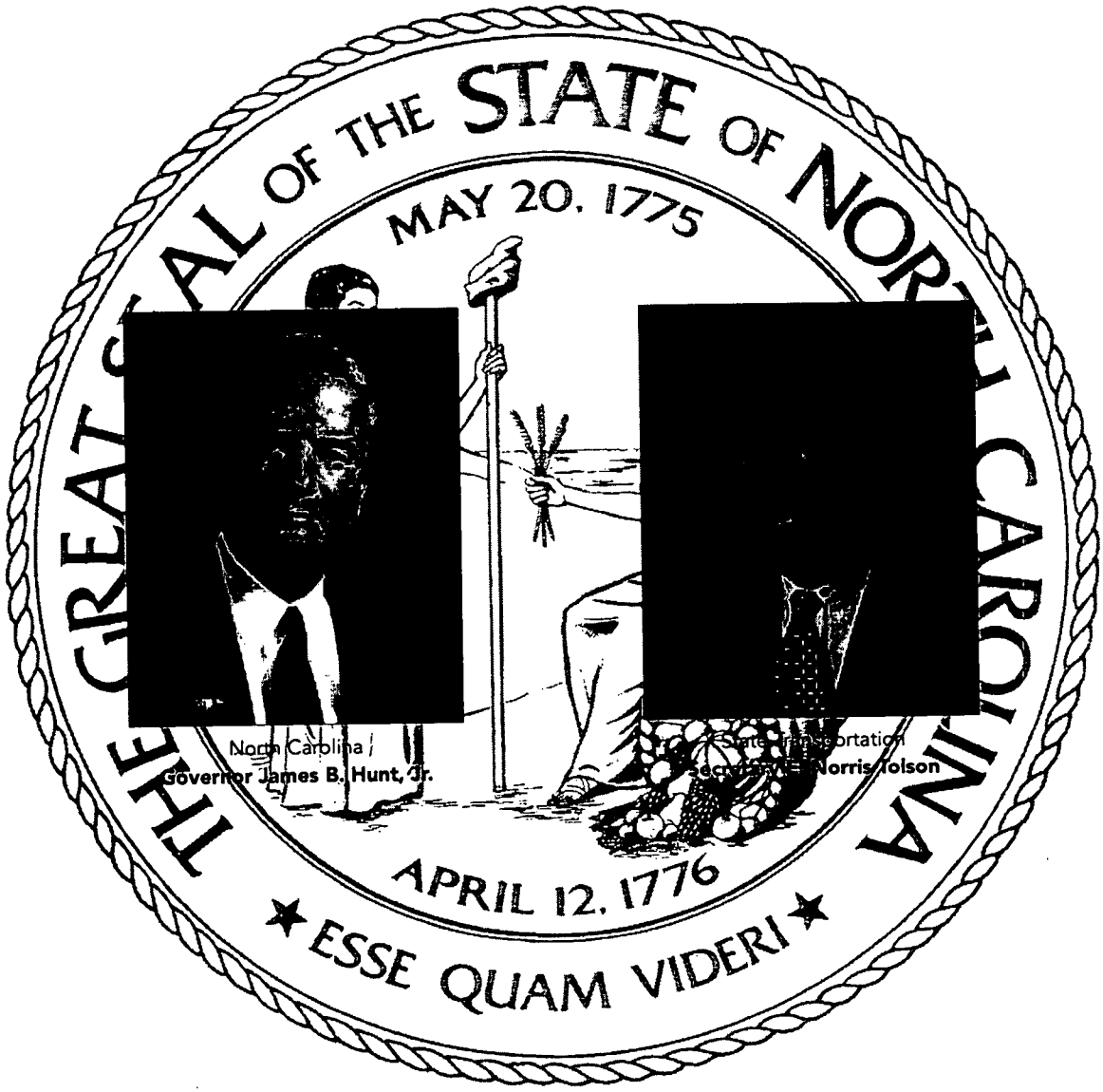
A Report from the North Carolina Governor's Highway Safety Program



NORTH CAROLINA DEPARTMENT OF TRANSPORTATION

FY 1998 Summary:

A Report from the North Carolina Governor's Highway Safety Program



North Carolina Governor's Highway Safety Program
215 East Lane Street, Raleigh, North Carolina 27601
Phone: 919.733.3083
Fax: 919.733.0604
Website: www.dot.state.nc.us/services/ghsp

The North Carolina Governor's Highway Safety Program (GHSP) was established in 1967 as a result of the Highway Safety Act (Public Law 89-564) in 1966 by the United States Congress.

As an agency within the North Carolina Department of Transportation (NCDOT), the GHSP is located in the state capital of Raleigh. Director Joe Parker receives the full support of State Transportation Secretary E. Norris Tolson and Governor James B. Hunt, Jr. The GHSP implements a variety of traffic safety initiatives and programs annually both directly and through the distribution and oversight of federal highway safety funds.

The GHSP is committed to addressing traffic safety concerns utilizing a collaborative approach. It serves as a resource and catalyst for the implementation of statewide traffic safety programs. Involvement and support from the law enforcement, health, youth, nonprofit, insurance, judicial, transportation, research, and education groups among others has been critical to the success of the traffic safety efforts in North Carolina.

GHSP Goals

The GHSP has developed the following six major goals:

- Reduce the number of serious injuries and fatalities on the state's roadways through the efficient use of highway safety resources available on the local, state and national level. These resources include both public and private sources.
- Develop and implement a strategic Highway Safety Action Plan identifying problems and countermeasures for addressing the nine Section 402 program areas: alcohol and other drug countermeasures, occupant restraints, traffic records, police traffic services, speed control, emergency medical services, motorcycles, pedestrians/ bicycles, and roadside safety -- plus work zone safety.
- Address highway safety issues through innovative means, by involving all sectors of the economy *(public and private)* in a coordinated, planned fashion.
- Increase public awareness of traffic safety issues and the impact traffic safety has on the state.
- Increase the GHSP's organizational effectiveness and ability to respond to traffic safety issues.
- Provide technical assistance, including training, to communities, state agencies, private sector groups and key practitioners.

Administrative Staff

Joe Parker
Director

Bill Stout
Deputy Director

Don Nail
Planning and Evaluation

Jill Warren Lucas
Public Affairs

Tony Humphries
Internal Affairs

GHSP Structure & Financial Summary

FY 1998 FINANCIAL SUMMARY

PROGRAM AREAS	FY 1998 EXPENDITURES	% OF EXPENDITURES TO PROGRAMMED AMOUNT	% OF TOTAL EXPENDITURES
Planning & Administration	$ 308,205	91.9%	6.5%
Community Traffic Safety Programs	269,919	62.4	5.7
Safe	[illegible]	86.7	3.0
Alcohol	334,715	82.1	7.1
Youth	[illegible]	[illegible]	2.2
Alcohol Incentive	748,105	44.0	15.9
Police Traffic Services	[illegible]	86.3	28.9
Occupant	194,272	52.2	4.1
Motorcycle	[illegible]	[illegible]	[illegible]
School Bus Safety	25,763	71.2	0.5
[illegible]	[illegible]	[illegible]	[illegible]
Traffic Records	32,428	81.1	0.7
[illegible]	[illegible]	[illegible]	[illegible]
DHHS Local Law Enforcement	688,809	71.4	14.6
TOTAL	$4,716,952	67.6	100.0

The GHSP consists of four divisions with distinct and separate functions.

General Administration:

This function is handled by the Director and Deputy Director. These positions provide leadership to support the entire operation of the GHSP and provide guidance for the success of the overall traffic safety program.

Planning and Evaluation:

This section is responsible for the oversight, monitoring, and evaluation of funding the agency receives for distribution to governmental and non-profit agencies. The section is also responsible for developing the annual benchmark report and highway safety action plan. Fiscal administration also resides in this section.

Public Affairs:

This section is responsible for the coordination and management of the GHSP's public information and education campaigns. All statewide publicity for traffic safety initiatives is coordinated through this section.

External Affairs:

This section is responsible for the implementation of statewide traffic safety programs. This section coordinates all GHSP outreach efforts.

Equipment Grants

During FY 1998, the GHSP presented its largest equipment grant ever to the Macon County Sheriff's Office -- $62,000 to provide 13 portable alcohol-breath testing devices and 13 in-car video cameras to help the officer stop impaired driving in the county.

The grant was awarded following a drunken driving crash in which a high school student and a coach were killed. One week later, just one hour and 49 minutes after the state's new DWI law took effect, a Macon County deputy became the first officer to sieze the vehicle of an impaired driver.

Overall Traffic Safety

Goals:

- Attain a mileage death rate of 1.80 for 1997, and a rate of 1.78 for 1999.
- Attain a severe injury rate of 10.6 for 1997, and a rate of 10.3 for 1999.



Photo by Shannon Bullock

Across North Carolina, officers checked for correct use of child safety seats and wrote tickets for child and adult passenger safety violations during "Click It or Ticket."

Efforts:

North Carolina is a leader in traffic safety. Strong state leadership has provided a foundation on which to build this role. Most recently, North Carolina has been a national leader in its efforts to significantly impact occupant protection, seat belt and child safety restraint usage rates statewide and to lower the number of impaired drivers on the roadways. The "Click It or Ticket" and "Booze It & Lose It" campaigns have had widespread impact on traffic safety in North Carolina.

"Click It or Ticket" and "Booze It & Lose It" are part of the overall Governor's Highway Safety Initiative (GHSI). The GHSI has demonstrated that through high profile aggressive traffic safety enforcement combined with an intense earned media campaign, traffic safety efforts can be extremely successful in preventing serious injuries related to motor vehicle crashes.

North Carolina is also extremely involved in the development of Safe Community coalitions. Several communities have active coalitions working to improve traffic safety, as well as community safety through a collaborative approach. Ten new Safe Community coalitions were formed in FY 1998 and support was maintained for the other 10 coalitions that were already in existence. The GHSP's goal is to extend Safe Communities to all 100 North Carolina counties.

In recent years, North Carolina has been successful in the passage of traffic safety legislation that will have long-term effects on the improvement of traffic safety. North Carolina was one of the first states to have a mandatory seat belt usage law that allowed for primary enforcement. The state also is one of a mi-

Traffic Unit Exceeds All Expectations

In 1995, the GHSP provided initial grant funding for the Raleigh Police Department's Traffic Enforcement Unit. The unit has helped reduce the rate of crashes in the capital despite an increasing population.

Combining the GHSP grant and funding provided by the City of Raleigh, the traffic enforcement program has cost approximately $2.2 million from 1995 to 1998. analysis showed the gram has saved Raleigh itizens more than $46 million in health-care related costs.

nority of states that currently has a 0.08 breath-alcohol concentration (BAC) *per se* law. Repeat DWI offenders driving on a revoked license lose their vehicle on the spot in North Carolina.

Young drivers have also been addressed through the implementation of one of the nation's first graduated licensing laws. It is anticipated that during the coming year North Carolina will strengthen the existing seat belt and child safety seat laws and possibly implement a bicycle helmet law and extend the use of red light running cameras statewide.

Outcomes:

The mileage death rate for 1997 was 1.81, while the severe injury rate was 12.3. The mileage death rate was on target, while the severe injury rate fell short of the goal by 16 percent.

"Saved By the Belt"

Among the features of the North Carolina Highway Safety Exposition is the "Saved by the Belt" Wall of Fame. The names of North Carolina drivers and passengers whose lives were saved through correct use of seat belts and child safety seats are displayed here. Certificates and special front license tags are presented to honorees.

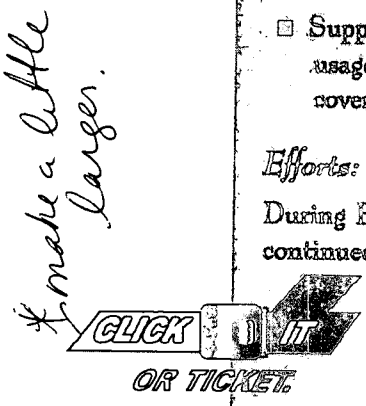
If you know someone who has been "Saved By the Belt," call the GHSP at 919-733-3083 for a nomination form. The form also is available at our website: www.dot.state.nc.us/services/ghsp

Goals:

- Maintain the seat belt usage rate of 83 percent during 1997, and achieve a rate of 85 percent in 1999.
- Increase the correct use of child safety restraints for children under 60 pounds from 30 percent during 1997 to 40 percent in 1999.
- Achieve 100 percent seat belt usage by uniformed law enforcement and public safety officers by the end of 1999.
- Support legislation to strengthen the mandatory seat belt usage law, increasing the associated fine, provide universal coverage, and add driver license points.

Efforts:

During FY 1998, the Governor's Highway Safety Program continued the "Click It or Ticket It" program that has become a national model for statewide seat belt education and enforcement campaigns. During the special "Click It or Ticket It" emphasis periods of May 18-June 7 and August 24-September 13, law enforcement agencies statewide conducted 2,815 seat belt checkpoints. These checkpoints resulted in 13,181 seat belt violations and 998 child safety seat violations. Additionally, 2,925 DWI arrests were made and 45,404 other traffic violations were issued. Also, five fugitives were arrested as a result of the checkpoints and more than 2,300 criminal violations were detected.



A statewide Public Service Announcement (PSA) campaign was launched in FY 1998. The campaign utilized law enforcement personnel from around the state to drive the message of "Click It or Ticket" to the local level. Localized media spots were produced in English and Spanish by the GHSP by utilizing law enforcement officers representing agencies in the media market where the spots were to air.

North Carolina launched a statewide campaign to get traffic safety messages to North Carolina's growing Hispanic community. Brochures that had been developed for the "Click It or Ticket" and "Booze It & Lose It" campaigns were translated into Spanish for distribution. The demand and popularity of these items has been tremendous.

The GHSP continued support for the Department of Insurance "Buckle Up Kids" (BUK) program. This program functions in 72 percent of the state's counties. The program has certified 91 instructors for delivery of basic child safety seat curriculum and 67 instructors for delivery of the advanced child safety seat curriculum. Through the end of FY 1998, BUK has distributed

"No Excusas"

To improve communications with the state's growing number of Spanish-speaking motorists, the GHSP created a new series of Spanish-language brochures and public service announcements. The campaign was recognized with the NCDOT Continuous Improvement Award in the "Most Improved Communication" category.

3,409 child safety seats and provided instruction on the proper usage of these devices. BUK held its second annual Statewide Child Safety Seat Bounty Program in FY 1998. This program collected 177 unsafe child safety seats in 24 counties. The seats were destroyed.

The North Carolina Partnership for Children (NCPC) received 1,179 child safety seats from the GHSP in FY 1998. The safety seats were distributed to needy children in 43 counties that had active Smart Start partnerships. An even larger distribution of seats is planned for FY 1999.

Law enforcement officers across the state have been receiving child safety seat training concerning the proper usage of the devices and instructions for training parents and guardians on the proper usage of these devices. During FY 1998, 1,000 officers statewide were trained.



Photo by Shannon Bullock

Joe Parker joins First Lady Carolyn Hunt, Dr. Herb Garrison and State Transportation Secretary Norris Tolson (from left) at the Smart Start car seat event.

Outcomes:

Statewide seat belt usage in 1997 was 84 percent. This slightly surpassed the anticipated goal of maintaining the usage rate at 83 percent. Unfortunately, child safety seat usage rates were not collected in 1997. However, considerable efforts were placed on training of law enforcement officers in the correct usage of child safety seats and the enforcement of child safety seat laws during FY 1998.

Law enforcement officers statewide have been extremely cooperative in the "Click It or Ticket" program. Officers have taken the lead on setting an example for motorists in always "buckling up." No scientific surveys are available on the usage of seat belts by law enforcement officers in North Carolina, but informal surveys reveal that usage rates are close to 100 percent.

North Carolina was very close to having much stronger mandatory occupant protection and child occupant protection legislation in FY 1998. One vote separated the state from having a doubling of the fine for non-compliance with the seat belt law, and requiring children to age 5 to ride in the rear seat. The law would have also raised from age 12 to age 16 the requirement for children to be in either a child restraint system or seat belt.

Legislative approval of these modifications appears likely in the 1999 Legislative Session along with other provisions originally sought in 1998, especially adding two driver license points for drivers failing to buckle themselves or their passengers.

A Model for the Nation

In July 1998, US Transportation Secretary Rodney Slater wrote to North Carolina Gov. Jim Hunt to commend his "outstanding leadership and dedicated support" of the national traffic safety priorities of getting motorists to wear seat belts and to not drive after drinking.

Slater stated that "North Carolina's 'Click It or Ticket' program serves as a model for the national 'Buckle Up America' campaign."

Impaired Driving

Goals:

- To reduce by five percent the percentage of alcohol-related severe injury rate from 2.90 to 2.76 by the end of 1997, and to 2.42 by the end of 1999.
- To reduce by five percent the fatality rate for alcohol-related traffic deaths from 27.17 to 25.81 percent of total traffic deaths by the end of 1997, and to 28.03 percent by the end of 1999.

Efforts:

During FY 1998 the GHSP continued its nationally renown program "Booze It & Lose It." During the special "Booze It & Lose It" emphasis period of June 29-July 5, law enforcement agencies statewide conducted 566 sobriety checkpoints. These checkpoints resulted in 1,232 DWI arrests. Additionally, the checkpoints resulted in 4,557 seat belt violations, 469 child safety seat violations, and more than 20,700 other traffic violations. Seven fugitives were arrested as a result of the checkpoints and more than 1,100 criminal violations were detected.



The Governor's Task Force on Driving While Impaired has been instrumental in the strengthening of North Carolina's DWI laws. Lieutenant Governor Dennis Wicker chairs the Task Force.

On December 1, 1997, North Carolina implemented a new enforcement tool to fight impaired driving by repeat DWI offenders. State law now allows officers to impound the vehicle of drivers arrested for DWI and driving with a revoked license. If convicted, the vehicle is sold and the proceeds are donated to the local school system. From December 1, 1997 to July 31, 1998 there were 2,945 vehicles impounded as a result of this law.

North Carolina's DWI laws were strengthened during the 1998 Legislative Session. Fines for all DWI offenses were doubled. A zero-tolerance law was passed for drivers of commercial vehicles, school buses, and day care vehicles, while a 30-day administrative license revocation was passed for underage streamlined to expedite the sale of impounded vehicles, and making it easier for innocent owners to reclaim their vehicles.

The GHSP funded a second Mobile Breath Alcohol Testing (BAT) Unit, or BAT Mobile in FY 1998. The vehicle contains all of the necessary supplies to process a motorist charged with impaired driving at sobriety checkpoints. The BAT Mobile is staffed and coordinated by the North Carolina Highway

Positive impact of .08 law

Since 1993, when North Carolina lowered its alcohol limit from .10 to .08, alcohol-related taffic fatalities have dropped dramatically. In 1992, 42 percent of all highway fatalties in North Carolina were alcohol related. In 1993, 34 percent of traffic fatalities were alcohol related. Since then, alcohol-related deaths in North Carolina have been below 34 percent, with a low of 27 percent in 1995.

While numbers for 1998 were not final at press time, drunk driving fatalities through August 1998 were the lowest they have been since 1992.

Patrol. The unit became operational in the fallof 1998. The first unit was placed into operation in 1996 by the Forensic Tests for Alcohol (FTA) Branch. The original unit participated in 59 DWI checkpoints and 54 public information and education events in FY 1998. The checkpoints yielded 774 DWI arrests, 4,060 traffic violations, and 461 criminal violations.



Photo by Charlie Jones

Officers across the state seized nearly 3,000 vehicles operated by repeat offenders since the new DWI law went into effect December 1, 1997.

The North Carolina Alcohol Law Enforcement (ALE) Agency conducted 32 "Cops In Shops" programs in 1998, resulting in 234 underage person alcohol purchase charges and 33 charges for use or display of a fictitious identification. ALE contacted 1,864 individuals through this program and made 573 arrests resulting in 764 charges. In addition to the "Cops In Shops" program, ALE delivered 599 "Be a Responsible Server" training programs educating 1,483 alcohol servers statewide.

The FTA Branch implemented a new program to assist in the prosecution of DWI cases in the state. A scientific research analyst was hired and trained to develop skills necessary for court testimony and to serve as a resource for district attorneys statewide. During FY 1998, this analyst testified in 31 cases, 29 of which resulted in a guilty verdict for the accused DWI offender. In addition to assisting in the prosecution of DWI cases, the analyst serves as a resource to the Governor's DWI Task Force and the General Assembly.

Outcomes:

The alcohol-related severe injury rate for 1997 was 2.69 percent. This exceeded the goal established for this benchmark value. However, the fatality rate for alcohol-related traffic deaths was 31.15 percent in 1997 resulting in a 1.3 percent increase over the 1996 level. During this same time period the of alcohol-related fatalities increased by two, while total traffic fatalities decreased by nine.

On Land – and on Water

For the first time, enforcement officers with the Division of Wildlife Resources and the Department of Parks & Recreation joined the "Booze It & Lose It" campaign to step up enforcement of impaired operation of watercraft laws.

While other law enforcement officers monitored state roadways during the busy Fourth of July holiday period, enforcement boats were used to conduct safety inspections on waterways, where officers issued citations to impaired operators.

Assistance to Localities

A major portion of the traffic safety efforts in North Carolina is directed to local traffic safety improvement. The total amount of funds expended at the local level in FY 1998 was $2,558,728. This represented 54.4 percent of the total traffic safety expenditures in FY 1998.

The bulk of local funding was directed to the Police Traffic Services program area. This section of the annual Highway Safety Plan allowed for the implementation of six new local law enforcement traffic safety units. North Carolina has been very successful in obtaining community support at the local level for implementation and continuation of traffic safety units.

The GHSP has also been instrumental in the placement of equipment to battle driving while impaired. Through license reinstatement fee funds paid by convicted impaired drivers, the GHSP was able to provide over 250 in-car video cameras to assist in the conviction of impaired driving suspects. These funds also allowed the GHSP to fund over 200 preliminary breath-testing units and assist several local agencies in obtaining sobriety checkpoint equipment.

Mini-grant funding was made available in many communities across the state last year. More than 26 high schools received funding for assistance in implementing traffic safety programs focusing on seat belt usage and alcohol awareness education. Many schools were able to conduct education events in conjunction with senior prom and graduation.

Mini-grant funding was also awarded to eight local communities for the implementation of the "Basics of Bicycling" educational curriculum in their local elementary schools.

Motorcycle safety training awareness courses were conducted statewide in FY 1998. There are now 17 training sites statewide offering motorcycle safety courses. The courses were conducted through local community colleges. In addition to the rider education courses, in FY 1998, 15 new instructors were trained.

The GHSP continued the operation of the highly successful "North Carolina Highway Safety Exposition." The Exposition was on display at 64 events in North Carolina during FY 1998 and toured by an estimated 1,269,050 visitors.



Photo by Charlie Jones

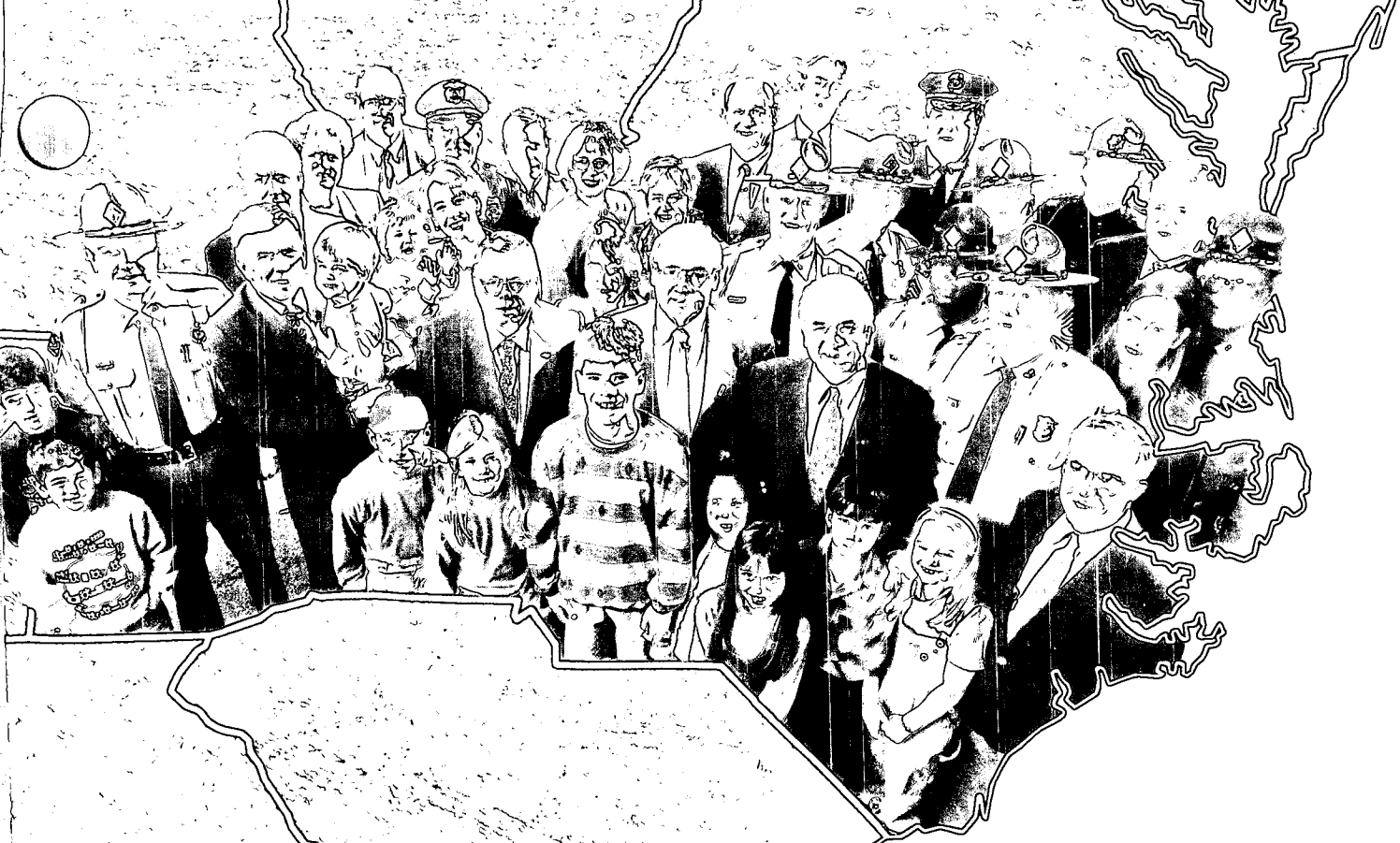
Visitors to the North Carolina State Fair learn about highway safety laws while touring the Highway Safety Exposition and get a sense of what .08 impairment feels like by using these driving similators.





The information in this document was prepared by the staff of the North Carolina Governor's Highway Safety Program, an agency of the North Carolina Department of Transportation. Copies were published at a cost of $2.00 each. For additional copies, or information about GHSP programs or North Carolina highway safety laws, please write or call:

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Website: www.dot.state.nc.us/services/ghsp



North Carolina Highway Safety Initiative

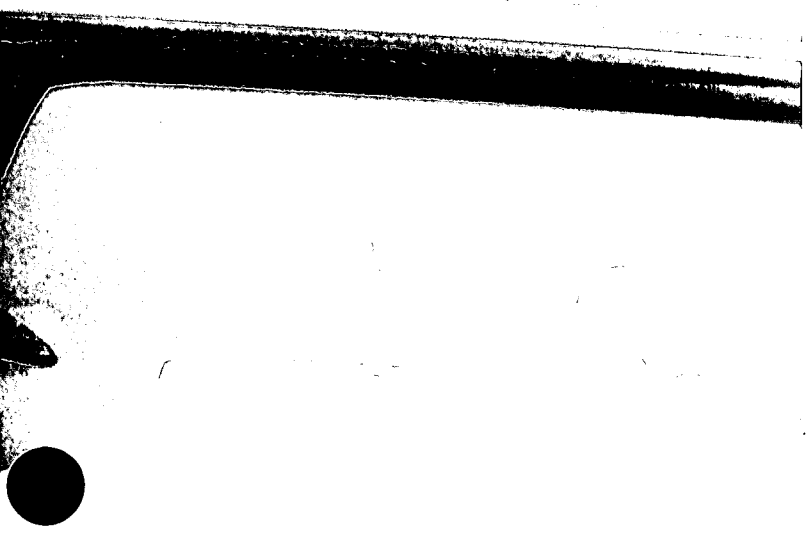
HOW TO DO IT

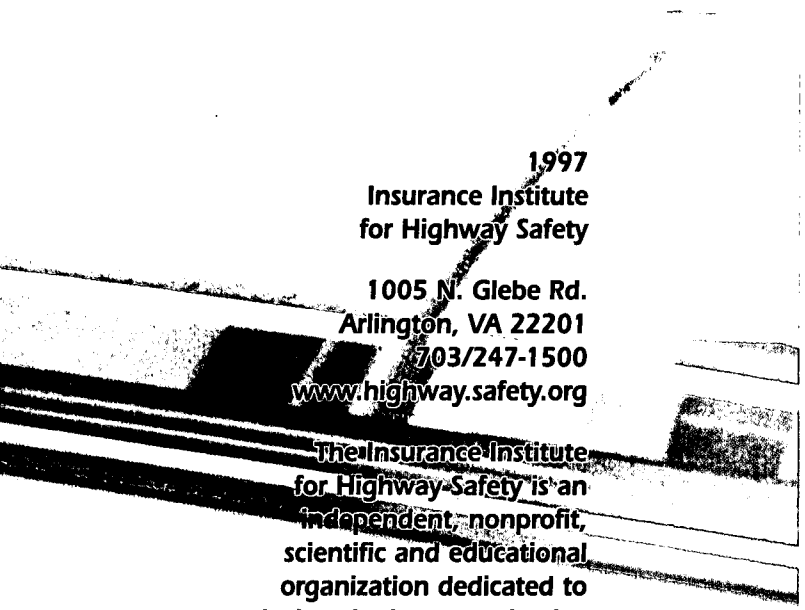
CLICK IT OR TICKET.
(Because It's Buckle Up Or Pay Up)

BOOZE IT & LOSE IT.









1997
Insurance Institute
for Highway Safety

1005 N. Glebe Rd.
Arlington, VA 22201
703/247-1500
www.highway.safety.org

The Insurance Institute for Highway Safety is an independent, nonprofit, scientific and educational organization dedicated to reducing the losses — deaths, injuries, and property damage — from crashes on the nation's highways. The Institute is wholly supported by auto insurers.

CLICK IT OR TICKET.

(Because It's Buckle Up Or Pay Up)

BOOZE IT & LOSE IT.

From top state officials to town safety officers and patrolmen in the smallest communities, North Carolinians mobilized in early 1993 to reduce deaths and injuries from motor vehicle crashes. The goal was more people buckling up and fewer drivers impaired by alcohol. After five years, "Click It or Ticket" had boosted belt use rates from 64 to 84 percent, putting this state among the best in the nation. The number of drivers with illegal blood alcohol concentrations fell by more than half, measured at sobriety checkpoints after "Booze It & Lose It."

What did it take to succeed in North Carolina? Three things to get started:

Top Down Commitment: "I have a personal commitment to highway safety," North Carolina Governor Jim Hunt says. "My daddy installed seat belts in our family vehicles in the 1950s and required their use. Years later, I was using a belt when I was hit by a drunk driver, and that's the reason I'm alive today and able to serve as governor of North Carolina."

Hunt's commitment, communicated to more than 400 city, county, and state law enforcement agencies, laid the foundation for both "Click It or Ticket" and "Booze It & Lose It."

Increasing belt and child restraint use and decreasing alcohol-impaired driving "not only saved lives, it saved money too," says North Carolina Insurance Commissioner Jim Long. "With all the attention to

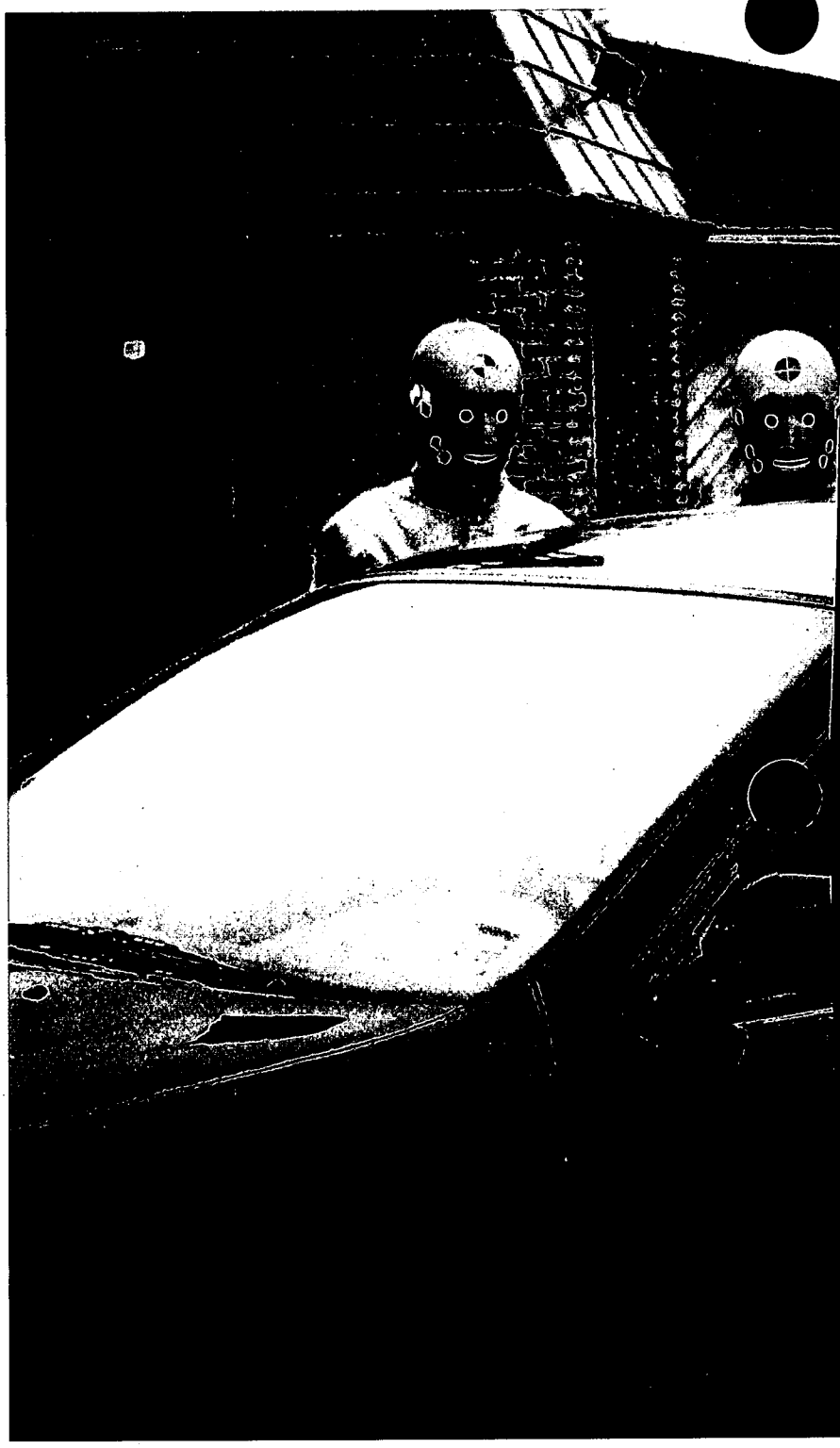
rising health care costs, we were overlooking one simple and important way to reduce costs. We made a commitment to prevention." Savings are estimated at $114 million over the five-year period.

2. Tandem Approach: Enforcement of belt, child restraint, and DWI laws was vigorous and well publicized. "The point is to magnify police enforcement with highly visible checkpoints and publicity so people understand they really might get a ticket if they violate the law," Insurance Institute for Highway Safety President Brian O'Neill explains. Research worldwide demonstrates the need for both enforcement and publicity to change behavior in regard to traffic laws.

3. Public-Private Partnership: The Governor's Highway Safety Program, headed by Joe M. Parker, coordinated the five-year initiative together with Jim Long's Department of Insurance. Auto insurers committed $3.5 million supplemented by state and local funds plus federal participation. The National Highway Traffic Safety Administration provided funds earmarked for local use. The Insurance Institute for Highway Safety supplied program direction and research design and assisted the University of North Carolina Highway Safety Research Center in evaluating the initiative.

Dubbed a "best practice" by the U.S. Department of Transportation, this partnership can be implemented elsewhere. President Clinton has asked states to work toward increasing belt use from 68 to 85 percent nationwide by the year 2000, and the federal plan includes elements that proved effective in North Carolina. The President also is calling on states to enact laws allowing officers to ticket motorists for failure to use belts alone instead of only in conjunction with another violation.

The five-year North Carolina initiative focused on safety belts and child restraints in the first year because this is where the greatest gains were likely. Af-

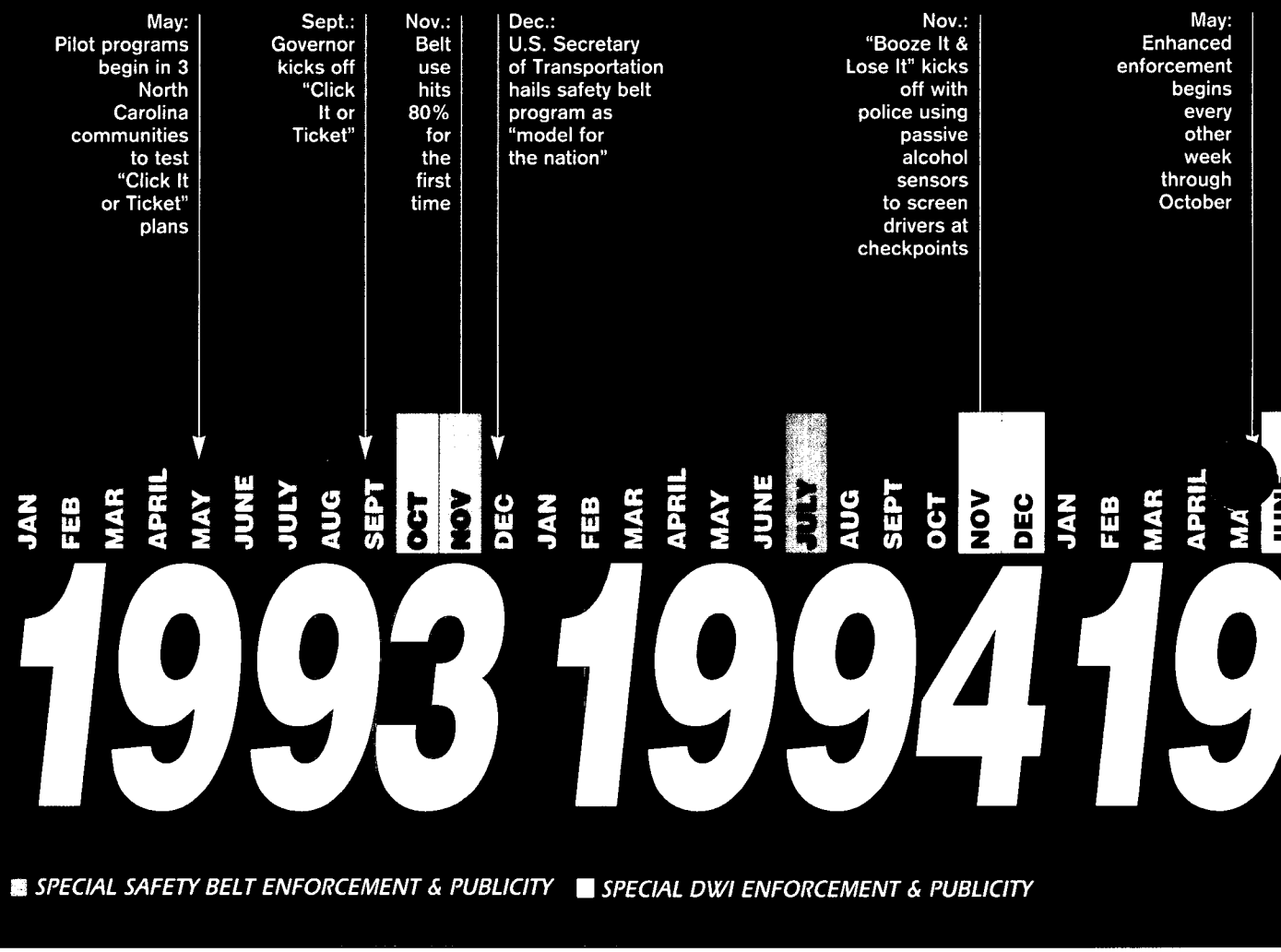


Success depends on TA



M APPROACH *of enforcement and publicity*

AT A GLANCE:
North Carolina highway safety initiative



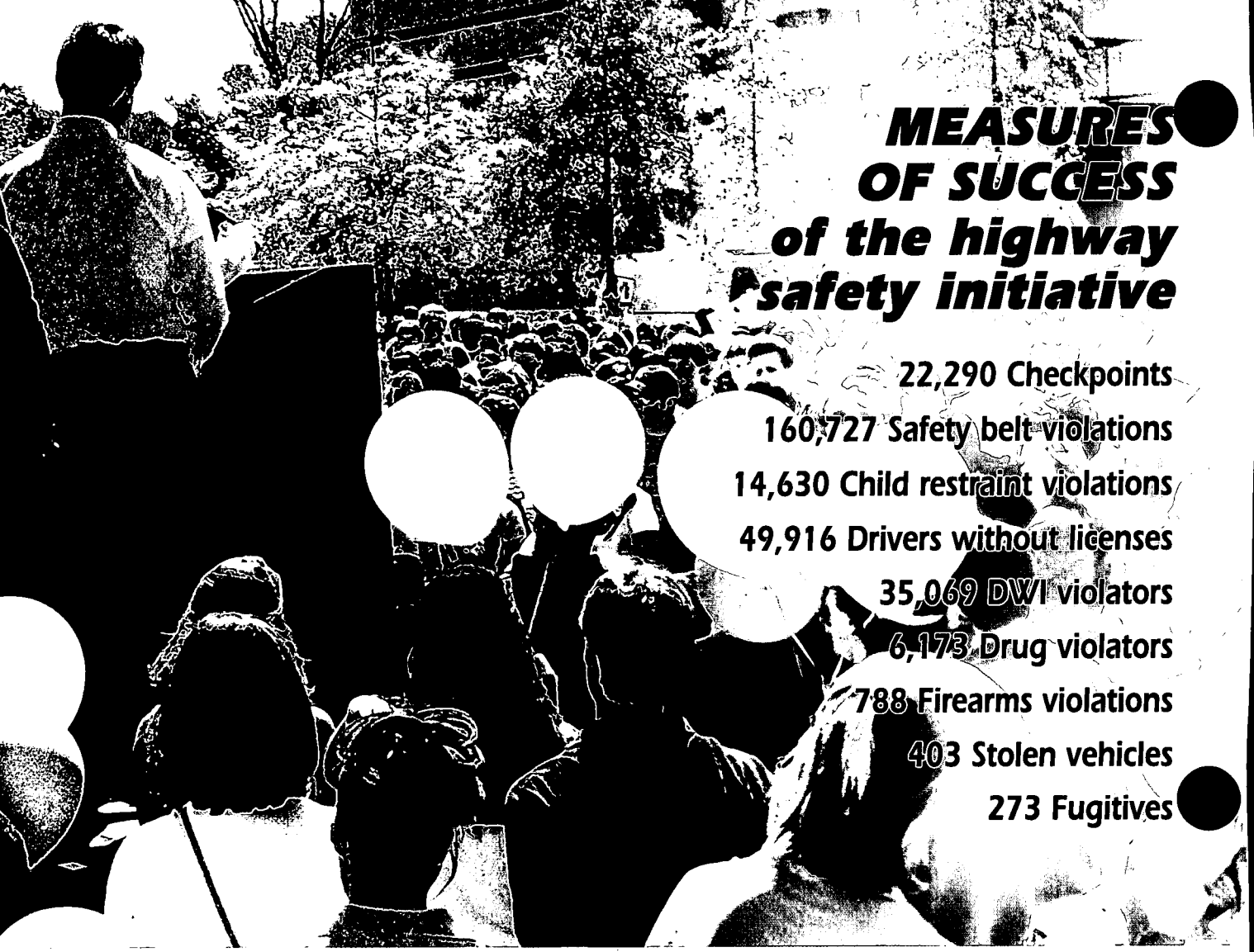
ter locking in and maintaining belt use gains, the scope of the highway safety program was widened in the second year to address the tougher issue of alcohol-impaired drivers.

Three pilot programs launched before the statewide initiative served as blueprints for the larger effort and helped build public support for highly visible enforcement. Motorists were informed through a two-week education and public information effort followed by three weeks of intensive ticketing by police with special enforcement training. Media saturation and an incentive program attracted attention and helped ensure positive reception — motorists who buckled up received goods and services donated by the private sector.



Three-week enforcement efforts accompanied by intensive publicity were implemented statewide throughout the five-year period. Surveys conducted before and after "Click It or Ticket" documented shifts in driver belt use rates, which improved during the program to 84 percent.

In the second year of the initiative, motorists were reminded that the penalty for driving while impaired by alcohol in North Carolina is loss of license on the spot under "Booze It & Lose It." Highly visible, well-publicized checkpoints increased public perception that impaired drivers were likely to be caught.



MEASURES OF SUCCESS of the highway safety initiative

22,290 Checkpoints

160,727 Safety belt violations

14,630 Child restraint violations

49,916 Drivers without licenses

35,069 DWI violators

6,173 Drug violators

788 Firearms violations

403 Stolen vehicles

273 Fugitives

Data gathered before the first enforcement effort indicated that 2.4 percent of drivers had blood alcohol concentrations at or above North Carolina's per se limit of 0.08 percent. In the "Booze It & Lose It" demonstration areas, the percentage of drivers with blood alcohol concentrations at or above 0.08 percent passing through state checkpoints declined from 2.0 percent before the program to 0.9 percent after it.

"There will never be enough police to detect every violator of traffic laws. But once drivers think there's a good chance violators will be detected, the number of offenders decreases," Allan Williams, the Insurance Institute for Highway Safety's senior vice president for research, points out. This is the rationale of the enforcement and publicity model that, before North Carolina proved it statewide, had succeeded in U.S. cities such as Elmira, New York, and in Australia, Canada, the Netherlands, and New Zealand. Now, for the first time, it has been systematically and successfully applied over a five-year period across an entire U.S. state.

Start with Good Laws: The cornerstone of the North Carolina highway safety initiative was the strength of the state's safety belt and DWI laws. The belt law is standard, or primary, which means police may stop a vehicle solely because of belt law violations.



Greatly enhancing enforcement opportunities, this type of law results in higher use rates because motorists know there's a better chance of being fined for not buckling up. (In many other states, police must have some other reason to stop a vehicle before belt citations may be issued.) The $25 fines collected for violating North Carolina's belt law go straight to public school programs.

The DWI law in North Carolina has teeth, too. Like 48 other states, it's a per se law defining it as a crime to drive with a blood alcohol concentration (BAC) at or above a proscribed level — and the level is 0.08 percent, not 0.10 percent as in most states. For drivers younger than 21, the threshold is an even tougher zero BAC.

Another strength of North Carolina's DWI law is a provision allowing for administrative suspension of drivers' licenses. Suspension or revocation traditionally follows conviction for DWI or other traffic offenses. But under administrative procedures in North Carolina and other states, a license may be revoked before conviction — in fact, right after arrest — when a driver fails or refuses to take a chemical test for alcohol. Research shows this sanction is effective. It reduces driver involvement in nighttime fatal single-vehicle crashes by about 9 percent.

Launch a Big, High-Profile Effort: North Carolina Governor Jim Hunt was a vocal supporter of the highway safety initiative from its inception, presiding at a kickoff press conference in Raleigh surrounded by hundreds of law enforcement officers, state officials, and citizens. "I'm strongly supporting this initiative for a simple reason," the Governor declared. "It will save lives and prevent serious injuries."

Hunt also visited some of the first safety belt checkpoints to demonstrate the type of enforcement that would take place statewide. His high-profile endorsement attracted intensive news coverage.

A prominent participant was North Carolina Insurance Commissioner Jim Long who noted that, in addition to lives saved and injuries prevented, there were monetary savings. "We're finding that many of those involved in vehicle crashes who aren't wearing safety belts also don't have health insurance," Long said as the highway safety initiative got under way. "The cost is passed on to the rest of us ... and it's a preventable cost if we can get people to buckle up."

Long crisscrossed the state to encourage local involvement, agreeing to have his beard shaved off in public in the county that achieved the highest belt use rate. He ended up having half of the beard shaved off in each of two North Carolina counties when a tie was declared. This



While Insurance Commissioner Long fulfilled a promise to have his beard shaved off in public in the county that achieved the highest belt use, Governor Hunt visited checkpoints (facing page).

newsworthy stunt landed Long and the "Click It or Ticket" program on the front page of local papers.

In addition to raising public awareness, the leadership roles played by top state officials helped to motivate state and local agencies and rally the police rank and file. "Police can be the slowest group to get involved. But with the high-level endorsements and the positive feedback once officers got involved and did a few checkpoints, the police became big supporters," says Terry Story, Safety Officer and Risk Manager for the Town of Boone.

Do Checkpoints, Regular Patrols: Highly visible and publicized checkpoints for both safety belt use and impaired driving were the main elements of the North Carolina program. Roving patrols also were employed. The checkpoints were manned in part by police on overtime paid by federal funds.

Although checkpoints provide the opportunity to ticket offenders, the ultimate goal is deterrence — no violators and therefore no tickets at all. Police coordination ensured the checkpoints were conducted with minimal inconvenience to motorists, and public response measured by polling data was overwhelmingly positive.

"At first there was some hostility toward the checkpoints, but that animosity lessened as the populace was educated," says Sgt. Ken Whitesell of the Guilford



Strong Public Support

Should officials who implement highway safety initiatives like North Carolina's worry about public backlash? Do citizens resent strong police enforcement of traffic laws? Not in North Carolina, where support for the enforcement and publicity program was strong.

A poll taken after the 1993 kickoff found nearly 9 out of 10 people familiar with the initiative and in favor of enforcement. A year later, after checkpoints in all 100 counties, another poll found that 57 percent of those who knew about the initiative said it had made them buckle up more often. After five years, more than 80 percent of respondents still said they favor strong enforcement of safety belt and DWI laws.

Only a third of those surveyed said the safety belt law was being enforced very strictly — let alone too strictly. Such support continued throughout the program.

A 1994 survey of law enforcement agencies found that 81 percent participated in "Click It or Ticket" checkpoints — all highway patrol units plus 78 percent of police departments and 72 percent of sheriffs' offices. Eighty-four percent said their communities support the highway safety initiative, and 91 percent said motorists' comments were favorable.



County Sheriff's Office. "The feedback changed to where some would even thank the officer or acknowledge that they were sorry, they knew they should be wearing a belt, as opposed to the early days when the response was 'I'm not hurting anyone, and you have no right to stop me.'"

Coordination Counts: Another key to success was unprecedented coordination and cooperation among the more than 400 law enforcement agencies statewide. "Our supervisors worked side by side with the supervisors of local police departments and sheriffs' offices," notes Major Ralph Price of the state highway patrol. "We also worked with the many military bases" located across North Carolina.

Col. E.W. Horton of the highway patrol says his troopers were "ideally positioned ... stationed in every county. And with our computer system linking all 100 counties, we were able to continuously track and update enforcement results."

The bonds forged among different branches of law enforcement had a carry over effect. "A big payoff was with Hurricane Fran in September of 1996," Major Price remembers. As calls poured into the highway patrol's emergency operations center, knowledge of the communities and personal relationships with local police enhanced the combined response of state and local authorities.

Coordination wasn't limited to law enforcement agencies. State and local police were assisted by health department personnel, fire and rescue squads, and others in the public health sector. It was a collaborative effort that Jackie McKoy, Scotland County's community traffic safety program coordinator, calls community building.

"The united effort was important," Sgt. Whitesell adds. "You must have the commitment of all agencies — highway patrol, department of motor vehicles, sheriffs'

Besides improving highway safety by enforcing safety belt and DWI laws, the North Carolina initiative produced an important bonus. When Hurricane Fran blew through the state in 1996, coordination among branches of law enforcement and public safety already was honed during three years of enhanced traffic law enforcement. As calls poured into the highway patrol's emergency operations center during the hurricane, officers were able to handle the crisis by coordinating with local police.



Wilmington Star-News



Officials emphasized infant and child restraint use as well as adult safety belt use — and kids across North Carolina got the message.



offices, individual police forces, as well as community-based groups."

Capt. John Ennis of the Greenville Police Department agrees. "The program gives local police officers and the highway patrol a chance to work together in a nonemergency situation. We also worked closely with the county injury prevention program, which assisted us with child restraint inspection clinics and trained officers to identify improperly installed child seats."

Child restraint clinics sponsored by county hospitals and health departments were held in conjunction with "Click It or Ticket" checkpoints across the state. Instead of being ticketed, first-time violators of the child restraint law were directed to the clinics for instruction.

"It was great to have all the different disciplines working together. It really enhanced our sense of community," Jessica Gurganus says. She's the community health educator at Pitt County Memorial Hospital who ran child seat clinics. "I'd never worked with law enforcement before and had some stereotypes, but it turned into a very pleasant experience. The police can be a big help in injury prevention, because they see what goes on out on the road. They can help us educate parents about car seats."

The cooperation took many other forms. Tim Edwards, safety director of Seymour Johnson Air Force Base in Goldsboro, points out that the U.S. Department of Defense has its own mandatory belt law, "so we jumped on the bandwagon" when the statewide initiative began, helping to raise belt use rates on and off the base.

Sandy Deskins, drug education coordinator in Monroe for Union County Public Schools and member of a county health coalition, says student antidrug groups at three high schools held fundraisers to purchase child safety seats for residents who couldn't afford them. The seats were sold at cost by Wal-Mart. In Scotland County, K-Mart cleared its parking lot for child seat clinics, and car dealers in many communities loaned vehicles so proper installation could be demonstrated.

"It's important to enlist volunteers from all agencies and the public and to share credit. The credit piece is real important," Gurganus notes.

Involve Kids as Well as Parents: From the beginning, the importance of properly restraining children was part of the message. A pilot study at elementary schools and daycare centers involved letters to parents announcing the resumption of safety belt checkpoints, urging proper restraint use, and explaining the need for kids to ride in the back seat.

Restraint of children at two pilot elementary schools increased significantly, from 36 to 64 percent at one school and from 49 to 71 percent at the other. Restraint use rates also rose at the daycare centers, though not as much. These results indicate that focused enforcement of laws and education can increase proper use of

To publicize the highway safety initiative, officials showcased the beneficiaries. Amber Ledford of Burnsville says she "put on a belt about three minutes before I wrecked." A sheriff had reminded her she might get a ticket if she didn't buckle up.



Motorists thought a checkpoint was around every corner — a perception crucial to success because it led to compliance even when no special enforcement was under way.

restraints among child passengers, but it was harder to get the parents to move children from the front to the back seats of their vehicles.

Generate Media Coverage: "People thought there was a checkpoint around every corner," says Major Price of the highway patrol. Creating this perception was critical to success.

Television, radio, and newspaper announcements encouraged North Carolina motorists to buckle up for safety's sake and warned them about the consequences — a $25 ticket — for failing to use their belts. Every dollar of the $4 million collected in fines during the initiative went to local school districts throughout the state.



Paid messages, used in the first two years of the highway safety initiative, were augmented and later superseded by extensive news coverage. State and national officials visited checkpoints and granted interviews to local media outlets. Weekly news releases reported the number of checkpoints conducted in each community and the number of citations issued, including charges for criminal offenses detected during traffic stops.

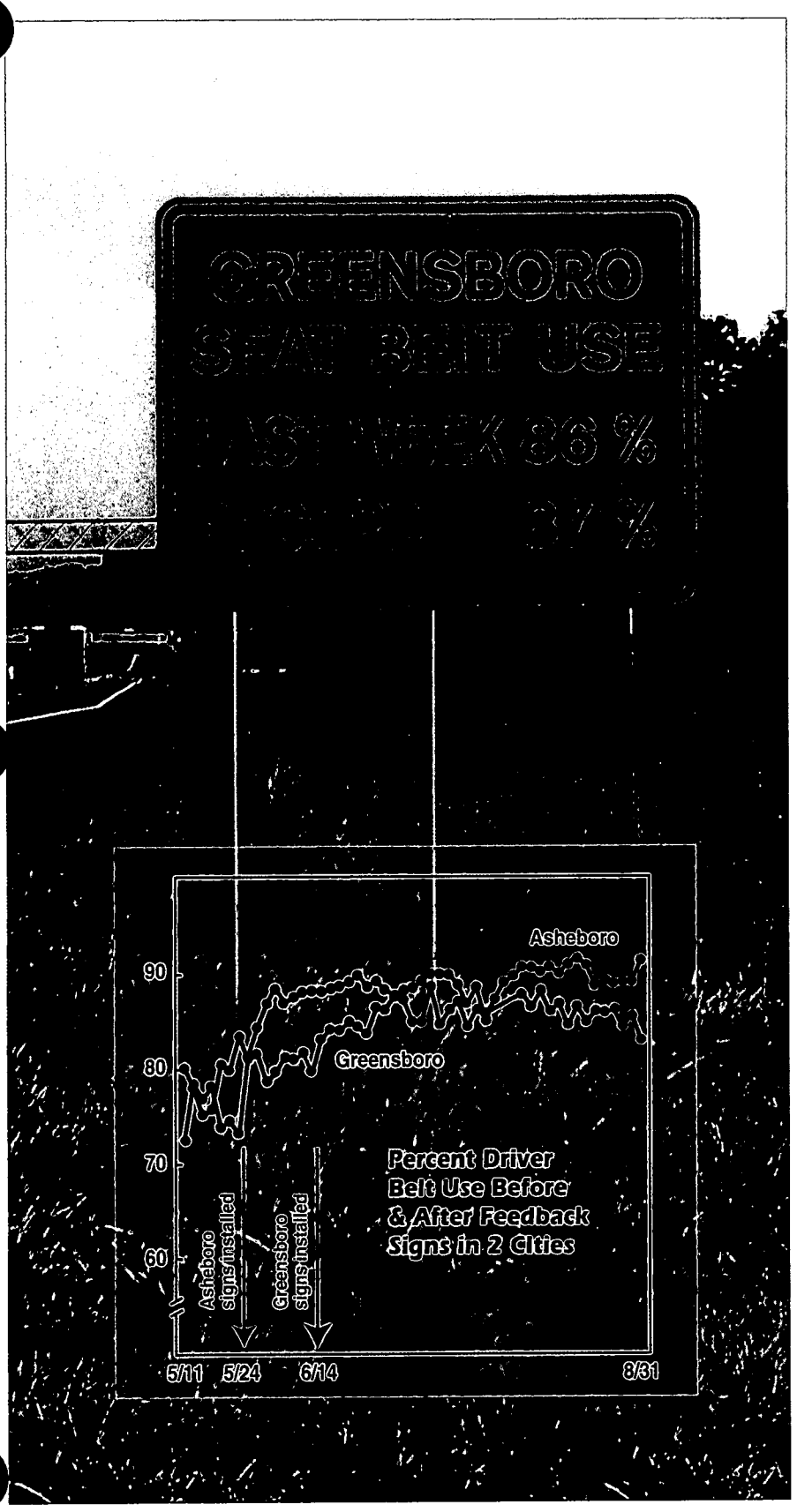
"You don't have to buy a lot of advertising to get the message out," says Joe M. Parker, director of the Governor's Highway Safety Program. "News organizations in North Carolina provided extensive coverage of the increased enforcement and the reasons for it. And we worked hard to keep interest up by traveling around the state and arranging events that would garner maximum attention."

Pitt County's Gurganus adds that "media coverage makes people susceptible to the message. TV sparks people's interest, and when you reinforce the message in person they're ready to hear it."

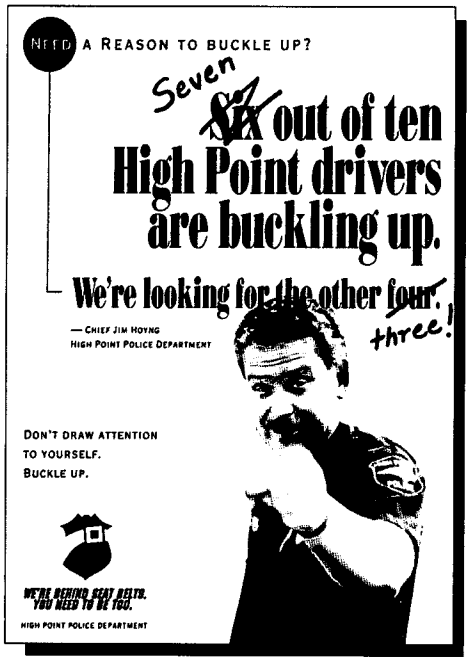
Also reported on a consistent basis were increases in belt use rates and decreases in the incidence of alcohol-impaired driving and how these successes translated into lives saved and injuries averted. Several police officers emphasized the importance of publicizing these results.

"When you put figures in front of people, show fatalities have declined along with serious injuries and that you saved in health care costs, that really has an impact," Captain Ennis of the Greenville police department points out.

Maintaining the program's high profile can even help reinforce the efforts of those charged with carrying it out. "Publicity, results, and side benefits like additional criminal arrests are important in convincing officers that this is a worthwhile use of their time," Officer D.B. Williams of the Andrews Police Department in Cherokee County explains.



In Greensboro and Asheboro, feedback signs posting the latest buckle-up rates helped boost and maintain belt use. Signs posted on well-traveled roads were changed weekly, so the information reminded motorists that belt use was being regularly monitored. This implied a strong and constant enforcement presence. Such signs later were used in other North Carolina cities. Schools and shopping malls also posted feedback signs to help spur local efforts to raise belt use.





An official in Sweden says authorities there modeled a safety belt enforcement and publicity program directly on the North Carolina initiative.

North Carolina Is a Model for the Nation

North Carolina is just one state, but its highway safety initiative is a model for the nation as well as the world. Its success is being noted. Tom Enright, the National Highway Traffic Safety Administration's administrator for the southeast region, says there's increased safety belt enforcement in Georgia, South Carolina, and Florida.

"We got information from North Carolina on 'Booze It & Lose It' and blatantly copied it," says Fred Hagan, president of Drive Smart Florida, a public/private partnership funded by federal funds and donations from insurers and other corporations. Sobriety checkpoints were conducted statewide in March and May 1997, with two more later in the year. Every county had a checkpoint or roving patrol. Enforcement was a joint effort of the Florida Highway Patrol and police departments and sheriffs' offices throughout the state. Hagan says 1,026 police officers participated in the first checkpoint, and the program generated intense publicity.

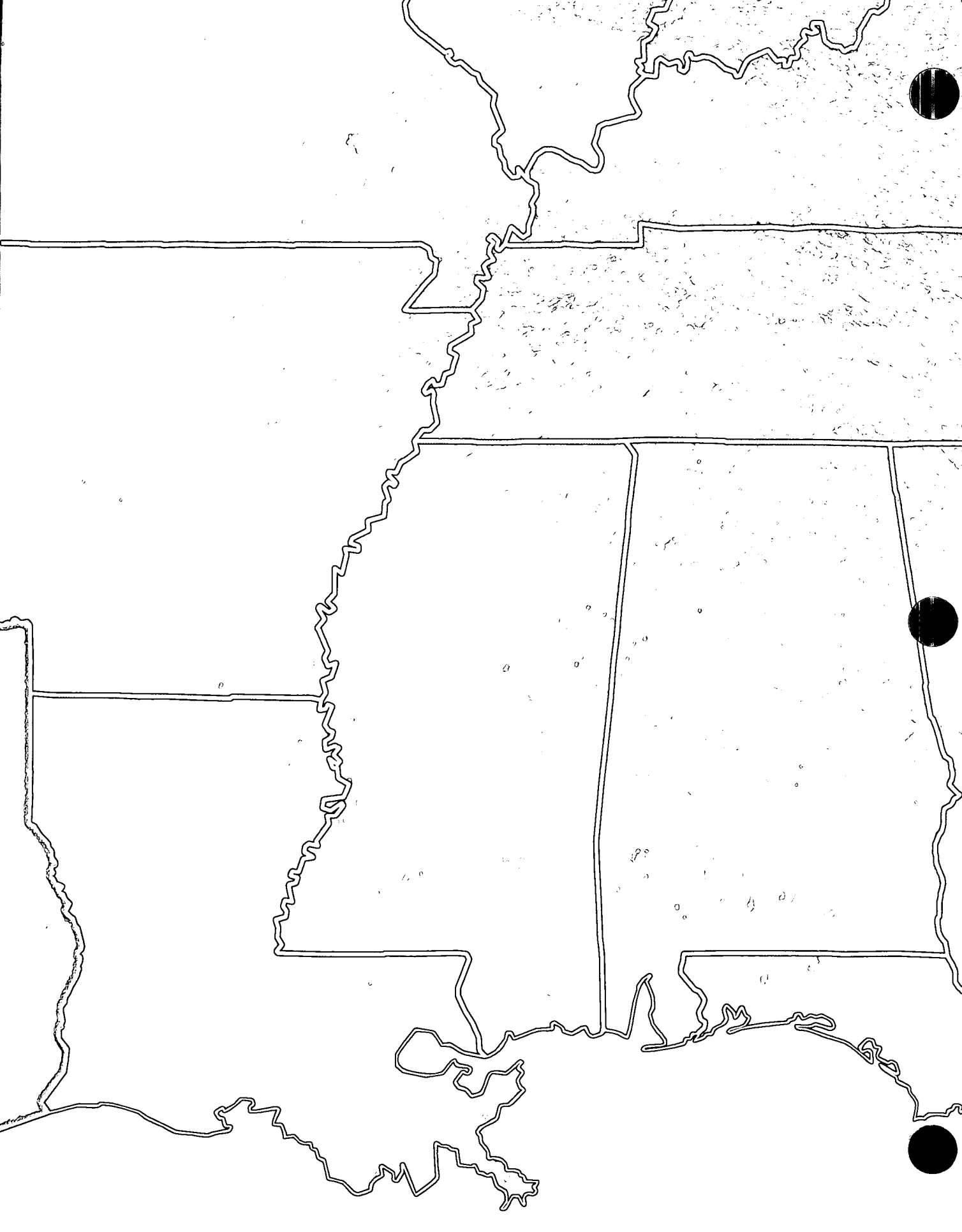
Separately, the Florida Highway Patrol conducted a program to increase restraint use. Called Operation Beltway, it included four two-week enforcement waves in 1996. Although hampered by a belt law that requires police to stop motorists first for another violation before they can ticket for not buckling up, the checkpoints raised Florida's belt use rate from about 50 percent to the low 60s, says Captain David Tripp of the highway patrol. Checkpoint stops in both programs averaged less than two minutes, and the response from citizens was positive.

North Carolina's influence reaches beyond the United States. Belt use campaigns in Swedish localities featured a publicity message copied from North Carolina. Posters featuring police helped get out the message that officers were looking for occupants who weren't buckled up. Though belt use rates are higher overall in Sweden than in the United States, Perry Hakansson of Sweden's National Traffic Foundation says only about 65-75 percent of front-seat occupants and 50 percent in back seats use belts in heavily populated areas. He adds that enforcement and publicity modeled on North Carolina's have been tried throughout the country, resulting in an average 6 percent increase in driver belt use.

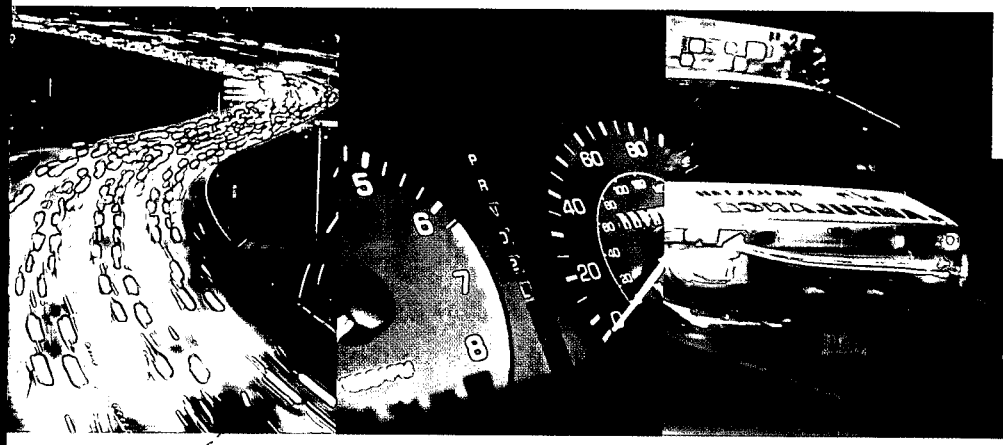
Hakansson describes an additional outcome that mirrors the North Carolina experience. "A campaign of this kind stimulates and motivates local police. An individual officer very often has only a vague idea of the meaning of enforcing belt laws. By giving local police forces the facts and letting the information phase pave the road for enforcement, we see an increased understanding of the whole issue."



The goal of safety belt and sobriety checkpoints and of all other enforcement associated with the North Carolina initiative wasn't to write lots of tickets. The ultimate goal was to issue no tickets at all because every motorist in the state learned to observe all traffic laws.



NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION



PROMOTING SAFE PASSAGE INTO THE 21ST CENTURY STRATEGIC PLAN 1998

NHTSA

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ON THE ROAD TO A HEALTHIER FUTURE



NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

PROMOTING SAFE PASSAGE INTO THE 21ST CENTURY

STRATEGIC PLAN 1998

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MESSAGE FROM THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATOR

The past four decades have witnessed dramatic reductions in the number of people killed and injured in traffic crashes on the nation's roadways. This is the result of safer vehicles and highways, fundamental changes in driver behavior, and a national commitment to healthier lifestyles (including advances in medical care and shifts in health behaviors). Agency programs during this period saved more than a quarter of a million lives and $700 billion.



Traffic crashes nonetheless continue to be a leading public health problem. Although the country can be proud of safety successes on record, motor vehicle crashes are still the leading cause of death for people ages 6 to 27 and impose an economic penalty on the public of $150 billion a year. In 1997 alone, 41,967 people were killed in traffic crashes and another 3.45 million were injured.

Since issuing our original strategic plan in 1994, the agency has made significant strides. We expanded our safety partnerships, focused attention on preventing crash injury, gave a face to the human tragedy resulting from crashes, and provided tools for safety advocates to take responsibility and work with us. Initiatives were undertaken to advance occupant protection, protect against head injury, and improve child passenger protection. We are working closely with states, industry, safety advocates, and the public to make travel safer.

We are pleased to issue a new strategic plan that updates important safety issues, agency priorities, and program strategies. The new plan is entitled "Promoting Safe Passage Into the 21st Century," and it was developed in concert with our partners from all sectors of the U.S. traffic safety community. I want to acknowledge and thank them for their contribution.

This plan identifies where we have been and where we are going as we continue to work on reducing the tragedy on the nation's highways. The model for our program design is the Haddon Matrix developed by the first administrator of the National Highway Traffic Safety Administration, who was a physician. We focus on pre-crash, crash, and post-crash portions of the problem, with activities relating to the people involved, the vehicles, and the environment. Specific problems are defined, and the strategies for addressing them are presented.

Internally, we are focusing on programs that reduce crash injuries, strengthen our staff, and position the agency so that we will be prepared to respond as the environment changes. Our goal is to work intermodally with all agencies in the Department of Transportation in a ONE DOT strategy. Externally, we will continue working with all of our partners to bring about changes needed to reduce deaths and injuries. We remain committed to being the world leader in developing innovative and effective safety programs, serving as a technical resource for the highway safety community, and fostering a work environment that is known for its productivity and effectiveness.

Ricardo Martinez, M.D.

MISSION AND LONG TERM GOALS

MISSION

The National Highway Traffic Safety Administration's (NHTSA) mission is to save lives, prevent injuries, and reduce traffic-related health care and other economic costs. The agency develops, promotes, and implements effective educational, engineering, and enforcement programs directed toward ending preventable tragedies and reducing safety-related economic costs associated with vehicle use and highway travel.

DEPARTMENT OF TRANSPORTATION GOALS

As an agency of the Department of Transportation (DOT), NHTSA is committed to an intermodal program focused on safety. In 1997, DOT published a new strategic plan addressing five goals: safety, mobility, economic growth and trade, human and natural environments, and national security. NHTSA's primary role within the Department is to improve traffic safety. NHTSA's programs also make contributions to DOT's mobility, economic growth and trade, and human and natural environment goals.

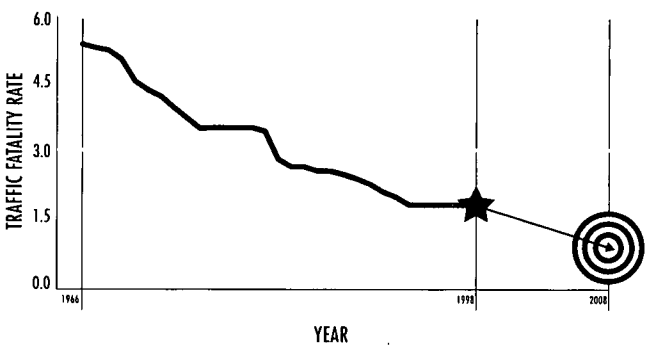
PUBLIC HEALTH PROBLEM

The prevalence and tragedy of motor vehicle injuries provide NHTSA with the challenge and opportunity to improve and increase crash and injury prevention measures. In the United States, injury is the leading cause of traumatic death for all ages from 1 to 44, and motor vehicle injury is the number one cause of death from injury (accounting for almost one-third of the deaths each year). Motor vehicle injury is the leading cause of death for persons ages 6 through 27 and the leading cause of occupational injury deaths, as well as the leading health care cost. Typically, persons injured in motor vehicle crashes suffer multiple injuries and often must endure long hospitalizations. Ten percent of crash victims with head injuries, for example, will be in a hospital or rehabilitation center for up to one year. Because most of these victims are young, their long-term disabilities carry a heavy cost burden.



NHTSA'S 2008 GOAL

NHTSA, working with the Federal Highway Administration (FHWA), established a goal of reducing highway fatalities and injuries 20 percent by the year 2008. This plan describes the strategies that NHTSA is undertaking to achieve this goal. These strategies, if successful, will reduce fatalities from 42,065 (1996) to about 33,500 (2008) and injuries from 3,511,000 (1996) to 2,809,000 (2008). With the expected increase in travel, meeting the 2008 goal will result in a concomitant decrease of 35 percent in the fatality rate. At a time when America is searching for ways to cut health care costs, reaching these objectives would result in a $2.3 billion annual reduction in health care costs.



ACCOUNTABILITY

Since its inception, NHTSA has tracked the number of traffic fatalities and injuries. This represents one means of measuring agency and program performance. This history, plus NHTSA's participation as a pilot agency in the Government Performance and Results Act (GPRA), led to NHTSA's being named by the President's Office of Management and Budget as 1 of only 10 "exemplar" Federal agencies in the pilot program. As GPRA approaches its fifth anniversary, NHTSA continues to push the envelope in such critical areas as conducting strategic planning, managing change, and driving accountability deeper into the organization. This plan is testimonial to how the agency is managed using the principles and philosophy of GPRA.





CUSTOMERS AND PARTNERS

CUSTOMERS

NHTSA's customers are the American people. They do not speak with a single voice, but with many. Every day, from every state, customers call into the Auto Safety Hotline, speak with NHTSA employees, and communicate through faxes, e-mail, and letters. Customers tell NHTSA what it is doing well, what it needs to do more of, and how it can do better. NHTSA views its job as not just listening, but hearing. The agency uses this ongoing dialogue to understand the current needs of customers more fully, as well as to anticipate future needs. That is one way NHTSA can foster innovation and better focus its resources.

This strategic plan puts into action what has been heard from customers, such as the need for safer air bags, the existence of safety defects in vehicles, and the inherent dangers in aggressive driving. The plan also demonstrates how NHTSA serves its diverse customer segments, such as older drivers, young children and people with disabilities. The many voices of the customer play a fundamental role in helping the agency create its strategic plans.

PARTNERS

NHTSA has used its leadership in traffic safety to form strategic alliances with valuable partners. The agency has emphasized the need for enlisting new, non-traditional partners, such as members and groups of the medical and allied health care professions. These partners help the agency build bridges to a broader set of customers. Partners are selected because of their unique strengths or abilities to deliver NHTSA's products and services to its customers. Approaching partnering from this perspective has produced customer benefits that are greater than would have been achieved if parties operated independently. In an environment in which cost-effective strategies are crucial, NHTSA's approach to partnering leverages resources and will become increasingly important for achieving its goals.



Some participating partners include:

Automobile, Trucks and Trailer Rental and Leasing Companies

Business Community

Community Groups

Consumer and Advocacy Groups

Crash Dummy, Test Equipment, and Instrumentation Manufacturers

Educational Community

Federal Agencies, state and Local Governments

Foreign Governments

Health Care Providers and Professionals

Insurance Industry

Law Enforcement and Legal Communities

Media and Communications

Motor Vehicle Administrators

Motor Vehicle and Equipment Manufacturers

National and International Standards Organizations

Professional and Amateur Sports Organizations

Professional Societies

Public Safety Organizations (Police, Fire, EMS)

Public Health and Injury Control Organizations/Associations

Research Community

Schools

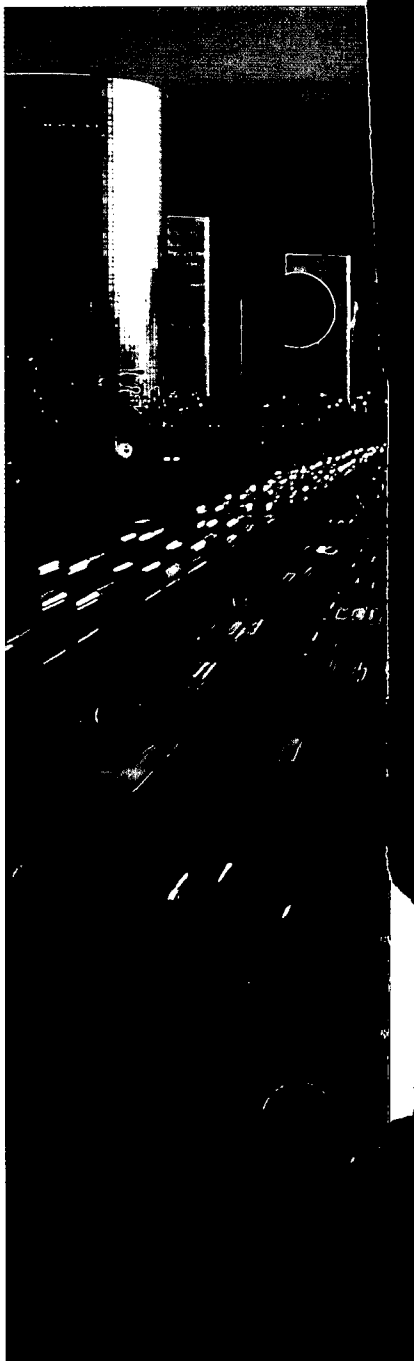
Trade Associations

ENVIRONMENT

In striving to meet its goals, NHTSA must consider the various factors affecting traffic safety. Factors that NHTSA management can control, such as research and regulations, are discussed in the strategy section of this plan. Factors outside the control of NHTSA management are called "environmental factors." The environment is defined as forces, social trends, and institutions that affect NHTSA. These powerful, fundamental forces create opportunities and threats that shape the future strategic direction of NHTSA. NHTSA will continually adapt its policies to environmental changes to achieve its goals.

Tracking changes in the environment allows NHTSA to make informed assumptions about how these forces will affect the future of traffic safety. The agency has conducted an extensive analysis of the environment and reviewed a similar analysis conducted by DOT. A complete discussion of the agency's analysis of the environment can be found in the NHTSA 2020 Report (which is available on the agency home page [http://www.nhtsa.dot.gov] and from the Office of Plans and Policy, 202/366-1574).

The assumptions used by management to make decisions about this plan are summarized next. The factors described will affect traffic safety well into the 21st century, requiring NHTSA to account for them by reshaping its strategic direction.



DEMOGRAPHICS

- POPULATION GROWTH: From 1995 to 2020, the U.S. population is predicted to grow by 21 percent. Without effective safety interventions, there will be more crashes and, consequently, higher fatality and injury levels.
- AGING OF THE U.S. POPULATION: The population of Americans over age 65 will increase by 56 percent by 2020. Special safety risks associated with older drivers, vehicle occupants and pedestrians will demand new strategies.
- PEOPLE WITH DISABILITIES: The percentage of people with disabilities increases with age (13.6 percent of people ages 18 to 44, 29.2 percent of those ages 45 to 64, and 84.2 percent of those ages 85 or older), thus demanding new strategies to reduce the safety risks for drivers with reduced functional capacity, vehicle occupants, and pedestrians.
- LARGE NUMBER OF YOUNGER DRIVERS: The population of drivers in the age group 16 to 24 will increase 19 percent by 2020. Unless effective strategies are implemented, a continued over representation of younger drivers in traffic crashes can be expected.

TRAVEL

- WOMEN IN THE WORKPLACE: The number of women in the workplace has nearly doubled since 1960. As a group, women traditionally have been safe drivers. However, as they have been assimilated into work-related travel, their fatality and injury rates have begun to approach those of the overall population.
- CONGESTION: There will be nearly 280 million registered vehicles in the United States in 2020. If driver stress resulting from this congestion leads to aggressive driving, America could see a significant increase in unsafe driving behaviors.

HEALTH CARE

- IMPROVEMENTS IN EMERGENCY MEDICAL SERVICE (EMS) AND TECHNOLOGY: By 2020, Emergency Medical Services will have evolved into a technologically advanced, community-based health management system that is fully integrated into the overall U.S. health care system. Automatic notification of vehicle crashes will facilitate more rapid response to assist victims. Crash and injury data linkages back to vehicle design will lead to significant safety improvements.



ECONOMY

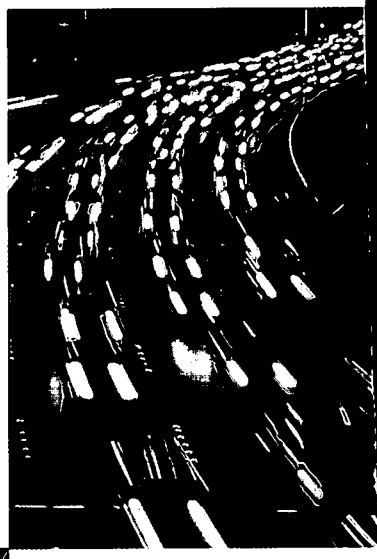
- ECONOMIC GROWTH: Fueled by increasing competition, economic expansion will accelerate, creating more highway travel, increasing the risk of crashes, and in turn, increasing traffic fatalities and injuries.
- THE GLOBAL MARKET AND HARMONIZATION: The global economy will intensify competition, thereby mandating the establishment of regulatory requirements and certification procedures that minimize the cost burden to vehicle manufacturers and consumers while ensuring safe vehicles for motorists worldwide.

NATURAL ENVIRONMENT

- VEHICLE EMISSIONS: The adverse effect of fossil fuels on the environment will increase pressure to develop vehicles that rely on energy sources less harmful to the environment. These vehicles will present new safety challenges, particularly as they are integrated into the existing fleet.

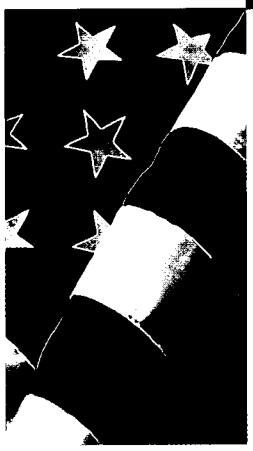
MOTOR VEHICLES

- DEMAND FOR SAFETY: The relative importance of safety in the consumer's vehicle decision-making process will continue to increase in importance.
- INTELLIGENT TRANSPORTATION SYSTEM (ITS) TECHNOLOGIES: The integration of electronic technology into the safety design of vehicles will accelerate the radically changing interface between humans and vehicles and affect driver behavior.
- VEHICLE SIZE COMPATIBILITY: The continued growth in light truck sales relative to passenger car sales will exacerbate the safety problems associated with multi-vehicle crashes.



GOVERNMENT

- THE ROLE OF GOVERNMENTS: Significant changes will occur in the way the Federal government interacts with state governments and individuals.
- GREATER PERSONAL RESPONSIBILITY: As the Federal government's involvement in the lives of citizens is reduced some responsibility is passed to state and local agencies, but personal responsibility for safety will become paramount and call for increased local resources.

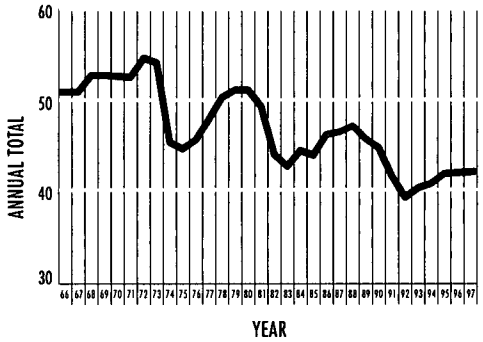


THE STATE OF TRAFFIC SAFETY

For over 30 years, NHTSA has tracked the number of traffic deaths, injuries and related statistics. The most important of these trends are presented below. Viewed as a whole, key trends demonstrate that the approaches used by NHTSA in the past were successful, but recently those trends have leveled off, indicating that NHTSA's historic approaches must be modified to meet its 2008 goals.

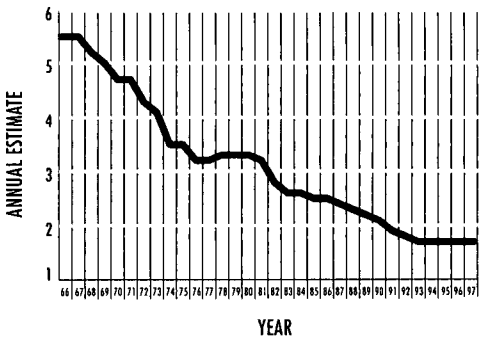
TRAFFIC FATALITIES

Since 1966, the number of traffic fatalities has declined, but remains at a high level. In 1997, 41,967 people were killed in motor vehicle crashes. Traffic crashes, in fact, account for 94 percent of all transportation fatalities.



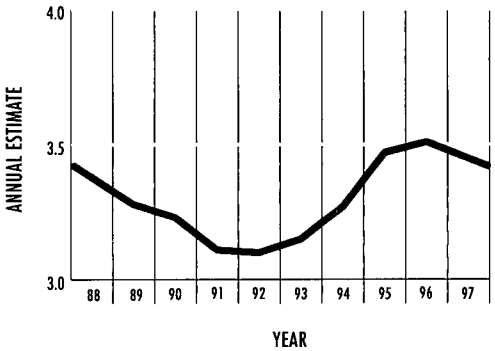
TRAFFIC FATALITY RATE

The fatality rate per 100 million vehicle miles traveled (VMT) has declined significantly since 1966. If the rate 30 years ago had persisted in 1997, more than 130,000 people would have died in crashes, instead of the 41,967 deaths reported. Since 1992, the rate has not declined, instead remaining stalled at 1.7 fatalities per 100 million VMT.



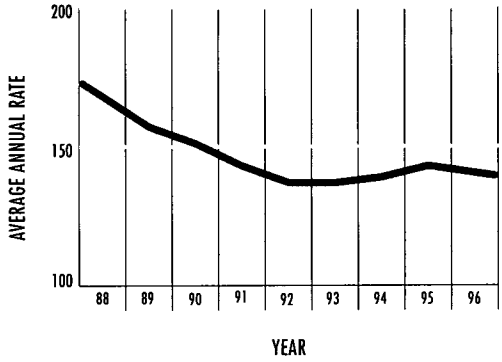
TRAFFIC INJURIES

Since 1988, the number of injuries has increased slightly. In 1997, an estimated 3.45 million people were injured in police–reported crashes, which is a 1.7 percent reduction from 1996. Traffic crashes account for 99 percent of transportation–related injuries each year.



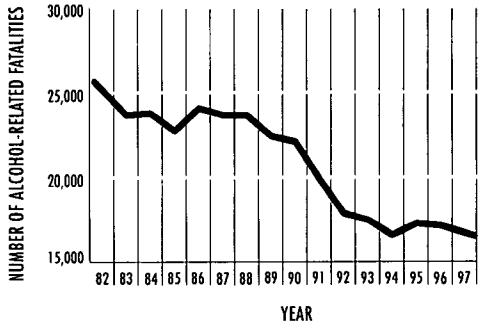
TRAFFIC INJURY RATE

The injury rate per 100 million VMT has declined overall from 169 in 1988 to 141 in 1996. The rate has been flat since 1992. Injuries result in societal costs of $77.7 billion, including $16.5 billion in health care costs.



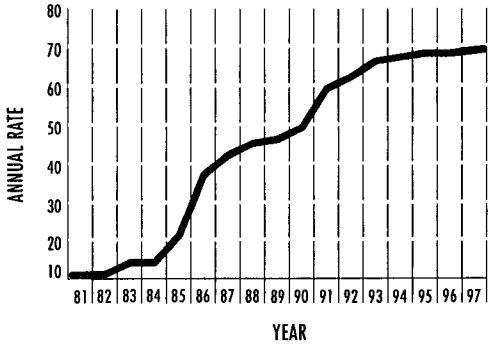
ALCOHOL TRAFFIC FATALITIES

Alcohol-related traffic fatalities have declined, falling almost 30 percent from 1986 to 1996. There were 16,189 alcohol-related traffic deaths in 1997, which represented 38.6 percent of total traffic fatalities, the lowest percentage on record. This rate is in marked contrast to rates for other years—40.9 percent in 1996 and 57.3 percent in 1982.



SEAT BELT USE

Seat belt use increased from an estimated 11 percent in 1981 to 69 percent in 1997. Belt use has increased only slightly in the past few years. Seat belts saved an estimated 10,414 lives in 1996, but 45 percent of passenger car occupants and 51 percent of light truck occupants involved in fatal crashes were unrestrained.



STRATEGY

Over the past 30 years, NHTSA developed successful strategies that helped reduce traffic fatalities and injuries. Recently, changing environmental conditions have resulted in flattened traffic death and injury trends. Nonetheless, NHTSA is committed to a goal of reducing fatalities and injuries 20 percent by the year 2008. To achieve this aggressive goal, the agency faces the challenge of identifying new approaches for driving down fatalities and injuries.

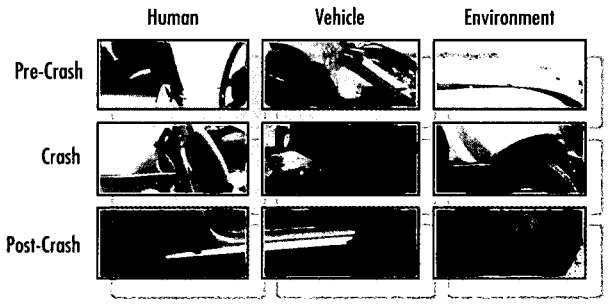
NHTSA HAS TWO STRATEGIES FOR ACHIEVING THE YEAR 2008 GOAL:

- Identify new approaches in the behavioral, vehicular and program delivery areas.
- Identify and correct operational impediments preventing NHTSA from implementing the new approaches.

The strategic plan describes activities for implementing these strategies.

- Safety: In this section vehicular and behavioral safety problems are defined and NHTSA's strategies for solving them are identified. For NHTSA to achieve the year 2008 goal, these strategies must be successful. The problems and strategies are organized according to the Haddon Matrix, which is composed of three time phases of the crash event plus the three areas (human, vehicle, and environment) influencing each of the phases.

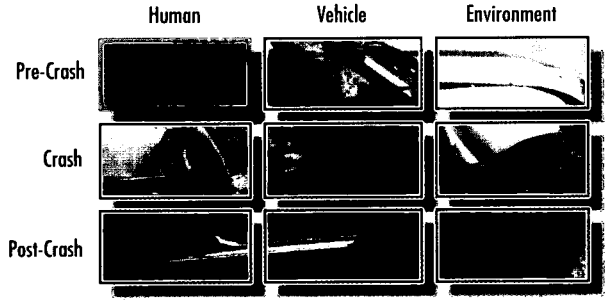
THE HADDON MATRIX



- Mobility, Economic Growth and Trade, Human and Natural Environments: Problems and strategies related to these DOT nonsafety goals are discussed. Although NHTSA's primary focus in these areas is on safety, solutions to the problems will produce secondary outcomes that directly contribute to DOT's nonsafety goals.
- Program Delivery: NHTSA's strategies for delivering its products and services are discussed. Cost–effective program delivery strategies are increasingly important as NHTSA seeks to meet expanding safety responsibilities.
- Corporate Management Strategies: This section identifies key operational areas that will enable NHTSA management to continue the agency's orderly transition to a modern, more effective organization.

SAFETY

PRE-CRASH ISSUES - HUMAN



ALCOHOL AND DRUGS

Problem:

Although alcohol-related fatalities have declined over the past 10 years, impaired driving remains a leading cause of traffic fatalities. Young drivers between 15 and 24 years of age are involved in 27 percent of alcohol–related fatalities. Repeat offenders account for about one-third of those arrested for driving while intoxicated (DWI). The agency reported that 16,189 alcohol-related traffic deaths occurred in 1997, which represented 38.6 percent of total deaths. Although this was a decrease of almost 1,000 deaths from 1996, crashes involving impaired drivers remain a major national problem. More than 321,000 people were injured in crashes in which the police reported that alcohol was present. The agency estimates that drugs other than alcohol are used by approximately 18 percent of the drivers killed in crashes. Unfortunately, drugs are often used in combination with alcohol which may compound the problem.

Strategy:

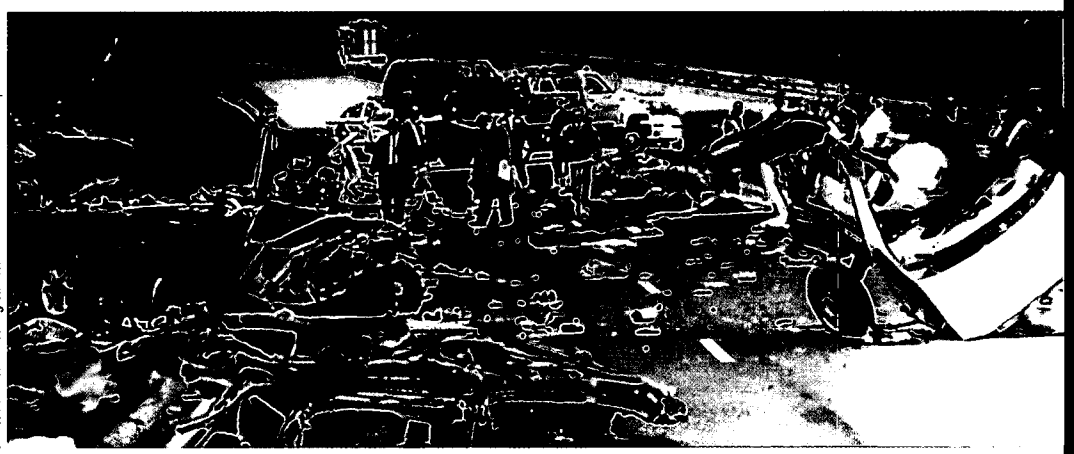
The agency's goal is to reduce the number of alcohol-related traffic fatalities to 11,000 by the year 2005. The agency will work with the states to achieve maximum impact from the resources available through new incentive grant programs, especially those associated with Section 410 and .08 BAC legislation. By implementing the legislative and programmatic initiatives needed to qualify for these grants, states will put in place more effective tools for deterring impaired driving. The agency will also promote additional best practices to states, communities, and national organizations using the framework of Partners in Progress: An Impaired Driving Guide to Action. The agency will develop programs to address the seven components of the Guide for Action, including: 1) public education, 2) individual responsibility, 3) health care community, 4) businesses and employers, 5) legislation, 6) enforcement and adjudication, and 7) technology. The agency will strengthen its partnerships and seek out new allies to help reach the national goal. NHTSA will promote passage of effective legislation and support prevention, education, and technical assistance activities for law enforcement officials, prosecutors, judges, and the public. Zero–tolerance laws have been promoted by the Administration as an effective tool against drunk drivers, especially younger drivers. The Presidential Initiative on Drugs, Driving and Youth uses similar strategies to reduce impaired driving by youth. In addition, the agency will use the Presidential Initiative on .08 BAC as a framework for collaborating with other Federal agencies, states, and communities for making .08 BAC the "law of the land".



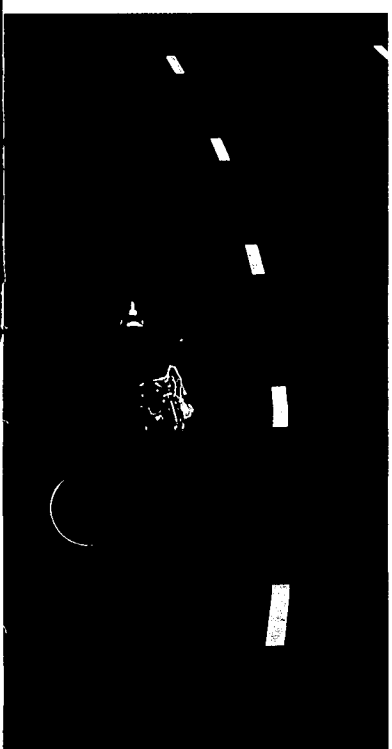
AGGRESSIVE DRIVING AND SPEEDING

Problem:

Driving behaviors likely to endanger people or property range from risky maneuvers such as tailgating to acts of violence and are defined as aggressive driving. Public opinion surveys indicate that aggressive driving actions, such as exceeding speed limits and driving too fast for conditions, changing lanes unnecessarily, following too closely, passing on the shoulder, running red lights, and others, are behaviors of concern and among the most prevalent actions associated with fatal and injury crashes. The public's concerns have been validated. Current understanding of these unsafe behaviors suggests that aggressive driving is associated with one-third of traffic crashes and two-thirds of the resulting fatalities. Speeding is one of the most prevalent factors contributing to traffic crashes and, in 1997, was associated with 30 percent of all fatal crashes, resulting in 13,036 deaths. Speeding was also a factor in crashes causing 116,000 injuries.



James A. Parcel - Washington Post



Strategy:

NHTSA's goal is to reduce speeding-related fatalities 5 percent by the year 2000. The agency's strategy will focus on: integration of traffic enforcement into overall state and community law enforcement, work with FHWA on automated enforcement equipment (to increase police effectiveness while cutting costs), and technical assistance, as well as demonstrations of interventions to deter aggressive driving. Research will study the role of speeding and aggressive driving in crashes; examine new measures against speeding, aggressive driving, and other unsafe driving acts; and collaborate with FHWA on setting speed limits and studying road design solutions to speeding and aggressive driving.

MOTORCYCLES

Problem:

In 1997, motorcycle fatalities constituted about 5 percent of the total annual traffic fatalities (2,106 fatalities). An additional 54,000 motorcyclists were injured in 1997. Measured in terms of vehicle miles traveled, motorcyclists are about 15 times more likely than passenger car occupants to die in a motor vehicle crash and 4 times as likely to be injured. The percentage of impaired motorcyclists involved in fatal

crashes has not declined in the past 10 years. The percentage of fatally injured operators who were improperly licensed remains high. Increasing motorcycle helmet usage is the single most effective way to prevent head injuries resulting from motorcycle crashes. Helmets are estimated to be 29 percent effective in preventing fatal injuries to motorcyclists, but the helmet use rate has been estimated at only 64 percent nationwide.

Strategy:

NHTSA's goals are to increase helmet use to 80 percent and to reduce motorcycle-related fatalities and injuries by 5 percent by the year 2000. This will be accomplished through a comprehensive approach that works to prevent crashes, reduce injuries during a crash, and provide rapid response and better treatment for crash victims. NHTSA's comprehensive approach consists of developing, testing, and urging adoption of program initiatives to support rider education programs; increasing the proportion of motorcyclists who are properly licensed; reducing the number of motorcyclists operating while impaired; raising driver awareness about sharing the road with motorcyclists; increasing the use of protective gear, including motorcycle helmets; and maintaining a strong safety assurance program for compliance with Federal safety requirements for helmets. A recently initiated strategic planning effort for motorcycle safety will solicit input from traffic and motorcycle safety partners and develop a blueprint for motorcycle safety activities over the next 5 years. NHTSA will also increase outreach in motorcycle safety to include health and medical partners, foster closer collaboration with law enforcement, and develop materials to specifically target these groups and involve them in motorcycle safety efforts.

PEDESTRIANS



Problem:

In 1997, about 5,300 pedestrians were killed and an estimated 76,550 were injured in traffic crashes in the United States. On average, a pedestrian is killed every 97 minutes and is injured every 6 minutes in a traffic crash. Pedestrian fatalities accounted for 86 percent of all non occupant deaths in 1996. Most deaths occur in urban settings, away from intersections, in normal weather, and at night. Over involved groups include males, children, and older adults. Almost half of pedestrian fatalities involve driver or pedestrian use of alcohol.

Strategy:

The agency's goal is to reduce the pedestrian fatality rate to 2.0 and the injury rate to 30.6 per 100,000 people by the year 2000. In addition, the DOT seeks to reduce pedestrian and bicycle injuries and fatalities by 10 percent by the year 2000. A combination of public information, enforcement, engineering, and outreach strategies will be used to reach these goals. Pedestrian research to identify effective countermeasures will focus on older, younger, and culturally diverse pedestrians, as well as those who are alcohol impaired. Research also will be conducted to identify motorists who are likely to be involved in collisions with pedestrians and to develop suitable countermeasures for these motorists. Programmatic approaches will include the Partnership for a Walkable America, a national public-private effort committed to promoting the changes needed to make America more walkable; continued partnership with FHWA to develop training and technical assistance materials promoting pedestrian safety; and efforts to develop case

studies of successful pedestrian programs and to identify strategies for increasing outreach to health care professionals, employers, and intergovernmental organizations.

BICYCLISTS



Problem:

In 1997, 813 bicyclists were killed and 58,000 were injured in motor vehicle crashes. Almost one-third of cyclists killed in traffic crashes were 5 to 15 years old, and the fatality rate for this group of ages is nearly double the rate for all bicyclists. Alcohol involvement for drivers or bicyclists was reported in one-third of the traffic crashes that resulted in cyclist fatalities in 1997. Wearing a helmet is the single most effective countermeasure available to reduce head injuries and fatalities that result from bicycle crashes. However, helmet usage is very low; only 20 percent of bike riders wear a helmet.

Strategy:

NHTSA's goal is to reduce bicyclist fatalities and injuries and increase bicycle helmet usage. The agency will use a combination of public information, legislation, enforcement, engineering, and outreach strategies targeted to both bicyclists and motorists. NHTSA will work closely with other Federal agencies, such as the FHWA, Centers for Disease Control and Prevention, Consumer Product Safety Commission, Department of Education, and national organizations, to ensure that these strategies are included in program development and are broadly disseminated. NHTSA will work with the National Bicycle Safety Network, a public-private partnership to improve bicycle safety and increase safe bicycle use; continue such educational efforts as "Ride Like a Pro" with the National Football League; develop technical assistance materials such as a how-to guide for organizing community bicycle safety events; work with national organizations to promote safe bicycling, including correct use of helmets; develop and test bicycle safety materials and approaches for use with at-risk youth in urban areas; and initiate development of a training program with Bicycle Law Enforcement Patrols to provide them with information and skills to educate communities about bicycle safety.

FATIGUE AND INATTENTION

Problem:

Sleep apnea, insomnia, narcolepsy, and other sleep disorders have been associated with passenger and commercial vehicle crashes. Driver fatigue, drowsiness, and inattention may be symptoms of sleep disorders or other causes of insufficient or poor–quality sleep. Surveys show that most drivers have experienced episodes of drowsiness while driving. NHTSA conservatively estimates that in recent years fatigue and drowsiness have been factors in about 56,000 crashes annually, resulting in an estimated 1,550 fatalities and 40,000 injuries a year.

Strategy:

NHTSA's strategy is to extend the understanding of the problem and educate motorists about the effect of sleep deprivation on driving behavior. NHTSA is partnering with the National Center on Sleep Disorders Research at the National Institutes of Health to identify the symptoms of sleep deprivation, high-risk groups,

and a research agenda. Public education campaigns targeted at high-risk groups are underway. Over-the-counter and prescription drugs that may cause drowsiness may be studied as well. In addition, NHTSA and FHWA are cooperating in laboratory and field research to study driver drowsiness detection devices and their potential to warn drivers in impending crash situations.

DRIVER LICENSING

Problem:

Road safety is threatened by unlicensed drivers who are unregulated and unaccountable. These include problem drivers whose licenses are suspended or revoked for serious violations such as aggressive driving, alcohol impairment, and hit-and-run incidents.

Strategy:

Electronic data bases providing information on problem drivers can improve the decision–making process for state officials. License administrators depend on fast access to accurate driver histories, including the National Driver Register's index of unsafe drivers who have lost their license. Pinpointing problem drivers helps agencies monitor individuals' unsafe driving behaviors and is the key to successful adjudication and rehabilitation. Agency technical assistance to states and national organizations supports a number of initiatives, including detecting fraudulent licenses, standardizing and linking state data files, exchanging driver records among governmental and private organizations, providing technology support for testing and licensing, and fostering such innovations as graduated licensing for novice drivers.

OLDER DRIVER SAFETY

Problem:

Physical dexterity and cognitive skills deteriorate with age, adversely affecting driving behavior. The Environment section of this plan indicated that the population of older people will increase sharply; thus, a greater number of older drivers will be on the road. As a group, older people are now over represented in terms of both driver and pedestrian deaths, on a per-mile basis. The per-mile fatality rate for older drivers is 16 times higher than the rate for drivers who are 25 to 65 years old. Although an older person involved in a motor vehicle crash is more likely to die than a younger person, because of increased frailty, older drivers have fewer crashes per licensed driver than do younger drivers. Without effective programs, older driver death and injury levels are expected to increase.



Strategy:

NHTSA's strategy is to enhance the older driver's ability to drive safely. Research is refining our understanding of medical and functional factors that influence driving behaviors and crash involvement. One agency initiative focuses on technical assistance to states in applicant screening, testing and evaluation, and other procedures for regulating older driver licensing. Model procedures will be field tested to guide licensing decisions, including such innovations as closer monitoring of older drivers through retesting and tracking of driving history. Research will examine driver-vehicle interactions and how operational changes can enhance safe driving. Research is examining crash effects on older occupants, with



the goal of increasing crash survivability. The ITS program and the new National Advanced Driving Simulator will provide research opportunities to improve crash avoidance capability for aiding older drivers. Strategies will also be developed to address issues surrounding older pedestrian safety.

YOUNG DRIVERS

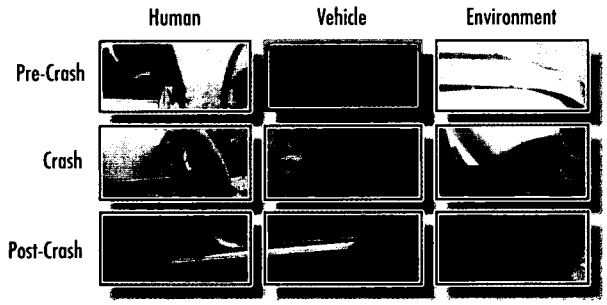
Problem:

High-risk behavior and driving inexperience contribute to young drivers' over involvement in crashes. As pointed out in the Environment section, the future growth of young drivers will be greater than that of the total population, thus continuing their over representation in crashes. In 1997, almost 5,700 drivers ages 16 to 24 were killed in traffic crashes, including 2,405 killed in alcohol-related crashes. Another 597,600 drivers were injured, including over 63,000 in crashes with alcohol involvement. A significant portion of young drivers in fatal crashes have invalid licenses, and their driving histories reflect license suspension or revocation. Alcohol impairment and failure to use seat belts are also frequently observed. Seventy-one percent of teens killed in car crashes were not wearing seat belts.

Strategy:

The agency's strategy consists of supporting state implementation of improved driver education and driver licensing procedures. Increasing seat belt use rates will improve crash protection for young drivers and occupants; therefore, education programs targeted to this population are being developed. Improving education about the effects of alcohol on driving behavior is a major priority, combined with enforcement techniques and programs to keep youth from obtaining alcohol. Legislation will be supported, including graduated licensing (i.e., progressing through stages before full licensure). The agency will work with states to identify strategies to enforce minimum drinking age laws, youth-specific sanctions, new detention procedures, and comprehensive community youth programs. The Transportation Equity Act for the 21st Century benefits youth traffic safety by providing incentive grants to reward states that enact zero tolerance, graduated licensing, nighttime driving restrictions, and programs to prevent drivers under age 21 from obtaining alcoholic beverages.

PRE-CRASH ISSUES - VEHICLE



CRASH AVOIDANCE

Problem:

Improvements in the crash–avoidance capabilities of existing and new vehicle systems can reduce the likelihood of collisions. These improvements could enhance the interaction of the driver with the vehicle, deliver more effective warnings to drivers about impending crashes, and enhance driver vision through improvements in current systems or advanced technologies, such as automatic cruise control, rear-end collision–avoidance systems, and lane change systems. The agency wants to identify changes to vehicles that will be the most effective at reducing total crashes.

Strategy:

The agency continues to focus its crash–avoidance research, regulatory, and safety assurance activities on reducing the number of collisions through compliance testing; investigations of potential safety defects; and improvements in direct and indirect visibility, braking, and directional and rollover stability, as well as vehicle lighting, signaling, and marking. The compatibility of driver-vehicle interfaces to improve future vehicle designs, which is discussed in the Intelligent Vehicle Initiative, is another major emphasis of research. The agency will also coordinate with the FHWA on its research involving ultraviolet and fluorescent lighting.

INTELLIGENT VEHICLE INITIATIVE

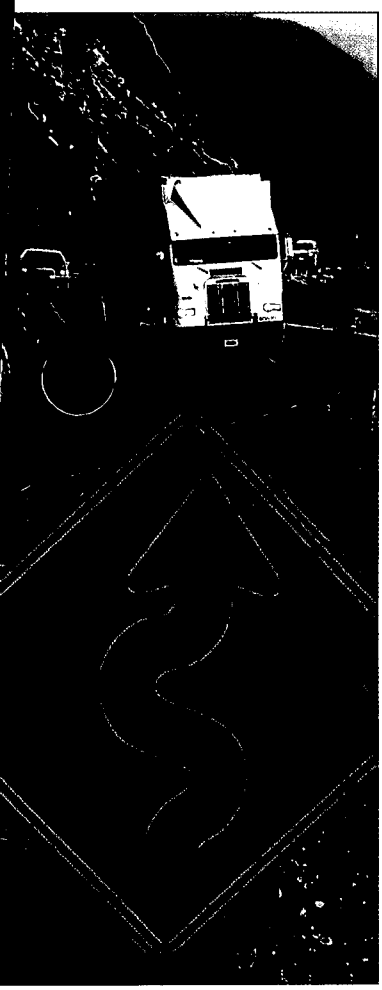
Problem:

Approximately 75 percent of the crashes that occur annually are of three types: rear–end, intersection, and road-departure collisions. In these situations, innovations are needed that enable a driver to be more aware of a potential crash and exert more control to avoid a collision. Part of the challenge is developing and integrating advanced sensing, on board computer, and driver interface technologies into vehicle safety systems.

Strategy:

The agency's goal is to reduce the total number of collisions annually by approximately 1 million within the next 10 to 20 years by introducing vehicle systems to avoid the three most common types of crashes. Since 1991, the agency has been undertaking research to develop tools to better understand driver-vehicle

interactions, define specific collision problem areas and causal factors, develop performance guidelines for possible remedies, facilitate the commercial development of promising systems, and assess the safety of systems that enhance mobility and productivity. The rear-end collision–avoidance activities are the highest priority and nearer to commercial application. The agency will shift its emphasis from narrowly focused projects to larger issues of system capability, usability, and benefits. As part of this effort, a demonstration vehicle will be developed that can be used to integrate several collision–avoidance systems and for driver acceptance tests.



HEAVY TRUCKS

Problem:

In 1997, a total of 5,355 fatalities and 133,000 injuries resulted from crashes involving heavy trucks. Of the fatalities resulting from crashes involving large trucks in 1997, 78 percent were occupants of another vehicle and 8 percent were nonoccupants. Among the key causes of heavy truck crashes are insufficient braking capability, loss of control, driver fatigue, and poor visibility. Safety defects in heavy trucks also contribute to crash injuries and fatalities.

Strategy:

NHTSA will work closely with the FHWA on heavy truck safety issues and projects such as "Share the Road," that educate drivers about driving safely around large trucks. NHTSA will continue its research, regulatory, and public information activities in such areas as anti-lock braking systems, electronically controlled braking, rollover countermeasures, truck visibility, truck underride, and drowsy driver detection and monitoring. In 1996, over 70 percent of fatal crashes involving large trucks and passenger vehicles involved one or more behavioral errors by passenger vehicle drivers. In addition, the agency will review its data systems to identify safety-related defect trends in heavy trucks.

SAFETY ASSURANCE

Problem:

Two factors that can contribute to avoidance of crashes and protection from fatality or injury are manufacturer compliance with applicable Federal safety standards and resolution of safety-related defects in motor vehicles. For these reasons, the agency conducts a variety of testing and investigations to ensure the safety of vehicles in use. Since inception of the agencies Safety Assurance Program, over 14 million vehicles and 24 million equipment items have been recalled for non-compliance and over 216 million vehicles and 34 million equipment items have been recalled to remedy safety defects. Another concern is altering of odometers in used vehicles, which has led to massive consumer fraud. Although numerous agency investigations have been referred to the U.S. Department of Justice for criminal prosecution, a significant problem remains.

Strategy:

The primary goal of the Safety Assurance program is to identify motor vehicles and motor vehicle equipment that fail to comply with Federal Standards or that contain safety-related defects and ensure that

the public is notified of these safety problems so they can be corrected. The program also seeks to test vehicles to ensure compliance with safety regulations. For example, the agency has initiated vehicle testing in connection with new standards for depowered air bags and other occupant protection measures. NHTSA also ensures that imported vehicles conform with all applicable Federal standards. Outreach to state motor vehicle agencies and other organizations will be emphasized to increase the reporting of defect-related problems through the agency's Auto Safety Hotline.

SCHOOL BUSES

Problem:

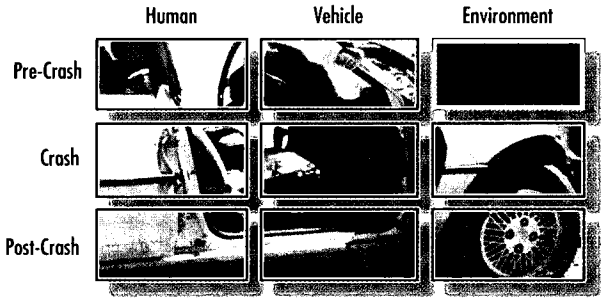
From 1977 to 1986, an average of 12 school bus occupants and 47 pedestrians (under age 19) were killed each year in school bus crashes. From 1987 to 1996, an average of 10 school bus occupants and 25 pedestrians were killed each year in school bus crashes, indicating a decline when compared to the same numbers for the 1977 to 1986 period. Although the number of fatalities and injuries is relatively small considering that school buses travel about 4.3 billion miles annually, a school bus crash is a serious and emotional safety issue. School bus crashes are a major concern for parents, the public, and safety organizations, because the health and safety of children is at stake.



Strategy:

School buses continue to be the safest form of highway transportation. Safe travel for children on school buses has always been a high priority for the agency. All new school buses are required to meet a number of specific Federal Motor Vehicle Safety Standards, including requirements for emergency exits, seating, fuel systems, roof structure, body joint strength, flammability of interior materials, mirrors, and stop signal arms. The agency will initiate an extensive two-year research program to examine current crash data for school buses; evaluate alternative occupant protection systems, and based on research findings, propose the next generation of occupant protection requirements for school buses. NHTSA will continue to work in cooperation with its partners to develop a policy for safely transporting preschool-age children in school buses. This policy can then be added to the National Guidelines for School Transportation. NHTSA has completed development of a training program for school bus drivers and is distributing it to school transportation managers. In addition, the agency will support development and implementation of community–based demonstration programs to address the high incidence of motorists illegally passing school buses stopped to load and unload children.

PRE-CRASH ISSUES - ENVIRONMENT



ROAD INFRASTRUCTURE

Problem:

Approximately 28 percent of all traffic fatalities from 1974 to 1994 were the result of collisions with fixed objects, such as trees, embankments, guardrails, and utility poles. Key causal factors in these collisions are driving errors associated with excessive speeding, evasive maneuvers, and inattention.

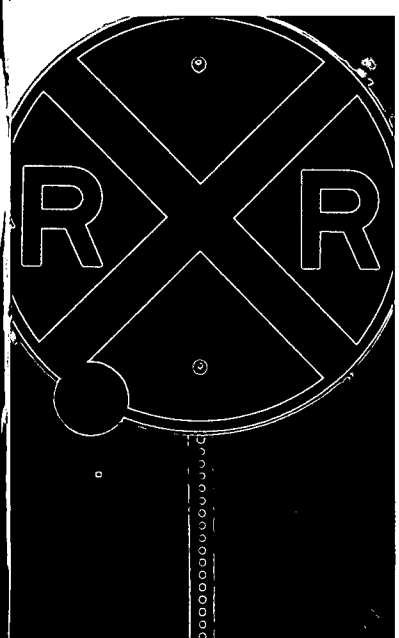
Strategy:

The agency will coordinate its activities with the FHWA in priority areas, such as speed management, work zone safety, run-off-road, and public outreach and education to prevent fatalities and injuries from these types of collisions. FHWA will deal with roadway design, maintenance, and operations, while NHTSA will coordinate with FHWA on problem identification, law enforcement, and outreach and education associated with road infrastructure and traffic control devices. Among the projects to be undertaken is a large–scale study to determine the crash risk of speeding.

RAIL GRADE CROSSINGS

Problem:

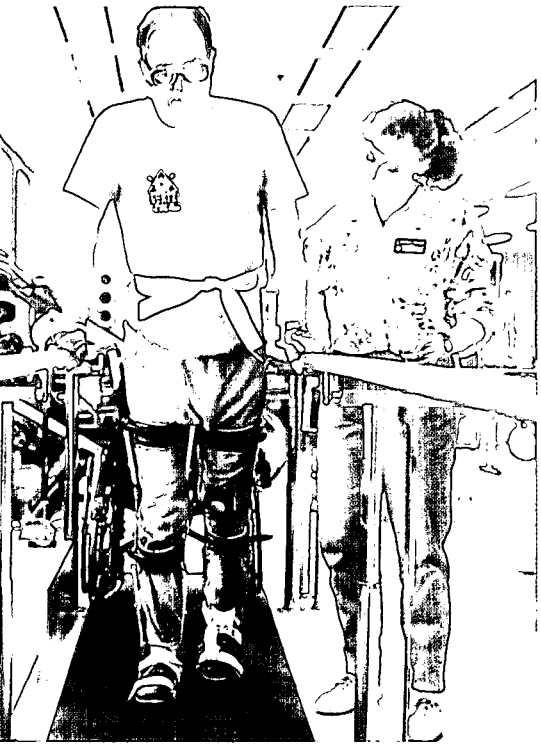
NHTSA's fatality data system reports that in 1997, 389 people were killed and 1,740 were injured in the United States in collisions with trains at highway-rail crossings. Key causal factors in these collisions are driving task errors resulting from obstructed vision, misjudgment, violation of signals and signs, or deliberately unsafe acts.

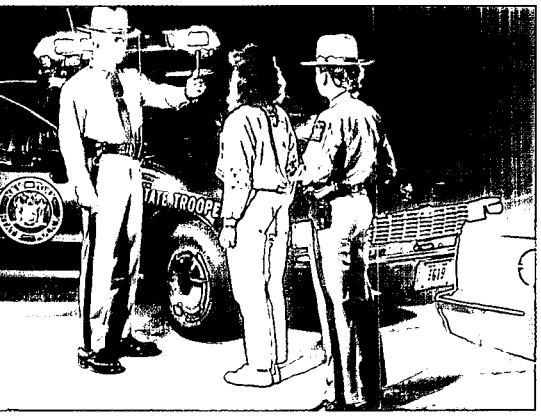


Strategy:

An intermodal task force identified six initiatives that Federal, state and local governments and railroads can take to improve rail crossing safety. They are: increased enforcement of traffic laws; safety improvement reviews of rail corridor crossings; increased public education and promotion of Operation Lifesaver, safety at private crossings, data gathering and research, and trespass prevention. NHTSA is supporting the goals of the Federal Railroad Administration and FHWA in the expansion of relevant sections of the Model Commercial Driver License Manual and will seek to increase attention to rail crossing safety in driver testing for commercial driver licenses.









NHTSA 1994–1998

1994

- Strategic Plan Roll-Out, Agency Repositioning Begins

1995

- Safe Communities Injury Control
- Expanded Auto Safety Hotline
- Intelligent Transportation Systems
- Partners in Progress - Alcohol Safety
- Patterns for Life - Child Safety
- Pilot Agency - Government Performance and Results Act

1996

- National Advanced Driving Simulator
- EMS Vision for the Future
- Section 402 Performance Based Safety Grants
- National Transportation Biomechanics Research Center
- Announce Comprehensive Strategy to Improve Airbag Safety and the Development of Advanced Restraint Systems

1997

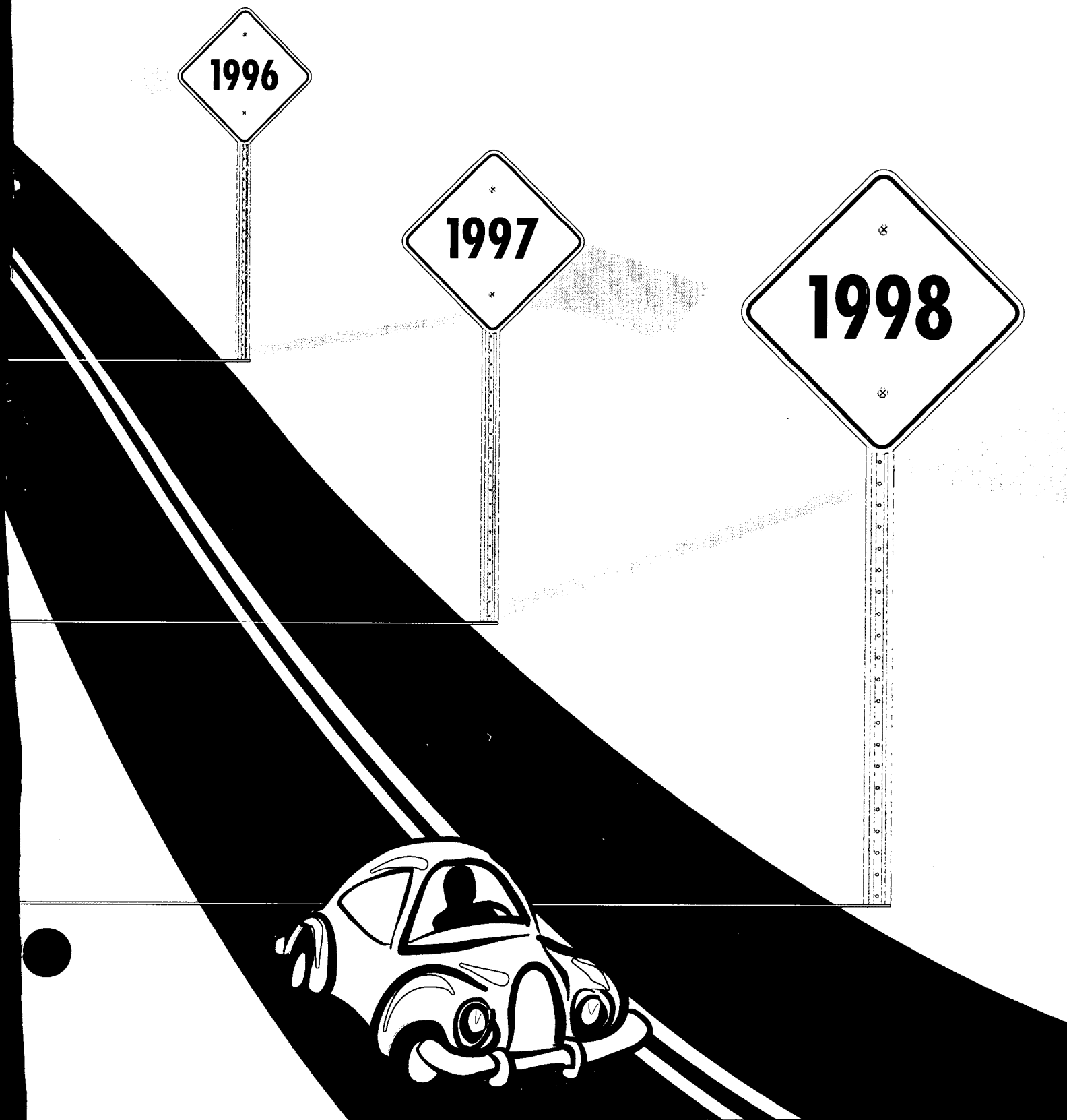
- President's Safety Belt Initiative (Buckle Up America Campaign)
- Proposed Universal Child Seat Attachments (UCRA)
- President's Initiative on Drugs, Driving and Youth
- Crash Injury Research and Engineering Network (CIREN)
- Moving Kids Safely
- Expanded New Car Assessment Program

1998

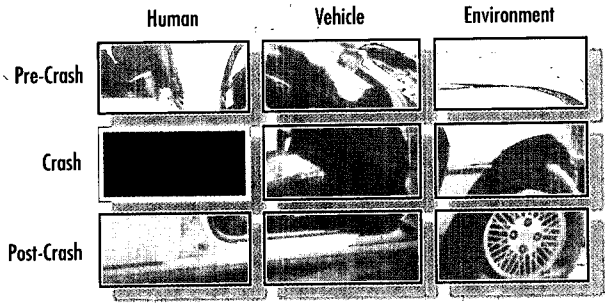
- Safety City Website [http://www.nhtsa.dot.gov/kids]
- Passage of Transportation Equity Act for the 21st Century
- Improved Head Impact Protection Rule
- Improved Truck Safety - braking and rear impact crash guards
- Issue Advanced Airbag Rule

ACCOMPLISHMENTS TIMELINE

NHTSA
People Saving People
http://www.nhtsa.dot.gov



CRASH ISSUES - HUMAN



BIOMECHANICS

Problem:

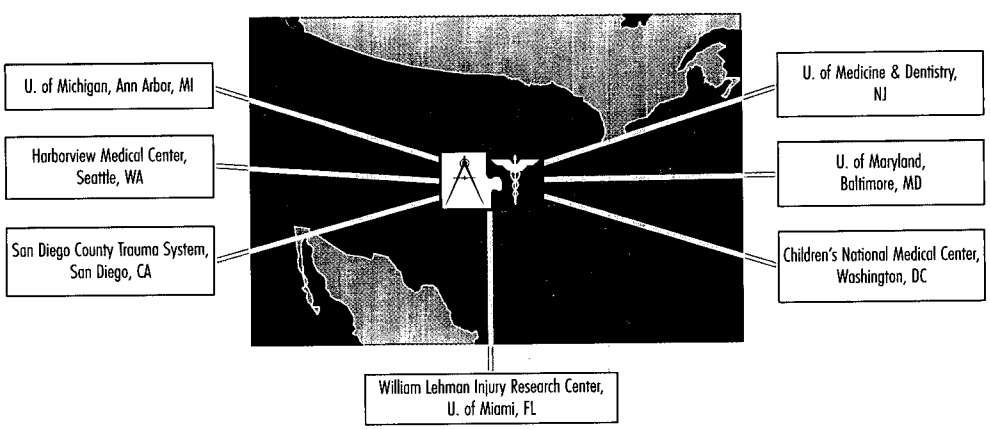
Biomechanics is the study of forces and motions acting on the human body and its response to them. It is essential to expand biomechanical understanding of the automotive injury process and develop technologies that will reduce impact injuries. Using this knowledge is critical to the agency's efforts to develop effective safety standards that improve vehicle crashworthiness.

Strategy:

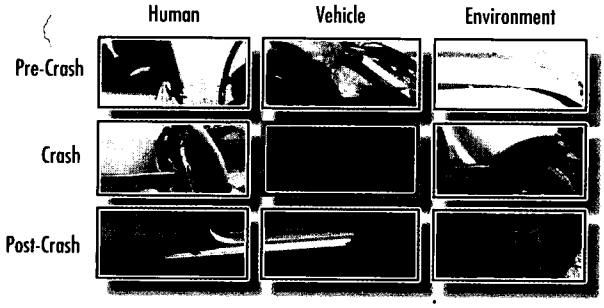
In 1997, the Department of Transportation created the National Transportation Biomechanics Research Center at NHTSA. In addition, the agency established the Crash Injury Research and Engineering Network (CIREN) to study significant crash conditions through computer-linked, detailed, hospital–based injury studies. The agency will: expand its effort to define physical conditions and human consequences of real-world crashes, gain a detailed understanding of the forces and motions the human body experiences in a crash and their relationship to the extent and severity of resulting injuries, develop computer models of the human body that can simulate human impact response and estimate the extent and severity of expected trauma, and construct dummy components and other mechanical trauma assessment devices that evaluate human risk. Special emphasis will be placed on understanding the biomechanics of pediatric injuries and developing 3–and 6–year–old child dummies, as well as a small female dummy.

The Nation's Largest Learning Laboratory for Crash Injury Research
CIREN
Crash Injury Research & Engineering Network

The Crash Injury Research and Engineering Network



CRASH ISSUES - VEHICLE



SEAT BELTS

Problem:

Increasing seat belt use from the 1996 level of 68 percent to the Presidential goal of 90 percent would prevent an estimated 5,536 fatalities, 132,670 injuries and save $8.8 billion. However, seat belt use remains low among such groups as young males and rural road users, and the rate of belt use has been stagnant in recent years. The rate increased only slightly, to 69 percent, in 1997. Much of this non use is attributed to part-time belt users who perceive a low crash risk in some situations. An estimated 5 to 10 percent of the population resists using seat belts under any conditions.

Strategy:



Increasing use of safety belts will have such a profound effect on fatalities and injuries that President Clinton established a national objective of increasing seat belt use to 85 percent by the year 2000 and 90 percent by the year 2005 in the Presidential Initiative for Increasing Seat Belt Use Nationwide. The initiative involves 1) building public-private partnerships; 2) enacting strong state legislation; 3) embracing active, high–visibility law enforcement; and 4) conducting well-coordinated, effective public education. Experience indicates that when these four elements exist together, they result in increased levels of belt use. This initiative will be continued through 2005, supplemented by periodic, week-long, nationwide enforcement and media efforts, such as "Operation ABC '98" and "Buckle Up America!" Week (conducted around Memorial Day 1998). Significant seat belt use increases resulted from that effort and similar events are being scheduled over the next several years to help achieve seat belt use goals. In addition, the agency will regularly review its data systems to identify potential safety-related defect trends in seat belts and continue to place strong emphasis on compliance of seat belts with applicable safety standards.

CHILD SAFETY SEATS



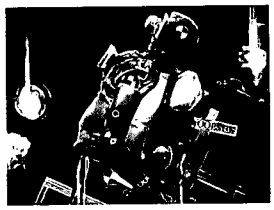
Problem:

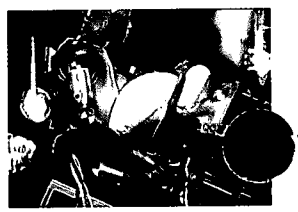
In 1996, the number of child occupant fatalities was 644. About 50 percent of children under age 5 who died in crashes were unrestrained. Of the remaining 50 percent, 26 percent were in an adult seat belt which does not provide effective protection for most children under age 5. Use of child safety seats declines sharply as the age of the child increases, although the reasons for this are not well understood. Other children were in child restraint systems that were not used properly. Incorrect use of locking and chest clips, inappropriate use of harness straps, and child seats facing the wrong direction are examples of seat misuse.

Strategy:

As a part of the Presidential Initiative for Increasing Seat Belt Use Nationwide, a goal was set to reduce the number of child occupant fatalities 15 percent by 2000 and 25 percent by 2005. The agency will establish state and regional networks to support the national campaign to increase the correct use of child safety seats and develop, produce, and disseminate child passenger safety educational materials. The agency will continue research to support the rulemaking on child/air bag interaction and publish a final rule on universal child restraint attachments. In addition, the agency provides assistance to states, communities, and private sector and national safety organizations and supports special programs to promote child safety seat use. The agency will also regularly review report data systems to identify safety-related defect trends in child safety seats. The agency will continue to provide technical assistance to state, county, and municipal law enforcement agencies, with the ultimate goal of training all patrol officers, troopers, and deputies in the enforcement of child passenger protection violations. Also, the agency will work with the states to help achieve the child passenger protection criteria of the new Section 405 incentive grant program. This will enable states to acquire additional funds to expand their child safety seat promotional efforts and will put in place improved laws and educational programs that will boost correct seat usage. The agency will continue to place strong emphasis on the compliance of child seats with safety standards and to investigate seats that have alleged safety defects.

ADVANCED RESTRAINT SYSTEMS







Problem:

The current generation of air bags is a proven safety tool for offering supplemental protection to vehicle occupants during significant crash events. Investigations have nonetheless confirmed that a relatively small number of crash situations (e.g., unrestrained or improperly restrained children and small adults) can result in fatality or injury.

Strategy:

The agency's goal is to improve the protection offered by air bag, seat belt, and child safety seat systems and to reduce the number of people seriously injured by air bag deployment. NHTSA is pursuing a comprehensive strategy to improve air bag safety. This includes action to require introduction of advanced air bags. Other actions include: developing tests for different crash situations, testing and evaluating advanced systems, regulatory actions to permit the installation of on-off switches in authorized cases, and

rulemaking actions to enable manufacturers to quickly develop and produce redesigned air bag systems, air bag warning labels for vehicles and child seats, and expanded crash investigations. Public information and education are conducted through partnerships involving campaigns, coalition efforts, and public awareness initiatives. Safety belt use, universal child restraint anchorage systems, correct use of child seats, rear seating for children, and a strong safety assurance program of compliance and defect investigations have also been key elements of the strategy.

CRASHWORTHINESS

Problem:

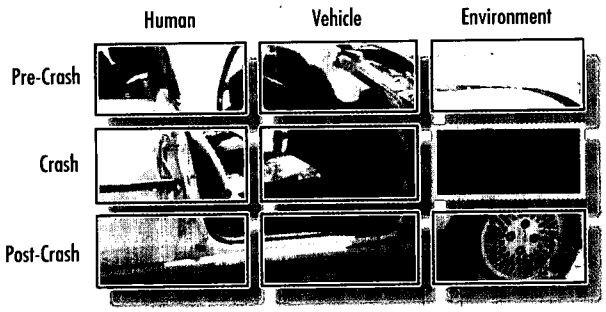
Approximately 80 percent of all fatalities are the result of collisions in which the front, left, and right sides of vehicles, are the initial points of impact. Rollover crashes also substantially contribute to fatalities on the Nation's highways. These types of collisions can be severe enough to threaten the integrity of vehicle structures, in turn compromising the vehicles ability to afford protection to occupants from fatal and serious injuries. Vehicle structures must be able to manage crash energy to prevent occupant compartment intrusion, ejection of passengers, and injuries from occupant impact with interior surfaces. Structural crash performance must also be compatible with occupant restraint systems.

Strategy:

NHTSA's strategy consists of crashworthiness research, vehicle performance regulations, enforcement of Federal safety standards, and consumer information on vehicle safety. Research, regulatory, and safety assurance initiatives address advanced occupant protection in various crash modes, including frontal, side and rollover crashes (which result in the majority of deaths and injuries). Priorities include roof crush resistance, advanced restraints, vehicle-to-vehicle collision compatibility, aggressivity of interior surfaces (including head impact protection), and offset frontal crash requirements. New international harmonization research on vehicle safety is underway. Consumer information on vehicle structure safety is provided through such programs as the New Car Assessment Program (NCAP), which tells the public how similar makes and models compare in safety performance during crash tests.



CRASH ISSUES - ENVIRONMENT



ROAD INFRASTRUCTURE

Problem:

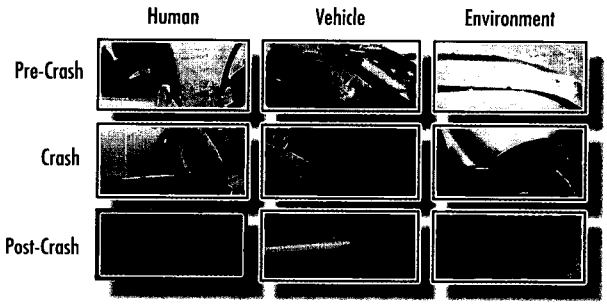
As mentioned in the pre-crash Environment Section, approximately 28 percent of all traffic fatalities from 1974 to 1994 were the result of collisions with fixed objects, such as trees, embankments, guardrails, and utility poles. Key factors in these collisions include the effects of roadway characteristics and conditions on the driver and vehicle performance and the physical properties of highway objects.

Strategy:

The agency will continue to coordinate with FHWA on traffic control device issues, such as installing and upgrading rumble strips, breakaway poles, and roadside barriers; widening travel lanes and shoulders, and improving pavement skid resistance.



POST-CRASH ISSUES - HUMAN



ACUTE CARE AND REHABILITATION

Problem:

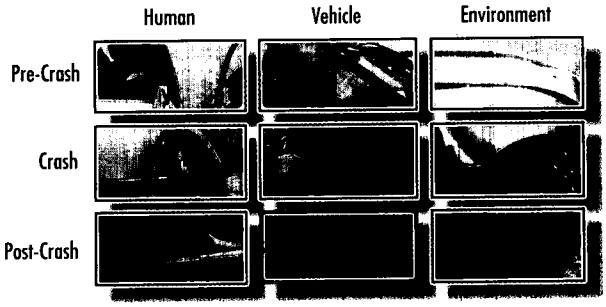
Motor vehicle crash injuries place a significant burden on the nation's health care resources, accounting for about 4 million emergency room visits a year and about 50 percent of all trauma center admissions. Preliminary estimates show that the public pays an increasingly larger share of the costs of care as injury severity increases. Nearly half the cost of long-term rehabilitation care for people injured in motor vehicle crashes is paid for by public assistance. Public assistance becomes necessary when the upper limits of insurance and personal savings have been reached.

Strategy:

Acute care and rehabilitation are primarily the responsibility of the health care industry. NHTSA's goal is to engage in partnerships with members of this industry and provide them the information they need to reinforce positive driver behavior at a time when the individual is likely to absorb these messages. This effort is accomplished via outreach to such organizations as the American Academy of Pediatricians, the American College of Emergency Medicine, and the Emergency Nurses Association. The information needed to develop the messages comes from a number of sources, including the agency's efforts in trauma research (the CIREN program), data linkage (the Crash Outcome Data Evaluation System [CODES] program), and the agency's efforts to develop injury outcome measures, including economic costs and other measures such as the Functional Capacity Index.



POST-CRASH ISSUES - VEHICLE



FIRES

Problem:

Fire in a crash is often associated with a breach in the integrity of a vehicle's fuel system. Although relatively infrequent, vehicle fires can have devastating consequences on fatalities and injuries. In 1995, fire occurred in 15,000 motor vehicle crashes, or 0.1 percent of total traffic crashes. Fire was also present in over 1,550 fatal crashes and 4,000 injury crashes.

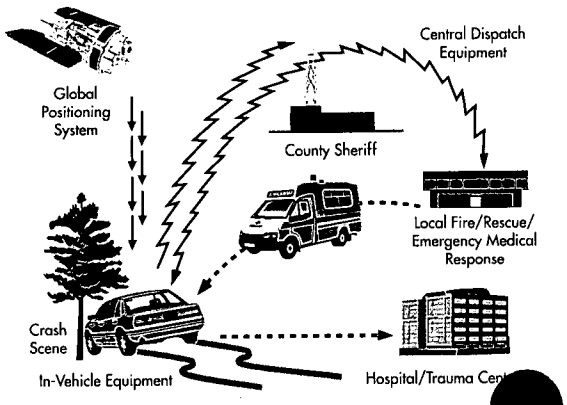
Strategy:

NHTSA's approach to preventing crash fire or mitigating its effects involves research, regulatory, and safety assurance initiatives focused on vehicle fuel system crashworthiness, flammability of materials in the vehicle interior, vehicle crash-and-burn tests, and evaluation of vehicle fluids and electrical systems. Fire suppression technology is also under consideration. Regulatory initiatives are under review that focus on modification of vehicle fuel systems to upgrade fuel containment in crashes and reduce flammability characteristics of vehicle materials.

AUTOMATED COLLISION NOTIFICATION

Problem:

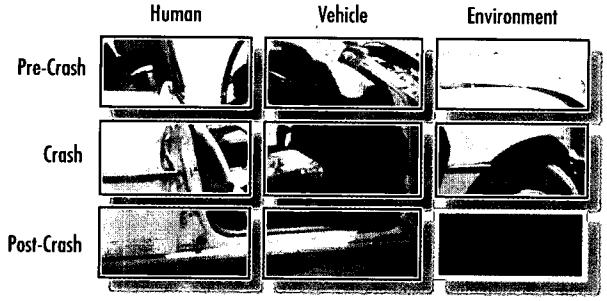
Although only 24 percent of crashes occur in rural areas, these crashes account for 59 percent of highway deaths. Delay in delivering emergency medical services is one of the factors contributing to the disproportionately high fatality rate for rural crash victims.



Strategy:

The agency is testing and evaluating the Automated Collision Notification (ACN) program as a key element in the NHTSA Intelligent Transportation System (ITS) research and development program. The ACN initiative is designed to reduce the time between the crash and the delivery of definitive pre-hospital medical care and other emergency services to the victims. This program promises to be especially beneficial for unwitnessed, single-vehicle crashes in rural areas.

POST-CRASH ISSUES - ENVIRONMENT



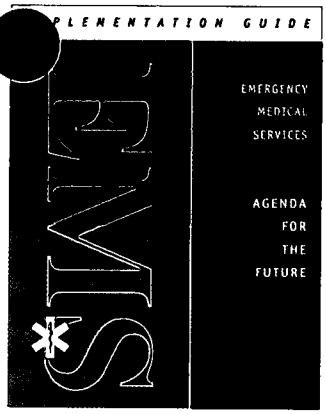
EMERGENCY MEDICAL SERVICES

Problem:

People injured in motor vehicle crashes require pre-hospital care and transport to a hospital emergency department or a trauma center. About 20 percent of all EMS responses are motor vehicle related.

Strategy:

NHTSA has developed an EMS Agenda for the Future (and an implementation guide) in cooperation with the EMS community to provide an overall direction to the nation's EMS program. NHTSA's goal is to enhance the performance of national emergency medical systems by contributing national leadership, facilitating establishment and maintenance of national standards, and providing resource information, materials, and research on EMS systems. The EMS program develops and distributes National Standard Curricula to educate pre-hospital care providers, including emergency medical technicians, dispatchers and ambulance drivers. These national standards are adopted by states as the regulatory standards of care for emergency medical technicians. The program also provides support in specific technical and system support areas. Examples include training programs on data management and quality improvement, peer assessments of state EMS systems, and public awareness campaigns. The agency is also developing partnerships with the telecommunications industry to facilitate the availability of enhanced "911" service nationwide for both conventional landwire telephone systems and wireless systems.



DOT HS 808 711





MOBILITY, ECONOMIC GROWTH, AND NATURAL ENVIRONMENT

MOBILITY

Problem:

The environmental analysis indicated that the population of people with disabilities will continue to increase. NHTSA's goal is to promote mobility and safety for people with disabilities by addressing vehicle safety and by providing safety information to manufacturers and the public. People who are physically challenged may require special equipment and safety modifications for using a vehicle. NHTSA estimated for 1995 that 383,000 vehicles had adaptive equipment, such as hand controls, steering controls, and joystick steering.

Strategy:

NHTSA will continue research, rulemaking, safety assurance, and consumer information activities in several areas to enhance safe mobility for people with disabilities. The agency is considering a rulemaking action concerning wheelchair lifts on motor vehicles and will look into developing a brochure or other consumer information materials for people buying modified vehicles or items of adaptive equipment. NHTSA will conduct research to better understand the crash-avoidance and crashworthiness characteristics of mechanical hand controls and initiate rulemaking actions, if appropriate. The agency will seek to address other critical safety issues for the disabled population with respect to the use of motor vehicles as they arise.

ECONOMIC GROWTH AND TRADE

Problem:

The Department's Strategic Plan promotes and implements a strategic goal designed to advance the country's economic growth and competitiveness, both domestically and internationally, through an efficient, flexible transportation system. Achievement of this goal takes many forms, including: reducing economic cost; ensuring movement of goods; reductions in time of delivery of people, goods, and services to their destinations; supporting economic deregulation; remaining competitive in all markets; soundness in major transportation investments; and increasing education and public awareness in the transportation field. Traffic safety problems associated with unsafe passenger and commercial vehicles, human behavioral issues, and roadway environment undercut all elements central to successful economic growth and trade. Failure to address and solve these safety issues has a direct negative effect on many of the key elements of our economic life. The resulting loss in human resources is enormous and enduring, as is the direct societal cost for our country (now exceeding $150 billion annually). The drain of this public health problem on both health care and governmental systems is significant and injurious to the general economic well-being of our country.

Strategy:

The mission of the agency is to reduce traffic crashes and the death and injuries associated with them and to reduce economic losses. A balanced strategy is planned, focused on both vehicle and behavioral safety problems. This will be achieved through initiatives designed to improve vehicle crashworthiness, occupant protection, and crash avoidance. Public information to aid consumers in selecting safer cars is planned. Crucial behavioral safety issues, such as driving while impaired, will be addressed. Education and outreach are planned to increase public awareness of all aspects of the problem, including various costs for the transportation and health systems.

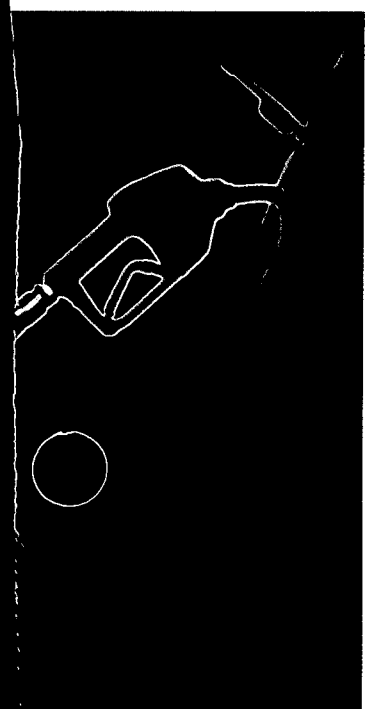
HUMAN AND NATURAL ENVIRONMENT

Problem:

As mentioned in the Environments Section, the next generation of vehicle designs will be driven by the need to reduce emissions. NHTSA must ensure that the new vehicle designs meet safety standards and that their crashworthiness is not compromised by the use of lightweight materials. Although the weight of new electric vehicle designs is similar to that of a midsize passenger car, ultralight and ultrastiff structures and unique geometries are being used that might affect the overall safety of the fleet. Passenger vehicle designs employing hybrid fuel technologies are being considered; when compared to current designs, these technologies may result in weight reduction of up to 40 percent, thus creating safety problems in multi-vehicle crashes.

Strategy:

NHTSA will continue to promote fuel efficiency through the Corporate Average Fuel Economy (CAFE) standards. NHTSA will continue to conduct research with FHWA and other agencies engaged in the development of next-generation vehicles and fuels, including the Partnership for a New Generation of Vehicles (PNGV). An analytical model that can be used to evaluate the crashworthiness of target vehicles in the PNGV research program will be developed. The agency will use rulemaking to ensure that electric passenger vehicles meet the safety performance criteria of Federal Motor Vehicle Safety Standards (FMVSS), and to deal with any safety issues of power systems and other characteristics of these vehicles.



PROGRAM DELIVERY

INTRODUCTION

This section of the plan highlights the major delivery systems used by NHTSA for disseminating its safety products and customer services. NHTSA's ultimate customer is the American public. As one way to leverage agency resources and maximize distribution of its products and services, NHTSA has developed strategic alliances and partnerships with states, local communities, the business sector, health and medical fields, manufacturers, safety advocates, and other national and local organizations that have similar missions.

The majority of NHTSA's efforts, while targeted at the American public, are implemented through the agency's partners, all of whom have unique organizational characteristics and strengths. Because of these unique characteristics and strengths, the delivery systems NHTSA uses to work with partners differ by type of partner. These systems are highlighted in the next paragraphs.

PUBLIC INFORMATION AND EDUCATION (PI&E)

Increasing awareness of the American people about safety behaviors needed to reduce traffic crashes, death, and injury is the primary objective of NHTSA's public information and education communications. These safety messages are delivered to the public through a variety of means, including the Auto Safety Hotline, technical assistance, NHTSA's Web site, exhibits, public service announcements, manuals, tool kits, brochures, posters, and publications. National public information campaigns are aimed at the most urgent national safety needs, including encouraging people to wear safety belts, placing kids in child safety seats, deciding not to drive after drinking, avoiding aggressive driving actions, and obeying speed limits. These messages also play a key role when used as a communications strategy to support a new countermeasure, such as a new primary seat belt law and increased enforcement of occupant protection laws.

TECHNICAL ASSISTANCE

NHTSA works continually with states, communities, and safety organizations to develop new products and services to make behavioral safety programs more effective. The state highway safety offices are key partners that work closely with the agency's regional offices in the process of developing and implementing new products and services. Demonstration grants and technical assistance to states and communities help to facilitate testing and evaluation of new programs. The purpose of technical assistance is to refine each new program, demonstrating its benefits to other states and, thereby, provide states with the latest strategies to address national highway safety problems.

TRAINING

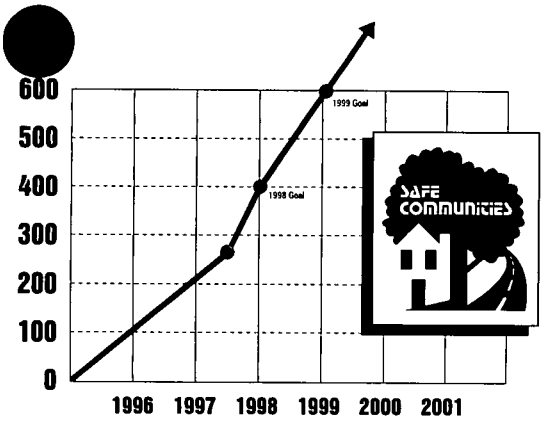
NHTSA training provides powerful strategies for saving lives. The workshops, courses, videos, and curricula focus on a wide variety of topics, from enforcing occupant protection laws, to adjudicating impaired-driving cases, to developing and running effective highway safety programs. Training is among the agency's highest priorities for upgrading all facets of safety program development, implementation, management, and assessment.

http://www.nhtsa.dot.gov

STATE GRANTS

NHTSA administers performance-based Section 402 formula grants and safety incentive grants to help states undertake statewide and local programs aimed at reducing highway fatalities and injuries. Under Section 402, states set their own goals, select appropriate programs, and as part of the performance-based agreement, evaluate and report on their results. Section 402 grants are the primary Federal means for providing highway traffic safety behavioral technical assistance to states and local communities and are based on national priorities such as alcohol, safety belts, traffic law enforcement, and roadway safety. Over the life cycle of programs begun with Section 402 grants, states and municipalities provide the majority of resources to continue programs beyond their startup phases.

The incentive grants administered by NHTSA reward states for implementing laws and programs proven to be highly effective in reducing crashes, death, and injury. Incentives have traditionally served as a key mechanism for getting particularly desirable high-impact highway safety strategies into operation nationally. An expanded set of incentives is a key feature of the Transportation Equity Act for the 21st Century. It rewards states with grants for complying with criteria that improve alcohol safety, occupant protection, and state safety data systems.



SAFE COMMUNITIES

Safe Communities is an injury prevention and control program currently in over 400 locations and slated for a total of 600 sites by 1999. NHTSA's goal is to increase the number of sites to 1,000 and enhance program capabilities of existing sites. We will also expand the Intermodal Safe Communities initiative. Safe Communities is organized around the principle that local communities are best able to identify their unique safety problems, prioritizing problems, and recruiting appropriate community resources to solve problems. NHTSA's role is to offer national leadership to states, communities, and national organizations, and provide materials, technical assistance, and best practices in the form of training, a service center, a Web site, newsletters, and other materials. Information for these materials is being obtained in part from a demonstration and evaluation program being implemented in seven communities.

NATIONAL ORGANIZATIONS

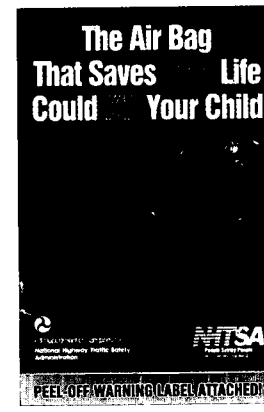
NHTSA develops strategic alliances with national organizations (e.g., private sector, nonprofit associations) that have complementary or similar missions. The agency seeks to work with national organizations having strong ties to groups of people that can implement or influence the implementation of NHTSA programs and services at national, state, and local levels. Strategic alliances offer a number of benefits to NHTSA and its customers: leveraging program strengths and resources of organizations with similar missions; broadening channels for program and message delivery; improving communication, understanding, and cooperation among organizations; and increasing the agency's ability to better understand and reach target populations. These benefits enable NHTSA and its partners to provide more cost-effective delivery of safety products and services to the public.

SAFETY PERFORMANCE STANDARDS

Automakers, safety equipment suppliers, and the insurance industry are among NHTSA's partners in helping to provide the public with safer vehicles. The agency's approach is to issue regulations that establish minimum performance levels for vehicle crashworthiness and crash avoidance, with the expectation that manufacturers will take steps to surpass minimum safety levels. In accomplishing its statutory requirements, NHTSA is moving beyond the role of simply being a regulator and is instead enhancing vehicle safety through new techniques of voluntary standards and negotiated rulemaking. The agency's goal is to partner with industry to ensure faster, more effective delivery of new vehicle safety features.

CONSUMER INFORMATION

The American public needs information to help them compare the safety performance of comparable vehicles during the process of buying a vehicle, and NHTSA is responding to that need. The agency's New Car Assessment Program (NCAP) provides information on crash test ratings for occupant crash protection of popular makes and models, thus strengthening market incentives for safer cars. The agency also plans to develop consumer information on previously owned vehicles. In addition, the agency is providing a broader range of vehicle safety information on the availability of advanced safety features, proper use of such safety features as ABS brakes and head restraints, and child passenger safety features.

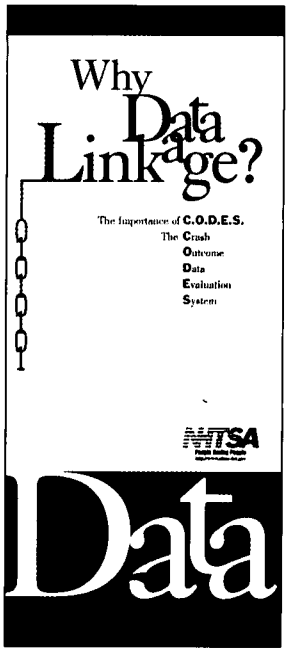


SAFETY ASSURANCE

The agency's compliance testing ensures that the benefits of Federal safety standards reach the American public. Investigation and resolution of potential safety defects, based primarily on motorist complaints to NHTSA through the Auto Safety Hotline and the Internet, also help to reduce risks. The agency's goal is to ensure that all instances of noncompliance and defects in motor vehicles and equipment are remedied, thus creating a safer environment for travel.

RESEARCH AND DEVELOPMENT

NHTSA's research products focus on changing driving behavior, evaluating safety programs, improving vehicle safety, and increasing injury mitigation. NHTSA data and research are used by other researchers, state and local governments, safety advocates and the private sector. Dissemination of research is aided through relationships with vehicle manufacturers and suppliers, research centers, medical and injury professionals, university researchers, and national and international vehicle safety organizations. Research findings are used by NHTSA and its partners to develop safety products and services for the public. The focus of NHTSA's research is increasingly intermodal, emphasizing the need for improved safety in all surface transportation modes.



SAFETY DATA SYSTEMS

NHTSA is the leading national resource for providing the public, safety partners, and all other public and private entities with national data and analyses on traffic crashes, death and injury. This information is crucial for understanding safety trends, designing strategies to combat problems, and evaluating program impact. The foundation of NHTSA's data system consists of the Fatality Analysis and Reporting System (FARS) and the National Automotive Sampling System (NASS), plus the State Data System, Special Crash Investigations, and other specialized crash and injury information files.

A major goal is to acquire better information about injuries resulting from traffic crashes. NHTSA's new CIREN program creates injury data links with hospital trauma centers, a critical resource in allying medical and engineering professions to study injury prevention. The National Transportation Biomechanics Research Center serves as the central entity to develop and disseminate to our partners new insights into how crash forces affect human bodies. The agency's CODES Program is offering startup grants to states interested in linking crash and medical treatment files. This data enhancement allows the recovery of crash victims to be tracked, and for the first time, shows states the true monetary cost of injuries when people fail to use occupant restraints.

INTERNATIONAL POLICY

NHTSA's international policy focuses on the identification, development and adoption of best practices from around the world concerning vehicle safety regulatory and research programs as well as traffic safety behavioral policies. One goal of the agency is, to the extent consistent with improving vehicle safety in the United States, to minimize divergences in vehicle safety standards (i.e., promote harmonization) in the global marketplace by coordinating research and assessing alternative regulatory approaches used in other countries. Achieving this goal will expedite research and implementation of regulatory measures, improve overall vehicle safety and contribute to increased economic efficiency and growth. Another goal is to coordinate with other countries in generating and gathering data regarding efforts to address behavioral issues such as seat belt use, drunk driving and pedestrian safety, to evaluate ongoing programs and learn from their experiences. Finally, the agency provides technical assistance to countries that are establishing vehicle and traffic safety programs. Motor vehicle crashes are a leading cause of injury and death to US citizens traveling abroad, especially in countries where safe vehicle and traffic environments are yet to be developed. Since the United States is at the forefront of automotive safety technology and NHTSA is a world leader in the area of vehicle and traffic safety, it is natural and appropriate for NHTSA to play this role.



CORPORATE MANAGEMENT STRATEGIES

NHTSA undertakes corporate management initiatives to enable it to more effectively and efficiently meet strategic goals. The agency is committed to aligning its activities with the management strategies outlined in the Department's 1997-2002 Strategic Plan. The six management strategies are: ONE DOT; Human Resources; Customer Service; Research and Technology; Information Technology; and Resource and Business Processes Management.

ONE DOT

The goal of ONE DOT is to create an effective decision-making architecture for the 21st Century Department of Transportation. NHTSA is taking an active leadership role in intermodal support of safety and other goals. NHTSA will contribute, for example, through its efforts to establish intermodal Safe Communities, colocate regional offices, and take a leadership role in intermodal task forces addressing safety problems.

HUMAN RESOURCES

The agency seeks to develop a diverse and highly skilled workforce that is knowledgeable, flexible, efficient, and resilient. New policies and practices that foster learning and development, such as participation in cross-functional teams and competency-based approaches to leadership development, will be encouraged. The agency will continue to promote diversity and ensure that the workforce reflects the national workforce. It will improve career opportunities for women and minorities by eliminating any artificial barriers to advancement and full contribution by all employees. Alternative approaches to a performance management system will be evaluated and steps will be taken to link performance to the Department's strategic goals. The use of awards and recognition for innovation, cost cutting, and customer service will be encouraged.

CUSTOMER SERVICE

NHTSA will create a customer-focused environment by encouraging communication, quality service, and innovation. NHTSA activities that address customer needs for information include the New Car Assessment Program, the Auto Safety Hotline, and the Internet Web site. These and other customer service activities will be improved to be more accessible and useful to customers. Using published customer service standards as a benchmark, the agency will use feedback from surveys, letters, and other means to improve service delivery.



RESEARCH AND TECHNOLOGY

The agency is committed to enhancing its research agenda through intermodal planning and cooperation on useful technological innovations, partnerships, studies, and education. The agency will participate in the creation of an integrated transportation research and development plan for the Department. NHTSA will contribute to meeting the goals of the National Science and Technology Council Committee on Transportation through research on information infrastructure issues for smart vehicles and operators, accessibility for aging and transportation-disadvantaged populations, and next-generation motor vehicle designs. The agency will foster cutting-edge research in human performance and behavior by developing innovative research tools that offer new opportunities for collaboration with other Federal agencies, institutes of higher learning, and the private sector.

INFORMATION TECHNOLOGY

The agency uses information technology to improve mission and process performance by employing systems that are secure, reliable, compatible, and cost effective. NHTSA will take actions to reduce the paperwork burden on the public, expand access to data, and undertake internal improvements to enhance information technology work processes. The agency will continue to take advantage of new tools, such as the Internet and teleconferencing, to improve communication and information exchange between its partners and the public. NHTSA will also ensure that existing information technology systems are year-2000 compliant.

RESOURCE AND BUSINESS PROCESS MANAGEMENT

NHTSA will foster innovative and sound business practices that ensure all operational programs provide the best service at the least cost to meet public needs. These practices are needed to ensure that the agency's resources are used in the best ways to advance its goals. The agency will build on recent efforts and continue to encourage the adoption of continuous improvement practices in all aspects of its operations. The agency will develop and use an array of internal measures that provide a balanced evaluation of progress toward improving the quality, timeliness, cost, and productivity of work processes. NHTSA will continue to improve by focusing on enhancing internal administrative processes for budgeting, acquisition and grants, and regulatory management.

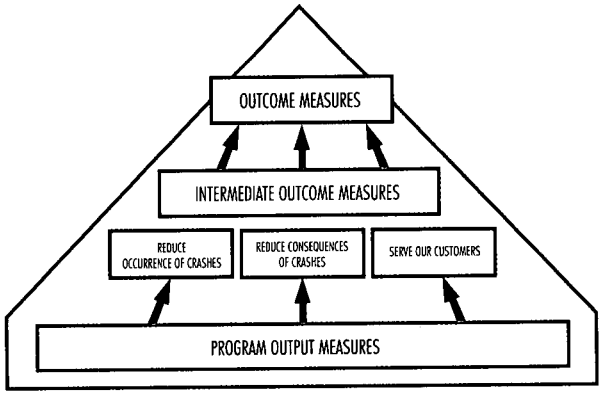
APPENDIX A–GPRA IMPLEMENTATION

The Government Performance and Results Act of 1993 requires Federal agencies to become more accountable to the American public. NHTSA's implementation of GPRA is demonstrated in this strategic plan. This appendix describes in greater detail the agency's views on performance measurement and the ways in which NHTSA coordinates with other Federal agencies. A schedule of significant upcoming program evaluations is also provided.

Since 1994, NHTSA has been a pilot agency for implementing GPRA and has produced annual performance plans and reports. The President's Office of Management and Budget designated NHTSA as 1 of only 10 "exemplar" pilots because of its use of outcome-oriented measures. The agency was able to achieve this recognition, because it has invested significant resources in data collection and analysis. In addition, the agency has integrated performance planning with its budget process and linked program measures to intermediate outcomes and the agency's overall safety outcomes.

PERFORMANCE MEASURES

The agency uses a three-level hierarchy of measures to assess its performance. NHTSA tracks these measures annually through its performance plans and reports. The agency has transformed the budget into a performance-based document by integrating the outcome measures of the performance plan with the output measures of the programs.



At the top of the hierarchy are overall outcome measures. These are measures that NHTSA can influence but not control. Primary outcome measures are fatalities and injuries.

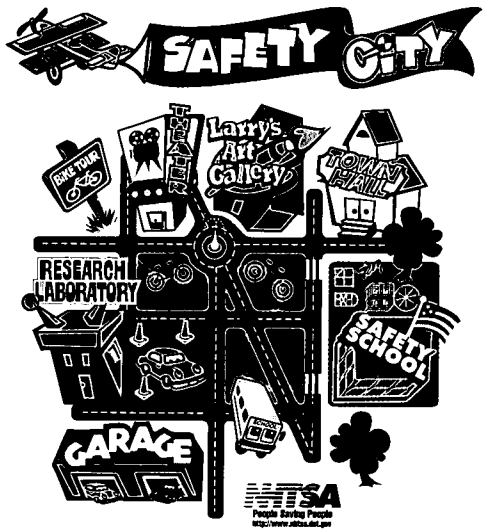
The second level, intermediate outcomes, are measures such as safety belt use rates that contribute to the reduction in crash deaths and injuries. There are three categories of intermediate outcome measures:

- REDUCE THE OCCURRENCE OF CRASHES: The most important function of the agency is to prevent a crash from happening. This is often referred to as crash avoidance (or "pre-crash" in the Haddon Matrix). The agency has several programs in place to help accomplish this such as vehicle safety standards for braking and lighting, don't drink and drive campaigns, Intelligent Vehicle Initiative research, compliance testing and defects investigation.

- MITIGATE THE CONSEQUENCES OF CRASHES: If a crash does occur, the agency strives to reduce the severity and increase the survivability of the event. This is known as crashworthiness (or "crash" in the Haddon Matrix). The agency accomplishes this through encouraging seat belt and helmet use, establishing vehicle safety standards for impact protection, supporting crashworthiness research, conducting compliance testing, and defects investigation.

- SERVE OUR CUSTOMERS: NHTSA's customers are the American public. The agency has several programs aimed at helping the public. People can call the toll-free Auto Safety Hotline to receive motor vehicle safety information, report a suspected safety defect, or ask how to fit their child safety seats into their cars. The NCAP crash tests new cars to assess their relative crashworthiness. It classifies the results using an easily understandable five-star rating system. NCAP disseminates this information in its popular brochure, "Buying a Safer Car". The National Center for Statistics and Analysis (NCSA) publishes fatality, injury, and crash data and responds to requests for specific data on crashes, injuries, and fatalities. The agency also maintains a highly successful World Wide Web site that helps customers find announcements, download agency publications, and search for recall information. It also includes a section for children ("Safety City").





On the third level are the program output measures. These are measures that programs can more easily control such as the length of time it takes to complete a rulemaking action. Each of the line items in the agency's budget includes program performance measures and their links to intermediate outcome and overall outcome measures.

The following table shows how each program area in NHTSA's budget contributes to the intermediate outcomes of the agency. In turn, the intermediate outcomes influence overall outcomes to help reduce the number of fatalities and injuries. These measures enable the agency to track the performance of its programs.

NHTSA Programs

	DOT Strategic Goals					
	Safety			Mobility	Economic Growth & Trade	Human & Natural Environment
	Reduce Occurrence of Crashes	Reduce Consequences of Crashes	Customer Service			
Safety Performance Standards						
Vehicle Regulations	X	X		X	X	
New Car Assessment Program		X	X			
Consumer Safety Information			X			
Fuel Economy Programs						X
Theft Program					X	
Safety Assurance						
Vehicle Safety Compliance	X	X				
Auto Safety Hotline			X			
Defects Investigation	X	X				
Odometer Fraud					X	
Highway Safety Programs						
Alcohol Program	X					
Drugged Driving Programs	X					
Pedestrian, Bicycle, and School Buses	X	X				
Motorcycle Safety	X	X				
Occupant Protection Program		X				
Safe Communities	X	X				
Patterns for Life	X	X				
Traffic Law Enforcement	X					
Emergency Medical Services		X				
Records and Licensing	X					
National Driver Register	X		X			
National Occupant Protection Use Survey		X	X			
Highway Safety Research	X	X				
TEA 21 Initiatives	X	X	X	X	X	X
Mission Support						
Program Evaluation	X	X				
Strategic/Program Planning			X			
Economic Analysis	X	X			X	
Research And Development						
Crash Avoidance Research	X					
NCSA Data Collection	X	X	X			
Biomechanics Research Center		X				
PNGV		X			X	X
Safety Systems		X		X	X	
VRTC	X	X				
Intelligent Transportation	X					
Advanced Driving Simulator	X					
Highway Traffic Safety Grants						
Section 402	X	X	X			
Alcohol Countermeasure Incentives	X		X			
Occupant Protection Incentives		X	X			
Child Passenger Protection Education	X		X			
State Safety Data Improvement	X		X			



CROSSCUTTING ACTIVITIES WITH OTHER AGENCIES

NHTSA works in partnership with many other Federal agencies to help achieve its goals. The table below highlights the major areas of crosscutting activity that contribute to NHTSA and DOT performance goals.

CROSS-CUTTING ACTIVITIES IN THE AREA OF TRANSPORTATION SAFETY

DEPARTMENT/AGENCY	FUNCTION
Commerce	Motor Vehicle Safety Harmonization
Consumer Product Safety Commission	Bicycle Helmet Use, Safety Recalls, Child Injury Prevention
Defense	National Transportation Biomechanics Research Center
Education	Statement of Commitment on Safety Issues, School Bus Safety
Energy	Fuel Economy, Alternative Fuel Vehicles
Environmental Protection Agency	Fuel Economy, Alternative Fuel Vehicles
Federal Emergency Management Agency	Federal Inter-Agency Committee on Emergency Medical Services
Health and Human Services	Healthy People 2000/2001, Injury Prevention, Emergency Medical Services, Sleep Disorders, Juvenile Justice, Child Injury Prevention
Interior	Traffic Safety Outreach, Implementation of Tribal Safe Community Program and Native American Injury Prevention Coalition Program, Section 402 Grants
Justice	Motor Vehicle Theft Prevention, Motor Vehicle Odometer Fraud, Safety Recalls
Labor	Federal Employee Seat Belt Program
National Aeronautics and Space Administration	Advanced Air Bag Safety
National Academy of Sciences	NHTSA/FHWA Speed Limit Program, Numerous Safety Studies
National Transportation Safety Board	Highway Crash Investigation, Safety Recommendations
State	Motor Vehicle Standards Harmonization
U.S. Trade Representative	Motor Vehicle Standards Harmonization

PROGRAM EVALUATIONS

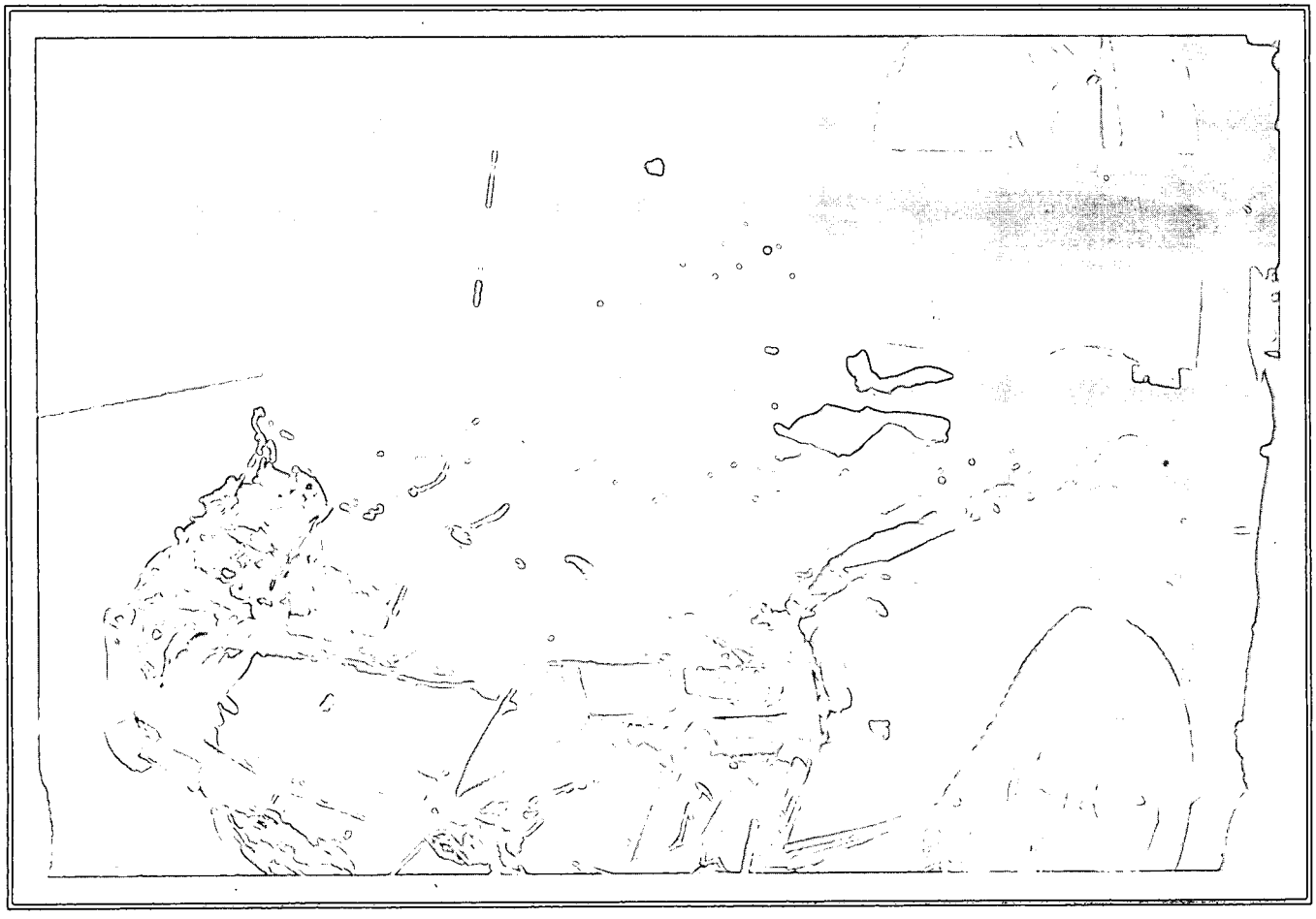
Evaluations play an integral part in NHTSA's planning and performance measurement system. The agency has been conducting evaluations of its motor vehicle safety standards since 1970. Managing for outcomes has placed a renewed emphasis on program evaluation within DOT and NHTSA, and the agency has an ambitious evaluation program planned.

These are evaluations undertaken or planned by NHTSA:

- EVALUATION OF SAFE COMMUNITIES DEMONSTRATIONS: This study will evaluate the impact on traffic crash fatalities and injuries of the Safe Communities Program approach (anticipated completion, 2000).
- SECTION 410 HIGHWAY SAFETY GRANT PROGRAM: The impact of the Section 410 Alcohol Incentive Grant program on state alcohol-related crash rates will be evaluated (anticipated completion, 1999).
- PRESIDENTIAL SEAT BELT INITIATIVE: NHTSA will evaluate the success of the Presidential Initiative in raising seat belt use nationwide (anticipated completion, 1999).
- HIGHWAY SAFETY ASSESSMENT: NHTSA analyzed the accomplishments of the highway safety program in 10 States and the contribution of Federal highway safety grants towards those accomplishments (completed, 1998).
- AUTO THEFT AND RECOVERY: This evaluation will determine the effectiveness of parts marking and anti-theft devices in reducing thefts and increasing vehicle recoveries and assess the impacts of the anti-theft acts of 1984 and 1992 (anticipated completion, 1998).
- ODOMETER FRAUD: NHTSA is estimating the incidence of odometer rollback in used passenger cars sold in the United States and assessing State and Federal programs to combat odometer fraud (anticipated completion, 1999).
- MOTOR VEHICLE CONTENT LABELING: The agency will study trends in U.S.-Canadian content in new cars and light trucks; find out if purchasers peruse, understand, and react to the labels; and study the response of manufacturers and dealers to the regulation (anticipated completion, 1999).
- THREE-POINT BELTS FOR BACKSEAT OCCUPANTS: This evaluation will determine whether the shift from lap belts to three-point belts has significantly reduced fatality and injury risk for backseat occupants, especially abdominal injuries in frontal crashes (anticipated completion, 1999).

1997

North Carolina Traffic Crash Facts



NC Department of Transportation
Division of Motor Vehicles
Traffic Records Section

VISITOR REGISTRATION SHEET

Highway Safety
Name of Committee

2/24/99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
EDDIE CALDWELL	HAFER, MCNAMARA, CALDWELL
Chris Valauri	N.C. Beer & Wine
Susan Valauri	Nationwide
Jill Warren Lucas	GHSP
Shannon Bullock	GHSP
Joe Porter	GHSP
Scott Marcuson	N.C. State Student
Ruth Sappie	NCDOT
Leon McKillop	Moore Van Allen
Mark Dixon	The Capitol Group

2-24-99

VISITOR REGISTRATION SHEET

~~THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES~~ Highway Safety

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Ruth Sappie	NCDOT
2.	DUANE MACENTEE	NC DOT
3.	AL DEITCH	YAIO/DOA
4.	Scott Murphy	AP
5.	Paula L. Stoef.	Covenant w/NC's Children
6.	CR Medlin	" " "
7.	[illegible]	NCATL
8.	Adam Sharpe	NCHAC
9.	Thomas Vance Bennett	NCCFTF
10.	T. Tall	The Pilot (So. Pines)
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HOUSE COMMITTEE ON HIGHWAY SAFETY

MARCH 10, 1999
1:00 p.m.
Room 415

AGENDA

Chair(s): Rep. Alma Adams & Rep. Wayne Goodwin

INTRODUCTIONS

BILLS TO BE CONSIDERED

HB 57	Motor Vehicle Occupant Restraint Safety
HB 180	Repeal Motor Safety Inspections

PRESENTATIONS

DISCUSSION

ADJOURNMENT

HIGHWAY SAFETY COMMITTEE MEETING
MINUTES FOR MARCH 10, 1999
Room 415 LOB

Bill(s) before the Committee:	HB 57 Motor Vehicle Occupant Restraints Safety HB 180 Repeal Safety Inspections
Bill(s) discussed:	HB 57 Motor Vehicle Occupant Restraints Safety
Action(s) taken:	NONE

Committee members in attendance were: Chairs Representatives. Adams (Presiding) and Goodwin, Representatives Alexander, Allred, Dedmon, Gray, Hurley, Justus, McComas, Sexton, and Wilson. **Also attending** : Giles Perry (Committee Counsel), staff, guests, and members of the press.

Narrative/Discussion: Presiding Chair Rep. Adams called the meeting to order at approximately 1:05 p.m. HB 57 Bill sponsor Rep. Alexander made a presentation before the group followed by additional presentations from:

- Dr. Steve Edwards – Raleigh Pediatrician
- Tom Enwright – National Safety Council
- Sgt. Jeff Winstead – State Highway Patrol
- Ms. Jane Penske – AAA
- Joe Parker – Governor's Highway Safety Commission

All the speakers urged committee members to support HB 57. Glenn Jernigan, representing private and christian schools expressed concerns about how HB 57, if adopted, would affect private schools. Other committee members asked further questions and continued discussion until the meeting ended.

Rep. Adams closed the meeting by thanking attending presenters and guests – The meeting was adjourned at approximately 1:50 p.m. with no action taken.

Respectfully Submitted,

Rep. Alma Adams
Chairperson

Kristen Younts
Committee Assistant

House Highway Safety Committee
Wednesday, March 10, 1999
House Bill 57: Motor Vehicle Occupant Restraints

Speakers:
Representative Martha Alexander
Principal Sponsor of HB 57

E. Stephen Edwards, M.D. — 5 Minutes
President Southeastern Division
of the American Academy of Pediatrics
Raleigh, NC

Mr. Tom Enright — 5 Minutes
Former Administrator
National Highway Traffic Safety Administration (NHTSA)
Atlanta, Ga.

Sgt. Jeff Winstead — 4 Minutes
NC State Highway Patrol

Jane Pinsky — 1 Minute
AAA Carolinas

Joe Parker
Director
Governor's Highway Safety Program — 2 Minutes

Agency's in support of Occupant Restraint Legislation

- GHSC
- UNC HSRC
- Child Fatality Task Force
- AAA Carolinas
- NC Medical Society
- NCDOT
- NC State Highway Patrol
- American Trauma Society
- AARP-55 Alive
- NC Covenant for Children
- MADD
- NC Department of Insurance
- Wake County Safe Kids Coalition
- NHTSA
- National Safety Council
- Air Bag & Seat Belt Safety Campaign
- American Coalition for Traffic Safety
- Federal Highway Administration
- Insurance Institute for Highway Safety
- Nationwide Insurance Enterprises

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

HOUSE BILL 57

Short Title: Motor Vehicle Occupant Restraints. (Public)

Sponsors: Representatives Alexander and Clary (Primary Sponsors); Boyd-McIntyre, Bridgeman, Cox, Easterling, Goodwin, Hensley, Jarrell, Luebke, Melton, and Mosley.

Referred to: Rules, Calendar and Operations of the House.

February 10, 1999

A BILL TO BE ENTITLED

AN ACT TO ENHANCE MOTOR VEHICLE OCCUPANT RESTRAINT SAFETY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-135.2A(a) reads as rewritten:

"(a) Each front seat occupant who is 16 years of age or older and each driver of a passenger motor vehicle manufactured with seat safety belts ~~in compliance with Federal Motor Vehicle Safety Standard No. 208~~ must have such a safety belt properly fastened about his or her body at all times when the vehicle is in forward motion on a street or highway in this State. When the vehicle is equipped with sufficient safety belts to accommodate each passenger seated in the rear seat, each rear seat occupant who is 16 years of age or older must have a seat safety belt properly fastened about his or her body in compliance with this section. ~~Each driver of a passenger motor vehicle manufactured with seat safety belts in compliance with Federal Motor Vehicle Safety Standard No. 208, who is transporting in the front seat a person who is (i) under 16 years of age and (ii) not required to be restrained in accordance with G.S. 20-137.1, must have the person secured by such a safety belt at all times when the vehicle is operated in forward motion on a street or highway in this State. Persons required to be restrained in accordance with G.S. 20-11 and G.S. 20-137.1 must be secured as required by those sections.~~"

Section 2. G.S. 20-135.2A(e) reads as rewritten:

"(e) ~~Any person violating this section during the period from October 1, 1985, to December 31, 1986, shall be given a warning of violation only. Thereafter, any person~~

~~violating~~ Any driver or passenger who fails to wear a seat belt as required by this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 3. G.S. 20-135.2A(f) reads as rewritten:

"(f) No ~~drivers license points or~~ insurance points or insurance surcharge shall be assessed on account of violation of this section. A driver's failure to wear a seat belt as required by this section while operating a passenger motor vehicle shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.21, 58-36-65, or 58-36-75."

Section 4. G.S. 20-135.2A(h) is repealed.

Section 5. G.S. 20-135.2B(c) reads as rewritten:

"(c) Any person violating this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 6. G.S. 20-135.2B(d) reads as rewritten:

"(d) No ~~drivers license points or~~ insurance points or insurance surcharge shall be assessed on account of violation of this section. A violation of this section shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.21, 58-36-65, or 58-36-75."

Section 7. Section 3 of Chapter 672 of the 1993 Session Laws is repealed.

Section 8. G.S. 20-137.1(a) reads as rewritten:

"(a) Every driver who is transporting ~~a child~~ one or more passengers of less than ~~12~~ 16 years of age shall have ~~the child~~ each such passenger properly secured in ~~a child~~ an age-appropriate passenger restraint ~~system (car safety seat) which meets federal standards applicable at the time of its manufacture. The requirements of this section may be met when the child is four years of age or older by securing the child in a seat safety belt.~~ system.

When a child is less than five years of age or less than 60 pounds in weight, the requirements of this section shall be met by securing the child in a child restraint system which meets federal standards applicable at the time of its manufacture. The child restraint system shall be secured in a rear seat of the vehicle if the vehicle has a rear seat that will accommodate a child restraint system.

When a child is five years of age or older or is 60 pounds or more in weight, the requirements of this section may be met by securing the child in a seat safety belt."

Section 9. G.S. 20-137.1(d) reads as rewritten:

"(d) No ~~driver license points or~~ insurance points shall be assessed for a violation of this section; nor shall a violation constitute negligence per se or contributory

negligence per se nor shall it be evidence of negligence or contributory negligence. A violation of this section shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.21, 58-36-65, or 58-36-75."

Section 10. This act becomes effective July 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

H57-CSRW-003
PROPOSED COMMITTEE SUBSTITUTE
HOUSE BILL 57
THIS IS A DRAFT 9-MAR-99 11:31:48
ATTENTION: LINE NUMBERS MAY CHANGE AFTER ADOPTION

Short Title: Motor Vehicle Occupant Restraints. (Public)

Sponsors:

Referred to:

February 10, 1999

A BILL TO BE ENTITLED

AN ACT TO ENHANCE MOTOR VEHICLE OCCUPANT RESTRAINT SAFETY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-135.2A(a) reads as rewritten:

"(a) Each front seat occupant who is 16 years of age or older and each driver of a passenger motor vehicle manufactured with seat ~~safety~~ belts ~~in compliance with Federal Motor Vehicle Safety Standard No. 208 must~~ shall have ~~such~~ a ~~safety~~ seat belt properly fastened about his or her body at all times when the vehicle is in forward motion on a street or highway in this State. When the vehicle is equipped with sufficient seat belts to accommodate each passenger seated in the rear seat, each rear seat occupant who is 16 years of age or older shall have a seat belt properly fastened about his or her body in compliance with this section. ~~Each driver of a passenger motor vehicle manufactured with seat safety belts in compliance with Federal Motor Vehicle Safety Standard No. 208, who is transporting in the front seat a person~~

~~who is (i) under 16 years of age and (ii) not required to be restrained in accordance with G.S. 20-137.1, must have the person secured by such a safety belt at all times when the vehicle is operated in forward motion on a street or highway in this State. Persons required to be restrained in accordance with G.S 20-11 and G.S. 20-137.1 must be secured as required by those sections.~~"

Section 2. G.S. 20-135.2A(e) reads as rewritten:

"(e) ~~Any person violating this section during the period from October 1, 1985, to December 31, 1986, shall be given a warning of violation only. Thereafter, any person violating~~ Any driver or passenger who fails to wear a seat belt as required by this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

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Section 4. G.S. 20-135.2A(h) is repealed.

Section 5. G.S. 20-135.2B(c) reads as rewritten:

"(c) Any person violating this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 6. Section 3 of Chapter 672 of the 1993 Session Laws is repealed.

Section 7. G.S. 20-137.1(a) reads as rewritten:

"(a) Every driver who is transporting ~~a child~~ one or more passengers of less than ~~12~~ 16 years of age shall have ~~the child~~ each such passenger properly secured in a child passenger restraint system ~~(car safety seat)~~ or seat belt which meets federal standards applicable at the time of its manufacture. ~~The requirements of this section may be met when the child is four years of age or older by securing the child in a seat safety belt.~~ In vehicles equipped with active passenger-side front air bags, children shall be properly secured in a rear seat unless the child restraint system is designed for use with air bags or the child is in a lap and properly fitted shoulder belt.

(1) A child less than five years of age and less than 40 pounds in weight shall be properly secured in a child passenger restraint system.

(2) A child five years of age or older, or a child weighing 40 or more pounds, shall be properly secured in a child passenger restraint system or seat belt."

Section 8. G.S. 20-137.1(d) reads as rewritten:

"(d) No ~~driver license points or~~ insurance points shall be assessed for a violation of this section; nor shall a violation constitute negligence per se or contributory negligence per se nor shall it be evidence of negligence or contributory negligence. A violation of this section shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.1, 58-36-65, or 58-36-75."

Section 9. This act becomes effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

H57-CSRW-003
PROPOSED COMMITTEE SUBSTITUTE
HOUSE BILL 57
THIS IS A DRAFT 9-MAR-99 16:37:53
ATTENTION: LINE NUMBERS MAY CHANGE AFTER ADOPTION

Short Title: Motor Vehicle Occupant Restraints. (Public)

Sponsors:

Referred to:

February 10, 1999

A BILL TO BE ENTITLED

AN ACT TO ENHANCE MOTOR VEHICLE OCCUPANT RESTRAINT SAFETY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-135.2A(a) reads as rewritten:

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~~who is (i) under 16 years of age and (ii) not required to be restrained in accordance with G.S. 20-137.1, must have the person secured by such a safety belt at all times when the vehicle is operated in forward motion on a street or highway in this State. Persons required to be restrained in accordance with G.S. 20-11 and G.S. 20-137.1 must be secured as required by those sections.~~"

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(1) A child less than five years of age and less than 40 pounds in weight shall be properly secured in a child passenger restraint system.

(2) A child five years of age or older, or a child weighing 40 or more pounds, shall be properly secured in a child passenger restraint system or seat belt."

Section 8. G.S. 20-137.1(d) reads as rewritten:

"(d) No ~~driver license points or~~ insurance points shall be assessed for a violation of this section; nor shall a violation constitute negligence per se or contributory negligence per se nor shall it be evidence of negligence or contributory negligence. A violation of this section shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.1, 58-36-65, or 58-36-75."

Section 9. This act becomes effective October 1, 1999.

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

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Raleigh, NC 27603-5925
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Research Division
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Raleigh, NC 27603-5925
(919) 733-2578

March 3, 1999

To: Members of the House Highway Safety Committee

From: Giles S. Perry, Committee Counsel

Re: House Bill 57 Motor Vehicle Occupant Restraints
Introduced by Representatives Alexander and Clary
Proposed Committee Substitute

House Bill 57 (proposed committee substitute) makes the following changes to current law:

Section 1 would require rear seat occupants 16 or older to wear seat belts. Current law only requires persons under 4, and persons in the back seat of a vehicle operated by a level 1 permittee or level 2 licensee to be belted or restrained.

Section 2 clarifies existing law – that drivers and passengers caught without seat belts fastened are subject to a $25 infraction penalty.

Section 3 provide that a person found responsible for not wearing a seat belt would be assessed 2 drivers license points (*NOT* insurance points).

Section 4 would delete an obsolete section requiring a 1988 report.

Section 5 clarifies existing law – that a person found responsible for transporting a child under 12 in an open pickup is subject to a $25 infraction penalty.

Section 6 deletes an obsolete section requiring a 1998 report.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Section 7 would:

--require a child under 5 and less than 40 lbs. to be in a child restraint system (current law--under 4)

--require a child 5 or over, or 40 lbs. or more, to be in a child restraint system or seat belt

--require a child under16 in a car equipped with passenger air bags to be in the back, unless the child restraint system is designed for use with air bags, or the child is in a properly fitted shoulder and seat belt.

Section 8 provides that a person found responsible for violating the amended child restraint law would be assessed 2 drivers license points (*NOT* insurance points).

Section 9 –effective date October 1, 1999.

VISITOR REGISTRATION SHEET

Highway Safety 3/10/99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	[illegible]	DMV
2.	[illegible]	GHSP
3.	Bill Hall	UNC HSRC
4.	TOM ENTWIGHT	NSP
5.	[illegible] Davis	Womble Carlyle - AAA
6.	Joe Parks	GHSP
7.	Jane Pinsky	AAA
8.	Eddie Caldwell	HMCCTC P.A.
9.	David Ferrell	HMCCTC P.A.
10.	Mark Newell	NCSSA
11.	[illegible]	NCSSA
12.	Andy Ellen	NCRMA & Tire & Retreaders Assoc.
13.	Ann Case	NCRMA / Tire & Retreaders Assoc.
14.	[illegible]	NC DMV. RMC
15.	[illegible]	NC Auto Dealers
16.	[illegible]	Capital Group
17.	Wayne Hurder	NC DMV - Driver Licens
18.	Gordon A. Joyner	NCHA & EMS
19.	Buddy White	NCAREMS
20.	Steve Woodson	NC Farm Bureau
21.	Reg Lester	IGONC
	FRED TAYLOR	WRAL-TV

(2)

VISITOR REGISTRATION SHEET

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Darrell Peoples	Peoples Tire + Auto
2.	John Hogan	Glenwood Exxon
3.	Reid Byrd	PEOPLES TIRE + AUTO
4.	Kim Hibbard	NCLM
5.	Sgt. JB Winstead	NCHP
6.	Jonathan Williams	CCPS
7.	Alan Mintz	Bailey & Dixon LLP
8.	Susan Vaccaro	Nationwide
9.	Leana Brookins Jeff	Alpha Kappa Alpha Sorority Inc
10.	Terry Andersm	Alpha Kappa Alpha Sorority, Inc.
11.	Tabella Campbell	Alpha Kappa Alpha SOR. INC
12.		
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(8)

VISITOR REGISTRATION SHEET

3/10

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Shannon Liggins	Zeta Xi AKA
Miami Cochran	Zeta Xi AKA
Blair Stitt	Just Inspections
Annie Belton	Phi Omega AKA
AQ-7/AKA Arenia Hammond	516 Chorus Way / Raleigh 27603
Anita Hammond	alpha Beta Alpha AKA / 2801 Shoreham St. / Durham 27707
Martha Livengood	Youth Advocacy & Involvement Office DOA
Vivian H. Burke	Mayor Pro Tem Winston Salem NC Public Safety Cte. for Safety Inspections
Terry Dawkins Peoples	

HOUSE COMMITTEE ON HIGHWAY SAFETY

MARCH 17, 1999
1:00 P.M.
Room 415

AGENDA

Chair(s): Rep. Alma Adams & Rep. Wayne Goodwin

INTRODUCTIONS

BILLS TO BE CONSIDERED	HB 57	Motor Vehicle Occupant Restraint Safety
	HB 180	Repeal Motor Safety Inspections

PRESENTATIONS

DISCUSSION

ADJOURNMENT

HIGHWAY SAFETY COMMITTEE MEETING
MINUTES FOR MARCH 17, 1999
Room 415 LOB

Bill(s) before the Committee:	HB 57 Motor Vehicle Occupant Restraints Safety
Bill(s) discussed:	HB 57 Motor Vehicle Occupants Safety
Action(s) taken:	Bill given unfavorable report; Committee Substitute Given favorable report

Committee members in attendance were: Chairs- Representatives Adams and Goodwin (Presiding), Representatives Alexander, Allred, Dedmon, Gray, Hurley, Justus, McComas, Mosely, Sexton, C. Wilson, Baddour, Cunningham, and Hackney. **Also attending:** Giles Perry (Staff). A Visitor Registration sheet is attached and made part of these minutes.

Narrative/Discussion: Presiding Chair Goodwin called the meeting to order at approximately 1:05 PM. Pages and staff were introduced. Paula Wolff with The Covenant with North Carolina's Children spoke in favor of HB 57. Rep. Allred proposed an amendment. Amendment was discussed and voted on. Amendment failed. Rep. Cunningham moves for favorable report on Committee Substitute for HB 57 Committee Substitute reported favorably.

Rep. Goodwin closed the meeting by thanking members and guests. The meeting was adjourned at approximately 1:50 PM.

Respectfully Submitted,

Rep. Wayne Goodwin
Chairman

Kristen C. Younts
Committee Assistant

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Goodwin & Adams** for the Committee on **Highway Safety**.

☐ Committee Substitute for
H.B. 57 A BILL TO BE ENTITLED AN ACT TO ENHANCE MOTOR VEHICLE OCCUPANT RESTRAINT SAFETY.

☐ 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 I.)

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

☐ 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)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

H57-CSRW-004
PROPOSED COMMITTEE SUBSTITUTE
HOUSE BILL 57
THIS IS A DRAFT 17-MAR-99 10:17:46
ATTENTION: LINE NUMBERS MAY CHANGE AFTER ADOPTION

Short Title: Motor Vehicle Occupant Restraints. (Public)

Sponsors:

Referred to:

February 10, 1999

A BILL TO BE ENTITLED

AN ACT TO ENHANCE MOTOR VEHICLE OCCUPANT RESTRAINT SAFETY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-135.2A(a) reads as rewritten:

"(a) Each front seat occupant who is 16 years of age or older and each driver of a passenger motor vehicle manufactured with seat ~~safety~~ belts ~~in compliance with Federal Motor Vehicle Safety Standard No. 208 must~~ shall have ~~such~~ a ~~safety~~ seat belt properly fastened about his or her body at all times when the vehicle is in forward motion on a street or highway in this State. When the vehicle is equipped with sufficient seat belts to accommodate each passenger seated in the rear seat, each rear seat occupant who is 16 years of age or older shall have a seat belt properly fastened about his or her body in compliance with this section. ~~Each driver of a passenger motor vehicle manufactured with seat safety belts in compliance with Federal Motor Vehicle Safety Standard No. 208, who is transporting in the front seat a person~~

~~who is (i) under 16 years of age and (ii) not required to be restrained in accordance with G.S. 20-137.1, must have the person secured by such a safety belt at all times when the vehicle is operated in forward motion on a street or highway in this State. Persons required to be restrained in accordance with G.S 20-11 and G.S. 20-137.1 must be secured as required by those sections.~~"

Section 2. G.S. 20-135.2A(e) reads as rewritten:

"(e) ~~Any person violating this section during the period from October 1, 1985, to December 31, 1986, shall be given a warning of violation only. Thereafter, any person violating~~ Any driver or passenger who fails to wear a seat belt as required by this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 3. G.S. 20-135.2A(f) reads as rewritten:

"(f) No ~~drivers license points or~~ insurance points or insurance surcharge shall be assessed on account of violation of this section. A driver's failure to wear a seat belt as required by this section while operating a passenger motor vehicle shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.1, 58-36-65, or 58-36-75."

Section 4. G.S. 20-135.2A(h) is repealed.

Section 5. G.S. 20-135.2B(c) reads as rewritten:

"(c) Any person violating this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 6. Section 3 of Chapter 672 of the 1993 Session Laws is repealed.

Section 7. G.S. 20-137.1(a) reads as rewritten:

"(a) Every driver who is transporting ~~a child~~ one or more passengers of less than ~~12~~ 16 years of age shall have ~~the child~~ each such passenger properly secured in a child passenger restraint system ~~(car safety seat)~~ or seat belt which meets federal standards applicable at the time of its manufacture. ~~The requirements of this section may be met when the child is four years of age or older by securing the child in a seat safety belt.~~ In vehicles equipped with active passenger-side front air bags, children shall be properly secured in a rear seat unless the child restraint system is designed for use with air bags or the child is in a properly fitted shoulder and seat belt.

(1) A child less than five years of age and less than 40 pounds in weight shall be properly secured in a child passenger restraint system.

(2) A child five years of age or older, or a child weighing 40 or more pounds, shall be properly secured in a child passenger restraint system or seat belt."

Section 8. G.S. 20-137.1(d) reads as rewritten:

"(d) No ~~driver license points or~~ insurance points shall be assessed for a violation of this section; nor shall a violation constitute negligence per se or contributory negligence per se nor shall it be evidence of negligence or contributory negligence. A violation of this section shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.1, 58-36-65, or 58-36-75."

Section 9. This act becomes effective October 1, 1999.

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

Elaine W. Robinson, Director
Administrative Division
Room 5, Legislative Building
16 W. Jones Street
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Raleigh, NC 27603-5925
(919) 733-2578

March 17, 1999

To: Members of the House Highway Safety Committee

From: Giles S. Perry, Committee Counsel

Re: House Bill 57 Motor Vehicle Occupant Restraints
Introduced by Representatives Alexander and Clary
Proposed Committee Substitute

House Bill 57 (proposed committee substitute) makes the following changes to current law:

Section 1 would require rear seat occupants 16 or older to wear seat belts, if the vehicle is equipped with sufficient seat belts to accommodate each rear seat passenger.

Section 2 clarifies existing law – that drivers and passengers caught without seat belts fastened are subject to a $25 infraction penalty.

Section 3 provide that a driver found responsible for not wearing a seat belt would be assessed 2 drivers license points (*NOT* insurance points).

Section 4 would delete an obsolete section requiring a 1988 report.

Section 5 clarifies existing law – that a person found responsible for transporting a child under 12 in an open pickup is subject to a $25 infraction penalty.

Section 6 deletes an obsolete section requiring a 1998 report.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Section 7. Current law requires a child less than 4 to be in a child restraint system, and a child from age 5-12 to be in a child restraint system or seat belt. This section would change the current law to:

--require a child under 5 and less than 40 lbs. to be in a child restraint system

--require a child 5 or over, or 40 lbs. or more, to be in a child restraint system or seat belt

--require a child under16 in a car equipped with passenger air bags to be in the back, unless the child restraint system is designed for use with air bags, or the child is in a properly fitted shoulder and seat belt.

Section 8 provides that a person found responsible for violating the amended child restraint law would be assessed 2 drivers license points (*NOT* insurance points).

Section 9 –effective date October 1, 1999.

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nator is responding to a call to
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nergency medical service as an
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official duties.
(c) of this section is a Class 1
1032; 1953, c. 354; 1955, c. 528;
; c. 1170, s. 2; 1967, c. 651, s. 1;
38, s. 2; 1979, c. 653, s. 1; c. 887;
Reg. Sess., 1986), c. 1027, s. 50;
1990), c. 1020, s. 2; 1991, c. 263,
Sess., c. 24, s. 14(c); 1993 (Reg.
8, s. 1; 1995 (Reg. Sess., 1996), c.

effective date of this act are not abated or affected by this act, and the statutes that would be applicable but for this act remain applicable to those prosecutions."

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective June 21, 1996, rewrote subdivision (b)(13).

Historic Vehicle Owner special
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Editor's Note. — Session Laws 1995, c. 379, s. 18.1, which amended this section, was effective July 6, 1995, but did not affect pending litigation.

§ 20-134. Lights on parked vehicles.

(a) Whenever a vehicle is parked or stopped upon a highway, whether attended or unattended during the times mentioned in G.S. 20-129, there shall be displayed upon such vehicle one or more lamps projecting a white or amber light visible under normal atmospheric conditions from a distance of 500 feet to the front of such vehicle, and projecting a red light visible under like conditions from a distance of 500 feet to the rear, except that local authorities may provide by ordinance that no lights need be displayed upon any such vehicle when parked in accordance with local ordinances upon a highway where there is sufficient light to reveal any person within a distance of 200 feet upon such highway.

(b) A motor vehicle operated on a highway by a rural letter carrier or by a newspaper delivery person shall be equipped and operated with flashing amber lights at any time the vehicle is being used in the delivery of mail or newspapers, regardless of whether the vehicle is attended or unattended. (1937, c. 407, s. 97; 1959, c. 1264, s. 9; 1995 (Reg. Sess., 1996), c. 715, s. 1.)

Effect of Amendments. — The 1995 (Reg. Sess., 1996) amendment, effective October 1, 1996, and applicable to offenses occurring on or after that date, added the subsection (a) designation, and added subsection (b).

§ 20-135.1: Repealed by Session Laws 1995 (Regular Session, 1996), c. 756, s. 30, effective June 21, 1996.

§ 20-135.2A. Seat belt use mandatory.

(a) Each front seat occupant who is 16 years of age or older and each driver of a passenger motor vehicle manufactured with seat safety belts in compliance with Federal Motor Vehicle Safety Standard No. 208 must have such a safety belt properly fastened about his or her body at all times when the vehicle is in forward motion on a street or highway in this State. Each driver of a passenger motor vehicle manufactured with seat safety belts in compliance with Federal Motor Vehicle Safety Standard No. 208, who is transporting in the front seat a person who is (i) under 16 years of age and (ii) not required to be restrained in accordance with G.S. 20-137.1, must have the person secured by such a safety belt at all times when the vehicle is operated in forward motion on a street or highway in this State. Persons required to be restrained in accordance with G.S. 20-11 and G.S. 20-137.1 must be secured as required by those sections.

(b) "Passenger Motor Vehicle," as used in this section, means a motor vehicle with motive power designed for carrying 10 passengers or fewer, but does not include a motorcycle, a motorized pedacycle or a trailer.

(c) This section shall not apply to any of the following:

(1) A driver or occupant with a medical or physical condition that prevents appropriate restraint by a safety belt or with a professionally certified mental phobia against the wearing of vehicle restraints;

(2) A motor vehicle operated by a rural letter carrier of the United States Postal Service while performing duties as a rural letter carrier and a motor vehicle operated by a newspaper delivery person while actually engaged in delivery of newspapers along the person's specified route;
(3) A driver or passenger frequently stopping and leaving the vehicle or delivering property from the vehicle if the speed of the vehicle between stops does not exceed 20 miles per hour;
(4) Any vehicle registered and licensed as a property-carrying vehicle in accordance with G.S. 20-88, while being used for agricultural or commercial purposes; or
(5) A motor vehicle not required to be equipped with seat safety belts under federal law.

(d) Evidence of failure to wear a seat belt shall not be admissible in any criminal or civil trial, action, or proceeding except in an action based on a violation of this section or as justification for the stop of a vehicle or detention of a vehicle operator and passengers.

(e) Any person violating this section during the period from October 1, 1985, to December 31, 1986, shall be given a warning of violation only. Thereafter, any person violating this section shall have committed an infraction and shall pay a fine of twenty-five dollars ($25.00). An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine. A person convicted of an infraction may not be assessed court costs.

(f) No drivers license points or insurance surcharge shall be assessed on account of violation of this section.

(g) The Commissioner of the Division of Motor Vehicles and the Department of Public Instruction shall incorporate in driver education programs and driver licensing programs instructions designed to encourage compliance with this section as an important means of reducing the severity of injury to the users of restraint devices and on the requirements and penalties specified in this law.

(h) The Department of Transportation through the Governor's Highway Safety Program shall evaluate the effectiveness of this section and shall include a report of findings in its report on highway safety no later than October 1, 1988. (1985, c. 222, s. 1; 1987, c. 623; 1991, c. 448, s. 1; 1994, Ex. Sess., c. 5, s. 1; 1997-16, s. 2.)

Editor's Note. —

Session Laws 1994, Extra Session, c. 5, s. 1, which amended this section, was effective March 3, 1994, and applicable to any trial, action, or proceeding commenced on or after that date.

Session Laws 1997-16, s. 10 provides that this act does not appropriate funds to the Division to implement this act nor does it obligate the General Assembly to appropriate funds to implement this act.

Session Laws 1997-16, s. 11, as amended by Session Laws 1997-443, s. 32.20, provides in part that this act becomes effective December 1, 1997.

Session Laws 1997-16, s. 11, as amended by Session Laws 1997-443, s. 32.20, provides in part that sections 1 through 7 do not apply to any person who holds a valid North Carolina limited learner's permit issued before the effective date of act, who holds a valid North Carolina learner's permit issued before the effective date of this act, or who is a provisional licensee and holds a valid North Carolina drivers license issued before the effective date of this act.

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Effect of Amendments. — The 1997 amendment, effective December 1, 1997,

in subsection (a) substituted "must" for "shall" twice, inserted "or her" preceding "body", substituted "(i)" for "(1)", "(ii)" for "(2)", "G.S. 20-11 and G.S.20-137.1 must"

CASE

Infants. — Evidence that an infant killed in a car accident was improperly sitting on the lap of, and within the seat belt of, the occupant of the front passenger's seat was not admissible in a personal injury and wrongful death action arising out of the accident. Chaney v. Young, 122 N.C. App. 260, 468 S.E.2d 837 (1996).

This section precludes the introduction of any evidence regarding seat belt use, etc. —

The evidence of the failure of the defendant to use her seat belt was not admissible in a DWI trial. State v. Williams, 113 N.C. App. 686, 440 S.E.2d 324 (1994).

Non-use of Seat Belts Probable

§ 20-135.2B. Transportin of age in ope of a vehicle p

(a) The operator of a vehicle area shall insure that no child u in the bed or cargo area of that area is a bed or cargo area witho construction.

(b) Subsection (a) of this sect following circumstances:
(1) An adult is present in th and is supervising the c
(2) The child is secured or r tured in compliance wi Standard No. 208, insta not less than 5,000 po approved by the Commi
(3) An emergency situation
(4) The vehicle is being op valid permit.
(5) The vehicle is being oper
(6) The vehicle is being op incorporated area with a

(c) Any person violating this infraction and shall pay a fine infraction is an unlawful act tha charging and trying an infraction but conviction of an infraction payment of a fine. A person con assessed court costs.

(d) No drivers license points or insurance surcharge shall be assessed on account of violation of this section. (1993 (Reg. Sess., 1994), c. 672, s. 1; 1995, c. 163, s. 7.)

Editor's Note. — Session Laws 1993 (Reg. Sess., 1994), c. 672, s. 4, made this section effective January 1, 1995.

Session Laws 1993 (Reg. Sess., 1994), c. 672, which added this section, in s. 2 provides: "The Commissioner of the Division of Motor Vehicles and the Department of Public Instruction shall incorporate in driver education programs and driver licensing programs instructions designated to encourage compliance with this act and to inform the public on the requirements and penalties specified in this law."

Session Laws 1993 (Reg. Sess., 1994), c. 672, which added this section, in s. 3 provides: "The Department of Transportation through the Governor's Highway Safety Program shall evaluate the effectiveness of this act and shall include a report of findings in its report on highway safety no later than January 1, 1998."

§ 20-136. Smoke screens.

Editor's Note. — Session Laws 1993, c. 539, s. 1257, which amended this section, in s. 1359, as amended by Session Laws 1994, Extra Session, c. 24, s. 14(c), provides: "This act becomes effective October 1, 1994, and applies to offenses occurring on or after that date. Prosecutions for offenses committed before the effective date of this act are not abated or affected by this act, and the statutes that would be applicable but for this act remain applicable to those prosecutions."

§ 20-137: Repealed by Session Laws 1995, c. 379, s. 18.2, effective July 1, 1995.

§ 20-137.1. Child restraint systems required.

(a) Every driver who is transporting a child of less than 12 years of age shall have the child properly secured in a child passenger restraint system (car safety seat) which meets federal standards applicable at the time of its manufacture. The requirements of this section may be met when the child is four years of age or older by securing the child in a seat safety belt.

(b) The provisions of this section shall not apply: (i) to ambulances or other emergency vehicles; (ii) when the child's personal needs are being attended to; (iii) if all seating positions equipped with child passenger restraint systems or seat belts are occupied; or (iv) to vehicles which are not required by federal law or regulation to be equipped with seat belts.

(c) Any person convicted of violating this section may be punished by a fine not to exceed twenty-five dollars ($25.00). No driver charged under this section for failure to have a child under four years of age properly secured in a restraint system shall be convicted if he produces at the time of his trial proof satisfactory to the court that he has subsequently acquired an approved child passenger restraint system.

(d) No driver license points or insurance points shall be assessed for a violation of this section; nor shall a violation constitute negligence per se or contributory negligence per se nor shall it be evidence of negligence or contributory negligence. (1981, c. 804, ss. 1, 4, 5; 1985, c. 218; 1993 (Reg. Sess., 1994), c. 748, s. 1.)

Improper Restraint. — that an infant killed in a was improperly sitting on th within the seat belt of, the the front passenger's seat

§ 20-137.2. Opera enfor ishme

Editor's Note. — Session c. 539, s. 362, which amend tion, in s. 1359, as amended Laws 1994, Extra Session, c. provides: "This act becomes tober 1, 1994, and applies

Part 10. Operation

§ 20-138.1. Impai

Cross References. — Fo of "alcohol concentration," 4.01(1b).

Legal Periodicals. — For note, "North Carolina a

I. In General.
II. Driving Under the Influ
V. Instructions.

I. IN GENERAL.

Constitutionality. — Revocation of one's driver's der § 20-16.5 and subsequ tions of DWI under this sec violate the prohibition agai jeopardy. State v. Rogers, 12 364, 477 S.E.2d 221 (1996).

Jurisdiction of State C ficer. — Trial court erred by that the arresting State Ca officer had no jurisdiction to fendant for DWI. State v. Dic N.C. App. 592, 481 S.E.2d 34

Quoted in State v. Snyde 61, 468 S.E.2d 221 (1996).

Cited in State v. Stafford App. 101, 440 S.E.2d 8 Camalier v. Jeffries, 113 N.C 438 S.E.2d 427 (1994); State 114 N.C. App. 479, 442 S (1994); Peal ex rel. Peal v.

VISITOR REGISTRATION SHEET

Highway Safety 3/17/99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. Michael E. Bryant	DRIVER LICENSE/DMV
2. Insp. Mike Gaither	DMV Enforcement
3. Maj Jimmy Edwards	" "
4. Major W. M. Autry	State Highway Patrol
5. Martha Livengood	DOA - YAIO
6. Reid Byrd	Peoples Tire and Auto
7. [illegible]	DMV
8. C Carter	BPMLL
9. Christina Medlin	Covenant w/ NCs Children
10. Jane Piascy	AAA Carolinas
11. Ginger Gay	MG News
12. Dawn Anderson	UNC-CH - DTT
13. Karyn Pamish	GHSP
14. Frank Smith	GHSP
15. Bill Hall	HSRC
16. [illegible]	Moore Van All
17. VL McBride	NCDA
18. Thomas Vance Bennett	NCCF TF
19. Paula A. Stoll	Covenant w/ NC's Children
20. Jim Honeycutt	Horsepath Transmission
21. [illegible]	NCSSA

HOUSE COMMITTEE ON HIGHWAY SAFETY

MARCH 24, 1999
1:00 P.M.
Room 415

AGENDA

CHAIR(S): Representatives Alma Adams & Wayne Godwin

INTRODUCTIONS

BILLS TO BE CONSIDERED HB 180 Repeal Motor Safety Inspections

PRESENTATIONS

DISCUSSION

ADJOURNMENT

HIGHWAY SAFETY COMMITTEE MEETING
MINUTES FOR MARCH 24, 1999
Room 415 LOB

Bill(s) before the Committee: HB 180 Repeal Safety Inspections

Bill(s) Discussed: HB 180 Repeal Safety Inspections

Action(s) taken: Bill given unfavorable report

Committee members in attendance were: Chairs – Representatives – Adams (Presiding) and Goodwin, Representatives Dedmon, Gray, Mosley, Sexton and Cunningham (Ex-Officio). Also attending: Giles Perry (Committee Counsel), staff, guests, and members of the press.

Narrative/Discussion: Presiding Chair Representative Adams called the meeting to order at approximately 1:05 p.m. HB 180 sponsor Representative Carpenter made a presentation before the committee followed by additional presentations from:

- Eugene Cella, DMV – opposed the bill.
- Sgt. Winstead, SHP – opposed the bill.
- Debra Bryan, American Lung Association – opposed the bill.
- Nancy Thompson, NC Citizens for Business and Industry – opposed the bill
- Jane Pensky, AAA Carolinas – opposed the bill.

Following the presentations a short discussion continued until Representative Cunningham moved that the committee give HB 180 an unfavorable report. **By unanimous vote the committee gave HB 180 an unfavorable report.**

Representative Adams closed the meeting by thanking attending presenters and guests – The meeting was adjourned at approximately 1:50 p.m. with HB 180 receiving an unfavorable report.

Respectfully Submitted,

Rep. Alma Adams
Chairperson

Kristen Younts
Committee Assistant

Highway Safety

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Adams and Goodwin** for the Committee on **HIGHWAY SAFETY**.

☐ Committee Substitute for
H.B. 180 A BILL TO BE ENTITLED AN ACT TO REPEAL THE MOTOR VEHICLE SAFETY INSPECTION.

☐ 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.

☒ 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)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 180

Short Title: Repeal Safety Inspections. (Public)

Sponsors: Representatives Carpenter; Allred, Baker, Buchanan, Cansler, Capps, Crawford, Davis, Howard, Kiser, Morris, Rayfield, Sexton, and Starnes.

Referred to: Highway Safety, if favorable, Finance.

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE MOTOR VEHICLE SAFETY INSPECTION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-183.2 reads as rewritten:

"**§ 20-183.2. Description of vehicles subject to ~~safety or~~ emissions inspection; definitions.**

~~(a) Safety. -- A motor vehicle is subject to a safety inspection in accordance with this Part if it meets all of the following requirements:~~

~~(1) It is subject to registration with the Division under Article 3 of this Chapter.~~

~~(2) It is not subject to inspection under 49 C.F.R. Part 396, the federal Motor Carrier Safety Regulations.~~

~~(3) It is not a trailer whose gross weight is less than 4,000 pounds or a house trailer.~~

(b) Emissions. -- A motor vehicle is subject to an emissions inspection in accordance with this Part if it meets all of the following requirements:

(1) It is subject to registration with the Division under Article 3 of this Chapter.

(2) It is not a trailer whose gross weight is less than 4,000 pounds, a house trailer, or a motorcycle.

(3) It is a 1975 or later model.

(4) It is powered or designed so that it could be powered by gasoline.

(5) It meets any of the following descriptions:

a. It is required to be registered in an emissions county.
b. It is part of a fleet that is operated primarily in an emissions county.
c. It is offered for rent in an emissions county.
d. It is a used vehicle offered for sale by a dealer in an emissions county.
e. It is operated on a federal installation located in an emissions county and it is not a tactical military vehicle. Vehicles operated on a federal installation include those that are owned or leased by employees of the installation and are used to commute to the installation and those owned or operated by the federal agency that conducts business at the installation.
f. It is otherwise required by 40 C.F.R. Part 51 to be subject to an emissions inspection.

(c) Definitions. -- The following definitions apply in this Part:

(1) Emissions county. -- A county in which the State either is required by federal law to conduct emissions testing or has agreed in its State Implementation Plan submitted to the federal Environmental Protection Agency to conduct emissions testing. The State Environmental Management Commission establishes the emissions counties pursuant to rules adopted under G.S. 143-215.107(a)(6).

(2) Federal installation. -- An installation that is owned by, leased to, or otherwise regularly used as the place of business of a federal agency."

Section 2. G.S. 20-183.3 reads as rewritten:

"**§ 20-183.3. Scope of ~~safety inspection and~~ emissions inspection.**

~~(a) Safety. -- A safety inspection of a motor vehicle consists of an inspection of the following equipment to determine if the vehicle has the equipment required by Part 9 of Article 3 of this Chapter and if the equipment is in a safe operating condition:~~

~~(1) Brakes, as required by G.S. 20-124.~~
~~(2) Lights, as required by G.S. 20-129 or G.S. 20-129.1.~~
~~(3) Horn, as required by G.S. 20-125(a).~~
~~(4) Steering mechanism, as required by G.S. 20-123.1.~~
~~(5) Windows and windshield wipers, as required by G.S. 20-127. To determine if a vehicle window meets the window tinting restrictions, a safety inspection mechanic must first determine, based on use of an automotive film check card or knowledge of window tinting techniques, if after-factory tint has been applied to the window. If after-factory tint has been applied, the mechanic must use a light meter approved by the Commissioner to determine if the window meets the window tinting restrictions.~~
~~(6) Directional signals, as required by G.S. 20-125.1.~~
~~(7) Tires, as required by G.S. 20-122.1.~~

~~(8) Mirrors, as required by G.S. 20-126.~~

~~(9) Exhaust system, as required by G.S. 20-128. For a vehicle that is subject to an emissions inspection in addition to a safety inspection, a visual inspection of the vehicle's emission control devices is included in the emissions inspection rather than the safety inspection.~~

(b) Emissions. -- An emissions inspection of a motor vehicle consists of a visual inspection of the vehicle's emission control devices to determine if the devices are present, are properly connected, and are the correct type for the vehicle and an analysis of the exhaust emissions of the vehicle to determine if the exhaust emissions meet the standards for the model year of the vehicle set by the Environmental Management Commission. To pass an emissions inspection a vehicle ~~must~~ shall pass both the visual inspection and the exhaust emissions analysis. ~~When an emmissions inspection is performed on a vehicle, a safety inspection must be performed on the vehicle as well.~~

(c) Reinspection After Failure. -- The scope of a reinspection of a vehicle that has been repaired after failing an inspection is the same as the original inspection unless the vehicle is presented for reinspection within 30 days of failing the original inspection. If the vehicle is presented for reinspection within this time limit ~~and the inspection the vehicle failed was a safety inspection, the reinspection is limited to an inspection of the equipment that failed the original inspection. If the vehicle is presented for reinspection within this time limit~~ and the inspection the vehicle failed was an emissions inspection, the reinspection is limited to the portion of the inspection the vehicle failed and any other portion of the inspection that would be affected by repairs made to correct the failure."

Section 3. G.S. 20-183.4 is repealed.

Section 4. G.S. 20-183.4C reads as rewritten:

"**§ 20-183.4C. When a vehicle ~~must~~ shall be inspected; one-way trip permit.**

(a) Inspection. -- A vehicle that is subject to ~~a safety inspection, an emissions inspection, or both must~~ an emissions inspection shall be inspected as follows:

(1) A new vehicle ~~must~~ shall be inspected before it is sold at retail in this State.

(2) A used vehicle ~~must~~ shall be inspected before it is offered for sale at retail in this State by a dealer at a location other than a public auction.

(3) A used vehicle that is offered for sale at retail in this State by a dealer at a public auction ~~must~~ shall be inspected before it is offered for sale unless it has an inspection sticker that was put on the vehicle under this Part and does not expire until at least nine months after the date the vehicle is offered for sale at auction.

(4) A used vehicle acquired by a resident of this State from a person outside the State ~~must~~ shall be inspected within 10 days after the vehicle is registered with the Division.

(5) A vehicle owned by a new resident of this State who transfers the registration of the vehicle from the resident's former home state to this State ~~must~~ shall be inspected within 10 days after the vehicle is registered with the Division.

(6) A vehicle that has been inspected in accordance with this Part ~~must~~ shall be inspected by the last day of the month in which the inspection sticker on the vehicle expires, unless another subdivision of this section requires it to be inspected sooner.

(b) Permit. -- The Division may issue a one-way trip permit to a person that authorizes the person to drive to an inspection station a vehicle whose inspection sticker has expired. The permit ~~must~~ shall describe the vehicle whose inspection sticker has expired. The permit authorizes the person to drive the described vehicle only from the place the vehicle is parked to an inspection station.

The Division may issue a 10-day temporary permit to a person that authorizes the person to drive a vehicle that failed to pass ~~either~~ the ~~safety inspection or~~ emissions inspection. The permit ~~must~~ shall describe the vehicle that failed to pass inspection and the date that it failed to pass inspection."

Section 5. G.S. 20-183.4D reads as rewritten:

§ 20-183.4D. Procedure when a vehicle is inspected.

(a) Receipt. -- When ~~a safety inspection mechanic or~~ an emissions inspection mechanic inspects a vehicle, the mechanic ~~must~~ shall give the person who brought the vehicle in for inspection an inspection receipt. The inspection receipt ~~must~~ shall state the date of the inspection, identify the mechanic performing the inspection, identify the station or self-inspector where the inspection was performed, and list the components of the inspection performed and indicate for each component whether the vehicle passed or failed. A vehicle that fails a component of an inspection may be repaired at any repair facility chosen by the owner or operator of the vehicle.

(b) Sticker. -- ~~When a vehicle that is subject to a safety inspection only passes the safety inspection, the safety inspection mechanic who performed the inspection must put an inspection sticker on the windshield of the vehicle at the place designated by the Division.~~ When a vehicle that is subject to ~~both a safety inspection and~~ an emissions inspection ~~passes both inspections or passes the safety inspection and~~ has a waiver for the emissions inspection, the emissions mechanic performing the inspection ~~must~~ shall put an inspection sticker on the windshield of the vehicle at the place designated by the Division.

(c) Content of Sticker. -- ~~An inspection sticker issued for a vehicle that is subject to a safety inspection only must be a different color from an inspection sticker issued for a vehicle that is subject to both a safety and an emissions inspection.~~ An inspection sticker ~~must~~ shall indicate when it expires, ~~must~~ shall be printed with a unique serial number and an official program seal, and ~~must~~ shall be counterfeit resistant. The side of an inspection sticker that is readable from the interior of a vehicle ~~must~~ shall contain the following information:

(1) The date the inspection was performed.

(2) The odometer reading when the inspection was performed.

(3) The signature, initials, or other identification of the mechanic who performed the inspection and put the sticker on the windshield.

(d) When Sticker Expires. -- An inspection sticker put on a vehicle that did not have an inspection sticker issued under this Part when it was brought in for inspection expires at midnight on the last day of the twelfth month after the month the inspection sticker is put on the vehicle. An inspection sticker put on a vehicle that had an inspection sticker that was put on under this Part when it was brought in for inspection expires as follows:

(1) If the expiration date of the inspection sticker the vehicle had when it was brought in for inspection is less than 12 full months from the date of the inspection, the inspection sticker expires at midnight on the last day of the twelfth month after the month the inspection sticker is put on the vehicle.

(2) If the expiration date of the inspection sticker the vehicle had when it was brought in for inspection is 12 or more months from the date of the inspection, the inspection sticker expires one year after the expiration date of the inspection sticker the vehicle had when it was brought in for inspection, regardless of whether there are 12 months in this period."

Section 6. G.S. 20-183.7 reads as rewritten:

"**§ 20-183.7. Fees for performing an inspection and putting an inspection sticker on a vehicle; use of civil penalties.**

(a) Fee Amount. -- When a fee applies to an inspection of a vehicle or the issuance of an inspection sticker, the fee ~~must~~ shall be collected. The following fees apply to an inspection of a vehicle and the issuance of an inspection sticker:

Type	Inspection	Sticker
~~Safety Only, Without After-Factory Tinted Window~~	~~$ 8.25~~	~~$ 1.00~~
~~Safety Only, With After-Factory Tinted Window~~	~~18.25~~	~~1.00~~
Emissions ~~and Safety, Without After-Factory Tinted Window~~	17.00	~~2.40~~ 2.40.
~~Emissions and Safety, With After-Factory Tinted Window~~	~~27.00~~	~~2.40.~~

The fee for performing an inspection of a vehicle applies when an inspection is performed, regardless of whether the vehicle passes the inspection. The fee for an inspection sticker applies when an inspection sticker is put on a vehicle. ~~The fee for performing an inspection of a vehicle with a tinted window applies only to an inspection performed with a light meter after a safety inspection mechanic determined that the window had after-factory tint.~~

A vehicle that is inspected at an inspection station and fails the inspection is entitled to be reinspected at the same station at any time within 30 days of the failed inspection without paying another inspection fee.

(b) Self-Inspector. -- The fee for an inspection does not apply to an inspection performed by a self-inspector. The fee for putting an inspection sticker on a vehicle applies to an inspection performed by a self-inspector.

(c) Fee Distribution. -- Fees collected for inspection stickers are payable to the Division of Motor Vehicles. The amount of each fee listed in the table below shall be credited to the Highway Fund, the Emissions Program Account established in subsection (d) of this section, the Volunteer Rescue/EMS Fund established in G.S. 58-87-5, the Rescue Squad Workers' Relief Fund established in G.S. 58-88-5, and the Division of ~~Environmental Management~~ Air Quality of the Department of Environment, Health, and Natural Resources:

Recipient	~~Safety Only Sticker~~	Emissions ~~and Safety~~ Sticker
~~Highway Fund~~	~~.75~~	~~.00~~
Emissions Program Account	~~.00~~	1.80
Volunteer Rescue/EMS Fund	~~.15~~	.15
Rescue Squad Workers' Relief Fund	~~.10~~	.10
Division of ~~Environmental Management~~ Air Quality	~~.00~~	.35.

(d) Account. -- The Emissions Program Account is created as a nonreverting account within the Highway Fund. The Division shall administer the Account. Revenue in the Account may be used only to fund the vehicle emissions inspection and maintenance program.

(e) Civil Penalties. -- Civil penalties collected under this Part shall be credited to the Highway Fund as nontax revenue."

Section 7. G.S. 20-183.8D reads as rewritten:

"**§ 20-183.8D. Suspension or revocation of license.**

~~(a) Safety. -- The Division may suspend or revoke a safety self-inspector license, a safety inspection station license, and a safety inspection mechanic license issued under this Part if the license holder fails to comply with this Part or a rule adopted by the Commissioner to implement this Part.~~

(b) Emissions. -- The Division may suspend or revoke an emissions self-inspector license, an emissions inspection station license, and an emissions inspection mechanic license issued under this Part for any of the following reasons:

(1) The suspension or revocation is imposed under G.S. 20-183.8B.

(2) Failure to pay a civil penalty imposed under G.S. 20-183.8B within 30 days after it is imposed."

Section 8. This act is effective when it becomes law.

North Carolina General Assembly
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March 10, 1999

To: Members of the House Highway Safety Committee

From: Giles S. Perry, Committee Counsel

Re: House Bill 180 Repeal Motor Vehicle Safety Inspection
Introduced by Representative Carpenter and others

House Bill 180 repeals the requirement for a annual motor vehicle safety inspections for vehicles registered in North Carolina.

Currently, 19 states and the District of Columbia require annual motor vehicle safety inspections: Delaware; Hawaii, Louisiana, Maine, Massachusetts, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Virginia, and West Virginia.

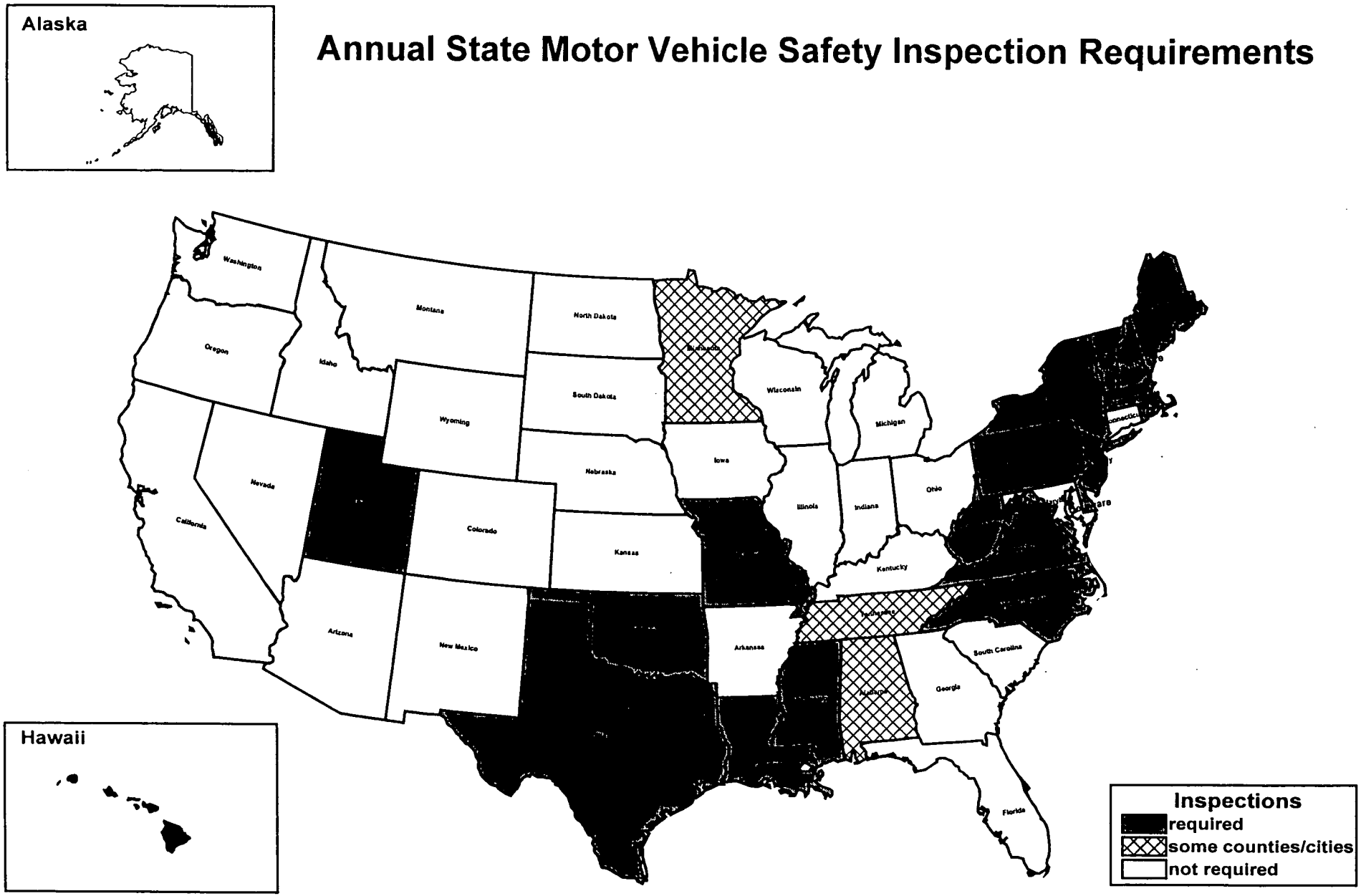
Three more states require annual motor vehicle safety inspections in some counties or cities: Alabama, Minnesota, Tennessee

No annual motor vehicle safety inspection is required in the other 28 states.

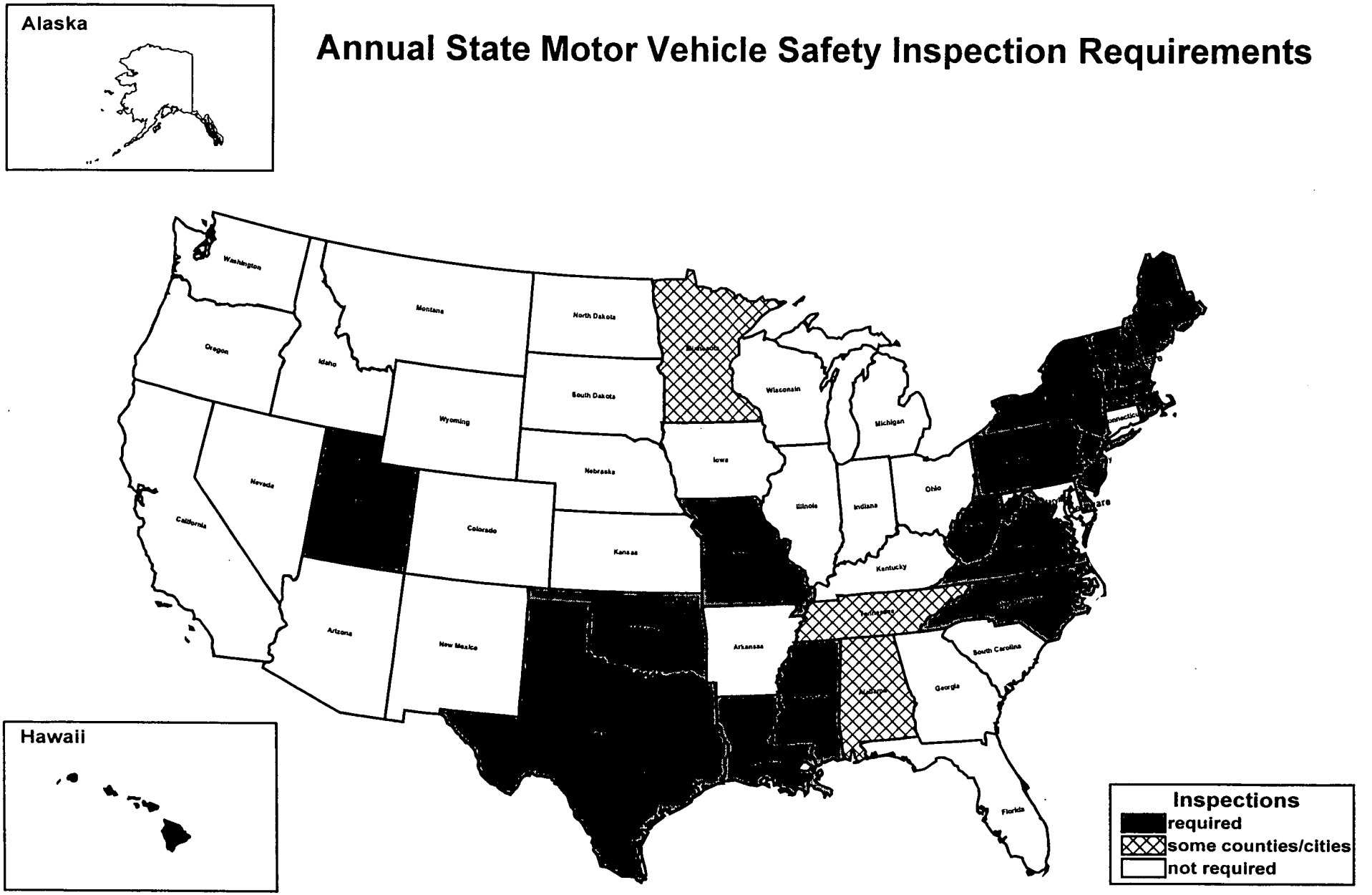
Source: 1999 AAA Digest of Motor Laws

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

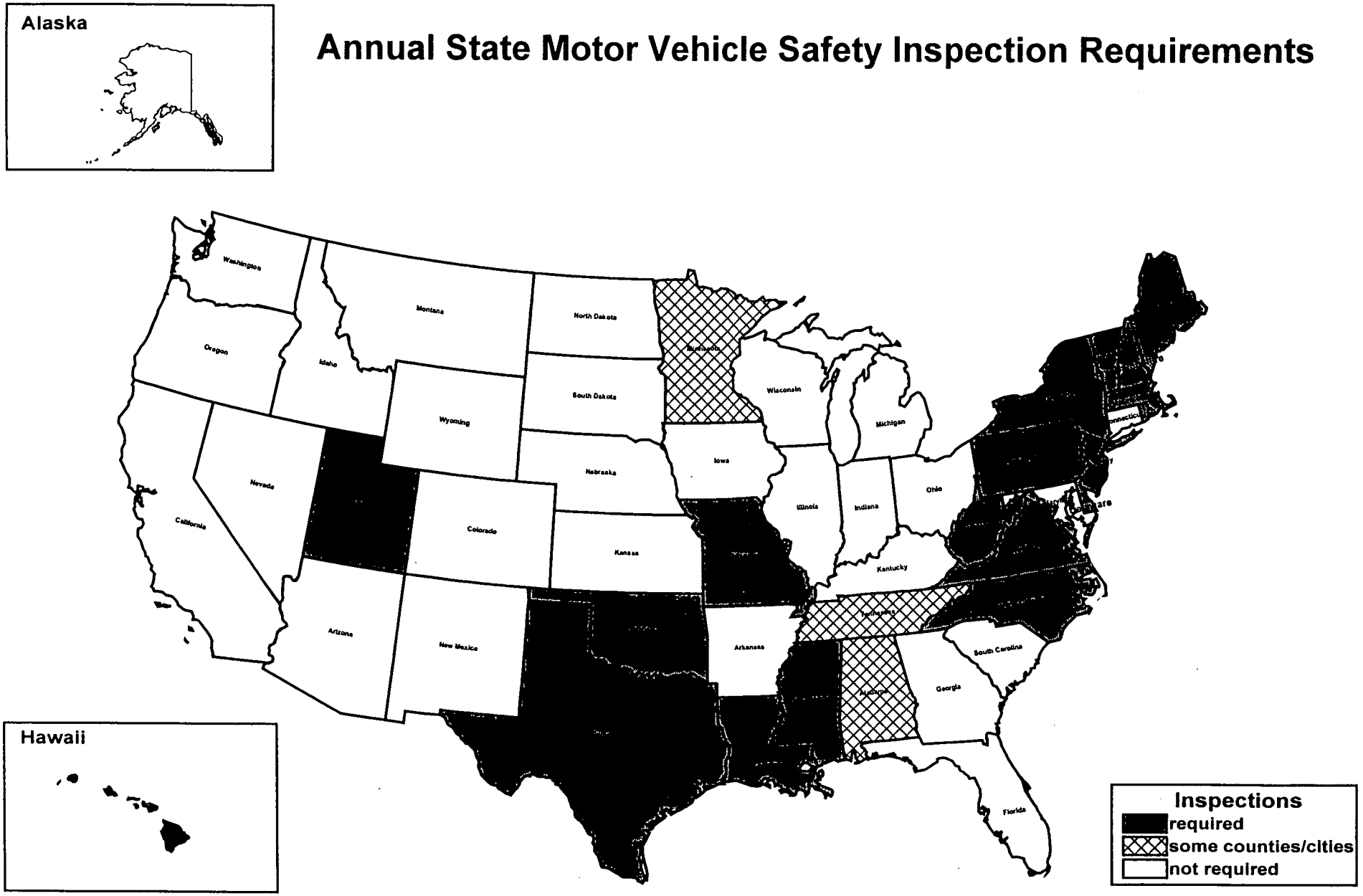
Annual State Motor Vehicle Safety Inspection Requirements



Annual State Motor Vehicle Safety Inspection Requirements



Annual State Motor Vehicle Safety Inspection Requirements



VISITOR REGISTRATION SHEET

Highway Safety 3/24/99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. Jeff Winstead	NC Highway Patrol
2. Gordon A Joyner	NCARD EMS
3. Paul F. Miller	NCSFA
4. Doug Dulcas	NC Forestry Assoc.
5. Randy Lisk	Autom. Parts Assn.
6. Sherol Brewer	NC Petroleum Council
7. Deborah Bryan	American Lung Assn of NC
8. Nat Mird	Consumer Council
9. Russell Hagaman	DENR, Div of Air Quality
10.	DMV
11.	NC DMV
12. Jane Pinsky	AAA
13. Ruth Sappre	NCDOT
14. Reg Lester	IGONC
15.	NCSSA
16. Carl S Mullinax	DUNCAN EXXON
17. Bill Snyder	Tree Inspection Station
18.	NC DOT
19.	Bowe & Assoc - CIADA
20. EDDIE CALDWELL	HMcCC&C, P.A.
21. David Ferrell	HMCCC&C, P.A.

VISITOR REGISTRATION SHEET

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. David Ferrell	HMCCC+C P.A.
2. Andy Ellen	NCRMA
3. Ann Coxe	NCRMA
4. Fran Preston	NCRMA
5. EDDIE CALDWELL	HMCC+CP.A.
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HOUSE COMMITTEE ON HIGHWAY SAFETY

APRIL 14, 1999
1:00 PM
Room 415

AGENDA

Chairs: Rep. Wayne Goodwin and Rep. Alma Adams

INTRODUCTIONS

SPEAKER: Norris Tolson- Secretary of Transportation

BILLS TO BE CONSIDERED—HB 898—Child Bicycle Safety Act

HIGHWAY SAFETY COMMITTEE MEETING
MINUTES FOR APRIL 14, 1999
Room 415 LOB

Bill(s) before the Committee: HB 898 Child Bicycle Safety Act

Bill(s) discussed: HB 898 Child Bicycle Safety Act

Action(s) taken: Bill given favorable report as amended

Committee members in attendance were: Chairs- Representatives Adams and Goodwin (Presiding), Representatives Alexander, Allred, Church, Hurley, Justus, Mosley. **Also attending:** Giles Perry (Staff). A Visitor Registration sheet is attached and made part of these minutes.

Narrative/Discussion: Norris Tolson, Secretary of the NC Department of Transportation gave a presentation on "Safety at DOT". New Public Service Announcements were played for the members.

Rep. McAllister presented her bill- HB 898. An amendment was offered by Rep. Allred and approved. Rep. Church made a motion for favorable report, which passed unanimously.

Rep. Goodwin closed the meeting by thanking members and guests. The meeting adjourned at approximately 1:50 PM.

Respectfully Submitted,

Rep. Wayne Goodwin
Chairman

Kristen C. Younts
Committee Assistant

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Adams and Goodwin** for the Committee on **Highway Safety**.

☐ Committee Substitute for
H.B. 898 A BILL TO BE ENTITLED AN ACT TO REQUIRE THE USE OF CERTAIN SAFETY EQUIPMENT BY CHILDREN WHILE THEY ARE BICYCLE OPERATORS OR PASSENGERS.

☐ 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~~ ☐ Ways and Means ☒.

☐ 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.

☐ 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)

2/24/99

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 898

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

H898-ARW-001 Page 1 of __

Date_____,1999

Comm. Sub. []
Amends Title []

Rep. Allred

1 moves to amend the bill on page 3, line 39,
2 by deleting the phrase "thirty dollars ($30.00)" and substituting
3 "ten dollars ($10.00)".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if **Senate** Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

HOUSE BILL 898

Short Title: Child Bicycle Safety Act. (Public)

Sponsors: Representatives McAllister; Adams, Alexander, Barbee, Brown, Church, Fitch, Hurley, Kinney, Mosley, and Warner.

Referred to: Highway Safety, if favorable, Ways and Means.

April 1, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE USE OF CERTAIN SAFETY EQUIPMENT BY CHILDREN WHILE THEY ARE BICYCLE OPERATORS OR PASSENGERS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 20 of the General Statutes is amended by adding a new Part 10B to Article 3 to read:

"Part 10B. Child Bicycle Safety Act.

"**§ 20-171.6. Short title.**

This Article shall be known and may be cited as the 'Child Bicycle Safety Act'.

"**§ 20-171.7. Legislative findings and purpose.**

(a) The General Assembly finds and declares that:

(1) Disability and death of children resulting from injuries sustained in bicycling accidents are a serious threat to the public health, welfare, and safety of the people of this State, and the prevention of that disability and death is a goal of all North Carolinians.

(2) Head injuries are the leading cause of disability and death from bicycling accidents.

(3) The risk of head injury from bicycling accidents is significantly reduced for bicyclists who wear proper protective bicycle helmets; yet helmets are worn by fewer than five percent (5%) of child bicyclists nationwide.

(4) The risk of head injury or of any other injury to a small child who is a passenger on a bicycle operated by another person would be

significantly reduced if any child passenger sat in a separate restraining seat.

(b) The purpose of this Article is to reduce the incidence of disability and death resulting from injuries incurred in bicycling accidents by requiring that while riding on a bicycle on the public roads, public bicycle paths, and other public rights-of-way of this State, all bicycle operators and passengers under the age of 18 years wear approved protective bicycle helmets; that all bicycle passengers who weigh less than 40 pounds or are less than 40 inches in height be seated in separate restraining seats; and that no person who is unable to maintain an erect, seated position shall be a passenger in a bicycle restraining seat and all other bicycle passengers shall be seated on saddle seats.

"**§ 20-171.8. Definitions.**

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

(1) 'Bicycle' means a human-powered vehicle with two wheels in tandem designed to transport, by the action of pedaling, one or more persons seated on one or more saddle seats on its frame. Such term also includes a human-powered vehicle designed to transport by the action of pedaling which has more than two wheels where the vehicle is used on a public roadway, public bicycle path, or other public right-of-way, but does not include a tricycle.

(2) 'Operator' means a person who travels on a bicycle seated on a saddle seat from which that person is intended to and can pedal the bicycle.

(3) 'Other public right-of-way' means any right-of-way other than a public roadway or public bicycle path that is under the jurisdiction and control of this State or a local political subdivision thereof and is designed for use and used by vehicular and/or pedestrian traffic.

(4) 'Passenger' means a person who travels on a bicycle in any manner except as an operator.

(5) 'Protective bicycle helmet' means a piece of headgear which meets or exceeds the impact standards for protective bicycle helmets set by the American National Standards Institute (ANSI) or the Snell Memorial Foundation.

(6) 'Public bicycle path' means a right-of-way under the jurisdiction and control of this State or a local political subdivision thereof for use primarily by bicycles and pedestrians.

(7) 'Public roadway' means a right-of-way under the jurisdiction and control of this State or a local political subdivision thereof for use primarily by motor vehicles.

(8) 'Restraining seat' means a seat separate from the saddle seat of the operator of the bicycle that is fastened securely to the frame of the bicycle and is adequately equipped to restrain the passenger in

such seat and protect such passenger from the moving parts of the bicycle.

(9) 'Tricycle' means a three-wheeled human-powered vehicle designed for use as a toy by a single child under the age of six years, the seat of which is no more than two feet from ground level.

"§ 20-171.9. Requirements for helmet and restraining seat use.

With regard to any bicycle used on a public roadway, public bicycle path, or other public right-of-way:

(a) It shall be unlawful for any person under the age of 18 to operate or be a passenger on a bicycle unless at all times when the person is so engaged he or she wears a protective bicycle helmet of good fit fastened securely upon the head with the straps of the helmet.

(b) It shall be unlawful for any person to be a passenger on a bicycle unless all of the following conditions are met:

(1) The person is able to maintain an erect, seated position on the bicycle;

(2) Except as provided in subdivision (3) of this subsection, the person is properly seated alone on a saddle seat (as on a tandem bicycle); and

(3) With respect to any person who weighs less than 40 pounds, or is less than 40 inches in height, the person can be and is properly seated in and adequately secured to a restraining seat.

(c) It shall be unlawful for any parent or legal guardian of a person below the age of 18 to knowingly permit such person to operate or be a passenger on a bicycle in violation of subsection (a) or (b) of this section.

(d) It shall be unlawful to rent or lease any bicycle to or for the use of any person under the age of 18 unless:

(1) The person is in possession of a protective bicycle helmet of good fit at the time of such rental or lease; or

(2) The rental or lease includes a protective bicycle helmet of good fit, and the person intends to wear the helmet, as required by subsection (a) of this section, at all times while operating or being a passenger on the bicycle.

(e) No negligence or liability shall be assessed on or imputed to any party on account of a violation of subsections (a), (b), or (c) of this section.

"§ 20-171.10. Civil penalties.

(a) Except as provided in subsection (b) of this section, any person violating any requirement set forth in G.S. 20-171.9 shall be held responsible for an infraction and may pay a civil fine of up to thirty dollars ($30.00), inclusive of all penalty assessments and court costs.

(b) In the case of a first conviction within a 12-month period of G.S. 20-171.9(a), (b), or (c), the court may waive the fine upon receipt of satisfactory proof that the person responsible for the infraction has purchased or otherwise obtained, as

appropriate, a protective bicycle helmet or a restraining seat, and uses and intends to use it whenever required under G.S. 20-171.9."

Section 2. This act becomes effective October 1, 1999.

HOUSE BILL 898:
Child Bicycle Safety Act

BILL ANALYSIS

Committee: House Highway Safety
Date: April 14, 1999
Version: First Edition

Introduced by: Rep. McAllister and others
Summary by: Giles S. Perry
Committee Counsel

House Bill 898 amends the motor vehicle laws to make several changes concerning bicycle safety.

Specifically, the bill addresses the following:

1. Rider/passenger helmets – The bill requires persons under 18 operating or riding as a passenger on a bicycle to wear a helmet.

2. Passenger seating – The bill requires any passenger (adult or child) on a bicycle to be properly seated and (for small child passengers) to be restrained

3. Parent responsibility – The bill makes it unlawful for a parent to knowingly allow a child under 18 to violate the rider/passenger helmet rules or the passenger seating rules.

4. Rental bike helmets –The bill requires persons who rent bicycles to include a helmet in the rental, unless the person renting the bicycle already has a helmet.

In addition, the bill provides that no negligence or liability is to be assessed or imputed for a violation of the rider/passenger helmet, passenger seating, or parental responsibility provisions, but could be for a violation of the rental bike helmet provision.

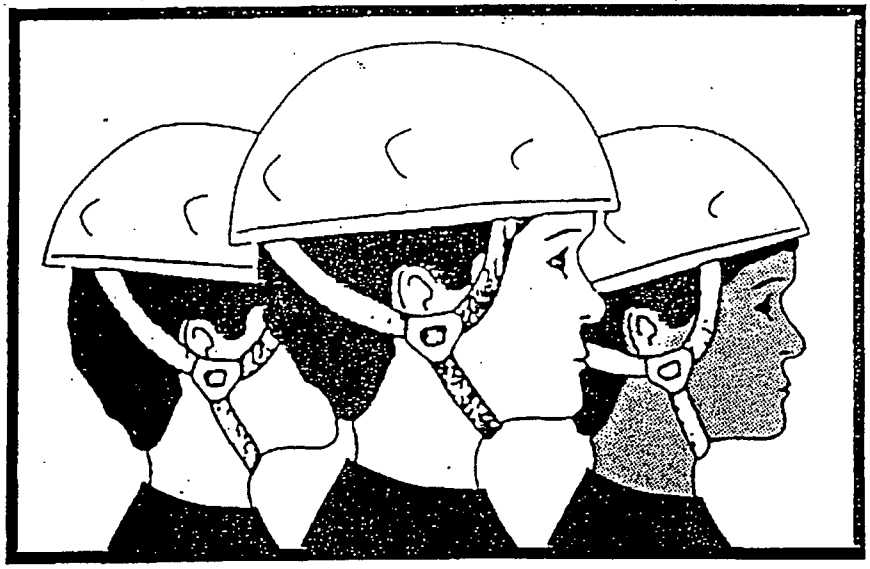
Violation of this statute would constitute an infraction subject to a $30 "civil fine", waivable for a first offense if the person purchases a helmet.

Effective date: October 1, 1999.

each person

FACT SHEET: CHILD BICYCLE SAFETY ACT

- A study by the University of North Carolina Highway Safety Research Center estimated that 800 children are hospitalized and 13,300 children receive emergency treatment for bicycle injuries each year in our state.
- According to a study by Duke University, if every bicycle rider in North Carolina wore a helmet, the annual savings would be $32 to $174 million, depending on the economic model used to calculate savings.
- Bicycle helmets reduce the risk of head injury by 85 percent.
- Legislation combined with education increases bicycle helmet use substantially more than education alone.



For further information, please call Thomas B. Cole, M.D., M.P.H., Chief, Injury Control Section, Division of Epidemiology, North Carolina Department of Environment, Health, and Natural Resources, at (919) 733-3222.

NC HOUSE COMMITTEE
CHILD SAFETY RESTRAINTS
March 10, 1999

GOOD AFTERNOON. I'M STEVE EDWARDS. I'VE PRACTICED PEDIATRICS IN RALEIGH FOR THE PAST 30 YEARS. DURING THIS TIME SAFETY SEATS FOR CHILDREN HAVE BECOME WIDELY ACCEPTED. I'VE SEEN CHILDREN PROTECTED IN WAYS I COULD NOT HAVE ENVISIONED WHEN I BEGAN PRACTICE.

OVER 45 YEARS AGO WHEN I WAS 15 YEARS OLD, I WAS INVOLVED IN A MINOR CAR ACCIDENT IN WHICH I WAS THROWN INTO A WINDSHIELD. I WAS UNCONSCIOIUS FOR AROUND 12 HOURS, SUFFERED MULTIPLE FACIAL LACERATIONS, AND, FORTUNATELY, RECOVERED COMPLETELY. NO ONE HAS EVER HAD TO CONVINCE ME TO WEAR A SEAT BELT.

ONE WEEK AGO A TEENAGE PATIENT OF MINE WAS INVOLVED IN AN AUTO ACCIDENT. WHEN I HAD LAST SEEN HIM IN THE FALL, WE HAD DISCUSSED AUTO SAFETY.. LAST WEDNESDAY HE FORGOT HIS SAFETY RESTRAINT AND WAS THROWN INTO A WINDSHIELD. HE SUFFERED A FRACTURED NOSE AND SERIOUS FACIAL LACERATIONS, BUT HE IS GOING TO BE ALL RIGHT

WITH PROPER SAFETY RESTRAINTS NEITHER OF THESE INJURIES WOULD HAVE OCCURRED. IN THE ROUGHLY 45 YEARS BETWEEN THE TWO ACCIDENTS,MUCH HAS HAPPENED TO FACILITATE AUTO SAFETY--THANKS LARGELY TO LEGISLATIVE ACTION WHICH HAS LED TO PUBLIC ACCEPTANCE. SAFETY SEATS ARE AVAILABLE FOR INFANTS AND CHILDREN AND PEOPLE USE THEM. FOR MANY YEARS NC HAS HAD LAWS REQUIRING SAFETY SEATS, AND, JUST AS IMPORTANTLY, HAS ENFORCED THOSE LAWS WITH PENALTIES. "CLICK IT OR TICKET." HAS MADE A DIFFERENCE.!

WHILE STATISTICIANS TALK MAINLY ABOUT DEATH STATISTICS, I DAILY SEE MOST EVIDENCE OF INJURIES SUCH AS CONCUSSIONS, LACERATIONS, FRACTURES, BRUISES, ETC. FOR EVERY DEATH THERE ARE AROUND 150 INJURIES. THESE VARY FROM MINOR TO DEVASTATING BUT ARE VERY SIGNIFICANT. IN THE LIVES OF CHILDREN AND THEIR

FAMILIES.

UNFORTUNATELY, THERE IS NO LAW REQUIRING CHILDREN BETWEEN THE AGES OF 5 AND 16 TO WEAR A SEAT BELT. NOW IS THE OPPORTUNITY TO CHANGE. THROUGH YOUR LEADERSHIP NC HAS EXPERIENCED GREAT RESULTS. NEW INFORMATION ABOUT SAFETY AND AIR BAGS MUST BE INCORPORATED. WE ALSO NEED SOMETHING TO GET PUBLIC ATTENTION. POINTS ON THE DRIVER'S LICENSE IS A PAINLESS WAY TO ACCOMPLISH THIS. THESE POINTS WOULD NOT ALTER INSURANCE POINTS.

I AM HERE TODAY AS A REPRESENTATIVE OF THE NC PEDIATRIC SOCIETY TO ASK YOUR SUPPORT OF THIS BILL. WE SUPPORT IT BECAUSE WE KNOW PEOPLE LISTEN TO YOU. THEY TRUST YOU TO CONSIDER MATTERS CAREFULLY. WHEN YOU SPEAK, THEY LISTEN. YOU HAVE THE POWER TODAY TO MAKE CHANGES WHICH WILL SAVE A SIGNIFICANT NUMBER OF NC LIVES AND PREVENT AN EVEN LARGER NUMBER OF INJURIES MANY OF WHICH SERIOUSLY IMPAIR QUALITY OF LIFE. PLEASE ACT TODAY TO SAVE CHILDREN--AND ADULTS.

VISITOR REGISTRATION SHEET

HIGHWAY SAFETY 4-14-99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	John McMillan	MKS
2.	Ann Case	NCRMA
3.	Steve Woodson	NC Farm Bureau
4.	Alan Miles	Bailey & Dixon LLP
5.	Leanne Fullbright	Moore & Van Allen
6.	Amy Fullbright	Hunton & Williams
7.		
8.		
9.		
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20.		
21.		

HOUSE COMMITTEE ON HIGHWAY SAFETY

APRIL 21, 1999
1:00 P.M.
Room 415

AGENDA

CHAIR(S): Representatives Alma Adams & Wayne Godwin

INTRODUCTIONS

BILLS TO BE CONSIDERED HB 1054 Activity Buses Stop-Railroad Crossings
HB 1203 Motorcycle Safety Act

PRESENTATIONS

DISCUSSION

ADJOURNMENT

HIGHWAY SAFETY COMMITTEE MEETING
MINUTES FOR APRIL 21, 1999
Room 415 LOB

Bill(s) before the Committee:	HB 1054 Activity Buses Stop- RR Crossings HB 1203 Motorcycle Safety Act
Bill(s) discussed:	HB 1054 Activity Buses Stop- RR Crossings HB 1203 Motorcycle Safety Act
Action(s) taken:	HB 1203 given favorable report

Committee members in attendance were: Chair- Representative Adams, Representatives Alexander, Church, Gray, Hurley, McComas, Mosley, Sexton. **Also attending:** Giles Perry (Staff). A visitor Registration sheet is attached and made part of these minutes.

Narrative/Discussion: Rep. Mosley presents her bill. Charles Mitchell, Assistant Director for School Bus and Traffic Safety with NC Department of Transportation speaks in favor of bill. Dean Denham, Operation Lifesaver, also speaks for bill. Members discuss bill and voting is put off until the next meeting.

Rep. Baker introduces his bill to the Committee. Steve Boyles, Motorcycle Training Co-ordinator speaks for the bill. Committee members discuss bill. Rep. Church moves for favorable report. Bill receives unanimous vote, and is re-referred to Finance.

Rep. Adams closed the meeting at approximately 1:50 PM.

Respectfully Submitted,

Rep. Alma Adams
Chairperson

Kristen C. Younts
Committee Assistant

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1203 A BILL TO BE ENTITLED AN ACT TO MODIFY THE REQUIREMENT FOR THE USE OF HELMETS BY OPERATORS AND PASSENGERS ON MOTORCYCLES AND TO INCREASE THE TAX ON PRIVATE MOTORCYCLE REGISTRATIONS THAT IS USED TO PROVIDE FUNDS FOR MOTORCYCLE SAFETY PROGRAMS.

☐ 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.

☐ 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)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1203*

Short Title: Motorcycle Safety Act. (Public)

Sponsors: Representatives Baker, Hill (Primary Sponsors); and Mosley.

Referred to: Highway Safety, if favorable, Finance

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE REQUIREMENT FOR THE USE OF HELMETS BY OPERATORS AND PASSENGERS ON MOTORCYCLES AND TO INCREASE THE TAX ON PRIVATE MOTORCYCLE REGISTRATIONS THAT IS USED TO PROVIDE FUNDS FOR MOTORCYCLE SAFETY PROGRAMS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-140.4(a) reads as rewritten:

"(a) No person shall operate a motorcycle or moped upon a highway or public vehicular area:

(1) When the number of persons upon such motorcycle or moped, including the operator, shall exceed the number of persons which it was designed to carry.

(2) Unless the operator and all passengers thereon wear safety helmets of a type approved by the Commissioner of Motor ~~Vehicles.~~ Vehicles, except that:

a. If the operator is 21 years of age or older and has had a motorcycle license or a motorcycle endorsement for more than 12 months, then the operator may operate the motorcycle without a helmet; and

b. If the operator is allowed to operate a motorcycle without a helmet pursuant to sub-subdivision a. of this subdivision and the passenger is 21 years of age or older, then the passenger may ride without a helmet."

Section 2. G.S. 20-87(6) reads as rewritten:

"**§ 20-87. Passenger vehicle registration fees.**

These shall be paid to the Division annually, as of the first day of January, for the registration and licensing of passenger vehicles, fees according to the following classifications and schedules:

. . .

(6) Private Motorcycles. -- The base tax on private passenger motorcycles shall be nine dollars ($9.00); except that when a motorcycle is equipped with an additional form of device designed to transport persons or property, the base tax shall be sixteen dollars ($16.00). A tax of ~~three dollars ($3.00)~~ five dollars ($5.00) is imposed on each private motorcycle registered under this subdivision in addition to the base tax. The revenue from the additional tax shall be deposited in the General ~~Fund.~~ Fund and shall be used to fund the Motorcycle Safety Instruction Program established pursuant to G.S. 115D-72."

Section 3. This act becomes effective October 1, 1999.

HOUSE BILL 1203:
Motorcycle Safety Act

BILL ANALYSIS

Committee:	House Highway Safety	**Introduced by:**	Reps. Baker and Hill
Date:	April 21, 1999	**Summary by:**	Giles S. Perry
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 1203 makes two changes related to motorcycles:

1.Current law requires all motorcycle drivers and passengers to wear helmets. House Bill 1203 would authorize the following persons to drive or ride without helmets --- Drivers 21 and older who have had a motorcycle license or endorsement for at least a year, and passengers of those drivers who are least 21.

2. Increase the motorcycle registration fee by $2 to fund the Motorcycle Safety Instruction program of the Community College system.

Effective Date: October 1, 1999.

HOUSE BILL 1203
MOTORCYCLE SAFETY ACT
REPRESENTATIVES BAKER AND HILL (primary sponsors)

The subject of helmet use by motorcyclists evokes emotional debate among various groups. Now that Federal Regulations no longer "require" states to enact mandatory statutes, the subject is being revisited in many state legislatures.

The debate is principally between the groups who claim that helmets save lives and save the public from having to pay the medical costs of uninsured victims, and groups that claim helmets cause deaths and mandatory helmet use is a government intrusion in freedom of choice of helmet use by the motorcyclist.

Much of the confusion on the efficacy of helmets stems from a lack of understanding of the real issues. Virtually all "safety" experts and medical personnel view the issue from the perspective of automobile safety where the main thrust is ***injury prevention.*** In motorcycle safety, the main thrust must be ***accident prevention*** due to the level of un-protection provided by the vehicle.

In the U.S., there are 25 states with mandatory helmet laws (similar to N.C.) and 25 states with a choice helmet law (generally with an age under which helmets are mandatory) including three states with no helmet law. There are approximately four million motorcycles registered in the U.S..

Over the last six years, the 25 mandatory helmet states have accounted for ***61.3%*** of registrations, ***65.1%*** of accidents, and ***63.5*** of fatalities. An analysis of the statistics shows that, in each of the last six years, the mandatory helmet law states have experienced a significantly greater incidence of accidents per 10,000 registrations as compared to the choice states.

The statistics also show that the fatality rate (per 100 accidents) of the choice states has actually been ***lower*** in two of the last six years when compared with the mandatory states.

The net result of the incidence of accidents plus the fatality rate shows that in five of the last six years, the fatality rate per 10,000 registrations has been lower in the choice states.

Why is this? Don't these facts fly in the face of the argument that helmets save lives? We believe the answer lies in arguments that motorcycle riders have made.

1. **Helmets impair vision, especially peripheral vision.**
2. **Helmets interfere with the ability to hear what is going on around you.**
3. **Helmets provide as exaggerated perception of protection and the cyclist takes chances that would otherwise not be taken.**

Over the last six years, North Carolina had averaged 65 fatalities per year. It has been estimated that if North Carolina could have achieved the accident and fatality rates of the last six years for the choice states, we would have averaged only 34 fatalities per year or a saving of 31 lives per year.

No one has ever been hurt in an accident that did not happen. Clearly accident prevention should be our objective.

The other issue often raised is the "public" costs associated with the treatment of injured motorcyclists

The UNC Highway Safety Research Center (publication HSRC-MP70) has addressed the issue of "public" costs. Excerpts follow:

1. "Motorcyclists.... are just as likely as other road trauma patients to be commercially or privately insured." (abstract)
2. Mean hospital charges are less for motorcyclists as compared with other road trauma patients.(Page 6, Table1)
3. "Helmet use was not found to be associated with overall injury severity..."(Page 12)
4. "Based on just the evidence regarding hospital charges, discharge facility, and insurance status, it would seem inappropriate to label motorcyclists "disproportionate consumers of public funds"." (Page 15)

Additionally, data from the North Carolina Trauma Registry for 13 major hospitals (including nine trauma centers) shows that the number of major head injuries to occupants of automobiles have been over 13 times greater than those for motorcycle operators and passengers during the 1994-1996 period. (Please note that these statistics do not cover all the hospitals in North Carolina.)

With the significant multiples of head injury for automobiles versus motorcycles, we have not heard a single suggestion that we make helmet use mandatory for auto occupants.

It is clear to us that mandatory helmet use by motorcyclists, in view of accident and fatality statistics and findings on public and societal costs, represents an unjustified, discriminatory, and deadly example of well-intended legislation.

The time has come to modify the North Carolina helmet law to allow motorcyclist the option of whether or not to utilize helmets.

To that end, legislation has been introduced that would allow motorcyclists who are 21 years of age and over who have had at least one year of licensed riding experience the option of helmet use. Additionally, the legislation would increase the special tag tax paid by motorcyclist from $3.00 to $5.00. These fees go to fund the Motorcycle Safety Instruction Programs in the community colleges.

MOTORCYCLE HELMET DATA

Selected Statistics

	Helmet States		Choice States		National	
	Accidents	Fatalities	Accidents	Fatalities	Accidents	Fatalities
1992	215.47	2.97	190.93	2.79	206.00	2.91
1993	222.21	2.98	194.02	2.90	211.24	2.95
1994	201.19	2.93	189.78	3.28	196.93	3.06
1995	195.77	2.95	169.89	3.17	185.89	3.03
1996	187.48	2.88	149.33	3.53	172.74	3.10
1997	193.13	2.93	138.42	3.44	171.14	3.10
TOTALS	202.45	2.94	171.59	3.16	190.51	3.02

Notes: Accidents are per 10,000 Registrations
Fatalities are per 100 Accidents

Source: American Motorcyclist Association

SELECTED STATISTICS
MOTORCYCLES NORTH CAROLINA

Year	Reg.	Acc.	Fat.	Fat/100acc.	Acc/10Mreg.
1992	59,219	1,822	62	3.40	307.67
1993	61,374	2,106	74	3.51	343.14
1994	65,247	2,049	60	2.93	314.04
1995	65,546	2,004	72	3.59	305.74
1996	68,533	2,015	62	3.08	294.02
1997	75,022	2,005	60	2.99	267.25
Average	**65,824**	**2,000**	**65**	**3.25**	**303.84**

SELECTED STATISTICS

MOTORCYCLE HELMET DATA

	Helmet States			Choice States			Total-National		
	Reg.*	Acc.	Fat.	Reg.*	Acc.	Fat.	Reg*.	Acc..	Fat.
1992	2,458	52,955	1,575	1,544	29,473	823	4,001	82,428	2,398
1993	2,352	52,270	1,557	1,498	29,062	844	3,850	81,332	2,401
1994	2,413	48,539	1,425	1,494	28,349	929	3,907	76,906	2,354
1995	2,441	47,795	1,410	1,509	25,637	812	3,950	73,432	2,221
1996	2,458	46,091	1,327	1,550	23,144	818	4,008	69,235	2,145
1997	2,417	46,675	1,369	1,594	22,060	759	4,011	68,735	2,128
6yr.av.	2,423	49,054	1,444	1,532	26,288	831	3,955	75,345	2,275
Acc./10M reg.		202.45			171.59			190.51	
Fatalities/100Acc.			2.94			3.16			3.02
%of National:		**61.3**			**65.1**			**63.5**	

***Registrations in Thousands**

Source: American Motorcyclist Association

NORTH CAROLINA MOTORCYCLE STATISTICS
RIDER EDUCATION GRADUATES

YEAR	Number of Graduates
1983	182
1984	224
1985	172
1986	171
1987	439
1988	516
1989	602
1990	997
1991	2095
1992	1958
1993	2214
1994	1566
1995	2404
1996	2835
1997	3210

Note: The increase in the tag fee is estimated to generate approximately $150,000 additional annual funding to the Safety Instruction Program. This additional money will allow the Community College System to expand the instruction programs.

Rider Safety Instruction is one of the keys to reducing fatalities.

MOTORCYCLE HELMET DATA

STATE DATA

Mandatory States	Choice States
Alabama	Alaska
California	Arkansas
Florida	Arizona
Georgia	Colorado
Kentucky	Connecticut
Louisiana	Delaware
Maryland	Hawaii
Mass.	Idaho
Michigan	Illinois
Mississippi	Indiana
Missouri	Iowa
Nebraska	Kansas
Nevada	Maine
New Jersey	Minnesota
New York	Montana
North Carolina	New Hampshire
Oregon	New Mexico
Pennsylvania	North Dakota
Tennessee	Ohio
Vermont	Oklahoma
Virginia	Rhode Island
Washington	South Carolina
West Virginia	South Dakota
Distr. Of Columbia	Texas
	Utah
	Wisconsin
	Wyoming

VISITOR REGISTRATION SHEET

Highway Safety — 4-21-99

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Charles D. Mitchell	1054
Steve Boyles	Concerned Bikers Association 1203
Rex Baker	NC House
Charles E Boone	CBA of NC
Dennis Tedder	CBA/ABATE of N.C
JAMES EVERHART	CBA/ABATE OF NC
Mike Hodges	CBA/ABATE of NC
Thomas Ray Barbour	CBA/ABATE of N.C.
MIKE MOHAN	CBA/ABATE of NC
John Meisch	CBA/ABATE of NC
Michael Hindle	CBA/ABATE of N.C.
LEM SPRINKLE	CONCERNED BIKERS ASSOC./ABATE OF NC.
Jay Barbour	Concerned Bikers Assoc/ABATE of N.C.
Dan Dalton	NC Operation Lifesaver
Joanne Steenhuis	Citizen
Ruth Sappie	NCDOT
Ron Akins	GNANC
Michael Harrold	NAII
Scott Mauk	AP

HOUSE COMMITTEE ON HIGHWAY SAFETY

APRIL 27, 1999
9:00 AM
Room 1425

AGENDA

Chair(s): Rep. Wayne Goodwin

INTRODUCTIONS

BILLS TO BE CONSIDERED HB 1054- Activity Buses Stop-RR Crossings
Rep. Mosley

DISCUSSION

ADJOURNMENT

HIGHWAY SAFETY COMMITTEE MEETING
MINUTES FOR APRIL 27, 1999
Room 415 LOB

Bill(s) before the Committee: HB 1054 Activity Buses Stop- RR Crossings

Bill(s) discussed: HB 1054 Activity Buses Stop- RR Crossings

Action(s) taken: Bill given favorable report

Committee members in attendance were: Chairs- Representatives Adams and Goodwin (Presiding), Representatives Alexander, Hurley, Justus, Mosley, Sexton. **Also attending:** Giles Perry (Staff). A Visitor Registration sheet is attached and made part of these minutes.

Narrative/Discussion: Presiding Chair Goodwin called the meeting to order at approximately 1:10 PM. Pages and staff were introduced. Bill Sponsor Rep. Mosley presented her bill. Charles Mitchell, Assistant Director for School Bus and Traffic Safety with NC Department of Transportation spoke for the bill and answered questions from members. Committee members discussed the bill and Rep. Justus made a motion for a favorable report, which passed unanimously.

Rep. Goodwin closed the meeting by thanking members, staff and guests. The meeting adjourned approximately 1:45 PM.

Respectfully Submitted,

Wayne Goodwin

Rep. Wayne Goodwin
Chairman

Kristen Younts

Kristen C. Younts
Committee Assistant

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1054 A BILL TO BE ENTITLED AN ACT TO REQUIRE ALL ACTIVITY BUSES TO STOP AT ALL RAILROAD CROSSINGS.

☒ 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.

☐ 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)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1054

Short Title: Activity Buses Stop-RR Crossings. (Public)

Sponsors: Representatives Mosley (By Request); and Cox.

Referred to: Highway Safety.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ALL ACTIVITY BUSES TO STOP AT ALL RAILROAD CROSSINGS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-142.3(a) reads as rewritten:

"(a) Before crossing at grade any track or tracks of a railroad, the driver of any school bus, any activity bus, any motor vehicle carrying passengers for compensation, any property-hauling motor vehicle over 10,000 pounds which is carrying hazardous materials, and any motor vehicle with a capacity of 16 or more persons shall stop the vehicle within 50 feet but not less than 15 feet from the nearest rail of the railroad. While stopped, the driver shall listen and look in both directions along the track for any approaching train and shall not proceed until he can do so safely. Upon proceeding, the driver of the vehicle shall cross the track in a gear that allows the driver to cross the track without changing gears and the driver shall not change gears while crossing the track or tracks."

Section 2. G.S. 20-142.3(b) reads as rewritten:

"(b) Except for school ~~buses,~~ buses and activity buses, the provisions of this section shall not require the driver of a vehicle to stop:

(1) At railroad tracks used exclusively for industrial switching purposes within a business district.

(2) At a railroad grade crossing which a police officer or crossing flagman directs traffic to proceed.

(3) At a railroad grade crossing protected by a gate or flashing signal designed to stop traffic upon the approach of a train, when the gate or flashing signal does not indicate the approach of a train.

(4) At an abandoned railroad grade crossing which is marked with a sign indicating that the rail line is abandoned.

(5) At an industrial or spur line railroad grade crossing marked with a sign reading "Exempt" erected by or with the consent of the appropriate State or local authority."

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

HOUSE BILL 1054:
Activity Buses Stop - RR Crossings

BILL ANALYSIS

Committee:	House Highway Safety	**Introduced by:**	Rep. Mosley
Date:	April 21, 1999	**Summary by:**	Giles S. Perry
Version:	First Edition		Committee Counsel

SUMMARY:

Current law requires school buses to stop at all railroad crossings: House Bill 1054 would also require activity buses to to stop at all RR crossings.

Effective Date: when it becomes law.

VISITOR REGISTRATION SHEET

Highway Safety — 4/27/99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ian Rose	UNC
Richard Westhoot	UTU
Deon Denton	NC Operation Lifesaver
Slobodan Malonevic	Belgrade
AB Swindle	C

HOUSE COMMITTEE ON HIGHWAY SAFETY

MAY 26, 1999
1:00 PM
Room 415

AGENDA

Chair(s): Rep. Wayne Goodwin
Rep. Alma Adams

INTRODUCTIONS

SPEAKER Doug Duncan, Director of Logging & Transportation, NC Forestry Assn.

DISCUSSION

ADJOURNMENT

HIGHWAY SAFETY COMMITTEE MEETING
MINUTES FOR MAY 26, 1999
Room 415 LOB

Committee members in attendance were: Chairs, Representatives Adams and Goodwin (Presiding), Representatives Alexander, Allred, Church, Hurley, Justus, McComas, Mosley, Sexton, Wilson. **Also, attending:** Giles Perry (Committee Staff). A visitor registration list is attached and made part of these minutes.

Narrative/Discussion: Rep. Adams called the meeting to order at 1:00 PM. The pages for the day were introduced. Mr. Doug Duncan, Director of Logging and Transportation for the NC Forestry Association was introduced as the speaker for the day. Mr. Duncan gave a presentation, which is attached and made a part of these minutes. Several committee members asked questions of Mr. Duncan and also of Major Charlie Cardin from the NC Department or Motor Vehicles, and Joe Wetherington from the NC Forestry Association. Dean Denham, from NC Operation Lifesaver spoke briefly. Rep. Mosley asked to also have recognized Elbert Peters from the NC Trucking Association, Dickie Westbrook from Norfolk Southern Railroad, and Ernie Ringold from Norfolk Southern Railroad and NC Operation Lifesaver. Mr. Duncan passed out a folder from the NC Forestry Association with several pieces of reading for the members.

Rep. Goodwin adjourned the meeting at approximately 1:50 PM.

Respectfully submitted,

Rep. Wayne Goodwin
Chairman

Kristen Younts
Committee Assistant

why we are here!
open discussion
group dynamics

DUNCAN
open questions at any time

Trucking Safety

- The Driver
- The Rig
- The Solution

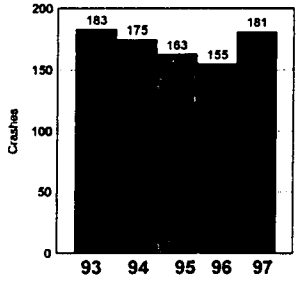
Bob Slocum and I
Forestry Issues => LIST
Has grown - update

Subject - Close to Home
Highways we drive on.

Why Does the Forest Products Industry Care?

- State's second largest business sector
- Products move several times by truck
- Our families, friends and employees are on the same roads
- Safety programs are easily adopted by others - wide impact

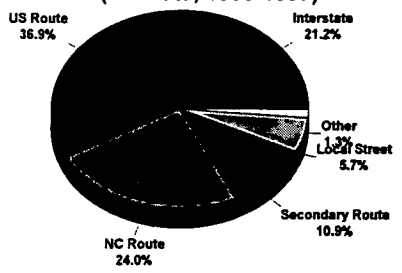
Fatal Crashes Involving Large Trucks in NC, 1993-1997



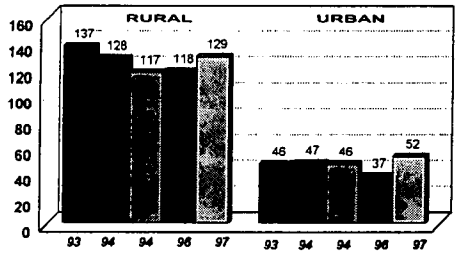
Sources (3) slides: FARS and NC Accident Data

=> Remove chart

Fatal Truck-Involvements by Functional Road Class (NC Data, 1993-1997)



Fatal Truck Involved Crashes in NC by Location (Rural vs Urban) 1993-1997



TRENDS

- RURAL NC AND US ROUTES
  - *7 OUT OF EVERY 10 FATAL INVOLVEMENTS*
- TRACTOR TRAILER
  - *83% OF ALL TRUCK INVOLVED FATALS*
- INTERSTATE WORK ZONES
  - *HEAD-ONS, REAR ENDS*
- ANGLE CRASH SITUATIONS
  - *INTERSECTIONS, PUBLIC/PRIVATE DRIVES*
- ENFORCEMENT
  - *SPEED, FOLLOWING DISTANCE, EQUIPMENT, DRIVER*

Ron Hughes, UNC Highway Safety Research Center

Circle

The Driver

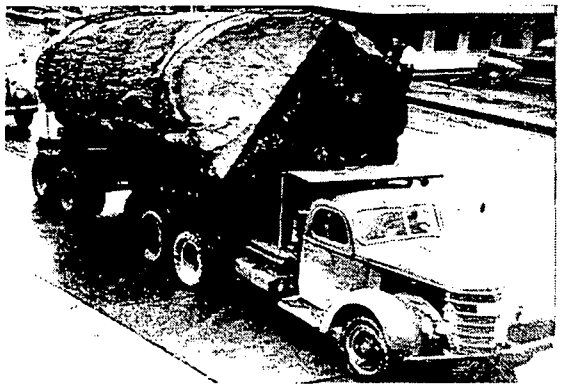
- Long haul vs. local
- Employee vs owner
- Full time vs part time
- Attitude and abilities

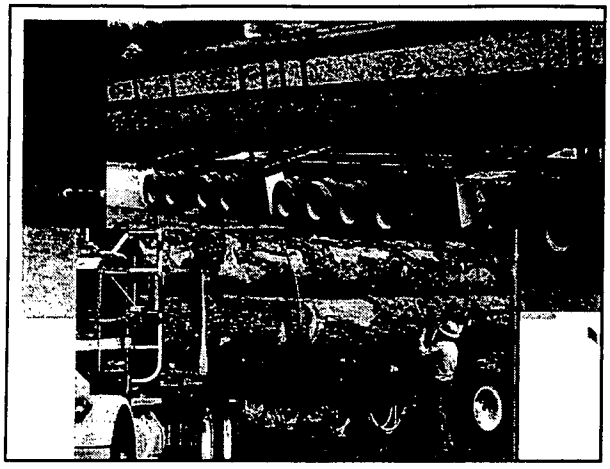


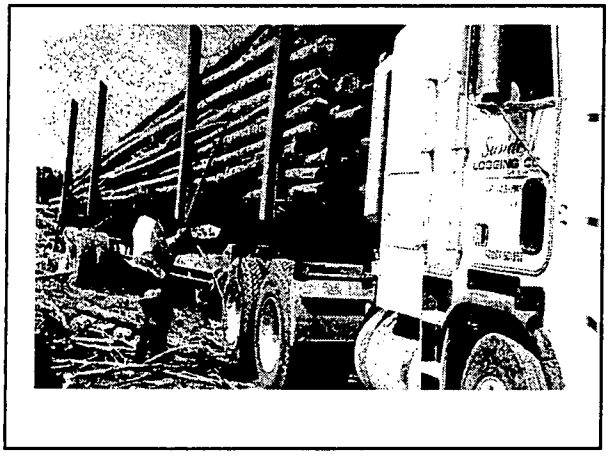
The Rig

- Design and age
- Road conditions
- Maintenance / repair
- Improvements
  - load light / flag
- Inspection









The Solution

- Changes in driver attitude / ability
- Industry support for safe rigs / safe drivers
- Safety based compensation (quality vs quantity)
- Partnership with allied groups
- Public education

wt MAX. / tiedowns / training

DMV, Comm. College, * Op Lifesaver

schools - teens, mature drivers

Forest Industry Response

- Partnership with NCDMV Enforcement
- Partnership with NC Community Colleges
- Encouraged vendor quality programs
- Developed driver based programs
  - –Defensive driving
  - –Truck inspections

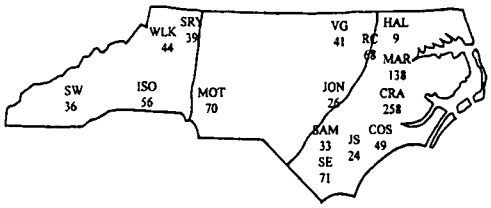
built in specs

Focus on last two!

Defensive Driving

- Conducted at 15 community college locations as of 4/99
- Available at all 58 locations
- 962 graduates in two years
- 4 hour video based, facilitated training
  - –Certified truck driver training instructor
  - –Qualified logger or trucker
  - –Operation Lifesaver instructor

Defensive Truck Driver Training Graduates





"Professional Hauling of Forest Products"

Video title : Green Light to Home

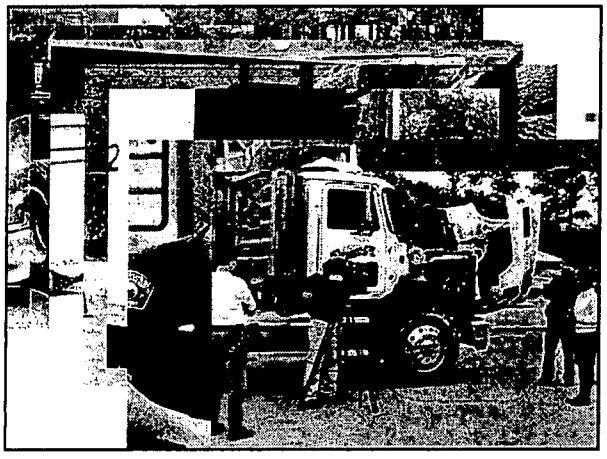
Volunteer Truck Inspections

- Conducted by NCDMV Enforcement
- Level one inspection - CVSA
- Industry provides reflective taping, safety items, lunch, other benefits
- Failed trucks are repaired on site and re-inspected
- Open to the public and media

Having many tools in the tool box is important.

Combination of educ. + enforcement

Spell out



CHARLIE CARDEN

(SHOW VIDEO)

DMV to speak

Key to the Solution

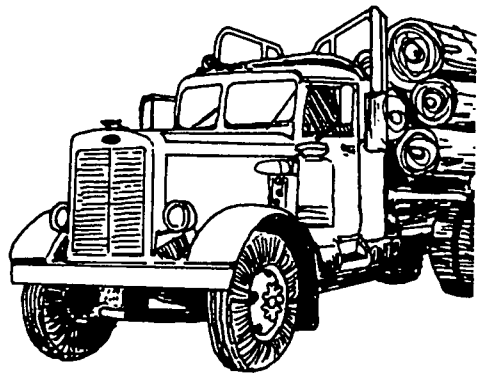
- Crashes are individual events impacting individuals
- Changes in individual attitudes and abilities are required
- Educational and enforcement programs must be meaningful to the individual

Take Home Lesson

- Professional drivers are responsible for themselves and all other drivers
- If you are not a professional, then you are what? _____
- With the best training and the best equipment.....safe driving is still an individual decision. *If you want to be a safe driver....you will be!*

PROFESSIONAL HAULING

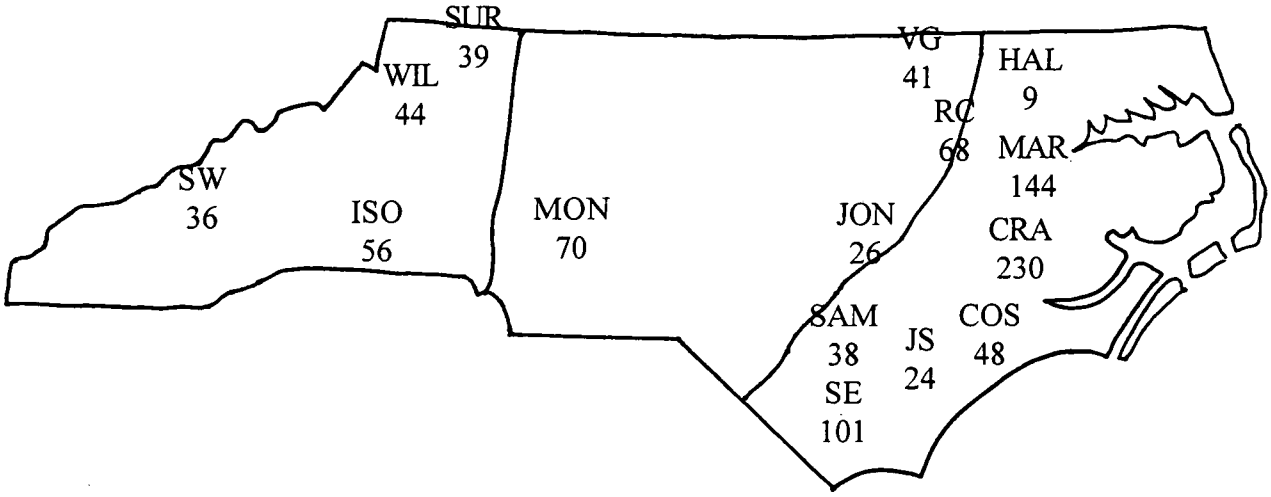
Staus 5-19-99



974 Graduates since April 1997

25 Sessions offered at 15 different community colleges

The NCFA Safety, Logging and Transportation is planning at least ten (10) workshop locations through 1999.



Driver Graduate Distribution
5-19-99

Coastal Carolina (COS)
Craven (CRA)
Halifax (HAL)
Isothermal (ISO)
James Sprunt (JS)
Johnston (JON)
Martin (MAR)
Motgomery (MON)
Roanoke-Chowan (RC)
Sampson (SAM)
Southeastern (SE)
Southwestern (SW)
Surry (SUR)
Vance-Granville (VG)
Wilkes (WIL)

VISITOR REGISTRATION SHEET

Highway Safety — 5/26/99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ruth Sappie	NCDOT
Charlie Carden	NCDOT - NCDMV Enforcement
Dave A Woody	NCDOT - NCDMV ENFORCEMENT
Elbert L. Peters, Jr	NC Trucking Association
Richard Westbrook	UTU
Dean Denham	NC OPERATION LIFESAVER - Raleigh
ERNIE RUGGOLD	NC OPERATION LIFESAVERS NORFOLK SOUTHERN
[illegible]	AAA Carolinas
[illegible]	Pro Logger Council / Frankie Brand Trucking Inc.
Dee A Watkington	Pro-Logger Council / NCFA Bd. Mem / NC Forest Products
ELAINA L. BLANKS	Institute of Government Intern
Michael Lieberman	Institute of Government Intern
Gokes Perry	Staff

1999

HOUSE INSURANCE COMMITTEE

MINUTES

HOUSE COMMITTEE ON INSURANCE
1999 SESSION

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
HURLEY, Bill, Chairman	Melissa Riddle Legislative Assistant	733-5601	2215	23
BARBEE, Bobby	Rosa Murray	733-5908	1025	54
BOYD-MCINTYRE, Flossie		733-5905	507	18
BRUBAKER, Harold	Cindy Coley	715-4946	1229	27
COLE, Nelson	Suzanne Smith	733-5779	1218	45
DEDMON, Andrew	Donna AbuHarb	733-5732	2213	12
DOCKHAM, Jerry	Joanna Mills	733-5822	1106	66
EARLE, Beverly	Ann Raeford	733-5747	535	95
ESPOSITO, Theresa	Judy Lowe	715-3009	418C	28
GRADY, Robert	Peggy Murray	715-9644	616	42
HARDAWAY, Thomas	Rita Harris	715-2530	634	60
HOLMES, George	Glenda Jacobs	733-5771	2119	29
HOWARD, Julia	Gail Stewart	733-5988	1023	51
MILLER, George	Betty Angell	733-5995	532	43
REDWINE, David	Nancy Brantley	733-5829	635	19
SAUNDERS, Drew, Vice-Chair	Ruth Fish	733-5776	1219	82
SMITH, Ronald	Jane Bass	733-5773	2223	2
WAINWRIGHT, William, Vice-Chair	Denise Smith	733-5898	614	8
WARNER, Alex	Ann Stancil	733-5853	1206	11

WILSON, Connie	Paula Covington	733-5903	501	73
WRIGHT, Tom	Clarestene Stewart	733-5754	528	5



Rep. Hurley
Chair



Rep. Saunders
Vice-Chair



Rep. Wainwright
Vice-Chair



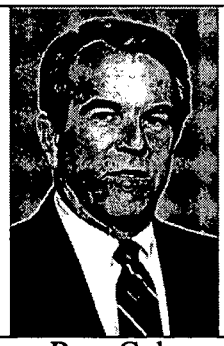
Rep. Barbee



Rep. Boyd-
McIntyre



Rep. Brubaker



Rep. Cole



Rep. Dedmon



Rep. Dockham



Rep. Earle



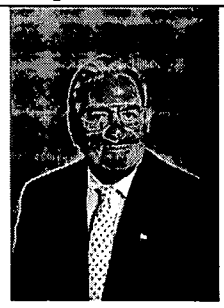
Rep. Esposito



Rep. Grady



Rep. Hardaway



Rep. Holmes



Rep. Howard



Rep. Miller



Rep. Redwine



Rep. Smith



Rep. Warner



Rep. C. Wilson



Rep. Wright

HOUSE INSURANCE COMMITTEE
1999 SESSION

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: INSURANCE Valid Through 29-JUL-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 165=	REDWINE	JUA REAUTHORIZATION	*R -CH. SL 99-0114	03-01-99	03-29-99
H 165=	REDWINE	JUA REAUTHORIZATION	*R -CH. SL 99-0114	04-14-99	
H 193	PRESTON	AMEND HOMEOWNERS' INS COVERAGE	HF-REPTD UNFAV	03-01-99	03-11-99
H 294=	HURLEY	LIFE AND HEALTH INS. AMENDMENTS	*R -CH. SL 99-0351	03-04-99	04-12-99
H 296=	HURLEY	INSURANCE TECHNICAL CHANGES	*R -CH. SL 99-0132	03-04-99	04-14-99
H 306=	HARDAWAY	INSURANCE AMENDMENTS	*R -CH. SL 99-0219	03-04-99	04-12-99
H 306=	HARDAWAY	INSURANCE AMENDMENTS	*R -CH. SL 99-0219	05-25-99	
H 314	BOYD-MCINTYRE	INSURANCE COVG./BONE MASS MSMT	*R -CH. SL 99-0197	03-04-99	04-27-99
H 322	WRIGHT	CREDIT HISTORY IN INSURANCE	H -REF TO COM ON INS	03-04-99	
H 678	SHERRILL	ACUPUNCTURIST REIMBURSEMENT	*S -REF TO COM ON HLTHCARE	03-29-99	04-26-99
H 713=	ALEXANDER	MENTAL HEALTH PARITY STUDY	*H -RE-REF COM ON RULES	03-30-99	04-21-99
H 714=	ALEXANDER	SUBSTANCE ABUSE/DIRECT PAY	*R -CH. SL 99-0199	03-30-99	04-23-99
H 715	ALEXANDER	UTILIZATION REVIEW/ASAM CRITERIA	*R -CH. SL 99-0116	03-30-99	04-23-99
H 744	**CANSLER**	**HEALTH ACCESS PILOT PROJECT**	***H -RE-REF COM ON INS**	**05-20-99**	
H 922=	HUNTER	REGULATE USED MOTOR VEHICLE PARTS	H -REF TO COM ON INS	04-05-99	
H 965=	COLE	FIRE MARSHALS IN PENSION FUND	H -RE-REF COM ON APPROP	04-12-99	04-21-99
H 990=	NESBITT	INCREASE AUTO INSURANCE COVERAGE	H -REF TO COM ON INS	04-13-99	
H 991	BADDOUR	WORKERS' COMP AND UIM INSURANCE	*R -CH. SL 99-0195	04-13-99	04-26-99
H1025	GARDNER	GROUP HEALTH CONTINUATION INSURANCE	R -CH. SL 99-0273	04-14-99	04-23-99
H1089	ARNOLD	SWEET POTATO INSURANCE RECLASS	H -REF TO COM ON INS	04-15-99	
H1093=	DOCKHAM	INSURANCE PREMIUM FINANCING	H -REF TO COM ON INS	04-15-99	
H1106	GIBSON	INSURER AUDITS PRIVILEGED	H -REF TO COM ON INS	04-15-99	
H1119	WRIGHT	CHILDREN/DISABLE ANESTH. DENTAL CARE	*R -CH. SL 99-0134	04-15-99	04-27-99
H1123=	MOSLEY	STATE HEALTH PLAN AMENDMENTS	H -REF TO COM ON INS	04-15-99	
H1126	HACKNEY	PHYS. CONTRACTS/NONCOMPETE PROHIBITE	*S -REF TO COM ON JUDICI	04-15-99	04-27-99
H1133	HACKNEY	HEALTH INS./LIABILITY	*S -HELD AS FILED	05-31-99	07-14-99
H1176	INSKO	CONTINUING CARE FACILITIES/LIENS	H -REF TO COM ON INS	04-15-99	
H1186	MINER	UNEARNED PREMIUM RESERVES	*H -PRES. TO GOV. 07-19	04-15-99	04-23-99
H1206	INSKO	HEALTH INS./MENTAL HLTH PRECERT.	*H -RE-REF COM ON RULES	04-15-99	04-27-99
H1217=	BADDOUR	VOLUNTEER RESCUE WORKERS	H -REF TO COM ON INS	04-15-99	

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: INSURANCE Valid Through 29-JUL-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H1458	**NESBITT**	**PRESC. DRUGS/STATE HEALTH PLAN FUNDS**	**H -REF TO COM ON INS**	**04-29-99**	
S 90=	FORRESTER	INSURANCE/COVER CONTRACEPTIVES	*R -CH. SL 99-0231	04-08-99	06-10-99
S 293	COOPER	PASTORAL COUNSELING REIMB/SUNSET OFF	*R -CH. SL 99-0186	04-07-99	05-31-99
S 344	FORRESTER	MGD CARE/SPECIALIST REFERRAL	R -CH. SL 99-0168	04-13-99	05-24-99
S 347	FORRESTER	PRES.DRUG FORMULARIES	*R -CH. SL 99-0178	04-20-99	05-24-99
S 389	MARTIN R	TOWN/COUNTY FINANCIAL REPORTS	*R -CH. SL 99-0192	04-13-99	05-31-99
S 394	HARTSELL	CREDIT CARD PAYMENT OF INSURANCE	*S -PRES. TO GOV. 07-19	04-07-99	07-06-99
S 513	WELLONS	PRESC. DRUG ID CARD	*R -CH. SL 99-0343	04-29-99	07-06-99
S 594	MILLER B	MISC. INSURANCE CHANGES	R -CH. SL 99-0294	04-28-99	06-22-99
S 643=	REEVES	INSURANCE PREMIUM FINANCING	*R -CH. SL 99-0157	04-29-99	05-24-99
S 685	LUCAS	HEALTH INSURANCE/PHYS. ASSISTANTS	R -CH. SL 99-0210	04-28-99	06-01-99
S 756=	HORTON	INCREASE AUTO INSURANCE COVERAGE	*R -CH. SL 99-0228	05-03-99	06-01-99
S 766	MILLER B	SERVICE CORP. AND HMO LAWS	R -CH. SL 99-0244	04-27-99	06-14-99
S 839	WELLONS	INSURANCE CLAIMS PAYMENTS/Y2K	*R -CH. SL 99-0184	04-29-99	05-24-99

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

ATTENDANCE

HOUSE COMMITTEE ON INSURANCE

1999 Session

DATES	2/18	3/11	3/25	4/8	4/15	4/20	4/21	4/22	4/23	4/26	4/27
HURLEY, Bill **CHAIR**	X	X	X	X	X	X	X	X	X	X	X
BARBEE, Bobby		X		X	X	X	X	X	X	X	X
BOYD-MCINTYRE, Flossie		X		X	X			X	X	X	X
BRUBAKER, Harold		X	X	X	X	X	X	X		X	X
COLE, Nelson	X	X	X	X	X	X	X	X	X	X	X
DEDMON, Andrew	X	X	X	X		X	X		X		X
DOCKHAM, Jerry	X	X		X	X	X	X	X	X		X
EARLE, Beverly	X				X	X			X		
ESPOSITO, Theresa	X	X	X	X	X	X	X	X	X		X
GRADY, Robert	X	X	X	X	X		X				X
HARDAWAY, Thomas	X		X	X	X		X	X	X		
HOLMES, George		X		X	X	X	X	X	X		X
HOWARD, Julia	X	X			X	X	X	X	X	X	
MILLER, George		X	X		X	X	X			X	
REDWINE, David	X	X	X	X	X	X		X	X		
SAUNDERS, Drew **VICE-CHAIR**		X	X	X	X	X	X	X	X	X	X
SMITH, Ronald (Ronnie)	X	X	X	X	X	X	X			X	X
WAINWRIGHT, William **VICE-CHAIR**	X	X	X		X				X		
WARNER, Alex	X	X	X	X	X	X	X	X			X
WILSON, Connie	X	X	X		X	X	X	X	X	X	X
WRIGHT, Tom	X	X	X	X		X	X				X
Ex-Officio Members											
HACKNEY, Joe						X	X		X		
BADDOUR, Phil							X		X		
CUNNINGHAM, W. Pete						X	X		X		

ATTENDANCE

HOUSE COMMITTEE ON INSURANCE

1999 Session

DATES	5/13	5/20	5/27	6/10	6/17	7/1	7/8				
HURLEY, Bill **CHAIR**	X	X	X	X	X	X	X				
BARBEE, Bobby	X	X	X	X		X	X				
BOYD-MCINTYRE, Flossie	X				X	X	X				
BRUBAKER, Harold		X	X		X	X	X				
COLE, Nelson	X	X	X	X	X	X	X				
DEDMON, Andrew	X	X		X	X	X	X				
DOCKHAM, Jerry	X		X	X		X	X				
EARLE, Beverly	X										
ESPOSITO, Theresa	X	X		X		X	X				
GRADY, Robert	X	X		X	X		X				
HARDAWAY, Thomas	X			X		X	X				
HOLMES, George	X										
HOWARD, Julia	X		X	X	X		X				
MILLER, George	X						X				
REDWINE, David				X							
SAUNDERS, Drew **VICE-CHAIR**	X	X		X	X	X	X				
SMITH, Ronald (Ronnie)	X	X	X			X	X				
WAINWRIGHT, William **VICE-CHAIR**	X		X		X	X	X				
WARNER, Alex	X	X				X					
WILSON, Connie	X	X	X		X	X	X				
WRIGHT, Tom	X			X	X						
Ex-Officio Members											
HACKNEY, Joe	X					X	X				
BADDOUR, Phil											
CUNNINGHAM, W. Pete							X				

MINUTES
HOUSE COMMITTEE ON INSURANCE
February 18, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on February 18, 1999, at 12:00 noon. Representative Hurley presided. Members present were: Cole, Dedmon, Dockham, Earle, Esposito, Grady, Hardaway, Howard, Redwine, Smith, Wainwright, Warner, C. Wilson, and Wright. A list of visitors attending is attached. (Attachment I).

Chairman Hurley called the meeting to order at 12:04 PM; introduced the pages, and indicated this was to be an introductory meeting. Introductions of Billy Crocker and Ed Worth with the Sergeant of Arms Staff, and Linwood Jones and Ed Rossi, Research Staff were made.

Chairman Hurley recognized Jim Long, Insurance Commissioner who, in turn, introduced members of his staff and defining their functions to include Bill Hale, Legislative Counsel, and Daschiel Propes, Chief Deputy Commissioner.

Representative Redwine addressed the issue of homeowner's insurance rates being raised. Mr. Long indicated the average statewide increase being sought was 15.6%. The compromise was 4.3% average statewide increase – about 28% of what was sought. This represents savings to the homeowners of North Carolina of 78.5 million dollars per year in premiums below what the industry requested. Barrier islands were capped at 20%. Inland portions were capped at 12%. Moving westward, there is a lesser increase. 1.8 billion dollars in storm damage claims have been paid since 1993. There is a concern about the amount of companies writing insurance in the eastern part of the state – goal to bring more competition to the coast. Representative Redwine indicated he felt coastal areas were subsidizing storms in other parts of the state.

Representative Smith was recognized and expressed concern about the number of companies writing insurance in the eastern part of the state. Mr. Long indicated that companies cannot be forced to write homeowners insurance.

Representative Wright was recognized and asked for a breakdown of the percentages of increase across the state to include percent requested and cap.

Representative Smith asked if it is a theory that companies tend to provide coverage where the greater increases are because they will make more money. Mr. Long indicated this was correct.

Daschiel Propes added comments pertaining to insurance at the beach. The Insurance Commission has been asked by the Legislative Research Committee on Insurance to come back to the General Assembly with a preliminary report by April 1st and a final report by December 1st to recommend several items. One of which is whether the two-year cap should be extended. Currently two or three companies are writing three-fourths of the coverage at the beach areas. The Fair Share plan was described.

Representative Redwine asked if the Legislature could do anything to encourage insurance companies to do business in coastal areas. Mr. Propes indicated the Insurance Commission is encouraging companies to write more business in coastal areas; however, once again he advised that according to the Attorney General there is not a way to make companies write policies. HB 452 was discussed.

Representative Dockham inquired about discounting. Mr. Propes indicated insurance companies are in open competition. Companies want to go where they will make larger profits.

Representative Smith asked if the Fair Plan has the same problems as the Beach Plan. The Fair Plan works like the Beach Plan – just covers area in the state other than the beach.

Representative Redwine indicated a system needs to be crafted where everyone can purchase insurance and not have certain areas discriminated against.

Mr. Propes disseminated various materials: a booklet for the 1995-1996 Biennial Report with the NC Department of Insurance and advised this will be updated in the near future. (Attachment II), Division Directory – "Who Does What" (Attachment III), and four brochures pertaining to the Department (Attachment IV).

Chairman Hurley recognized Bill Hale, who will be present at all of the meetings. Mr. Hale indicated they would be having some legislation forthcoming. More details will be provided at next meeting.

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

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

Attachment I

VISITOR REGISTRATION SHEET

INSURANCE — 2-18-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jim Bradley	NC DOI
Angela C. Ford	NCDOI
Mark Gleason	The Capitol Group
Kathy Kaplan	
Susan Valauri	Nationwide
Wake Harris	NC DOI
Barbara Morales Burke	NCDOI
Alan Miles	Bailey & Dixon LLP
Ken Wright	BCBSNC
Andy Ellen	NC Retail Merchants
William Riddick	DOR
Art Pope	NCRMA
Amy Fullbright	Hanton & Wms.
Paul Mahoney	NC Assn Health Plans
Lisa Piercy	NC Assn Life Underwriters

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VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

2-18-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Steve Woodson	NC Farm Bureau
Wm H Potts Jr	NCPHA/NCDA
Paula Tocuk Gupton	NC Farm Bureau
S Wheeler	NC Med. Society
Katherine Miller	Hays Kaplan
Robert Paschall	Young, Moore & Henderson, P.A.
Daschiel Cooper	NC DOI
Adam Searcy	NCHAC
Joyce Peters	MIAMSI
Mike Tyson	County Jail, MD
John Borowski	Zeb Alley P.A.

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DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Actuarial Services - Dobbs - Suite 3083
PHONE: 733-3284
FAX: 715-7564

DEPUTY COMMISSIONER: John Donaldson - Ext. 260

SENIOR DEPUTY COMMISSIONER: Alex Spencer - 733-2205 Ext. 123
Lisa Zimmerman, Administrative Asst. - 733-2205 Ext. 135

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Assists in the review of rate, form and statistical filings; conducts actuarial studies for financial evaluation.

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Walter James	Ext. 262	Life, Accident and Health
Arthur Schwartz	Ext. 259	All lines except workers' compensation
Quang Nguyen	Ext. 256	Data Base Management and Special Projects
Mike Wells	Ext. 261	Accident and Health
Dale Evans	Ext. 255	Self-Insured Funds
Vacant	Ext. 257	Workers' compensation loss cost filings
David Rosenzweig	Ext. 258	Workers' compensation loss cost filings
Jo Ann Edwards	Ext. 254	Office Assistant IV

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Administration - Dobbs - Suite 4140
PHONE: 733-7349
FAX: 733-6495

COMMISSIONER: James E. Long

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Management of all Divisions in the Department as well as staff responsibilities of personnel, controller's office, public information and legislative liaison.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Dascheil Propes	733-0433	Chief Deputy Commissioner - Legislative Counsel, Public Information Office, Office of the State Fire Marshall and Regional Offices
Wake Hamrick	733-3362	Assistant Commissioner - Technical Services, Public Services and Company Services Groups, Personnel, Controller's Office
Bill Hale	733-4529	Legislative Counsel
Jennifer Gullette	733-5238	Public Information Officer

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Starla McKenney	715-7775	Special Assistant
Lorrie Icenhour	733-7349	Executive Assistant to the Commissioner; provides administrative support to the Commissioner
Judy Gray	733-3362/0433	Executive Assistant to the Chief Deputy Commissioner and Assistant Commissioner; supervises receptionist
Wendy Holland	733-7349	Secretary/receptionist
Ellie Sprenkel	733-4529	Paralegal/administrative support for Legislative Counsel
Wendi McLendon-Pruett	733-5238	Assistant Public Information Officer
Lizz Wall	733-5238	Public Information Office Assistant; back-up receptionist

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Agent Services - Dobbs - Suite 3238
PHONE: 733-7487
FAX: 715-3794

DEPUTY COMMISSIONER: Shirley H. Williams - 733-1641

SENIOR DEPUTY COMMISSIONER: Angela Ford - 733-4935
Latane Williams - Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Regulates all licensed agents, brokers, limited representatives, appraisers and adjusters authorized to do business in North Carolina. This includes pre-licensing education, continuing education, agency audits and regulatory actions.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Lewis Johnson	733-1640	Education/Agency Examiner
Teresa Knowles	733-1647	Licensing/Financial Section

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Tish Bynum	733-1641	Administrative Assistant to Deputy Commissioner

<u>Licensing/Financial Section</u>

Doris Peppers	733-1638	Lead worker
Lucille Flowers	733-7487	Switchboard operator
Lorraine Williams	733-7487	Switchboard operator
Vacant	733-1650	Corporations, brokers, letters of certification and clearance
Helen Lockamy	733-1635	Agent and Adjusters license applications; pre-licensing education waivers and viatical brokers licenses
Christina Hunter	733-7487	Receptionist
Voice Response	981-5244	General licensing information and licensing requirements
Vanessa Harrell	733-1649	Accounting clerk
Brenda Perry	733-1648	Accounting clerk
Vacant	733-1637	Mail clerk

(Agent Services continued)

Education Section

Dolores Renfrow	733-1642	Course analyst/instructor approval
Belinda Nicholson	733-1643	Rosters, schedules, exemptions and extensions
Kela Cooper	733-1644	Rosters, schedules, exemptions and extensions
Maurice Alston	733-7487	Education/agency examiner
Lee Booker	733-7487	Education/agency examiner
Teri Robinson	733-7487	Education/agency examiner
Vacant	733-7487	Education/agency examiner
Voice Response	800/931-7111	General information, course credits and schedules

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Consumer Services - Dobbs - Suite 3040
PHONE: 733-2032; 800/546-5664; TDD-715-0319; Small Groups-800/762-5547
FAX: 733-0085

****Note: Direct all calls to the Communication Specialists' area rather than to a specific number.****

DEPUTY COMMISSIONER: Bill Stevens - 733-4813

SENIOR DEPUTY COMMISSIONER: Angela Ford - 733-4935
Latane Williams, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Consumer complaints and inquires concerning all lines of insurance.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Brenda Smith	733-2032	Communications Specialists handling all new incoming calls
Dianne Lancaster	715-0310	Property and Casualty Section
Terry Dorman	715-0321	Life and Health Section
Susan Austin	733-2004	Support Section

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

All new calls should be directed to: (919)733-2032; 1-800-JIM-LONG; 1-800-762-5547 (small groups); (919) 715-0319 (TDD)

Tim Peedin	715-0311	Property & Casualty Specialist
Kim Perry	715-0312	Property & Casualty Specialist
Paul Marshall	715-0313	Property & Casualty Specialist
Joyce Johnson	715-0314	Property & Casualty Specialist
John Tally	715-0315	Property & Casualty Specialist
Delton Daughtry	715-0316	Property & Casualty Specialist
Wanda Williams	715-0317	Property & Casualty Specialist
Janet Morris	715-0318	Life & Health Specialist
Robert (Bob) Harvell	715-	Life & Health Specialist
Michael Di Pierro	715-0320	Life & Health Specialist
Martha Wall	715-0322	Life & Health Specialist
Joe Williams	715-0323	Life & Health Specialist
Millicent Harris	715-0324	Life & Health Specialist
Becky Thornton	715-0351	Life & Health Specialist
John Wrenn	733-2032	Communication Specialist
Terry Lowery	733-2032	Communication Specialist
Rosemary Beatty	733-2032	Communication Specialist
Vacant	733-2032	Communication Specialist
Vacant	733-2032	Communication Specialist
Vacant	733-2032	Communication Specialist
Quinetta Lyons	733-2004	Support Staff
Lana Mangum	733-2004	Support Staff
Frankie Turner	733-2004	Support Staff

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Controller's Office - Dobbs - Suite 4092
PHONE: 733-3352
FAX: 715-7083

CONTROLLER: Jim Newman

ASSISTANT COMMISSIONER: Wake Hamrick - 733-3362
Judy Gray, Executive Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Prepare and adjust budgets; monitor divisional budget needs; process cash receipts; prepare cash disbursements; manage cash; control fixed assets; employee payroll; leave record accounting; contract approval; financial statement preparation; insure proper internal accounting control and procedures are in place; maintain NC accounting system (NCAS); Departmental purchasing; process and deliver all mail.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Jim Crooke	733-3352	Budget administration; responsible for day-to-day operation and staff management; supervises accounts payable and payroll
Lorraine Richardson	733-3355	Departmental purchasing; assigns temporary and permanent vehicles; recycling; parking; building coordinator; telephone cards; supervises mailroom personnel

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Laresia Everett	733-3352	Cash management; chief accountant; financial statement preparation; liaison to the state auditor; Zenith; grant administration
Tami Luckwaldt	733-3352	NCAS Accounting System (NCAS); fixed assets; salary control; expansion budget
James Reed	733-3352	Process cash receipts; motor pool billings and logs; general employee travel reimbursements; American Express Cards; travel agency payables
Tammie Hicks	733-3352	Payroll Officer; employee payroll; employee leave records; sales tax; 1099's; health benefits
Francis Smith	733-3355	Assist in purchasing functions; fixed asset inventory control; check writing duties for employees and vendors
Beverly Young	733-3352	Direct and match invoices; accounts payables; SIPS billing
Joan Watson	733-3352	Direct and match invoices; telephone bills; accounts payable; returned checks; contracts; requisitions and training requests

(Controller's Office continued)

Candace Jackson	733-3352	Assist Controller in various projects; verify and file time sheets
Richard Kilgo	733-2187	Mailroom services; stock and supplies
Earl Partin	733-2187	Mailroom services; stock and supplies

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Eastern Regional Office, 1249 Colony Drive, New Bern, 28562
PHONE: (252)514-4813
FAX: (252)514-4818

DEPUTY COMMISSIONER: Max A. Powell

CHIEF DEPUTY COMMISSIONER: Dascheil D. Propes - 919/733-0433
Judy Gray, Executive Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Serving 32 Easternmost counties for consumer complaints, agent inquiries, inquiries on manufactured housing, state building codes, fire and rescue, SHIIP; link between Raleigh office and the east. Commissioner's liaison with county/local government officials; ENC legislators; regulated entities.

SUPERVISOR'S MAJOR AREAS OF RESPONSIBILITY

Max Powell	Formulation and interpretation of policies; interaction management; field contacts with consumers; regulated entities; county and municipal officials and civic groups.

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Kay Bennett	Assistant Director for ERO; consumer complaints; agent inquiries; initial contact on manufactured housing; fire and rescue; state building codes; SHIIP
Joan Buck	Receptionist; Communications Specialist

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Engineering & Codes - 410 N. Boylan Avenue, 27603
PHONE: 733-3901
FAX: 733-9171

DEPUTY COMMISSIONER: Grover Sawyer

SENIOR DEPUTY COMMISSIONER: Tim Bradley - 733-6008
Mary Clayton, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

North Carolina Building Codes: Building, Residential, Plumbing, Mechanical, Electrical, Gas, Handicapped Accessibility, Modular; North Carolina Building Code Council; North Carolina Code Officials Qualifications Board; North Carolina Home Inspectors Licensure Board

MAJOR AREAS OF RESPONSIBILITY

Kelly Williams	Receptionist and switchboard operator
<u>Accessibility Section</u>	
Jeff Kanner	Handicapped Accessibility Code
<u>Code Council Section</u>	
Elaine Brown	Supervisor, Building Code Council, Code Publications and Sales
Jackie Grizzel	Code Council agendas and minutes
Terri Tart	Code Sales; Secretary
<u>Electrical Section</u>	
Jim Carpenter	Supervisor, Electrical Codes
Ron Chilton	Electrical Codes
Tim Norman	Field Inspector - Piedmont
Richard Dawson, Jr.	Field Inspector - Eastern NC
Richard Carpenter	Field Inspector - Western NC
<u>Home Inspection Section</u>	
Vacant	Supervisor, Education Coordinator for Home Inspectors Board
Jimmy Hughes	Home Inspectors Licensure Board Investigator
Jennifer Hollyfield	Certification Section Secretary
<u>Mechanical Section</u>	
Henry Webster	Supervisor, Plumbing, Mechanical and Fire Codes
Richard Dipert	Fire Prevention Codes
Billy Hinton	Mechanical and Energy Codes
<u>Q-Board Certification Section</u>	
Mike Page	Supervisor, Code Officials Qualification
Wanda Edwards	Code Official Complaint Investigations
Kathy Williams	Code Official Applications and Examinations
Reginald Hunter	Code Official Educational Program Development
Tammy Parker	Secretary

(Engineering continued)

Plan Review Section

Barry Gupton	Supervisor, Building and Residential Codes
Tim Morrison	Building & Residential Codes
Laurel Wright	Building & Residential Codes
David Mallette	Building & Residential Codes
William Murchison	Building & Residential Codes
Carole Acquesta	Building & Residential Codes
Glenda Mann	Code Consultant Typing and Filing
Dena Yarborough	Code Consultant Typing and Filing

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Financial Evaluation - Dobbs - Suite 3031
PHONE: 733-5633
FAX: 715-7230

DEPUTY COMMISSIONER: Ray Martinez - 733-2002

SENIOR DEPUTY COMMISSIONER: Alex Spencer - 733-2205 Ext. 123
Administrative Asst. - Lisa Zimmerman - 733-2205 Ext. 135

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Financial surveillance, license/registration renewal, maintenance of corporate records of all licensed insurance companies, surplus lines companies, accredited re-insurers, risk retention companies and purchasing groups; admission of insurance companies; regulation of continuing care facilities; conduct financial examinations of domestic insurance companies and participate in audits of licensed foreign insurance companies; regulation and financial examination of employers and employer groups authorized to self-insure for workers' compensation insurance.

MAJOR AREAS OF RESPONSIBILITY:

Tom Smith	Ext. 221	Receptionist
Ganesh Tangela	Ext. 242	Applications Programmer
Dee Williams	Ext. 241	Administrative Secretary

Company Admissions - Suite 3031

Bob Stamey	Ext. 239	Director
Thomas Wilkins	Ext. 238	Senior Financial Analyst
Jo Ann Helms	Ext. 237	Office Assistant

Financial Analysis - Suite 3020 - Fax: 715-7230

Joyce Stevens	Ext. 246	Chief Financial Analyst
Teresa Browning	Ext. 244	Administrative Assistant

Domestic Company Analysis - (A)Suite 3031(2) - Fax: 715-7230/(B)Suite 3067 - Fax: 715-9745

Helen Smith	Ext. 235(B)	Assistant Chief Financial Analyst
Hosam Abdulkareem	Ext. 234(A)	Financial Analyst
Dawn English	Ext. 250(B)	Financial Analyst
Betty Jackson	Ext. 233(A)	Financial Analyst
Lori Markle	Ext. 252(B)	Financial Analyst
Jackie Obusek	Ext. 229(A)	Financial Analyst
Lisa Snyder	Ext. 230(A)	Senior Financial Analyst
George Urko	Ext. 271(A)	Financial Analyst
Ellen Steinbrook	Ext. 243(B)	Office Assistant
Kathy Sykes	Ext. 232(A)	Corporate Records
Vacant	Ext. 228 (A)	Financial Analyst

(Financial Evaluation continued)

Foreign Company Analysis - (A)Suite 3031(1) - Fax: 715-7230/(B)Suite 3067 - Fax: 715-9745

Marwan Zabaneh	Ext. 224(A)	Assistant Chief Financial Analyst
Larry Boykin	Ext. 222(A)	Senior Financial Analyst
Avery Carlock	Ext. 223(A)	Financial Analyst
Susan Coble	Ext. 227(A)	Financial Analyst
Andrea Millington	Ext. 245(B)	Financial Analyst
Anthony Plocharczyk	Ext. 236(A)	Financial Analyst
Jeff Trendel	Ext. 268(A)	Financial Analyst
Vacant	Ext. 231(A)	Financial Analyst
Vacant	Ext. 270(B)	Financial Analyst
Angie Bryant	Ext. 225(A)	Processing Assistant

Collateral Security Unit - Suite 4011 - Fax: 715-3806

Linda Lloyd	Ext. 248	CSU Manager

Financial Examination - 401 Glenwood Avenue - Phone: 733-2205 - Fax: 715-1130

Joe Peiso	Ext. 129	Chief Financial Examiner
Peggie Dillon	Ext. 154	Program Assistant
Dave Baylock	Ext. 155	Assistant Chief Examiner
Robert Stanfield	Ext. 175	Assistant Chief Examiner
Gwen Tann	Ext. 174	Company Examiner
Stephen Johnson	Ext. 160	Company Examiner
John Dion	Ext. 169	Company Examiner
Vacant	Ext. 176	Company Examiner
Christiel Rhem	Ext. 173	Company Examiner

Financial Examiners - Ext. 171 or 172 to leave message

Vacant	Tina Renfrow
Michael Hall	Tony Riddick
Dennis Hrynkow	Sunil Sharma
Reid Langford	Bill Speed
Susan Loy	Henry Merritt
Herb Maltba	Tia N. Jones
Robert McGee	Albert Henthorn, Jr.

Continuing Care - Suite 4011 - Fax: 715-3806

Bill Darden	Ext. 247	Director
Vacant	Ext. 249	Processing Assistant

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Information Systems - Dobbs - Suite 3004
PHONE: 733-5411
FAX: 733-0085

DIRECTOR: John Coan - Ext. 5

SENIOR DEPUTY COMMISSIONER: Alex Spencer - 733-2205 Ext. 123
Lisa Zimmerman - Administrative Asst. - 733-2205 Ext. 135

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Information resources management; technology selection and utilization. Examples: computers, software, local area networks, data communications, telephones, fax machines, copiers, modems, peripherals for entire department.

SUPERVISOR'S MAJOR AREAS OF RESPONSIBILITY

John Coan	Ext. 5	Technology utilization planning and compliance, IRM governance, requisition review, liaison with SIPS and IRMC. Manage IS staff. Selected software support.
Matt Gross	733-2205 Ext. 124	Application Development Manager. Database administration and application development; system analysis and PC support for assigned divisions (alt. John Coan). Supervise application developers and contract programmers.

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Vacant	Ext. 3	Network Manager. E-mail system management; LAN management and PC support for assigned divisions (alt. Larry Brewer).
Larry Brewer	Ext. 2	PC Support Manager. Security administration, application programming, and LAN and PC support for assigned divisions (alt. Network Administrator). Supervise temporary support staff.
Ava Smith	Ext. 1	Training, help desk client support, computer experts group, and fixed assets administration (alt. assigned support person for appropriate division)
Vacant	733-2205 Ext. ??	Application Developer
Vacant	733-2205 Ext. ??	Application Developer
Vacant	Ext. 4	Temporary User Support Staff Member
Vacant	Ext. 4	Temporary User Support Staff Member

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Investigations - Dobbs - Suite 3128
PHONE: 733-7434
FAX: 715-1156

DIVISION HEAD: William C. Creel

SENIOR DEPUTY COMMISSIONER: Angela Ford - 733-4935
Latane Williams - Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Conducts criminal investigations of insurance-related crimes committed by policyholders, claimants, insurance producers and insurance companies.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Robert Brown	Field Supervisor (Western NC)
Jack Wood	Field Supervisor (Raleigh) Assistant Deputy Commissioner
Fred Clemons	Field Supervisor (Eastern NC)
Teresa Berry	Administrative Assistant, Support Staff

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Roy Bennett	Investigator (Wake Forest)
Martha Ann Ford	Investigator (Charlotte)
Albert Koehler	Investigator (Raleigh)
Richard Kinn	Investigator (Roxboro)
Ann R. Mauney	Investigator (Asheboro)
William Mangum	Investigator (Raleigh)
Herbert Miller	Investigator (Raleigh)
Benny Mullinex	Investigator (New Bern)
Susan Rollins	Investigator (Hickory)
Ben Tesh	Investigator (Asheboro)
Evelyn Trusty	Investigator (Raleigh)
Nesa Jones	Processing Assistant
Joyce Williams	Processing Assistant

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Legal Department - Dobbs Building - Suite 3178
PHONE: 715-0011
FAX: 715-8889

GENERAL COUNSEL: Peter Kolbe - Ext. 2

COMMISSIONER: Jim Long - 733-3058
Lorrie Icenhour, Executive Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Provides internal legal advice to all parts of the department, acts as liaison with the Attorney General's Office and acts as moderator and hearing officer in administrative hearings. Additionally, the unit is involved with and litigates hearings on all statutory Rating Bureau rate filings, and administrative hearings regarding such topics as license suspension/revocation and wrong doings by insurance companies as well as preparing complex orders and memoranda for the Commissioner.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Peter Kolbe	715-0011 Ext. 2	General Counsel; Gives legal advice to entire department; serves as hearing officer in administrative proceedings; acts as liaison with Attorney General's office.

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Kristin Eldridge	715-8967 Ext. 256	Special Counsel; litigates and conducts hearings related to rate filings.
Sherri Hubbard	715-8967 Ext. 255	Special Counsel; litigates and conducts hearings related to rate filings.
Tricia Ford	715-8967 Ext. 257	Legal Assistant to the Special Counsel
Mary Faulkner	715-0011 Ext. 1	Legal Assistant to the General Counsel

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Life and Health - Dobbs - Suite 4064
PHONE: 733-5060
FAX: 715-3547

DEPUTY COMMISSIONER: Tom Jacks - Ext. 349

SENIOR DEPUTY COMMISSIONER: Barbara Morales Burke - 733-6350
Angie Brogden, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Oversee federal and state life and health insurance reform, legislative and policy issues. Review policy form filings and premium rate revisions made by life and health insurance companies. Administer Small Employer Group Health Insurance reforms. Responsible for federal health insurance reform legislation, long term care, small employer group health insurance, uniform claims, viatical settlements, Third Party Administrators (TPAs), medical saving accounts, credit insurance annuities.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Rodney Finger	Ext. 348	Assistant Deputy Commissioner; federal health insurance reform legislation; life and health insurance
Theresa Shackleford	Ext. 351	Life and health insurance; long term care
Jean Holliday	Ext. 346	Life and health insurance; viatical settlements, TPAs, and Medical Savings Accounts

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

SPECIALITY AREAS - NOTE: All staff handle all subjects

Garlinda Taylor	Ext. 347	Managed Care
Roberta Hamby	Ext. 343	Small Employer Group
Bob Stokes	Ext. 314	Uniform Claims
Rebecca Hill	Ext. 355	Viatical settlements; TPAs; Medical Saving Accounts
Jenny Fogleman	Ext. 344	TPAs
Cara Smith Shackelford	Ext. 352	Credit insurance
Carolyn Thomas	Ext. 345	Annuities
Kim Sheppard	Ext. 341	General life and health insurance
Florence Westin	Ext. 342	General life and health insurance
Carol Dail	Ext. 356	General life and health insurance

ADMINISTRATIVE SUPPORT STAFF

Lisa Runkal	Ext. 340	Administrative Support to Deputy Commissioner and Assistant Director
Sylvia East	Ext. 313	Receptionist
Elizabeth Marchessault	Ext. 315	Approval Clerk
Brandy Wilkes	Ext. 354	Disapproval Clerk
Bernadette Byrne	Ext. 353	TPA Clerk

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Managed Care & Health Benefits - 111 Seaboard Avenue, 27604
PHONE: 715-0526
FAX: 715-0198

DIVISION HEAD: Nancy O'Dowd

SENIOR DEPUTY COMMISSIONER: Barbara Morales Burke - 733-6350
Angie Brogden, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Multiple Employer Welfare Arrangements (MEWAs); Health Maintenance Organizations (HMOs); Preferred Provider Organizations (PPOs); and Utilization Review Organizations (UROs); reviews HMO and PPO provider contracts; HMO licensure and examinations.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

DeAnne Nelson	715-5618	Assistant Deputy Commissioner
Dionne Wells	715-4463	HMO Examinations and HMO Applications
Ted Hamby	715-9652	HMO and PPO provider contracts, MEWA, provider complaints, general inquiries regarding managed care regulation
Vacant		Data analysis and reporting

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Vacant	715-0526	Receptionist; distributes company application forms (HMO, PPO, UR) and company lists
Donna Champion	715-2927	Administrative assistant; office operations
Cheryl Bivens	715-0193	HMO and PPO provider contracts, PPO and UR regulations, provider complaints, general inquiries regarding managed care regulation
Snezana Vukina	715-8483	HMO and PPO provider contracts, PPO and UR regulations, provider complaints, general inquiries regarding managed care regulation
Cynthia Sebastian	733-9152	HMO exams and applications
Vacant	715-8601	HMO exams and applications
Lalita Wells	715-8482	HMO exams and applications
Phyllis Wyrick	715-9638	HMO exams and applications
Brian Goble	715-9637	HMO exams and applications
Renita Miller	715-5097	HMO exams and applications

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Manufactured Building - 410 N. Boylan Avenue, 27603
PHONE: 733-3901 or 800/587-2716 (consumer complaints)
FAX: 715-9693

DEPUTY COMMISSIONER: Pat Walker - pgr. 919/874-5022

SENIOR DEPUTY COMMISSIONER: Tim Bradley - 733-6008
Mary Clayton, Administrative Assistant - 733-3901

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Warranty complaints; licensing of manufactured housing manufacturers; dealers; set-up contractors and salespersons; testing; certification of modular manufacturers and third party agencies; modular complaints.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Hazel Stephenson	Office operations; complaints and hearings - pgr. 919/874-5028
David Goins	Inspections - pgr. 919/874-5024
Alan Greene	Code interpretations - pgr. 919/982-1401

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Joe Sadler	Code interpretations
Vacant	Code interpretations
Karen Holden	Complaints
Ellen Tyndall	Complaints
Avis Alston	Complaints
Deborah Watkins	Licensing
Hilda Garrett	Inspections - pgr. 919/874-5025
Jeff Britt	Inspections - pgr. 919/874-5026
Lane Pethal	Inspections - pgr. 919/874-5027
Steve Smith	Inspections - pgr. 919/874-5320
Richard Walton	Inspections - pgr. 919/874-5023
Vacant	Inspections

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Market Examinations - 111 Seaboard Avenue, 27604
PHONE: 733-0055
FAX: 715-8448

DEPUTY COMMISSIONER: Louis Belo

SENIOR DEPUTY COMMISSIONER: Barbara Morales Burke - 733-6350
Angie Brogden, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Field Examinations of market practices of property and casualty and life and health insurance companies.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Bob Peoples	Assistant Deputy Commissioner
Ernest Nickerson	Examination Supervisor - Life and Health
Ken Johnson	Examination Supervisor - Life and Health
Jerry Willis	Examination Supervisor - Property and Casualty
Fred Fuller	Examination Supervisor - Property and Casualty
Jack Bigler	Examination Supervisor - Property and Casualty

NON-SUPERVISOR'S MAJOR AREAS OF RESPONSIBILITY:

Janet Hagwood	Accounting Technician
Theresa Henderson	Technical Assistant
Joe Johnson	Senior Analyst - Property and Casualty
Jerry Polenz	Senior Analyst - Property and Casualty
Gary Jones	Senior Analyst - Property and Casualty
Reggie Heard	Senior Analyst - Property and Casualty
Bill George	Analyst - Property and Casualty
Eric Pettice	Analyst - Property and Casualty
Vicki Marshall	Senior Analyst - Life and Health
Donna Gonzales	Analyst - Life and Health
Stacey McFarlin	Analyst - Life and Health
Sandy Preston	Analyst - Life and Health

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Office of the State Fire Marshal - 111 Seaboard Avenue, 27604
PHONE: 733-2142
FAX: 733-9076

SENIOR DEPUTY COMMISSIONER: Tim Bradley - 733-6008
Mary Clayton, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Fire and rescue training, fire and rescue grants, governmental services and inspections of fire departments.

Grants/Injury Prevention/Program Development

Deb Hicks		Assistant Director
Cindy Fuller Soule		NC Safe Kids
Peggy Price		Buck Up Kids
Lauren Thompson		Grants
Judy McGhee		Receptionist
Heidi Jackson		Processing Assistant - Grants
Paul Jones	733-3901	NC Safe Kids
Debbie DaSilva	733-3901	NC Safe Kids

Program Development

Claude Shew	Fire & Rescue Training Supervisor
Vacant	Fire & Rescue Training Instructor
Christopher Best	Fire & Rescue Training Instructor
Susan Butterfield	Fire & Rescue Training Instructor
Trisha Tripp	Program Assistant

State Fire & Rescue Commission - 733-5435 or 800/634-7854
Certification programs for firefighters and rescue personnel; fire incidents

Ken Briscoe	Manager
Mike Edwards	Certification Specialist
Frank Bailey	Certification Specialist
Steve Sloan	Certification Specialist
Ellen Sullivan	Administrative Secretary
Kim Dorman	Certification Records
Taylor Mishoe	Office Assistant

(Office of the State Fire Marshal continued)

Training and Fire Department Inspections

Larry Hughes	Assistant Director/Training & Inspections
Keith McLeod	Inspections Supervisor
Herb Coffey	Fire Safety Inspector
A.C. Daniels	Fire Safety Inspection
Robert Swiger	Fire & Rescue Training Supervisor
Mike Calhoun	Fire & Rescue Training Instructor
Gene Gladin	Fire & Rescue Training Instructor
Jim Covington	Fire & Rescue Training Instructor
Greg Chatham	Fire & Rescue Training Instructor
Joe Burris	Fire & Rescue Training Instructor
Mike Williams	Fire & Rescue Training Instructor
Linda Flowers	Accounting Technician
Melissa Parrish	Inspections
Bonnie Harris	Field Training Office Assistant

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Personnel - Dobbs - Suite 4092
PHONE: 733-5578
FAX: 715-7083

PERSONNEL OFFICER: Ronnie Condrey - Ext. 227

ASSISTANT COMMISSIONER: Wake Hamrick - 733-3362
Judy Gray, Executive Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Recruitment and staffing; orientation of new employees; job classification; pay; benefits; employee relations; performance evaluations; personnel policies; safety and health; workers compensation; longevity; Employee Assistance Program; unemployment insurance.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Ronnie Condrey	Ext. 227	Employee relations: *grievances, disciplinary policy, Employee Assistance Program* (alt. Lois Hall) Establish and interpret personnel policies (alt. Lois Hall) In-range salary adjustment policy (alt. Lois Hall) Salary studies (alt. L. Hall) Telecommuting (alt. A. Breazeale)

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Lois Hall	Ext. 230	Position descriptions and classification studies (alt. R. Condrey) Salary reserves (alt. R. Condrey) Longevity: *employee eligibility* (alt. L. Howell) Span of Control (alt. R. Condrey) Overtime Laws (alt. R. Condrey)
Andrea Breazeale	Ext. 225	Education and training assistance: *policy interpretation,application/ reimbursement processing; LOMA; HIAA; etc.* (alt. S. Harrison) Training classes/ Supervisory classes: *Illegal Workplace Harassment; Interaction Management* (alt. R. Condrey) Performance Management: *policy interpretation; training; final appraisal processing* (alt. R. Condrey) Violence in the Workplace Policy (alt.R. Condrey) Leave policy: *sick days; vacation; voluntary shared leave; adverse weather; Family & Medical Leave Act, Special Olympics, Child Involvement* (alt. L. Hall) Retirement: *PREPARE* (alt. L. Hall) Disability: *short term; long term* (alt. L. Hall) Safety and Health: *evacuation plan* (alt: R. Condrey) Worker's Compensation (alt. L. Howell)

(Personnel continued)

Lisa Howell	Ext. 226	Recruitment Application for employment Applicant testing for clerical jobs Starting salaries Orientation of new employees Exit interviews (alt. R. Condrey) Wellness Program (alt. A. Breazeale) Governor's Management Internship Program Unemployment Insurance
Sue Harrison	Ext. 222	Administrative Support Employee benefits: *explanation and processing paperwork for health insurance; 401(k); Deferred comp., NC Flex, etc.* (alt. L. Howell) Vacancy listings (alt. Lisa Howell) Temporary Employees (alt L. Howell) Intranet Photos Employment verification *(for loans, etc.)* ID Photos
Ann Jackson (part-time)	Ext. 223	Administrative Support Service Awards (alt S. Harrison)
Becky Watkins (part-time)	Ext. 223	Administrative Support

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Property and Casualty - Dobbs - Suite 4036
PHONE: 733-3368
FAX: 733-4264

DIVISION HEAD: Charles Swindell - Ext. 226

SENIOR DEPUTY COMMISSIONER: Barbara Morales Burke - 733-6350
Angie Brogden, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

The Property and Casualty Division has the responsibility of reviewing policy forms, rates and rules which insurance companies wish to use for both commercial and personal lines of property and liability coverage. This division also collects surplus lines taxes.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Bernard Cox	Ext. 227	Assistant Deputy Commissioner; personal lines
Wilhelmina Muhaimin	Ext. 224	Supervisor; commercial property; workers' compensation; bonds; employee leasing
Richard Powell	Ext. 236	Supervisor; commercial casualty; inland marine; crime; aviation

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Carol Allred	Ext. 212	Deputy Commissioner's secretary; bureau licenses
Helen Best	Ext. 217	Beach/FAIR/Flood; BOP; Deviations; HO/Dwelling; auto
Donna Byrd	Ext. 211	Filing Fees
Jackie Darden	Ext. 237	Title; credit; pollution; boiler and machinery; commercial auto
Peggy Dean	Ext. 229	Surplus lines
Marie Dunn	Ext. 210	Computer expert, data entry
Kelly Rickets	Ext. 228	Animal mortality; farm/crop; medical malpractice; E&O
Nelson Whitley	Ext. 238	Prepaid legal; deviations; animal mortality; personal umbrella
Dianne Woodby	Ext. 234	Assists surplus lines; deviations

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Regulatory Actions - 401 Glenwood Avenue, 27603-1219
PHONE: 733-2205
FAX: 733-2206

DEPUTY COMMISSIONERS: Boyce Oglesby - Ext. 162 & Gene Lay - Ext. 125

SENIOR DEPUTY COMMISSIONER: Alex Spencer - Ext. 123
Lisa Zimmerman, Administrative Assistant - Ext. 135

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Administrative Supervision Division
Administrative supervision and close monitoring of potentially troubled insurance entities

Estate Operations Division
Liquidation of insolvent insurance entities

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Boyce Oglesby	Ext. 162	Administrative Supervision Division
Gene Lay	Ext. 125	Estate Operations Division & RAD Trust

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Administrative Supervision Division

Jan Andrews	Ext. 138	Regulatory Specialist
Joe Holloway	Ext. 132	Regulatory Specialist
Kathleen Grimmell	Ext. 165	Regulatory Specialist
Sara Gosnell	Ext. 127	Regulatory Specialist
Ron Sauer	Ext. 156	Regulatory Specialist

Estate Operations Division

Kevin Brown	Ext. 167	Regulatory Specialist
Vacant	Ext.	Administrative Assistant
Jatinder Sharma	Ext. 166	Regulatory Specialist
Craig Wilkey	Ext. 164	Network Administrator

RAD Trust

Sharon Holt	Ext. 120	Administrative Assistant
Wendy Forth	Ext. 143	Research Analyst
Peggy Houston	Ext. 163	Research Analyst
Ann Diggs	Ext. 126	Accounting
Kalani Parker	Ext. 130	Accounting
Paula Snell	Ext. 131	Accounting
Beverly Janssen	Ext. 0	Receptionist

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Seniors' Health Insurance Information Program (SHIIP) - 111 Seaboard Avenue
PHONE: 733-0111
FAX: 733-3682 or 1-800-443-9354

DEPUTY COMMISSIONER: Carla Obiol

SENIOR DEPUTY COMMISSIONER: Barbara Morales Burke - 733-6350
Angie Brogden, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Provides information to consumers on Medicare, Medicare supplement insurance, claims processing, Medicare HMOs, and long-term care insurance.

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Jeanie Allen	SHIIP Trainer
Stephanie Bias	Communication Specialist
Sharon Crudup	Communication Specialist
Jennifer Davis	SHIIP Trainer
Lisa Gibson	SHIIP Trainer
Kristie Melvin	Outreach Coordinator
Barbara Pope	SHIIP Trainer
Mae Tomlinson	Receptionist
Rhonda Watson	Office Manager
Diana Weber	SHIIP Trainer

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Special Services - Dobbs - Suite 3140
PHONE: 733-2200
FAX: 715-1156

DEPUTY COMMISSIONER: Fred Mohn - 715-5305

SENIOR DEPUTY COMMISSIONER: Angela Ford - 733-4935
Latane Williams, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

The licensing and the investigation of bail bondsmen, bail bond runners, surety bondsmen; insurance premium finance companies; collection agencies; and motor clubs.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Nancy Renn	715-5315	Governmental Accounts Auditor and Office Manager
John Brim	715-5318	Field Supervisor, Criminal Investigations Unit

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Dick Barnes	733-2200	Governmental Accounts Auditor
Jimmy Coleman	733-2200	Motor Club Administrator; applications; licenses
Kim Lazenby	715-5313	Bail bondsmen's security; process all fees; administrative assistant
Ernestine McKenney	733-2200	Receptionist; mail; staff support
Lisa Runkal	733-2200	Staff support
Robin Williams	715-5306	Processing assistant; staff support
Karen Wells	715-5319	Bail bondsmen's applications; licenses; continuing education; staff support

Investigators

Terry Abney	Twyla Covington
Darrell Jernigan	Roy McBride, Jr,
Joe Marks	Larry Reeves
Lewis Sasser	Allen Surratt

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: State Property Fire Insurance Fund - 410 N. Boylan Avenue, 27603
PHONE: 733-3901
FAX: 733-9171

DEPUTY COMMISSIONER: Jim Roberts

SENIOR DEPUTY COMMISSIONER: Tim Bradley - 733-6008
Mary Clayton, Administrative Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

(1) Insure all State-owned property
(2) Review and approve plans for all new and renovated State buildings
(3) Consult on State Building Code and National Fire Codes *
(4) Fire protection systems engineering and acceptance testing *
(5) Risk management consulting for State agencies & local governments
(6) Public Officers and Employee Liability Insurance Commission (POELIC)
(7) Inspect all State facilities annually for fire and life safety

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY:

Jim Roberts	State facility inspection inquiries; construction plan review issues
Jack Cooke	State property insurance matters

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Dean Andrews	Field Inspector
Richard Bolyard	Claims and loss control questions, loss reporting
Julia Brown	State property insurance billing; loss reporting
Mae Dalton	State property insurance values; loss reporting
Susan Gentry	Building Code questions and plan review
Howard Gerringer	Building Code questions and plan review
Kenneth Houglan	Field Inspector
Pat Howell	Status of inspections of state property
David McCracken	Field Inspector
Michael McCrain	Field Inspector
Joe Rippard	Risk management consulting and POELIC
Edward Strickland	Field Inspector
Bob Thompson	Fire protection and electrical systems
Eric Tjalma	Building Code questions and plan review
Jean Williams	Status of plan reviews for state property
Jim Yancey	Fire protection and electrical systems

* NOTE: Questions <u>not</u> involving State-owned facilities should be directed to the Engineering Division.

DIVISION DIRECTORY
"Who Does What"

February 1999

DIVISION: Western Regional Office, PO Box 1688, Asheville, NC 28802
PHONE: (828) 251-6483
FAX: (828) 251-6124

DEPUTY COMMISSIONER: Charles "Skeeter" Curtis

CHIEF DEPUTY COMMISSIONER: Dascheil Propes - 733-0433
Judy Gray, Executive Assistant

DIVISION'S MAJOR AREAS OF RESPONSIBILITY:

Serving 29 Westernmost counties for consumer complaints, agent inquiries and hearings on manufactured housing; State Building Code; Fire & Rescue (including delivery of Volunteer Fire Fund & EMS grant checks); SHIIP; link between Raleigh office and the west; Commissioner's liaison with county/local government officials, WNC legislators, regulated entities and civic groups.

SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Skeeter Curtis	Formulation and interpretation of policies; interaction management; field contacts with consumers; regulated entities; county and municipal officials and civic groups.

NON-SUPERVISORS' MAJOR AREAS OF RESPONSIBILITY

Joan Creasman	Assistant Deputy Commissioner; office management; consumer complaints; agent inquiries; initial contact on Manufactured Housing; Fire & Rescue; State Building Code; SHIIP; support for supervisor.
Jim Francis	Receptionist; communications specialist

Buckle Up Kids *for life!*

Our Commitment to Safety

Your North Carolina Department of Insurance is committed to highway safety and injury prevention. Trauma from motor vehicle crashes is the leading cause of death and serious injury to children ages one and older in North Carolina.

Studies have shown that child safety seats ***do*** save lives, but only if they are used ***correctly***. North Carolina's Buckle Up Kids Program was created to enhance the prevention efforts of rescue providers throughout the state and is funded, in part, by the Governor's Highway Safety Program.

The Fire and Rescue Division of the Department of Insurance serves as a focal point for fire and rescue activities in our state. Our staff works closely with fire and rescue departments in promoting injury prevention programs in local communities. These programs also assist in reducing the high medical and associated insurance costs our citizens pay.

Only 70% of drivers properly restrain children, and 20-30% of those drivers grossly misuse child restraint systems.

Education Saves Lives

The goal of the Buckle Up Kids program is to save lives and help reduce serious injuries to children by implementing child passenger safety programs in all 100 counties.

Nationally, approximately 1,400 children ages 14 and under are killed each year and an estimated 269,000 are injured as passengers in motor vehicles. The correct use of child safety seats is extremely effective, reducing the risk of death by 71 percent, hospitalizations by 67 percent, and minor injuries by 50 percent.

Which Seats to Use

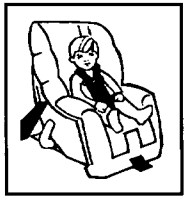
North Carolina law requires children under age four to be secured in a child safety seat. Children between age 4 and 12 must wear seat belts.

However, the law is a ***minimum*** standard. Proper restraints are determined by a child's ***weight***, not age. Buckle Up Kids' extensive training educates professionals who in turn help those who transport children (parents, caretakers, teenagers, baby-sitters, etc.) to understand what safety experts recommend.



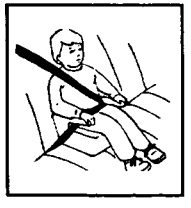
Infant Safety Seats

- For children up to 20 lbs. and about one year old.
- Always ride rear facing.
- Rear-facing child safety seats ***must not*** be placed in a front seat with a passenger-side air bag.
- Always follow manufacturer's instructions.



Convertible Child Safety Seats

- For infants and children up to 40 lbs.
- For infants, recline and rear-facing.
- Rear-facing child safety seats ***must not*** be placed in a seat with a passenger-side air bag.
- For toddlers, upright and forward facing.
- Always follow manufacturer's instructions.



Booster Seats

- For children who have outgrown convertible seats but are too small for seat belts to fit properly (40 lbs. until the seat belt fits properly).
- Always follow manufacturer's instructions for use with shoulder harness or with lap belt only.

Safety Checklist ☑

Is the seat or child positioned in the rear seat?

☑ **Yes** ☐ No

The rear seat is generally much safer than the front seat in a crash and is recommended for all children. The center-rear is the safest position in the vehicle. ***Never put a rear-facing child seat in the front seat of a car with a passenger-side airbag.***

Does the safety seat have a label that identifies manufacturer, model name and number, and date of manufacture?

☑ **Yes** ☐ No

If no, do not use the safety seat. Without the label, you will not know for sure if it is safe to use.

Is the safety seat tightly secured with a seat belt?

☑ **Yes** ☐ No

If no, the seat and child will fly around or out of the car in a crash. A "locking clip" may be needed to insure tightness.

If the infant is under 20 lbs, is he/she facing the

☑ **Yes** ☐ No

In the event of a crash, the back of the safety receive most of the force. The back of a rear-fa needs to be at a 45 degree angle.

Is the harness in good condition and being used

☑ **Yes** ☐ No

Harnesses need to come up from below the sho come through the lowest slots, for the rear-fac If in a front-facing position, the harness usual moved to the upper harness slots.

For more information about safety seats

1-800-634-7854

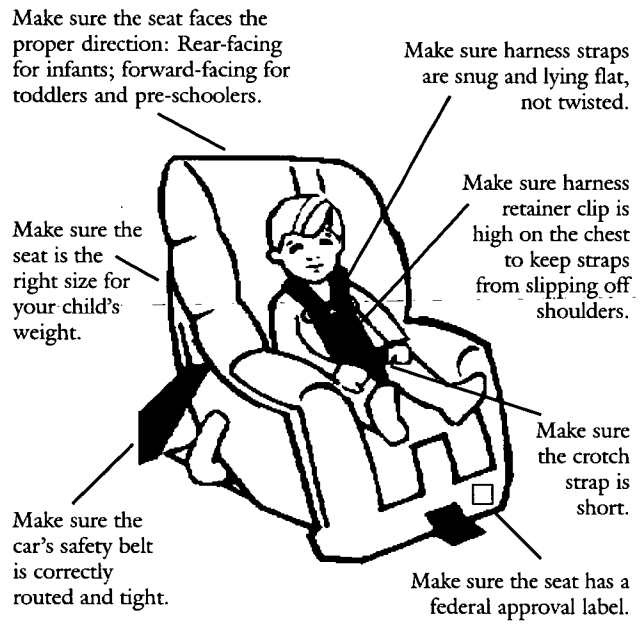
Attachment IV

North Carolina's Child Safety Seat Law

- Children under age 4 must ride in a child safety seat that meets federal motor vehicle safety standards at time of manufacture.
- Children under age 12 must ride in a restraint system (seat belt or child safety seat) in both the front or back seats.
- Law applies to all passenger vehicles with both in-state and out-of-state registration.
- Driver is held responsible for proper restraint of children.
- Fine is $25, plus court costs.

Safety seats protect children from death and injury in crashes, but only if they're used correctly - be sure to follow the manufacturer's instructions on every ride.

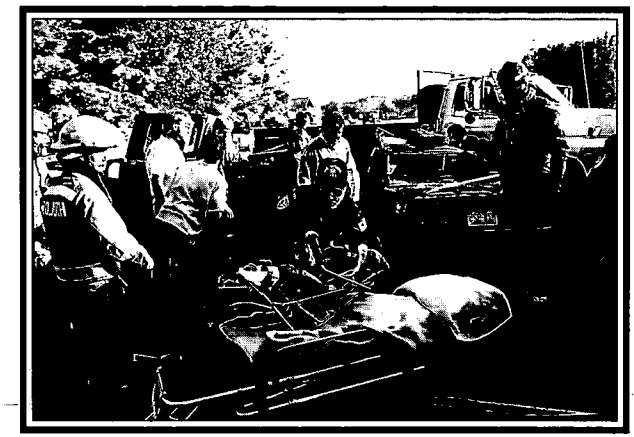
Do it right.
Your child's life is in your hands!



Buckle Up Kids Program
North Carolina Department of Insurance
Fire and Rescue Services Division
PO Box 26387, Raleigh, NC 27611
Phone: 919-733-2142
Fax: 919-733-9076
Toll-Free 1-800-634-7854

The NC Department of Insurance printed 5,000 copies of this publication at a cost of $0.11 per copy.

There's only *one* way to use a child safety seat . . .



Correctly!

This child survived a fatal wreck, suffering only scratches and bruises, because he was secured by a safety seat in the back of the car. The driver was killed when the car was struck by a pick-up truck.

Buckle Up Kids *for life!*

NORTH CAROLINA SAFE DRIVER INCENTIVE PLAN

The North Carolina Safe Driver Incentive Plan (SDIP) was enacted by the General Assembly to reward safe drivers with the lowest possible insurance rates. Drivers who are convicted of moving traffic violations and/or cause accidents will be charged higher premiums in accordance with their driving records.

SDIP points are charged as follows for convictions and at-fault accidents occurring during the **Experience Period:**

12 Manslaughter or Negligent Homicide
Prearranged Highway Racing or Lending a Car for Prearranged Highway Racing
Hit-and-Run — Bodily Injury or Death
Driving with Blood-Alcohol Level .08 or More
Driving a Commercial Vehicle with Blood-Alcohol Level .04 or More
Driving While Impaired
Transporting Illegal Intoxicating Liquor for Sale

10 Highway Racing or Lending a Car for Highway Racing
Speeding to Elude Arrest

8 Driving During Revocation or Suspension of License or Registration

4 Reckless Driving
Hit-and-Run — Property Damage Only
Passing a Stopped School Bus
Speeding in Excess of 75 mph when the Speed Limit is Less than 70 mph
Speeding in Excess of 80 mph when the Speed Limit is 70 mph or Greater
Driving by a Person Less than Age 21 after Consuming Alcohol or Drugs

3 At-Fault Accident that Occurs *Before January 1, 1998*, Resulting in Death, or Bodily Injury*, or Property Damage Only of $2,000 or More
At-Fault Accident that Occurs *On or After January 1, 1998*, Resulting in Death, or Bodily Injury* in Excess of $1,500, or Property Damage of $2,500 or More**

2 Illegal Passing
Following Too Closely
Driving on Wrong Side of Road
At-Fault Accident that Occurs *Before January 1, 1998*, Resulting in Property Damage in Excess of $1,000, but less than $2,000
At-Fault Accident that Occurs *On or After January 1, 1998*, Resulting in Property Damage in Excess of $1,500, but less than $2,500**
Speeding More than 10 mph Over the Speed Limit Provided the Total Speed is in Excess of 55 mph, but less than 76 mph
Speeding 10 mph or Less in Excess of Speed Limit in a Speed Zone of 55 mph or Greater

1 All Other Moving Violations
At-Fault Accident That Occurs *Before January 1, 1998*, Resulting in Property Damage Only of $1,000 or less
At-Fault Accident That Occurs *On or After January 1, 1998*, Resulting in Bodily Injury* of $1,500 or less, or Property Damage of $1,500 or Less**
Speeding 10 mph or Less in Excess of Speed Limit of Less than 55 mph

Revision 1/98

Special Exemptions

No SDIP points will be charged for:

An accident provided:

- there is property damage only
- amount of damage is $1,000 or less ($1,500 or less if accident occurs on or after January 1, 1998)
- there is no conviction for a moving violation in connection with the accident; and
- no licensed operators in the household have convictions or at-fault accidents during the experience period.
- An insurance company may require that the insured be covered by that company for six continuous months.

Speeding 10 mph or less over the posted speed limit; provided:

- the violation did not occur in a school zone;
- there is not another moving traffic violation for the experience period (an isolated Prayer for Judgment Continued (PJC) will not count as a prior conviction for the purpose of this exception).

One PJC for each household every three years; however:

- a second PJC may cause points to be charged according to the underlying convictions.

$ INSURANCE POINTS WILL COST YOU MONEY! $

POINTS	% RATE	COST IF BASIC RATE IS $300	POINTS	% RATE	COST IF BASIC RATE IS $300
1	25%	$375	7	180%	$840
2	45%	$435	8	220%	$960
3	65%	$495	9	260%	$1,080
4	90%	$570	10	300%	$1,200
5	120%	$660	11	350%	$1,350
6	150%	$750	12	400%	$1,500

Experience Period — The three years immediately preceding the date of application or the preparation of the renewal.

* *No SDIP points will apply for Bodily Injury if the insured furnishes proof that costs were solely for diagnostic purposes.*

** *The greatest number of points will be applied for at-fault accidents resulting in Property Damage and Death or Bodily Injury*

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SAFETY FIRST!

A message from
Insurance Commissioner Jim Long

In 1996, impaired drivers killed 460 North Carolinians. That's more than a person per day. It's time for the killing to stop.

In November 1994, state and law enforcement leaders announced the start of the *Booze It & Lose It* campaign; a statewide crackdown on drunk driving in North Carolina.This initiative of the Governor's Highway Safety Program includes annual sobriety checkpoints in all 100 counties. People who drive while impaired in North Carolina *will* be caught and *will* lose their licenses *on the spot.*

According to estimates from the NC Department of Transportation, drunk drivers cost North Carolina taxpayers nearly *$1 billion* in health care, insurance and other related costs each year. That translates to a cost of about $214 a year for *each* licensed driver in the state.

The high price of a DWI conviction should make people think twice before drinking and driving. Besides losing driving privileges, a DWI conviction is time-consuming and expensive. The tab can run as high as *$6,000* for the first DWI offense. Insurance rates alone jump at least *400 percent* if you are convicted.

Last year, in just one week, *Booze It & Lose It* personnel staffed 734 checkpoints statewide, arresting 1,423 people for driving while impaired. In addition, 11 fugitives were apprehended and 331 drivers were cited on drug charges.

We know that traffic enforcement programs save lives and prevent injuries. Each year in North Carolina, more than 11,000 alcohol-related traffic crashes take their toll in death and injury. Fewer deaths and injuries also mean that taxpayers and insurance consumers will pay less to absorb the health and medical costs that are caused by drunk drivers.

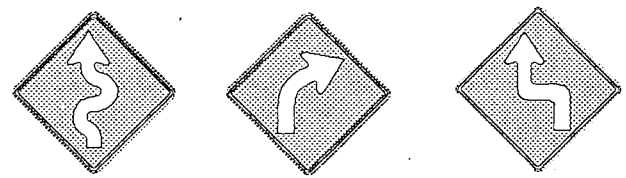
If you drink, call a cab or appoint a designated driver, but *don't drink and drive!* You could save your driving privileges and possibly your life.

BOOZE IT & LOSE IT.



North Carolina
Governor's Highway Safety Initiative

10,000 copies of this public document were printed at
a cost of $578.00 or $.0.0578 per copy. 98-14414

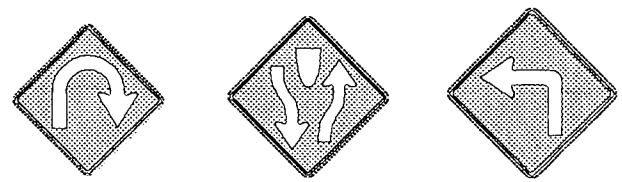


IT PAYS TO BE A SAFE DRIVER



Jim Long, Insurance Commissioner

North Carolina
Department of Insurance



If You Have an Automobile Accident

If you are involved in an automobile accident and someone is injured, contact 911 or an emergency service. While waiting for help, try to make the injured person as comfortable as possible without moving him or her.

If an accident results in more than $1,000 property damage, injury or death you are required by law to notify the police.

However, it is a good idea to notify the police following all accidents. The police will complete a form known as an Accident Report. This report will contain a description of the accident and a diagram of the locations of all cars involved in the accident. This report may be helpful to the adjuster handling your claim.

Filing a Claim

Notify your agent or company promptly as to how, when and where the accident or loss occurred. Provide the names and addresses of the other driver involved, any injured persons, and any witnesses.

Liability Claim - Who was at fault?

The insurance adjuster will be investigating the accident to determine who was negligent. Remember, the automobile liability insurance policy promises to pay for bodily injury or property damage for which the insured becomes **legally responsible** due to negligence.

However, if the other driver is deemed to be partially at fault (contributory negligence), North Carolina law bars that driver from collecting for his damages. Also, if it is determined that you contributed to the accident, you will not be able to collect from the other person's liability coverage. If contributory negligence is determined on your part your insurance rates will be affected if the total damage to both cars exceeds $1,500 or if there is bodily injury.

Damage to your Auto Claim

Who was at fault is not an issue on these type claims, except to determine if your insurance company will subrogate the negligent driver (ask for reimbursement of the money it pays out plus your deductible). Oftentimes, especially if there is some question of negligence, it may be more expedient to present the claim to your own collision insurance company and let it handle the claim for you.

Automobile Insurance Coverages

Liability

Mandatory

In North Carolina, the Financial Responsibility Laws require that **Liability** coverage be maintained. The minimum coverage requirements include $25,000 bodily injury for each person; $50,000 total bodily injury for all persons in an accident; and $15,000 for property damage. This coverage will pay up to policy limits for injury, death and/or property damage which you cause to the **other** person as a result of an automobile accident. Liability coverage will not pay for damages to your vehicle or for injuries that the driver of your vehicle sustains.

Collision/Other Than Collision

Voluntary

Collision coverage will pay for damages to your vehicle that arise from its upset or impact with another vehicle or object.

Other Than Collision (Comprehensive) coverage handles damages arising from falling objects, fire, theft, hail, glass breakage, contact with animals, etc.

Collision and Other Than Collision coverage is usually purchased with a deductible of $100, $250, or higher which is deducted from the amount the company owes you. Remember, this coverage is optional and not required by law. However, it may be required by your lending institution or lessor.

Medical Payments

Voluntary

Medical Payments coverage pays reasonable expenses ***incurred*** for necessary medical and funeral services. This coverage will pay for expenses that are incurred within three years from the date of the accident. Medical Payments coverage applies to you and any occupants of your vehicle who may be injured. This coverage also applies to you and family members, who are residents of your household, that are injured in any other vehicle or struck by a vehicle while a pedestrian.

Uninsured/Underinsured Motorist

Voluntary

Uninsured Motorist coverage pays if you are injured by a hit-and-run vehicle, or a vehicle that does not have liability insurance. It also covers damages to your property caused by an uninsured motorist.

Underinsured Motorist coverage is also available to provide additional bodily injury coverage to you and the occupants of your vehicle in case the at-fault vehicle is inadequately insured. Inadequately insured means that the at-fault vehicle has liability limits which are lower than the value of your bodily injury claim.

Uninsured and Underinsured Motorist coverage may be purchased in limits up to $1 million. If a policy holder does not desire this coverage, it must be rejected in writing.

Additional Coverages

The aforementioned represent the primary and basic coverages provided in a Personal Automobile Insurance Policy. However, there are additional coverages that can be purchased by endorsement and for an additional premium, such as

- Extended Transportation Expenses Coverage
- Towing and Labor Costs Coverage
- Rented Vehicles Coverage

You should check with your agent about these and other coverages that you might need.

Obtain the following information *BEFORE* leaving the scene of the accident:

- ⇨ The names, addresses and phone numbers of everyone involved
- ⇨ The other motorist's drivers license number
- ⇨ The name, address, telephone number of the owner of the other car especially if it is different from the driver
- ⇨ The year, make, model, and license tag of the other car
- ⇨ The other motorist's insurance company and policy number
- ⇨ The names and addresses of anyone who might have seen the accident happen

A Message from Insurance Commissioner Jim Long



It is the responsibility of the North Carolina Department of Insurance to keep consumers informed. Insurance is a complex issue and it is my hope that the information provided here will be useful in helping you better understand automobile insurance coverage, how to file a claim, and what is involved with settling your claim.

We are very proud of the services our department provides to the citizens of North Carolina. Our Consumer Services Office will be happy to answer any questions you may still have.

Please contact the Consumer Services Office if you need additional information:

North Carolina Department of Insurance
430 North Salisbury Street
PO Box 26387
Raleigh, NC 27611
1-800-546-5664 • 919-733-2032

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Guide to AUTOMOBILE COVERAGES AND CLAIMS

Jim Long, Insurance Commissioner

North Carolina Department of Insurance

Your Insurance Department

The Department of Insurance performs a variety of functions that affect the lives of North Carolinians in a number of ways. The commissioner and department:

- License and regulate insurance companies, agents, brokers and claims adjusters.
- Oversee the operations of insurance companies to help assure financial health
- Regulate premium rates insurance companies may charge and the policy forms they may use in providing coverage
- Provide information and assistance to insurance consumers
- Prohibit unfair and deceptive trade practices in the business of insurance
- Train volunteer counselors to assist senior citizens in the areas of Medicare, Medicare supplement and long-term care insurance
- Help businesses and individuals find needed insurance coverage
- Administer the state building code and ensure handicapped accessibility
- Train our state's fire and rescue personnel

Regulatory/Public Services Group

The **Agent Services Division** regulates and issues licenses for insurance agents, adjusters, brokers and appraisers, reviews applications for and oversees licensing examinations, and maintains a file on every licensed individual doing business in the state of North Carolina.

The **Consumer Services Division** helps North Carolina consumers get answers to their insurance questions and resolve their insurance problems. A large staff of consumer specialists advise and acquaint consumers with courses of action they may pursue to solve their particular problems.

The **Special Services Division** is responsible for licensing and investigating complaints related to insurance premium finance companies, professional bail bondsmen and runners, collection agencies and motor clubs.

The **Investigations Division** is responsible for investigating criminal violations of North Carolina's insurance laws. Requests for investigations come from within the department, consumers, law enforcement agencies, local, state and federal agencies and insurance companies.

Company Services Group

The **Financial Evaluation Division** monitors the solvency of insurance companies; reviews for admission out-of-state, domestic, and surplus lines companies seeking to do business in the state; and audits domestic and foreign insurance organizations.

The **Actuarial Services Division** assists in the review of rate, form, and statistical filings. The division also conducts actuarial studies for financial evaluation work and is involved in special projects and studies.

The **Information Systems Division** manages the department's information technology resources, which include data processing, word processing, office automation, data communications and voice communications.

The **Regulatory Actions Division** closely monitors the financial condition and operations of domestic insurance companies to determine whether a troubled entity can be prevented from going into formal delinquency proceedings by returning the insurer to sound financial condition and good business practices.

Technical Services Group

The **Property and Casualty Division** reviews homeowners, automobile, workers' compensation and other personal, commercial property or casualty insurance policies, rates and rules. The division also licenses rating, advisory and underwriting organizations.

The primary responsibility of the **Life and Health Division** is the review of rate, rule and policy form filings made by life and health insurance companies. The division also administers life replacement regulations.

The **Market Examinations Division** monitors insurance companies' behavior in the marketplace, especially as it affects consumers. The division conducts field examinations of the market practices of domestic and foreign insurers and their representatives.

The **Managed Care and Health Benefits Division** monitors and regulates the activities of health maintenance organizations, preferred provider organizations, utilization review organizations, multiple employer welfare arrangements, and third-party administrators.

The **Seniors' Health Insurance Information Program** has trained thousands of adults in every North Carolina county to counsel other older adults in the areas of Medicare regulations, Medicare supplement insurance, long-term care insurance and claims procedures.

Safety Services Group

The **Engineering Division** administers the state building code. Providing staff to the N.C. Building Code Council and the N.C. Code Official Qualifications Board, the division is comprised of seven sections: code consultant, electrical, mechanical, modular, inspector certification, building code council and handicapped accessibility.

The **Manufactured Building Division** works to assure that construction standards for manufactured homes are maintained and that warranty obligations under state law are met. The division monitors handling of consumer complaints, licenses the makers of manufactured homes, dealers, sales representatives and setup contractors, and acts as staff for the N.C. Manufactured Housing Board.

The **State Property Fire Insurance Fund** administers the self-insurance fund for state-owned property and vehicles, and assists local governments with property and casualty insurance programs. This program also makes available professional liability coverages for law enforcement officers, public officials and employees of any political subdivision of the state. This section also provides staff, administration, and research services to the Public Officers and Employees Liability Insurance Commission (POELIC).

The **Fire and Rescue Services Division** administers the Firemen's Relief Fund, trains fire departments and rescue squads and works to improve fire and rescue protection. The division also administers matching dollar-for-dollar grants to volunteer fire departments and rescue squads and offers fire prevention education in the public schools. This section also provides staff, administration, and research services to the Fire and Rescue Commission.

Special Programs and Services

Market Assistance Program

Begun in 1986 as a result of an availability crisis in commerical liability coverages, the MAP program, which is housed in the Consumer Services Division, helps individuals and businesses find needed insurance.

Regional Offices

The department's offices in New Bern and Asheville bring the full range of department services closer to the people of North Carolina. Each year these offices assist more than 25,000 North Carolinians.

Message from the Commissioner



Here at the North Carolina Department of Insurance, we're very proud to provide our fellow North Carolinians with a wide range of services.

Our jobs include essential services like regulating insurance coverages, training firefighters, and interpreting the state building code.

Every day millions of our citizens are touched in some way by what we do. I hope this brochure will help us serve you in new and even better ways.

Jim Long
Commissioner of Insurance
State Fire Marshal

Department of Insurance

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P.O. Box 26387 • Raleigh, NC 27611
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Seniors' Health Insurance Program	733-0111
SHIIP Toll-Free Number	(800) 443-9354
Actuarial Services	733-3284
Agent Services	733-7487
Agent Continuing Education	(800)931-7111
Assistant Commissioner	733-0433
Budget Officer	733-3352
Chief Deputy Commissioner	733-3362
Chief Legislative Counsel	733-4529
Commissioner Jim Long	733-7349
Company Admissions	733-5633
Engineering	733-3901
Field Audit	733-5631
Financial Compliance	733-5633
Financial Evaluation	733-5633
Fire and Rescue Services	733-2142
General Counsel	715-0011
Investigations	733-7434
Life and Health	733-5060
Managed Care and Health Benefits	715-0526
Manufactured Building	733-3901
Market Examinations	733-0055
Personnel	733-5578
Public Information	733-5238
Property and Casualty	733-3368
Regulatory Actions	733-2205
Special Services	733-2200
State Property Fire Fund	733-3901
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Asheville Fax	(704) 251-6124

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YOUR North Carolina Department of Insurance



Jim Long Commissioner

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 11, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 11, 1999, at 12:00 noon. Representative Hurley presided. Members present were: Barbee, Boyd-McIntyre, Brubaker, Cole, Dedmon, Dockham, Esposito, Grady, Holmes, Howard, Miller, Redwine, Saunders, Smith, Wainwright, Warner, Wilson, and Wright. A list of visitors attending is attached. (Attachment I).

Chairman Hurley called the meeting to order at 12:00 noon; introduced the pages, and the following bills were considered:

House Bill 165, entitled, AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS was before the committee for consideration (bill summaries attached). Representative Redwine, sponsor, was recognized to explain the bill. Sections 1 through 4 of the bill would restore the authority of the Commissioner of Insurance to create risk-sharing plans or require insurance companies to prepare such plans to jointly provide insurance when coverage in the market is not readily available and the Commissioner finds that it is in the public interest to make it available. The insurance mechanism established under these plans is known as a joint underwriting association (JUA). The bill was recommended by the Legislative Research Study Commission on Insurance Issues. This basically came from the problem generated in part by the difficulty in homeowner's insurance availability on the beaches and coastal communities. The authority to require JUA's was first given to the Commissioner of Insurance in 1986 as a means to address problems businesses were having in finding liability insurance. However, the JUA authority can also be used for many other types of insurance with the exception of life or health insurance. This authority has been set to expire every two years so the General Assembly can review it before deciding to renew. The bill was authorized until last year. Under the JUA authority if the Commissioner finds, after a public hearing, there is insurance coverage not readily available in a voluntary market, and the public interest requires this be made available, he can order insurers to form a JUA to underwrite all eligible risks that no individual insurer is willing to voluntarily insure. There are safeguards. The hearing must be conducted pursuant to the Administrative Procedures Act, and two legislative committees – Gov. Ops. and the APA Oversight Committee. If the Commissioner adopts this plan after the hearing a copy must be provided to these committees. The Commissioner's JUA authority would expire July 1, 2001, unless renewed again before then. Section 5 and 6 rewrite the immunity clauses under the Beach and FAIR Plans. The immunity clauses would protect the Beach and FAIR Plan employees, their agents, the Department of Insurance, and insurance companies from liability for good faith actions taken in carrying out their duties in the

FAIR and Beach Plans. Section 7 would delete a reference in the Beach Plan laws under the Beach Plan Association's duties with respect to "essential property insurance". The plan offers more than just essential property insurance; thus, this conforming change is needed.

Linwood Jones indicated that although the bill summary sounds as if there cannot be any insurance companies writing this type of insurance to form a JUA , in general, if the Commissioner determines you just cannot obtain this insurance in the marketplace and he finds it is in the public interest to require a JUA, the steps to form a JUA can be taken.

Representative Holmes asked if any legislation was previously introduced to extend this authority. Representative Redwine responded by indicating that it was introduced and passed in the Senate, but the House Insurance Committee did not pass same. Linwood Jones indicated SB 843 was passed by the Senate, but no conference report came from the House for other reasons. He was advised SB 843 contained a lot of different issues, not just JUA's. The other bill was never discussed in the House.

Representative Dockham asked if this would give the Commissioner the right to form a JUA for any type of insurance. Representative Redwine indicated yes, other than life and health. Representative Dockham asked for a good definition of public interest. Bill Hale indicated the bill was giving back something that had been on the books for a number of years and had nothing to do with affordability. If the JUA were formed, the rates would have to be actuarially sound. The bill deals purely with the availability of insurance if not readily available. Public interest would be on a case to case basis – no real definition. This law has never been used. It facilitated the marketplace to work better.

Representative Holmes indicated he understood this would not be effective if there was a market. Representative Redwine indicated there does not have to be a complete non-availability situation. Bill Hale indicated the term not readily available applies. This law can apply statewide or in any part of the state where the coverage is not readily available.

Representative Esposito asked if the General Assembly would be giving the authority to the Commissioner of Insurance to tell insurance companies they will do this. Representative Redwine indicated theoretically yes, after the proper steps were taken. Bill Hale indicated the Commissioner's decision would not necessarily be the final decision. The court or General Assembly could overturn the decision.

Representative Wainwright indicated he previously introduced a bill pertaining to windstorm and hail damage, the Commissioner indicated you could not make the insurance company write any coverage. Would this bill give the Commissioner the authority to make insurance companies provide this coverage? Representative Redwine indicated yes, if all the steps are taken and approved. Bill Hale indicated without this type of law, companies cannot be forced to write coverage.

Representative Redwine questioned if the bill is really needed – he does not want it to be an intimidation tool. Representative Redwine indicated it is a tool, not an intimidation tool.

Chairman Hurley recognized Alan Miles with the American Insurance Association, which represents 250 companies, who addressed the committee. The members of this association oppose the bill primarily sections 1 through 4. Do not feel this is an answer to the problems at the cost, already a JUA in place at the beach and coastal counties. The association is part of a committee the Commissioner of Insurance has established to try to find potential solutions. JUA's would be a drastic measure. Would be a way of forcing companies to pay losses where they had not collected a premium or written a policy. Feel it should remain in the province of the General Assembly.

Representative Holmes asked how a company would have to pay losses for a policy it had not written. Mr. Miles indicated the JUA could assess every company in NC who writes policies to pay part of the losses. Representative Redwine indicated that is the way the Beach Plan works now. There is a guarantee fund available.

Representative Wilson asked how much was assessed for the lack of money the industry had. Bill Hale indicated had the insurance companies retained the profit they had made in collecting premiums over the past 25 years, they would not have had to be assessed anything. Since the profits were not held in reserve, between three storms it was $240 million dollars.

Representative Miller indicated he felt the committee was not comfortable with all that was said during the meeting, and made a motion that a sub-committee be formed to further study the bill and report back to the committee. The motion carried. Chairman Hurley will appoint a sub-committee.

House Bill 193, entitled, AN ACT TO ALLOW PERSONS TO OBTAIN HOMEOWNERS' INSURANCE WITHOUT PURCHASING COVERAGE FOR STRUCTURES OTHER THAN RESIDENTIAL DWELLINGS was before the committee for consideration (bill summary attached). Representative Preston, sponsor, was recognized to explain the bill. A constituent feels his homeowner's policy as it now exists overinsures his property since he does not have other structures. Feels neighbors with other structures are paying the same policy price he is, and he does not have additional structures. This bill would require insurance companies that sell homeowners insurance to make the "other structures" coverage under the homeowner's insurance policy optional. After some discussion, Representative Wilson made a motion that this bill be referred to a sub-committee. Motion was accepted. Representative Saunders indicated he opposed sending this bill to a sub-committee. Representative Wilson withdrew her motion to refer HB 193 to a sub-committee. Representative Saunders made a motion that the bill be given an unfavorable report. The motion carried.

There being no further business, the Chair adjourned the meeting at 12:42 p.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

Attachment I

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

March 11, 1999 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY AND ADDRESS
1.	[redacted] Alan Miles	Bailey & Dixon LLP
2.	Bob Price	Jordan Price Wall
3.	John McMillan	Maupin, Fulton & Spence
	Lisa Piercy	NC Life Underwriters
	Susan Valaurie	Nationwide
	Jack Cummings	Nationwide
	Robert PASchal	Young, Moore & Henderson, P.A.
	Stephanie Mansur	NC Assoc. of Realtors
	Mike Caputo	NCIBA
	Rebecca McGhee	Smith Anderson
	Jenny Fullbright	Hunton & Williams
	Carol Williams	NCMBA
	[illegible]	NCAIP
	Janice Peters	NAIFA-NC
	Barrett Brewer	Capital Strategies
	H.D. Reaves Jr	Home Federal S&L, Fayetteville
	[illegible]	Progress Energy & Carolina Pow. & Light Co.
	[illegible]	Bode Call & Stroupe
	Chris Valaurie	N.C. Bankers Assn
	Lisa Lewis	[illegible]
	Jim Blackburn	County Commissioners Assoc.
	[illegible]	Insurance Dept
	Dasheil Propes	"
	Jean Preston	Asst Sgt Rep - (Vice Sponsor)
	A. Salij	BUS. Journal
	[illegible]	Retired
	[illegible]	Moore & Van Allen
	[illegible]	[illegible]

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 165

Short Title: JUA Reauthorization. (Public)

Sponsors: Representatives Redwine; and Hill.

Referred to: Insurance.

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS.

The General Assembly of North Carolina enacts:

Section 1. Article 42 of Chapter 58 of the General Statutes, which expired July 1, 1997, is reenacted.

Section 2. G.S. 58-42-1, as reenacted in Section 1 of this act, 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,~~ Article 3A of Chapter 150B of the General Statutes, 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 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 approval."

Section 3. G.S. 58-42-45, as reenacted by Section 1 of this act, reads as rewritten:

"**§ 58-42-45. Article ~~not~~ subject to Administrative Procedure ~~Act.~~ Act; legislative oversight of plans.**

(a) The provisions of Chapter 150B of the General Statutes shall ~~not~~ apply to this ~~Article, except that G.S. 150B-39 and G.S. 150B-41 apply to hearings conducted under G.S. 58-42-1.~~ Article.

(b) At the same time the Commissioner issues a notice of hearing under G.S. 150B-38, the Commissioner shall provide copies of the notice to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations. The Commissioner shall provide the Committee and Commission with copies of any plan promulgated by or approved by the Commissioner under G.S. 58-42-1(1) or (2)."

Section 4. G.S. 58-42-55, as reenacted in Section 1 of this act, reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article shall expire on July 1, ~~1997.~~ 2001."

Section 5. G.S. 58-45-60 reads as rewritten:

"**§ 58-45-60. Association and Commissioner immune from liability.**

There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner or any of his staff, the Association or its agents or employees, or against any participating insurer, for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the Association, or at any administrative hearings conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 6. G.S. 58-46-35 reads as rewritten:

"**§ 58-46-35. Reports of inspection made available; immunity from liability.**

All reports of inspection performed by or on behalf of the association shall be made available to the members of the association, applicants and the Commissioner. There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner, any of his staff, the association or any of its agents or employees, or against any participating insurer for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the association, or at any administrative hearing conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 7. G.S. 58-45-15 reads as rewritten:

"**§ 58-45-15. Powers and duties of Association.**

The Association shall, pursuant to the provisions of this Article and the plan of operation, and with respect to ~~essential property insurance on insurable property,~~ the insurance coverages authorized in this Article, have the power on behalf of its members:

(1) To cause to be issued policies of insurance to applicants;

(2) To assume reinsurance from its members;
(3) To cede reinsurance to its members and to purchase reinsurance in behalf of its members."

Section 8. 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 9. This act is effective when it becomes law.

North Carolina General Assembly
Legislative Services Office

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March 9, 1999

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Counsel

RE: House Bill 165 (JUA Reauthorization)

Sections 1 through 4 of the bill restore the authority of the Commissioner of Insurance to create risk-sharing plans or require insurance companies to prepare such plans to jointly provide insurance when coverage in the market is not readily available and the Commissioner finds that it is in the public interest to make it available. The insurance mechanism established under these plans is also known as a "joint underwriting association."

The authority to require joint underwriting associations was first given to the Commissioner of Insurance in 1986 as a means to address problems businesses were having in finding liability insurance. However, the JUA authority can also be used for many other types of insurance when those coverages are no longer readily available in the market, including, for example, property insurance, credit insurance, auto insurance, and workers' compensation insurance. It cannot be used for life insurance or health insurance. Since its inception in 1986, this authority has been set to expire approximately every two years so that the General Assembly can review it before deciding to renew it. The authority expired in 1997.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

The Legislative Research Commission's Study Committee on Insurance Issues has recommended the renewal of the JUA authority because of concerns about homeowners' insurance availability on the beaches and in the coastal counties. The JUA authority has not been exercised in the past.

Under the JUA authority, if the Commissioner finds, after a public hearing, that a particular insurance coverage is not readily available in the voluntary market and that the public interest requires that it be made available, he can order insurers to form a joint underwriting association to underwrite all eligible risks that no individual insurer is willing to voluntarily insure. The hearing must be conducted pursuant to the APA, and two legislative committees (Gov. Ops. And the APA Oversight Committee) must be notified of the hearing. If the Commissioner adopts a JUA plan after a hearing, a copy of the plan must also be provided to these committees. The Commissioner's JUA authority would expire July 1, 2001, unless renewed again before then.

Sections 5 and 6 of the bill rewrite the immunity clauses under the Beach and FAIR Plans. The immunity clauses protect the Beach and FAIR Plan employees, their agents, the Department of Insurance, and insurance companies from liability for good faith actions taken in carrying out their duties under the FAIR and Beach Plans. These plans are a type of statutorily-mandated joint underwriting association that provide property insurance coverage to persons who have difficulty obtaining that coverage in the voluntary market.

Section 7 deletes a reference in the Beach Plan laws to the Beach Plan Association's duties with respect to "essential property insurance." The Beach Plan now offers more than just essential property insurance; thus, this conforming change is needed.

Section 8 is a severability clause.

Section 9 makes this act effective when it becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 10, 1999

TO: House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: H.B. 165 – JUA Reauthorization

In 1986 during a one-day extra session that addressed a real crisis in the availability of property and liability insurance, a law was enacted that enabled the Commissioner and the insurance industry to provide insurance coverage that was unavailable in all or part of the State if the public interest required the availability of that particular coverage. The General Assembly placed a sunset date on the law; and extended the sunset date every two years until last year. In the 1997 Session, S.B. 843 contained another extension of the sunset date, among other things. Because of differences between the Senate and House on House changes made in S.B. 843, the law expired.

The risk sharing plan legislation in the bill before you today is designed to address any inadequacy or unavailability of amounts and kinds of property and liability insurance (all insurance except life and health insurance) that are needed by citizens of North Carolina. It must be emphasized that this bill does not and can not address the issue of affordable insurance.

The bill would authorize the Commissioner of Insurance to create risk sharing plans or call upon insurance companies to prepare risk sharing plans for his approval. Nothing in the bill precludes insurers from establishing plans on their own; and the bill is not intended to discourage participation in voluntary programs, such as market assistance programs. In fact, another statute (G.S. 58-40-75) authorizes insurers to act in concert in creating and administering market assistance programs. This alleviates any concerns of insurers that they might be violating any antitrust laws.

According to the bill, the Commissioner must first determine, after a hearing, (1) that an amount or kind of property or liability insurance is not readily available in

the voluntary market and (2) that the public interest requires the availability of that insurance. Persons in the State who would, *under reasonable underwriting standards*, be entitled to coverage but are otherwise unable to obtain the coverage, could be insured under a risk sharing plan.

All companies that are licensed to write the particular coverage, their agents, and any rating organizations that propose rates and policy forms for the coverage, would be required to participate in a risk sharing plan. The Commissioner must grant exclusions for anyone whose solvency would be impaired by participation in a risk sharing plan. Insurers and reinsurers that are not required to participate could volunteer to join a in a risk sharing plan. Each participating insurer and agent would have to provide to applicants information about all services prescribed in the risk sharing plan.

Each risk sharing plan would provide for its own: risk classifications; premium rates, which can not be inadequate, unfairly discriminatory, or excessive; policy forms; agents' and brokers' commissions; the bases of participation of insurers and agents; marketing facilities; the conditions under which risks will be accepted; and equitable apportionment of profits or losses experienced by the risk sharing plan. The Administrative Procedure Act will apply to the adoption and approval of risk sharing plans. In addition, procedures would be established in each risk sharing plan for applicants and participants to have grievances reviewed by an impartial body. Also, the Commissioner would be required to inform and report to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations if he exercises his authority under this law.

Another two sections of the bill rewrite the immunity provisions in the statutes covering the FAIR and Beach Plans. The governing boards, association employees, and Department employees could not be sued for any action taken by them in good faith and in the performance of their powers and duties under the FAIR and Beach Plan laws. A final section of the bill makes a clarifying amendment in the Beach Plan law that enables the Plan to purchase reinsurance for any of the kinds of insurance it issues (i.e., crime, wind and hail).

Reported Out
3-11-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 193 A BILL TO BE ENTITLED AN ACT TO ALLOW PERSONS TO OBTAIN HOMEOWNERS' INSURANCE WITHOUT PURCHASING COVERAGE FOR STRUCTURES OTHER THAN RESIDENTIAL DWELLINGS.

☐ 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.

☒ 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)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 193

Short Title: Amend Homeowners' Ins. Coverage. (Public)

Sponsors: Representative Preston.

Referred to: Insurance.

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO ALLOW PERSONS TO OBTAIN HOMEOWNERS' INSURANCE WITHOUT PURCHASING COVERAGE FOR STRUCTURES OTHER THAN RESIDENTIAL DWELLINGS.

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. Other structures coverage in homeowners' insurance.**

(a) All insurers shall offer insureds or prospective insureds purchasing coverage against loss to real property under this Article the option to purchase coverage for dwellings or structures without purchasing coverage for other structures on the property on which the dwelling or structure is located, whether or not other structures exist on the property at the time coverage is purchased. Insurers shall not require as a condition for issuing or renewing coverage against loss to real property that the insured or prospective insured purchase coverage for other structures. Insurers may not refuse to issue or renew coverage against loss to real property under this Article solely on grounds that the insured or prospective insured declines to accept coverage that includes coverage for other structures.

(b) Insurers shall disclose in writing to insureds or prospective insureds purchasing insurance against loss to real property that they are not required to purchase coverage for other structures.

(c) As used in this section, the term 'other structures' means structures on the real property set apart from the dwelling or structure that is the subject of the policy by

clear space, including structures connected to the dwelling or structure that is the subject of the policy by only a fence, utility line, or similar connection."

Section 2. Article 44 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-44-60. Other structures coverage in real property insurance.**

(a) All insurers shall offer insureds or prospective insureds purchasing coverage against loss to real property under this Article the option to purchase coverage for dwellings or structures without purchasing coverage for other structures on the property on which the dwelling or structure is located, whether or not other structures exist on the property at the time coverage is purchased. Insurers shall not require as a condition for issuing or renewing coverage against loss to real property that the insured or prospective insured purchase coverage for other structures. Insurers may not refuse to issue or renew coverage against loss to real property under this Article solely on grounds that the insured or prospective insured declines to accept coverage that includes coverage for other structures.

(b) Insurers shall disclose in writing to insureds or prospective insureds purchasing insurance against loss to real property that they are not required to purchase coverage for other structures.

(c) As used in this section, the term 'other structures' means structures on the real property set apart from the dwelling or structure that is the subject of the policy by clear space, including structures connected to the dwelling or structure that is the subject of the policy by only a fence, utility line, or similar connection.

(d) This section does not apply to commercial real property."

Section 3. 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 and extra expense 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.

(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 in the beach and coastal areas 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. Catastrophic losses, as determined by the Association and approved by the Commissioner, that are covered under the windstorm and hail coverage in the beach and coastal areas shall be adjusted by the licensed insurer that issued the essential property insurance and not by the Association. Expenses incurred by the licensed insurer in adjusting windstorm and hail losses shall be reimbursed by the Association.

(f) Policies shall comply with the provisions of G.S. 58-36-105."

Section 4. Article 46 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-46-60. Compliance with law governing coverage of other structures.**

Policies under this Article shall comply with the provisions of G.S. 58-36-105."

Section 5. The North Carolina Rate Bureau shall amend applicable rules and plans to implement this act no later than October 1, 1999. In accordance with sound actuarial principles, the North Carolina Rate Bureau shall adjust the premium rates for coverage against loss to residential real property under the applicable Articles of Chapter 58 of the General Statutes to implement this act. Amendments to rules or plans pursuant to this section shall become effective January 1, 2000, and shall apply to policies issued or renewed on or after that date.

Section 6. This act is effective when it becomes law and applies to policies issued or renewed on or after January 1, 2000.

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March 8, 1999

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Staff Counsel

RE: House Bill 193 – Amend Homeowners' Insurance Coverage

Section 1 of House Bill 193 requires insurance companies that sell homeowners insurance to make the "other structures" coverage under the homeowners insurance policy optional. The insurer must disclose in writing to policyholders and prospective policyholders that they are not required to purchase "other structures" coverage. Sections 2, 3 and 4 also require that "other structures' coverage be made optional for other types of residential insurance policies that may include this coverage, including policies purchased through the Beach Plan and the FAIR Plan. This bill does not cover commercial insurance policies.

The term "other structure" is defined in the bill and in the standard homeowners insurance policy (HO-3) as a structure on the residence premises that is set apart from the dwelling by clear space or that is attached only by a fence, utility line, or similar connection.

This bill would take effect October 1, 1999. The Rate Bureau, which has jurisdiction over homeowners insurance policies and rates, would be required to adjust the rates to reflect this change in the law. The change would begin to apply as policies are issued or renewed on or after January 1, 2000.

H193-SMRN99-001

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 25, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 25, 1999, at 12:00 noon. Representative Hurley called the meeting to order and introduced the page, Tamahl Gorham from Wake County. The following Committee members were present: Representatives Brubaker, Cole, Dedmon, Esposito, Grady, Hardaway, Miller, Redwine, Saunders, Smith, Wainwright, Warner, C. Wilson, and Wright. A list of visitors attending is attached (Attachment I).

Chairman Hurley announced that the Chair had appointed Representatives Wainwright, Chair, Grady, Holmes, Miller, Redwine, Saunders and Smith to serve on a subcommittee to study House Bill 165, JUA Reauthorization. The first order of business was a report from the subcommittee.

House Bill 165, entitled, AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLAN, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS was before the Committee. Representative Wainwright was recognized to explain the committee substitute, which was the subcommittee's recommendation to the full committee. He noted three changes to the original bill. (1) Page 1, Subsection (a) 9-15, the AIA had an interest in changing the language, but the committee could not come to a full agreement, so they returned to the language in the original bill that said is not readily available in the voluntary market. In effect there were no changes to subsection (a); (2) Page 2, between lines 5 and 9 there was an agreement to insert – Consistent with G.S. 54-42-5(a) (2), the Commissioner shall reevaluate a plan promulgated pursuant to this section and shall terminate the plan upon determining that the insurance coverage is readily available in the voluntary market or that the public interest no longer requires the operation of the plan; (3) Page 2, line 14 – 17 – (2) The making and filing of rates that are not excessive, inadequate, or unfairly discriminatory and that are calculated on an actuarially sound basis, (items underlined were inserted). Linwood Jones, committee counsel, indicated a technical change needed to be made on page 2, line 10, to read Section 2.1. G.S. 58-42-20 as reenacted by Section 1 of this Act reads as rewritten. Representative Wilson moved to amend the committee substitute on page 2, line 5, by adding "at least annually". The amendment was adopted (Attachment II). Representative Warner made a motion to roll the amendment into the committee substitute and give a favorable report to the committee substitute, unfavorable to the original bill. Motion passed.

Proposed committee substitutes for the following three bills along with summaries were provided to each member. Bill Hale with the Department of Insurance briefly explained each bill.

House Bill 294, entitled, AN ACT TO PROVIDE MEDICARE SUPPLEMENT INSURANCE FOR PERSONS WHO DELAY MEDICARE PART B ENROLLMENT; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME ENROLLMENT; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME INSURANCE; TO CONFORM NORTH CAROLINA'S 1997 POST-MASTECTOMY RECONSTRUCTIVE SURGERY LAWS TO THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998; TO UPDATE THE LAW ON VIATICAL SETTLEMENTS; AND TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE. Part 1 corrects a mistake from 1997 dealing with what types of insurance the preexisting conditions do not apply to, basically this would cover specified disease policies such as cancer insurance and fixed indemnity policies. Part 2 - new provisions for disability income insurance are added. Part 3 brings the reconstructive surgery law into conformance with the Federal law in effect. Part 4 deals with Viatical Settlements – a viatical settlement is where a company will purchase the life insurance policy of someone who is terminally or chronically ill to enable the individual to obtain money needed for medical assistance up front. This provision would update our law to reflect the changes in the industry. Part 5 deals with what type of standards should be established for credit insurance for family leave.

House Bill 296, entitled, AN ACT TO REPEAL OBSOLETE OR UNNECESSARY LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES. Several of the provisions in this bill were in another technical bill in 1997 that was passed by both chambers but ended up in a conference committee. The provisions basically deal with repealing obsolete laws, making some grammatical corrections to laws, repealing some unnecessary provisions, making some conforming changes, clarifying changes, taking care of laws which have expired, making some name changes, and doing some cross references.

House Bill 306, entitled, AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE

REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, AND TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES. Changes deal with hearings to make the Chapter 58 information comply with the Administrative Procedures Act; provision on Continuing Care Retirement Receiverships, amending laws on handicapped individuals with respect to health insurance and to give group homes a break on their insurance; clarity on a law pertaining to Worker's Compensation Managed Care; provision to totally deregulate air craft insurance; amendments to surplus lines act – speciality lines; provision amending Workers' Compensation Self-Insurance law; provision for Repeal Requirement of Biennial Report; provision to repeal the requirement that insurance companies send in notices when they stop doing a certain type of commercial property and liability insurance through an agency; and technical amendments on mortality tables and reserves for life insurance companies.

Bill Hale told the Committee he would explain in more detail the proposed committee substitutes at the next Insurance Committee meeting. (Attachment III – bill summaries from Bill Hale).

Chairman Hurley indicated the above 3 bills would be considered at the next meeting.

There being no further business, the Chair adjourned the meeting at 12:30 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

Attachment I

VISITOR REGISTRATION SHEET

~~APPROPRIATIONS/Subcommittee on Natural and Economic Resources~~ INSURANCE

March 25, 1999

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lisa Percy	NC Assoc of Life Underwriters
Sam Taylor	Womble Carlyle Sandridge & Rice
Larry Heckner	Household Financial Group
Stephanie Mansur	NC Assoc. of Realtors
Bob Price	Assn of NC Ins. Cos.
[illegible]	NCSOS
Annie Wine	NCACDC
[illegible]	
Crissy Porter	Bone & Associates
Jim Stuart	Stuart Law Firm – NCSIGA
Betsy Cooke	" "
Steve Woodson	NC Farm Bureau
[illegible]	NCDOJ
[illegible]	NCAHIP
Paul Mahoney	NCANP
Ken Kinion	American General Financial Corp
James Andrews	NC State AFL-CIO
Barrett Brewer	Capital Strategies
[illegible]	Moore & Van Allen
R. Paul Wilson	NCMBA
Kim Hibbard	NCLM
John McMillan	MFDS
Mary Miles	Bailey & Dixon LLP
Alina Gregory	Poyner & Spruill
Hugh Wilson	NCHA
G. Peyton Maynard	GPM
George Troutman	Transylvania Co. Insural.
John Bardish	Zeb Alley P.A.

VISITOR REGISTRATION SHEET

~~APPROPRIATIONS/Subcommittee on Natural~~
Insurance ~~and Economic Resources~~ March 25, 1999
Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ed Owens	American Diabetes Assoc.
W.E. Potter	NCOS - NCOTA
Tom Eagan	Morris Van Allen
Julia Cunningham	NCOSA
Robert Parker	Young, Moore & Henderson
Sheila McInerney	DOI
Bill Wade	DOI
Amal Sahi	Triangle Bus. Journal

Reported out 3-29-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 165 A BILL TO BE ENTITLED AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS.

☐ 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.

☐ 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)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 165
Committee Substitute Favorable 3/29/99

Short Title: JUA Reauthorization. (Public)

Sponsors:

Referred to:

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS.

The General Assembly of North Carolina enacts:

Section 1. Article 42 of Chapter 58 of the General Statutes, which expired July 1, 1997, is reenacted.

Section 2. G.S. 58-42-1, as reenacted in Section 1 of this act, reads as rewritten:

"**§ 58-42-1. Establishment of plans.**

(a) If the Commissioner finds, after a hearing held in accordance with ~~G.S. 58-2-50,~~ Article 3A of Chapter 150B of the General Statutes, 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 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 approval.

(b) Consistent with G.S. 58-42-5(a)(2), the Commissioner shall at least annually reevaluate a plan promulgated pursuant to this section and shall terminate the plan

upon determining that the insurance coverage is readily available in the voluntary market or that the public interest no longer requires the operation of the plan."

Section 2.1. G.S. 58-42-20, as reenacted by Section 1 of this act, reads as rewritten:

"**§ 58-42-20. Classification and rates.**

Each plan shall provide for:

(1) The method of classifying risks;

(2) The making and filing of rates ~~which~~ that are not excessive, inadequate, or unfairly discriminatory and that are calculated on an actuarially sound basis and policy forms applicable to the various risks insured by the plan;

(3) The adjusting and processing of claims;

(4) The commission rates to be paid to agents or brokers for coverages written by the plan; and

(5) Any other insurance or investment functions that are necessary for the purpose of providing adequate and readily accessible coverage."

Section 3. G.S. 58-42-45, as reenacted by Section 1 of this act, reads as rewritten:

"**§ 58-42-45. Article ~~not~~ subject to Administrative Procedure ~~Act.~~ Act; legislative oversight of plans.**

(a) The provisions of Chapter 150B of the General Statutes shall ~~not~~ apply to this ~~Article, except that G.S. 150B-39 and G.S. 150B-41 apply to hearings conducted under G.S. 58-42-1.~~ Article.

(b) At the same time the Commissioner issues a notice of hearing under G.S. 150B-38, the Commissioner shall provide copies of the notice to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations. The Commissioner shall provide the Committee and Commission with copies of any plan promulgated by or approved by the Commissioner under G.S. 58-42-1(1) or (2)."

Section 4. G.S. 58-42-55, as reenacted in Section 1 of this act, reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article shall expire on July 1, ~~1997.~~ 2001."

Section 5. G.S. 58-45-60 reads as rewritten:

"**§ 58-45-60. Association and Commissioner immune from liability.**

There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner or any of his staff, the Association or its agents or employees, or against any participating insurer, for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the Association, or at any administrative hearings conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the

Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 6. G.S. 58-46-35 reads as rewritten:

"**§ 58-46-35. Reports of inspection made available; immunity from liability.**

All reports of inspection performed by or on behalf of the association shall be made available to the members of the association, applicants and the Commissioner. There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner, any of his staff, the association or any of its agents or employees, or against any participating insurer for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the association, or at any administrative hearing conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 7. G.S. 58-45-15 reads as rewritten:

"**§ 58-45-15. Powers and duties of Association.**

The Association shall, pursuant to the provisions of this Article and the plan of operation, and with respect to ~~essential property insurance on insurable property,~~ the insurance coverages authorized in this Article, have the power on behalf of its members:

(1) To cause to be issued policies of insurance to applicants;

(2) To assume reinsurance from its members;

(3) To cede reinsurance to its members and to purchase reinsurance in behalf of its members."

Section 8. 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 9. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 165
Proposed Committee Substitute H165-PCS4141-RN

Short Title: JUA Reauthorization. (Public)

Sponsors:

Referred to:

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS.

The General Assembly of North Carolina enacts:

Section 1. Article 42 of Chapter 58 of the General Statutes, which expired July 1, 1997, is reenacted.

Section 2. G.S. 58-42-1, as reenacted in Section 1 of this act, reads as rewritten:

"**§ 58-42-1. Establishment of plans.**

(a) If the Commissioner finds, after a hearing held in accordance with ~~G.S. 58-2-50,~~ Article 3A of Chapter 150B of the General Statutes, 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 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 approval.

(b) Consistent with G.S. 58-42-5(a)(2), the Commissioner shall at least annually reevaluate a plan promulgated pursuant to this section and shall terminate the plan

upon determining that the insurance coverage is readily available in the voluntary market or that the public interest no longer requires the operation of the plan."

Section 2.1. G.S. 58-42-20, as reenacted by Section 1 of this act, reads as rewritten:

"**§ 58-42-20. Classification and rates.**

Each plan shall provide for:

(1) The method of classifying risks;

(2) The making and filing of rates ~~which~~ that are not excessive, inadequate, or unfairly discriminatory and that are calculated on an actuarially sound basis and policy forms applicable to the various risks insured by the plan;

(3) The adjusting and processing of claims;

(4) The commission rates to be paid to agents or brokers for coverages written by the plan; and

(5) Any other insurance or investment functions that are necessary for the purpose of providing adequate and readily accessible coverage."

Section 3. G.S. 58-42-45, as reenacted by Section 1 of this act, reads as rewritten:

"**§ 58-42-45. Article ~~not~~ subject to Administrative Procedure ~~Act.~~ Act; legislative oversight of plans.**

(a) The provisions of Chapter 150B of the General Statutes shall ~~not~~ apply to this ~~Article, except that G.S. 150B-39 and G.S. 150B-41 apply to hearings conducted under G.S. 58-42-1.~~ Article.

(b) At the same time the Commissioner issues a notice of hearing under G.S. 150B-38, the Commissioner shall provide copies of the notice to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations. The Commissioner shall provide the Committee and Commission with copies of any plan promulgated by or approved by the Commissioner under G.S. 58-42-1(1) or (2)."

Section 4. G.S. 58-42-55, as reenacted in Section 1 of this act, reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article shall expire on July 1, ~~1997.~~ 2001."

Section 5. G.S. 58-45-60 reads as rewritten:

"**§ 58-45-60. Association and Commissioner immune from liability.**

There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner or any of his staff, the Association or its agents or employees, or against any participating insurer, for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the Association, or at any administrative hearings conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the

Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 6. G.S. 58-46-35 reads as rewritten:

"**§ 58-46-35. Reports of inspection made available; immunity from liability.**

All reports of inspection performed by or on behalf of the association shall be made available to the members of the association, applicants and the Commissioner. There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner, any of his staff, the association or any of its agents or employees, or against any participating insurer for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the association, or at any administrative hearing conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 7. G.S. 58-45-15 reads as rewritten:

"**§ 58-45-15. Powers and duties of Association.**

The Association shall, pursuant to the provisions of this Article and the plan of operation, and with respect to ~~essential property insurance on insurable property,~~ the insurance coverages authorized in this Article, have the power on behalf of its members:

(1) To cause to be issued policies of insurance to applicants;

(2) To assume reinsurance from its members;

(3) To cede reinsurance to its members and to purchase reinsurance in behalf of its members."

Section 8. 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 9. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 165

Short Title: JUA Reauthorization. (Public)

Sponsors: Representatives Redwine; and Hill.

Referred to: Insurance.

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS.

The General Assembly of North Carolina enacts:

Section 1. Article 42 of Chapter 58 of the General Statutes, which expired July 1, 1997, is reenacted.

Section 2. G.S. 58-42-1, as reenacted in Section 1 of this act, 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,~~ Article 3A of Chapter 150B of the General Statutes, 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 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 approval."

Section 3. G.S. 58-42-45, as reenacted by Section 1 of this act, reads as rewritten:

"**§ 58-42-45. Article ~~not~~ subject to Administrative Procedure ~~Act.~~ Act; legislative oversight of plans.**

(a) The provisions of Chapter 150B of the General Statutes shall ~~not~~ apply to this ~~Article, except that G.S. 150B-39 and G.S. 150B-41 apply to hearings conducted under G.S. 58-42-1.~~ Article.

(b) At the same time the Commissioner issues a notice of hearing under G.S. 150B-38, the Commissioner shall provide copies of the notice to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations. The Commissioner shall provide the Committee and Commission with copies of any plan promulgated by or approved by the Commissioner under G.S. 58-42-1(1) or (2)."

Section 4. G.S. 58-42-55, as reenacted in Section 1 of this act, reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article shall expire on July 1, ~~1997.~~ 2001."

Section 5. G.S. 58-45-60 reads as rewritten:

"**§ 58-45-60. Association and Commissioner immune from liability.**

There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner or any of his staff, the Association or its agents or employees, or against any participating insurer, for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the Association, or at any administrative hearings conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 6. G.S. 58-46-35 reads as rewritten:

"**§ 58-46-35. Reports of inspection made available; immunity from liability.**

All reports of inspection performed by or on behalf of the association shall be made available to the members of the association, applicants and the Commissioner. There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner, any of his staff, the association or any of its agents or employees, or against any participating insurer for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the association, or at any administrative hearing conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 7. G.S. 58-45-15 reads as rewritten:

"**§ 58-45-15. Powers and duties of Association.**

The Association shall, pursuant to the provisions of this Article and the plan of operation, and with respect to ~~essential property insurance on insurable property,~~ the insurance coverages authorized in this Article, have the power on behalf of its members:

(1) To cause to be issued policies of insurance to applicants;

(2) To assume reinsurance from its members;
(3) To cede reinsurance to its members and to purchase reinsurance in behalf of its members."

Section 8. 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 9. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

Attachment II

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

moves to amend the bill on page 2, line 5

( ) WHICH CHANGES THE TITLE

by adding at the end of the line "at least annually"

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

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March 9, 1999

MEMORANDUM

TO: House Insurance Committee

FROM: Linwood Jones, Counsel

RE: House Bill 165 (JUA Reauthorization)

Sections 1 through 4 of the bill restore the authority of the Commissioner of Insurance to create risk-sharing plans or require insurance companies to prepare such plans to jointly provide insurance when coverage in the market is not readily available and the Commissioner finds that it is in the public interest to make it available. The insurance mechanism established under these plans is also known as a "joint underwriting association."

The authority to require joint underwriting associations was first given to the Commissioner of Insurance in 1986 as a means to address problems businesses were having in finding liability insurance. However, the JUA authority can also be used for many other types of insurance when those coverages are no longer readily available in the market, including, for example, property insurance, credit insurance, auto insurance, and workers' compensation insurance. It cannot be used for life insurance or health insurance. Since its inception in 1986, this authority has been set to expire approximately every two years so that the General Assembly can review it before deciding to renew it. The authority expired in 1997.

The Legislative Research Commission's Study Committee on Insurance Issues has recommended the renewal of the JUA authority because of concerns about homeowners' insurance availability on the beaches and in the coastal counties. The JUA authority has not been exercised in the past.

Under the JUA authority, if the Commissioner finds, after a public hearing, that a particular insurance coverage is not readily available in the voluntary market and that the public interest requires that it be made available, he can order insurers to form a joint underwriting association to underwrite all eligible risks that no individual insurer is willing to voluntarily insure. The hearing must be conducted pursuant to the APA, and two legislative committees (Gov. Ops. And the APA Oversight Committee) must be notified of the hearing. If the Commissioner adopts a JUA plan after a hearing, a copy of the plan must also be provided to these committees. The Commissioner's JUA authority would expire July 1, 2001, unless renewed again before then.

Sections 5 and 6 of the bill rewrite the immunity clauses under the Beach and FAIR Plans. The immunity clauses protect the Beach and FAIR Plan employees, their agents, the Department of Insurance, and insurance companies from liability for good faith actions taken in carrying out their duties under the FAIR and Beach Plans. These plans are a type of statutorily-mandated joint underwriting association that provide property insurance coverage to persons who have difficulty obtaining that coverage in the voluntary market.

Section 7 deletes a reference in the Beach Plan laws to the Beach Plan Association's duties with respect to "essential property insurance." The Beach Plan now offers more than just essential property insurance; thus, this conforming change is needed.

Section 8 is a severability clause.

Section 9 makes this act effective when it becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 10, 1999

TO: House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: H.B. 165 – JUA Reauthorization

In 1986 during a one-day extra session that addressed a real crisis in the availability of property and liability insurance, a law was enacted that enabled the Commissioner and the insurance industry to provide insurance coverage that was unavailable in all or part of the State if the public interest required the availability of that particular coverage. The General Assembly placed a sunset date on the law; and extended the sunset date every two years until last year. In the 1997 Session, S.B. 843 contained another extension of the sunset date, among other things. Because of differences between the Senate and House on House changes made in S.B. 843, the law expired.

The risk sharing plan legislation in the bill before you today is designed to address any inadequacy or unavailability of amounts and kinds of property and liability insurance (all insurance except life and health insurance) that are needed by citizens of North Carolina. It must be emphasized that this bill does not and can not address the issue of affordable insurance.

The bill would authorize the Commissioner of Insurance to create risk sharing plans or call upon insurance companies to prepare risk sharing plans for his approval. Nothing in the bill precludes insurers from establishing plans on their own; and the bill is not intended to discourage participation in voluntary programs, such as market assistance programs. In fact, another statute (G.S. 58-40-75) authorizes insurers to act in concert in creating and administering market assistance programs. This alleviates any concerns of insurers that they might be violating any antitrust laws.

According to the bill, the Commissioner must first determine, after a hearing, (1) that an amount or kind of property or liability insurance is not readily available in

the voluntary market and (2) that the public interest requires the availability of that insurance. Persons in the State who would, *under reasonable underwriting standards*, be entitled to coverage but are otherwise unable to obtain the coverage, could be insured under a risk sharing plan.

All companies that are licensed to write the particular coverage, their agents, and any rating organizations that propose rates and policy forms for the coverage, would be required to participate in a risk sharing plan. The Commissioner must grant exclusions for anyone whose solvency would be impaired by participation in a risk sharing plan. Insurers and reinsurers that are not required to participate could volunteer to join a in a risk sharing plan. Each participating insurer and agent would have to provide to applicants information about all services prescribed in the risk sharing plan.

Each risk sharing plan would provide for its own: risk classifications; premium rates, which can not be inadequate, unfairly discriminatory, or excessive; policy forms; agents' and brokers' commissions; the bases of participation of insurers and agents; marketing facilities; the conditions under which risks will be accepted; and equitable apportionment of profits or losses experienced by the risk sharing plan. The Administrative Procedure Act will apply to the adoption and approval of risk sharing plans. In addition, procedures would be established in each risk sharing plan for applicants and participants to have grievances reviewed by an impartial body. Also, the Commissioner would be required to inform and report to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations if he exercises his authority under this law.

Another two sections of the bill rewrite the immunity provisions in the statutes covering the FAIR and Beach Plans. The governing boards, association employees, and Department employees could not be sued for any action taken by them in good faith and in the performance of their powers and duties under the FAIR and Beach Plan laws. A final section of the bill makes a clarifying amendment in the Beach Plan law that enables the Plan to purchase reinsurance for any of the kinds of insurance it issues (i.e., crime, wind and hail).

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 294

Short Title: Life & Health Ins. Amendments/AB. (Public)

Sponsors: Representatives Hurley; Mosley, Edwards, and Gibson.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE MEDICARE SUPPLEMENT INSURANCE FOR PERSONS WHO DELAY MEDICARE PART B ENROLLMENT; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME INSURANCE; TO CONFORM NORTH CAROLINA'S 1997 POST-MASTECTOMY RECONSTRUCTIVE SURGERY LAWS TO THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998; TO UPDATE THE LAW ON VIATICAL SETTLEMENTS; AND TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE.

The General Assembly of North Carolina enacts:

PART I. MEDICARE SUPPLEMENT OPEN ENROLLMENT.

Section 1. Article 54 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-54-55. Open enrollment for persons who delay Medicare Part B enrollment.**

In addition to any other provision in this Article or any rule adopted under this Article that is directly or indirectly related to guaranteed issue or open enrollment, an insurer shall expand open enrollment to include those persons who have delayed Medicare Part B enrollment beyond attaining the age of 65 years because they were working and were covered by an individual or group health plan."

PART 2. DISABILITY INCOME INSURANCE.

Section 2. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-51-130. Standards for disability income insurance policies.

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

(1) 'Disability income insurance policy' or 'policy' means a policy of accident and health insurance that provides payments when the insured is unable to work because of illness, disease, or injury.

(2) 'Policy' includes the certificates referred to in subsection (b) of this section.

(b) Applicability. -- This section applies to all policies used in this State, including certificates issued under group policies that are used in this State. This section also applies to a certificate issued under a policy issued and delivered to a trust or to an association outside of this State and covering persons residing in this State.

(c) Disclosure standards. -- Every disability income insurance policy shall include provisions, where applicable, addressing:

(1) Terms of renewability.

(2) Initial and subsequent conditions of eligibility.

(3) Nonduplication of coverage.

(4) Preexisting conditions.

(5) Probationary periods.

(6) Benefit limitations, exceptions, and reductions.

(7) Elimination periods.

(8) Requirements for replacement.

(9) Recurrent conditions.

(10) Definitions of terms.

(d) Preexisting Conditions. -- If an insurer does not seek a prospective insured's medical history in the application or enrollment process, the insurer shall not deny a claim for disabilities that commence more than 24 months after the effective date of coverage on the grounds the disability is caused by a preexisting condition. A policy shall not define a preexisting condition more restrictively than 'a condition for which medical advice, diagnosis, care, or treatment was received or recommended within the 24-month period immediately preceding the effective date of coverage of the insured person.'

(e) Exceptions. -- Nothing in this section prohibits an insurer from:

(1) Using an application or enrollment form designed to elicit the medical history of a prospective insured.

(2) Underwriting based on answers on the form according to the insurer's established standards.

(3) Contesting the answers in accordance with G.S. 58-51-15(a)(2)a.

(f) Required Provisions. -- Each policy shall include:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the exceptions, reductions, and limitations contained in the policy.

(3) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

(g) Other Applicable Provisions. -- G.S. 58-51-95(f) applies to individual policies and G.S. 58-51-80(g) applies to group policies.

(h) Other Income Sources. -- If a policy contains a provision that provides for integration of benefits with other income sources, it shall include a definition of what is considered other income sources and a complete description of how benefits will be reduced by other income sources, if at all. No disability income policy shall provide that the amount of any disability benefit paid to the insured shall be reduced by reason of any cost-of-living increase, designated as such under the federal Social Security Act, if the cost-of-living increase occurs during the period for which benefits are payable."

PART 3. RECONSTRUCTIVE SURGERY CONFORMING CHANGES.

Section 3.1. G.S. 58-51-62 reads as rewritten:

"**§ 58-51-62. Coverage for reconstructive breast surgery ~~resulting from~~ following mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under ~~G.S. 58-50-60~~ G.S. 58-50-56 ~~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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter."

Section 3.2. G.S. 58-65-96 reads as rewritten:

"**§ 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 benefit plan under G.S. 58-50-56 ~~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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the certificate, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter."

Section 3.3. G.S. 58-67-79 reads as rewritten:

"**§ 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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the plan upon enrollment and annually thereafter."

PART 4. VIATICAL SETTLEMENTS.

Section 4. G.S. 58-58-42 reads as rewritten:

"**§ 58-58-42. Viatical settlements.**

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

~~(1) "Broker" means a person who, for consideration and on behalf of another, offers or advertises the availability of viatical settlements, introduces viators to providers, or offers or attempts to negotiate viatical settlement contracts between a viator and one or more providers; it does not mean an attorney, accountant, or financial planner retained to represent a viator and whose compensation is not paid by a provider.~~

(1a) 'Financing entity' means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any person that may be a party to a viatical settlement contract and that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a licensed viatical settlement provider to act as a participant in a financing transaction.

(1b) 'Financing transaction' means a transaction in which a viatical settlement provider or a financing entity obtains financing for viatical settlement contracts, viaticated policies or interests therein including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering either registered or exempt from registration under federal and State securities law, or any direct purchase of interests in a policy or certificate, if the financing transaction complies with federal and State securities law.

(2) 'Policy' means an individual life insurance policy or a certificate under a group life insurance policy.

(2a) 'Viatical settlement broker' means a person that on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers. 'Viatical settlement broker' does not include an attorney, accountant, or financial planner who is retained to represent the viator and whose compensation is paid directly by or at the direction of the viator.

~~(3) "Provider" means a person who enters into a viatical settlement contract with a viator. "Provider" does not mean:~~

~~a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.~~

~~b. The issuer of a policy providing accelerated benefits under 11 NCAC 12.1200.~~

~~c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.~~

(4) 'Viatical settlement contract' or 'contract' means a written agreement entered into between a viatical settlement provider and a viator that establishes the terms under which the viatical settlement provider will pay consideration that is less than the expected death benefit of the viator's policy in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or a portion of the policy to the viatical settlement provider. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

(4a) 'Viatical settlement provider' means a person who enters into a viatical settlement contract with a viator. 'Viatical settlement provider' also means a person that obtains financing from a financing entity for the purchase, acquisition, transfer, or other assignment of one or more viatical settlement contracts, viaticated

policies, or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates, or otherwise disposes of one or more viatical settlement contracts, viaticated policies, or interests therein. 'Provider' does not mean:

a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.

b. The issuer of a policy providing accelerated benefits under 11 NCAC 12.1200.

c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.

(4b) 'Viatical settlement representative' means a person who is an authorized agent of a viatical settlement provider or viatical settlement broker, as applicable, who acts in any manner in the solicitation of a viatical settlement. A viatical settlement representative is deemed to represent only the viatical settlement provider or viatical settlement broker. Viatical settlement representative does not include:

a. An attorney, accountant, or financial planner or any person exercising a power of attorney granted by a viator.

b. Any person who is retained to represent a viator and whose compensation is paid by or at the direction of the viator, regardless of whether the viatical settlement is consummated.

(4c) 'Viaticated policy' means a policy that has been acquired by a viatical settlement provider under a viatical settlement contract.

(5) "Viator" means the owner or holder of a policy insuring the life of an individual who has ~~a catastrophic or life-threatening~~ an illness or condition that is catastrophic, life-threatening, or chronic, and who enters into or seeks to enter into a viatical settlement contract.

(a1) Fiduciary Duty. -- Regardless of the manner in which a viatical settlement broker is compensated, a viatical settlement broker represents only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

(b) Registration. -- No person may act as a ~~provider~~ viatical settlement provider, viatical settlement representative, or viatical settlement broker, or enter into or solicit a contract without first registering with the Commissioner. The applicant shall register on a form prescribed by the Commissioner. The Commissioner may require the applicant to disclose fully the identity of all stockholders, partners, officers, and employees. The Commissioner may refuse registration of any partnership, corporation, or other business entity if not satisfied that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct meets the standards of this section. Registration of a partnership, corporation, or other

business entity authorizes all members, officers, and designated employees to act as viatical settlement providers under the registration; all of those persons must be named in the application and any supplements to the application. Before any registration is complete, the Commissioner shall investigate each applicant and may register the applicant if the Commissioner finds that the applicant:

(1) Has provided a detailed plan of operation.

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for.

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied.

(4) If a corporation, is incorporated under the laws of this State or is a foreign corporation authorized to transact business in this State.

No registration is complete for any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the Commissioner or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(c) Enforcement. -- The Commissioner may issue a cease and desist order upon any viatical settlement provider if the Commissioner finds that:

(1) There was any misrepresentation in the application for registration;

(2) The viatical settlement provider has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a viatical settlement provider;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to policy owners;

(4) The viatical settlement provider has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or

(5) The viatical settlement provider has violated a provision of this section.

(d) Approval of Contracts. -- No viatical settlement provider may use any viatical settlement contract in this State unless it has been filed with and approved by the Commissioner. Any contract form filed with the Commissioner is deemed to be approved if it has not been disapproved within 90 days after the filing. The Commissioner shall disapprove a contract form if, in the Commissioner's opinion, any provision of the contract is unreasonable, contrary to the public interest, or otherwise misleading or unfair to the policy owner.

(e) Reporting Requirements. -- Each viatical settlement provider shall file with the Commissioner on or before March 1 of each year a statement containing the information required by the rules adopted by the Commissioner.

(e1) Identity of Viator. -- Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement representative, viatical settlement broker, insurance company, insurance company agent, insurance broker, information

bureau, rating agency or company, or any other person with actual knowledge of viator's identity, shall not disclose that identity to any other person unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator has provided prior written consent to the disclosure.

(2) Is provided in response to an investigation by the Commissioner or any other governmental officer or agency.

(3) Is a term of or condition to the transfer of a viaticated policy by one viatical settlement provider to another viatical settlement provider.

(f) Examination. -- The Commissioner may, when the Commissioner deems it to be reasonably necessary to protect the public interest, examine the business and affairs of any ~~provider~~ viatical settlement provider, representative, or broker, or applicant for registration. The Commissioner may order any ~~provider~~ viatical settlement provider, representative, or broker, or applicant to produce records, books, files, or other information that is necessary to ascertain whether or not the ~~provider~~ viatical settlement provider, representative, or broker, or applicant is acting or has acted in violation of this section or otherwise contrary to the public interest. The ~~provider~~ viatical settlement provider, representative, or broker, or applicant shall pay the expenses incurred in conducting an examination. Names and individual identification data for all viators are confidential and shall not be disclosed by the Commissioner. The viatical settlement provider shall maintain records of all transactions of contracts and make the records available to the Commissioner for inspection during reasonable business hours. A viatical settlement provider shall maintain records of each viatical settlement until five years after the death of the insured.

(g) Disclosure. -- A viatical settlement provider shall disclose the following information to the viator no later than the date the contract is signed by all parties:

(1) Options other than the contract for a person with a catastrophic or life-threatening illness, including, but not limited to, accelerated benefits offered by the issuer of the policy.

(2) The fact that some or all of the contract consideration may be taxable, and that assistance should be sought from a personal tax advisor.

(3) The fact that the contract consideration could be subject to the claims of creditors.

(4) The fact that receipt of the contract consideration may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements; and that advice should be obtained from the appropriate government agencies.

(5) The viator's right to rescind a contract ~~within 30 days after the date it is executed by all parties or~~ within 15 days after the receipt

of the contract consideration by the ~~viator, whichever is less, as provided~~ viator as provided in subsection (h) of this section.

(6) The date by which the contract consideration will be available to the viator and the source of the consideration.

(7) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator and that assistance should be sought from a financial adviser.

(g1) Disclosure Before Contract Execution. -- A viatical settlement provider shall disclose the following information to the viator before the date the viatical settlement contract is signed by all parties:

(1) The affiliation, if any, between the viatical settlement provider and the issuer of an insurance policy to be viaticated.

(2) If a policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured, the viator shall be informed of the possible loss of coverage on the other lives and be advised to consult with his or her insurance producer or the company issuing the policy for advice on the proposed viatication.

(3) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy. The viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy, and the viatical settlement provider's interest in those benefits.

(h) General Rules. -- A viatical settlement provider entering into a contract with a viator shall first obtain:

(1) A written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence.

(2) A witnessed document in which the viator (i) consents to the contract, (ii) acknowledges the catastrophic or life-threatening illness, (iii) represents that the viator has a full and complete understanding of the contract, (iv) represents that the viator has a full and complete understanding of the benefits of the policy, and (v) releases the medical records and acknowledges that the contract has been entered into freely and voluntarily.

All medical information solicited or obtained by any viatical settlement provider is subject to all State laws relating to confidentiality of medical information. All contracts entered into in this State shall contain an unconditional refund provision for at least 30 days after the date of the contract, or 15 days after the receipt of the viatical settlement proceeds, whichever is less.

(i) Contract Consideration. -- Immediately upon receipt from the viator of documents to effect the transfer of the policy, the viatical settlement provider shall

direct the contract consideration to an escrow or trust account managed by a trustee or escrow agent in a ~~bank approved by the Commissioner, pending acknowledgment of the transfer by the issuer of the policy.~~ State or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The account shall be managed by a trustee or escrow agent independent of the parties to the contract. The trustee or escrow agent shall transfer the proceeds that are due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer. Failure to tender the viatical settlement contract consideration by the date disclosed to the viator renders the contract ~~null and void.~~ voidable by the viator until the time consideration is tendered to and accepted by the viator.

(j) Authority to Adopt Standards. -- The Commissioner may:

(1) Adopt rules to implement this section.

(2) Establish standards for evaluating reasonableness of payments under contracts. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy.

(3) Establish appropriate registration and other regulatory requirements for brokers.

(4) Repealed by Session Laws 1998-211, s. 32.

(k) Unfair Trade Practices. -- A violation of this section is considered an unfair trade practice under Article 63 of this Chapter."

PART 5. FAMILY LEAVE CREDIT INSURANCE.

Section 5. Article 57 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-57-115. Family leave credit insurance standards; policy provisions.**

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

(1) 'Foster child' means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

(2) 'Immediate family member' means a spouse, child (natural, adopted, or foster), or parent.

(3) 'Placement in the foster home' means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

(b) Coverage. -- Insurers may provide coverage for loss of income because of voluntary, employer approved, leave of absence for specified reasons. The insured shall not be required to meet any federal requirements in order to qualify for benefits

provided by this coverage. Benefits shall be paid to the creditor to reduce the insured's indebtedness.

(c) Eligibility. -- Coverage may be provided or offered to all debtors who have not yet reached their 71st birthday and have been working for wages for a minimum of 30 hours per week for the past 12 consecutive months.

(d) Qualifying Events. -- Benefits shall be paid only for the following qualifying events:

(1) An accident involving sickness of, or incapacitation of an immediate family member that requires the insured to attend to the family member's needs.

(2) Birth of a child or children.

(3) Adoption of a child or children.

(4) Placement in the foster home of a foster child or children.

(5) The insured's principal residence is in a federally declared disaster area.

(6) The insured is called to active military duty.

(7) The insured is called to jury duty.

(e) Exclusions. -- Coverage shall not contain any exclusions except:

(1) Retirement of the insured from employment.

(2) Voluntary resignation of the insured from employment.

(3) Seasonal unemployment of the insured.

(4) Involuntary unemployment of the insured.

(5) Disability of the insured.

(6) Employment termination because of willful or criminal misconduct of the insured.

(f) Notice. -- The insurer shall send a notice to the insured at the insured's home address to inform the insured that benefits have been paid, including the dates and the amount of payment. The notice shall be sent to the insured within 60 days after the last day of the benefit period.

(g) Minimum Amounts. -- The minimum monthly benefit amount shall be level for the entire benefit period. The minimum monthly benefit amount shall equal or exceed the minimum monthly payment required by the creditor, plus the premium charge for the coverage attributable to the benefit period.

(h) Miscellaneous Provisions. -- Any waiting period for benefits shall not exceed 30 days. The insured shall provide satisfactory evidence of employer approval of qualified leave. Lump-sum benefits are prohibited. Refunds of unearned single premiums shall be equal to the pro rata unearned gross premium.

(i) Rates. -- Premium rates shall be actuarially demonstrated to generate a sixty percent (60%) loss ratio. Joint coverage rates shall be one and two-thirds (1 2/3) times the approved single rate. Rates shall be filed for approval before they can be used.

(j) Reports. -- By March 30 of each year every insurer writing family leave coverage shall file a statistical report of the past calendar year's actuarial experience for that coverage. The report shall demonstrate the actual experience loss ratio for

the calendar year and shall include the: number of insureds, total premium volume, total number of claims, total claims volume, total number of claims for each eligible leave event, average monthly benefit per claim for each event, and premium refunds."

PART 6. EFFECT OF HEADINGS.

Section 6. 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 7. EFFECTIVE DATES.

Section 7. Sections 2, 4, and 5 of this act become effective October 1, 1999. The remainder of this act is effective when it becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 25, 1999

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: PCS for HB 294 – Life & Health Insurance Amendments

PART I. HEALTH INSURANCE.

Section 1 corrects a mistake in the 1997 Health Insurance Portability and Accountability Act. In that Act (S.L. 1997-259), an existing statute dealing with pre-existing conditions for individual health insurance policies was amended so that it would not apply to the many types of policies to which the Act did not apply. However, there were two types to which the other statute used to and still should apply. They are specified disease policies (i.e., cancer insurance) and hospital indemnity or other fixed indemnity policies (i.e., pays a fixed dollar amount for hospitalization). Section 1 would bring those policies back under the individual policy pre-existing condition law.

PART II. DISABILITY INCOME INSURANCE.

Section 2 adds a new G.S. 58-51-130 to establish standards for disability income insurance policies regarding disclosure, preexisting conditions, integration of benefits, and required provisions.

PART III. RECONSTRUCTIVE SURGERY CONFORMING CHANGES.

Sections 3.1, 3.2, and 3.3 amend the statutes regarding coverage for reconstructive breast surgery following a mastectomy to require coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas, and to require notice of the coverage to insureds, all to conform North Carolina's 1997 post-mastectomy reconstructive surgery laws to the federal Women's Health and Cancer Rights Act of 1998

PART IV. VIATICAL SETTLEMENTS.

Section 4 amends the law on viatical settlements to define or redefine "financing entity," "financing transaction," "viatical settlement broker," "viatical settlement contract," "viatical settlement provider," "viatical settlement representative," "viaticated policy," and "viator." It provides that a viatical settlement broker who represents only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the viator's best interest. It makes the viatical settlement representatives and the viatical settlement brokers (as well as the viatical settlement

providers) subject to registration and examination. It adds a provision restricting disclosure of identity of the viator. It amends the provision regarding disclosure of information by a viatical settlement provider to the viator before the execution of the viatical settlement contract. These changes are recommended by the National Association of Insurance Commissioners, which has been monitoring the viatical settlement industry over the last few years. The purpose of the changes is to update North Carolina's law to keep current with changes in that industry.

PART V. FAMILY LEAVE CREDIT INSURANCE.

Section 5.1 adds a new G.S. 58-57-115 by establishing standards for family leave credit insurance policies to provide coverage for the loss of income because of voluntary, employer approved, leave of absence for birth or adoption of a child, illness of family member, or other specified reasons. Sections 5.2 and 5.3 make conforming changes to two other credit insurance laws.

PART VI. EFFECT OF HEADINGS.

Section 6. The headings to the parts of the act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of the act.

PART VII. EFFECTIVE DATES.

Section 7. Except for the provisions regarding reconstructive surgery, the act is effective Oct. 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 296

Short Title: Insurance Technical Changes/AB. (Public)

Sponsors: Representatives Hurley; Gibson and Melton.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE OR UNNECESSARY LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1.1. G.S. 58-3-125, 58-6-10, 58-7-150, and 58-71-90 are repealed.

Section 1.2. 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 1.3. 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 1.4. 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."

PART II. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION.

Section 2.1. 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 2.2. 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 2.3. 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 2.4. 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 2.5. 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 III. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 3.1. 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 3.2. 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 3.3. 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:

(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.~~ jurisdiction. 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~~ gender 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 3.4. 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 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 3.5. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar ~~year~~ year, or later with the approval of the Commissioner, 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 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 3.6. 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 3.7. 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 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 3.8. 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 3.9. 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 3.10. 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 3.11. 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 3.12. 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 IV. HEALTH INSURANCE CLARIFYING CHANGES.

Section 4.1. G.S. 58-50-130(a) is amended by adding a new subdivision to read:

"(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 that period in the health benefit plan held at the time by the small employer."

Section 4.2. G.S. 58-51-55(d) 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 4.3. G.S. 58-65-90(d) 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 4.4. G.S. 58-67-75(d) 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 4.5. G.S. 58-51-15(h) 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 4.6. G.S. 58-68-40(e) 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 4.7. G.S. 58-68-60(b)(2) 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 4.8. Section 3.19 of Session Law 1997-519 reads as rewritten:

"Section 3.19. Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of

~~G.S. 58-50-50 or G.S. 58-50-55~~ G.S. 58-65-140, 58-50-50, or 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.16 or Section 3.17 of this act."

PART V. BAIL BONDS.

Section 5. 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 VI. AGENT ASSOCIATIONS MERGER.

Section 6.1. G.S. 58-32-1 reads as rewritten:

"**§ 58-32-1. Commission created; membership.**

There is hereby created within the Department a Public Officers and Employees Liability Insurance Commission. The Commission shall consist of 11 members who shall be appointed as follows: the Commissioner shall appoint six members as follows: two members who are members of the insurance industry who may be chosen from a list of ~~three~~ six nominees submitted to the Commissioner by the Independent Insurance Agents of North Carolina, ~~Inc., and a list of three nominees submitted by the Carolinas Association of Professional Insurance Agents, North Carolina Division, Inc.;~~ one member who is employed by a police department who may be chosen from a list of three nominees submitted to the Commissioner jointly by the North Carolina Police Chiefs Association and North Carolina Police Executives Association, and one member who is employed by a sheriff's department who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Sheriff's Association; one member representing city government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina League of Municipalities; and one member representing county government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Association of County Commissioners; and the General Assembly shall appoint two persons, one upon the recommendation of the Speaker of the House of Representatives, and one upon the recommendation of the President Pro Tempore of the Senate. The Commissioner or ~~his~~ the Commissioner's designate shall be an ex officio member. Appointments by the General Assembly shall be made in accordance with G.S. 120-121, and vacancies in those appointments shall be filled in accordance with G.S. 120-122. The terms of the initial appointees by the General Assembly shall expire on June 30, 1983. The Secretary of the Department of Crime Control and Public Safety or ~~his~~ the Secretary's designate shall be an ex officio member. The Attorney General or ~~his~~ the Attorney General's designate shall be an ex officio member. One insurance industry member appointed by the Commissioner shall be appointed to a term of two years and one insurance industry member shall be

appointed to a term of four years. The police department member shall be appointed to a term of two years and the sheriff's department member shall be appointed to a term of four years. The representative of county government shall be appointed to a term of two years and the representative of city government to a term of four years. Beginning July 1, 1983, the appointment made by the General Assembly upon the recommendation of the Speaker shall be for two years, and the appointment made by the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall be for four years. Except as provided in this section, if any vacancy occurs in the membership of the Commission, the appointing authority shall appoint another person to fill the unexpired term of the vacating member. After the initial terms established herein have expired, all appointees to the Commission shall be appointed to terms of four years.

The Commission members shall elect the ~~chairman and vice-chairman~~ chair and vice-chair of the Commission. The Commission may, by majority vote, remove any member of the Commission for chronic absenteeism, misfeasance, malfeasance or other good cause."

Section 6.2. G.S. 58-37-35(d) reads as rewritten:

"(d) The Facility shall be administered by a Board of Governors. The Board of Governors shall consist of 12 members having one vote each from the classifications hereinafter enumerated plus the Commissioner who shall serve ex officio without vote. Each Facility insurance company member serving on the Board shall be represented by a senior officer of the company. Not more than one company in a group under the same ownership or management shall be represented on the Board at the same time. Five members of the Board shall be selected by the member insurers, which members shall be fairly representative of the industry. To insure representative member insurers, one each shall be selected from the following groups: the American Insurance Association (or its successors), the Alliance of American Insurers (or its successors), the National Association of Independent Insurers (or its successors), all other stock insurers not affiliated with the above groups, and all other nonstock insurers not affiliated with the above groups. The Commissioner shall appoint two members of the Board who shall be Facility insurance company members domiciled in this State. The Commissioner shall appoint one member of the Board who shall be selected from a list of two nominees submitted by the Auto Insurance Agents of North Carolina, Inc. The Commissioner shall appoint four members of the Board who shall be fire and casualty insurance agents licensed in this State and actively engaged in writing motor vehicle insurance in this State. The Commissioner shall select ~~one agent~~ two agents from among a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina, ~~Inc., and one agent from among a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents.~~ Inc., (or its successors). The initial term of office of said Board members shall be two years. Following completion of initial terms, successors to the members of the original Board of Governors shall be selected to serve three years. All members of the Board of Governors shall serve until their successors are selected and qualified and the Commissioner may fill any vacancy on the Board from any of

the aforementioned classifications until such vacancies are filled in accordance with the provisions of this Article. The Board of Governors of the Facility shall also have as nonvoting members two persons who are not employed by or affiliated with any insurance company or the Department and who are appointed by the Governor to serve at ~~his~~ the Governor's pleasure."

Section 6.3. G.S. 58-33-135(b) reads as rewritten:

"(b) The ~~fire and casualty~~ property and liability advisory committee shall comprise:

(1) Two employees of the Department of Insurance;

(2) ~~One representative~~ Two representatives from a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina;

~~(3) One representative from a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents (North Carolina Division);~~

(4) One representative of a licensed property and ~~casualty~~ liability insurance company writing business in this State that operates through an exclusive agency force;

(5) One representative from a list of two nominees submitted by the North Carolina Adjusters Association;

(6) One representative of ~~fire~~ property and ~~casualty~~ liability insurers from a list of two nominees submitted by the Association of North Carolina Property and Casualty Insurance Companies; and

(7) One representative from a list of two nominees submitted by the Department of Community Colleges."

PART VII. MISCELLANEOUS CORRECTIONS.

Section 7.1. G.S. 58-3-15 reads as rewritten:

"§ 58-3-15. Additional or coinsurance clause.

No insurance company or agent licensed to do business in this State may issue any policy or contract of insurance covering property in this State ~~which shall contain~~ that contains any clause or provision requiring the insured to take or maintain a larger amount of insurance than that expressed in ~~such~~ the policy, nor in any way provide that the insured shall be liable as a coinsurer with the company issuing the policy for any part of the loss or damage to the property described in ~~such~~ the policy, and any such clause or provision shall be null and void, and of no effect: Provided, the coinsurance clause or provision may be written in or attached to a policy or policies issued when there is printed or stamped on the ~~filing face~~ declarations page of ~~such~~ the policy or on the form containing ~~such~~ the clause the words 'coinsurance contract,' and the Commissioner may, in ~~his~~ the Commissioner's discretion, determine the location of the words 'coinsurance contract' and the size of the type to be used. If there ~~be~~ is a difference in the rate for the insurance with and without the coinsurance clause, the rates for each shall be furnished the insured upon request."

Section 7.2. G.S. 58-30-5 reads as rewritten:

"**§ 58-30-5. Persons covered.**

The proceedings authorized by this Article may be applied to:

(1) All insurers ~~who~~ that are doing, or have done, an insurance business in this State, and against whom claims arising from that business may exist now or in the future.

(2) All insurers ~~who~~ that purport to do an insurance business in this State.

(3) All insurers ~~who~~ that have insureds resident in this State.

(4) All persons organized or in the process of organizing with the intent to do an insurance business in this State.

(5) All persons subject to Articles 64, 65 and 66, or 67 of this Chapter; except to the extent there is a conflict between the provisions of this Article and the provisions of those Articles, in which case those Articles will govern.

(6) Self-insured group workers' compensation funds ~~organized under G.S. 97-93(a)(2).~~ subject to Article 47 of this Chapter."

Section 7.3. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity that is or should be licensed under Articles 7, 16, 26, 47, 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).~~ or under Article 5 of Chapter 97 of the General Statutes. For the purposes of this Article, 'insurer' also includes continuing care retirement centers that are or should be licensed under Article 64 of this Chapter."

PART VIII. AUTOMOBILE INSURANCE.

Section 8.1. G.S. 58-36-75(c) is repealed.

Section 8.2. 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 8.3. 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 dollars ($100,000)~~ one million dollars ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;

Uninsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

Section 8.4. 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~~ chair and shall ~~then~~ meet ~~thereafter as often as~~ at the call of the ~~chairman shall require~~ chair or at the request of ~~three~~ four members of the Board of Governors. The ~~chairman~~ chair 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~~ chair for more than two consecutive ~~years.~~ years; provided, however, that a member may continue to serve as chair until a successor chair is elected and qualified."

Section 8.5. 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;~~ losses; (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 8.6. 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 8.7. 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)~~ G.S. 58-37-40(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 8.8. 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 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 8.9. G.S. 58-37-75 is repealed.

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 9. 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. RECODIFICATION CORRECTIONS.

Section 10. The phrase "Articles 1 through 64 of this Chapter" is deleted and replaced by the words "this Chapter" wherever it occurs in each of the following sections of the General Statutes:

G.S. 58-1-1.	Title of the Chapter.
G.S. 58-1-15.	Warranties by manufacturers, distributors, or sellers of goods or services.
G.S. 58-2-40.	Powers and duties of Commissioner.
G.S. 58-2-45.	Orders of Commissioner; when writing required.
G.S. 58-2-90.	Extent of review under § 58-2-80.
G.S. 58-2-150.	Oath required for compliance with law.
G.S. 58-2-155.	Investigation of charges.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-5.	No insurance contracts except under Articles 1 through 64 of this Chapter.
G.S. 58-3-30.	Meaning of terms "accidental injury", and "accidental means".
G.S. 58-3-35.	Stipulations as to jurisdiction and limitation of actions.
G.S. 58-3-85.	Corporation or association maintaining office in State required to qualify and secure license.
G.S. 58-3-105.	Limitation of risk.
G.S. 58-3-130.	Agent, adjuster, etc., acting without a license or violating insurance law.
G.S. 58-3-145.	Solicitation, negotiation, or payment of premiums on insurance policies through credit card facilities prohibited; exceptions.
G.S. 58-5-50.	Deposits of foreign life insurance companies.
G.S. 58-5-55.	Deposits of capital and surplus by domestic insurance companies.
G.S. 58-5-90.	Deposits held in trust by Commissioner or Treasurer.
G.S. 58-5-100.	Deposits by alien companies required and regulated.
G.S. 58-6-5.	Schedule of fees and charges.
G.S. 58-6-15.	Licenses run from July 1.
G.S. 58-7-1.	Application of Articles 1 through 64 of this Chapter and general laws.
G.S. 58-7-15.	Kinds of insurance authorized.
G.S. 58-7-75.	Amount of capital and/or surplus required; impairment of capital or surplus.
G.S. 58-7-115.	Increase of capital stock.
G.S. 58-8-20.	Mutual companies with a guaranty capital.
G.S. 58-13-15.	Definitions.
G.S. 58-13-20.	Exception.
G.S. 58-15-15.	Risk limitations.

G.S. 58-15-30.	License, surplus, and deposit requirements.
G.S. 58-15-35.	Continuation of business under prior requirements.
G.S. 58-15-45.	Attorney's domicile.
G.S. 58-16-1.	Admitted to do business.
G.S. 58-16-5.	Conditions of admission.
G.S. 58-16-15.	Foreign companies; requirements for admission.
G.S. 58-16-40.	Alternative service of process on insurers.
G.S. 58-16-50.	Action to enforce compliance with this Chapter.
G.S. 58-19-10.	Subsidiaries of insurers.
G.S. 58-19-35.	Examination.
G.S. 58-20-10.	Commercial Fishermen Hull Insurance, and Protection and Indemnity Clubs authorized.
G.S. 58-22-30.	Countersignature not required.
G.S. 58-22-50.	Administrative and procedural authority regarding risk retention groups and purchasing groups.
G.S. 58-24-130.	Annual license.
G.S. 58-24-140.	Foreign or alien society admission.
G.S. 58-25-25.	Conditions precedent to doing business.
G.S. 58-28-1.	Purpose of Article.
G.S. 58-30-75.	Grounds for rehabilitation.
G.S. 58-33-120.	Agent, adjuster, etc., acting without a license or violating insurance law.
G.S. 58-34-5.	Retrospective compensation agreements.
G.S. 58-40-65.	Insurers authorized to act in concert.
G.S. 58-40-130.	Financial disclosure; rate modifications; reporting requirements.
G.S. 58-41-10.	Scope.
G.S. 58-43-1.	Performance of contracts as to devices not prohibited.
G.S. 58-43-35.	Punishment for issuing fire policies contrary to law.
G.S. 58-50-25.	Nurses' services.
G.S. 58-50-30.	[Note: Effective until July 1, 1999.] Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, or advanced practice registered nurse.
G.S. 58-51-20.	Renewability of individual and blanket hospitalization and accident and health insurance policies.
G.S. 58-51-35.	Insurers and others to afford coverage to mentally retarded and physically handicapped children.
G.S. 58-51-40.	Insurers and others to afford coverage for active medical treatment in tax-supported institutions.
G.S. 58-51-45.	Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.
G.S. 58-52-1.	Definitions.

G.S. 58-52-5.	Joint action to insure persons 65 years of age or over and their spouses permitted; associations of insurers; individual and group policies.
G.S. 58-52-15.	Forms and rate manuals subject to § 58-51-1; disapproval of rates.
G.S. 58-54-1.	Definitions.
G.S. 58-57-1.	Application of Article.
G.S. 58-58-25.	Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.
G.S. 58-58-55.	Standard nonforfeiture provisions.
G.S. 58-58-160.	Voting power under policies of group life insurance.
G.S. 58-60-1.	Purpose of Article.
G.S. 58-65-130.	Amendments to certificate of incorporation.
G.S. 58-69-45.	Insurance licensing provisions not affected.

PART XI. EXAMINATION LAW -- CROSS REFERENCE CORRECTIONS.

Section 11.1. G.S. 58-3-155(c) reads as rewritten:

"(c) No licensed property or casualty insurer that has control of a broker may accept insurance from the broker in any transaction in which the broker, when the insurance is placed, is acting as such on behalf of the insured for any compensation, commission, or thing of value unless the broker, before the effective date of the coverage, delivers written notice to the prospective insured disclosing the relationship between the insurer and broker. The disclosure must be signed by the insured and must be retained in the insurer's underwriting file until the completion and release of the examination report under ~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 for the period in which the coverage is in effect. If the insurance is placed through a subbroker that is not a controlled broker, the controlling insurer shall retain in its records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has notified or will notify the insured."

Section 11.2. G.S. 58-20-30 reads as rewritten:

"**§ 58-20-30. Financial monitoring and evaluation of clubs.**

Each club shall be audited annually, at the Club's expense, by a certified public accounting firm. A copy of the audit report shall be furnished to each member, and to the Commissioner. The trustees shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expenses reserves of the Club, including estimate of losses and loss adjustment expenses incurred but not reported. The provisions of G.S. 58-2-131 through ~~G.S. 58-2-133,~~ G.S. 58-2-134, G.S. 58-2-150, 58-2-160, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and G.S. 58-6-5 apply to each Club and to persons that administer the Clubs."

Section 11.3. G.S. 58-21-40(c) reads as rewritten:

"(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each advisory organization; in which case the provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-180, 58-2-185, 58-

2-190, 58-2-195, and 58-2-200 shall apply. If the Commissioner finds the advisory organization or any member thereof to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation."

Section 11.4. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, G.S. 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 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, 58-7-175, 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, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

Section 11.5. G.S. 58-26-10 reads as rewritten:

"**§ 58-26-10. Financial statements and licenses required.**

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The Commissioner shall annually license such companies and their agents."

Section 11.6. G.S. 58-34-2(m) reads as rewritten:

"(m) The acts of an MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined by the Commissioner under ~~G.S. 58-2-131, 58-2-132, or 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 as if it were an insurer."

Section 11.7. G.S. 58-47-100 reads as rewritten:

"**§ 58-47-100. Examinations.**

~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 apply to groups."

Section 11.8. G.S. 58-47-195 reads as rewritten:

"**§ 58-47-195. Examinations.**

TPAs and service companies may be examined under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.9. G.S. 58-64-55 reads as rewritten:

"**§ 58-64-55. Examinations; financial statements.**

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a facility offering continuing care in this State to examine its books and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the facility examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference."

Section 11.10. G.S. 58-67-100(a) reads as rewritten:

"(a) The Commissioner may make an examination of the affairs of any health maintenance organization and the contracts, agreements or other arrangements

pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years. Examinations shall otherwise be conducted under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.11. G.S. 143-215.94I(g) reads as rewritten:

"(g) Each pool shall be audited annually at the expense of the pool by a certified public accounting firm, with a copy of the report available to the governing body or chief executive officer of each member of the pool and to the Commissioner. The board of trustees of the pool shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expense reserves of the pool, including an estimate of losses and loss adjustment expenses incurred but not reported. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and 58-6-5 apply to each pool and to persons that administer the pools. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year. All financial statements required by this section shall be prepared in accordance with generally accepted statutory accounting principles."

PART XII. MOTOR CLUBS.

Section 12.1. G.S. 58-69-1, 58-77-1, and 58-77-5 are repealed.

Section 12.2. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-2. Definitions.**

As used in this Article:

(1) 'Branch or district office' means any physical location, other than a motor club's home office, where the motor club or its representatives conduct any type of business authorized under this Article.

(2) 'Motor club' means any person, whether or not residing, domiciled, or chartered in this State, that, in consideration of dues, assessments, or periodic payments of money, promises its members to assist them in matters relating to the ownership, operation, use, or maintenance of motor vehicles by rendering three or more of the following services:

a. Automobile theft reward service. -- A reward payable to any person, law enforcement agency, or officer for information leading to the recovery of a member's stolen vehicle and to the apprehension and conviction of the person or person's unlawfully taking the vehicle.

b. Bail or cash appearance bond service. -- The furnishing of cash or a surety bond for a member accused of a violation of the motor vehicle law, or of any law of this State by reason of an automobile accident to secure the member's release and subsequent appearance in court.

c. Emergency road service. -- Roadside adjustment of a motor vehicle so that the vehicle may be operated under its own power.

d. Legal service. -- Providing for reimbursement to a member for attorneys' fees if criminal proceedings are instituted against the member as a result of the operation of a motor vehicle.

e. Map service. -- The furnishing of road maps to members without cost.

f. Personal travel and accident insurance service. -- Making available to members a personal travel and accident insurance policy issued by a duly licensed insurance company in this State.

g. Touring service. -- The furnishing of touring information to members without cost.

h. Towing service. -- Furnishing means to move a motor vehicle from one place to another under power other than its own.

(3) 'Licensee' means a motor club to which a license has been issued under this Article."

Section 12.3. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-50. Authority for qualified surety companies to guarantee certain arrest bond certificates.**

(a) Any domestic or foreign surety company that is authorized to do business in this State may become a surety, by filing with the Department an undertaking to become a surety, in an amount not to exceed one thousand five hundred dollars ($1,500) with respect to each guaranteed arrest bond certificate issued by a motor club.

(b) The undertaking shall be in a form to be prescribed by the Department and shall state:

(1) The name and address of the motor club or clubs with respect to which the surety company undertakes to guarantee the arrest bond certificates.

(2) The unqualified obligation of the surety company to pay the fine or forfeiture, in an amount not to exceed one thousand five hundred dollars ($1,500) of any person who, after posting a guaranteed arrest bond certificate which the surety has undertaken to guarantee, fails to make the appearance for which the guaranteed arrest bond certificate was posted."

Section 12.4. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-55. Guaranteed arrest bond certificates accepted.**

(a) Any guaranteed arrest bond certificate guaranteed by a surety company under G.S. 58-69-50 shall be accepted in lieu of cash bail or other bond in an amount not to exceed one thousand five hundred dollars ($1,500) as a bail bond, when signed by the person whose signature appears on the certificate, to guarantee the appearance of that person in any court in this State at the time set by the court when the person is arrested for the violation of any motor vehicle law of this State or any motor vehicle ordinance of any municipality of this State. The guaranteed arrest bond certificate shall not apply to, and shall not be accepted in lieu of, cash bail or bond when the person has been arrested for any impaired driving offense or for any felony.

(b) A guaranteed arrest bond certificate that is posted as a bail bond in any court shall be subject to the forfeiture and enforcement provisions with respect to bail bonds in criminal cases as provided by law."

PART XIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 13.1. G.S. 58-47-65(f)(3) reads as rewritten:

"(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~~ each member. The financial statements are confidential, but the Commissioner may use them in any judicial or administrative proceeding."

Section 13.2. G.S. 58-47-85(2)c. reads as rewritten:

"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, which, at a minimum, is 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."

Section 13.3. G.S. 58-47-120(f)(11) reads as rewritten:

"(11) Qualifications for group membership, including underwriting guidelines and procedures to identify ~~members~~ any member that ~~are~~ is in a hazardous financial ~~conditions.~~ condition."

Section 13.4. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

~~(1) Obtain from each member self-insurer and file with the Commissioner individual reports specifying the aggregate benefits each member paid during the previous calendar year, and the annual standard premium that would have been paid by the individual member self-insurer during the previous calendar year, pursuant to manual rates established by the North Carolina Rate Bureau and using the experience rating procedure approved by the Commissioner for that member self-insurer or the annual premium collected by each group member self-insurer during the prior calendar year. These reports shall be due on or before July 15 following the close of that calendar year, except that this deadline may be extended by the Commissioner for up to three additional months for good cause shown.~~

(2) Assess each member of the Association as follows:

a. Each individual member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual ~~standard premium~~ gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual ~~standard premium.~~ gross premiums. Each group member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~premium collected by~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this one-quarter of one percent (0.25%) assessment. Assessments paid by members pursuant to this

subdivision shall be credited toward the tax paid by self-insurers under Article 8B of Chapter 105 of the General Statutes. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll information as determined under G.S. 105-228.5(b), (b1), and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.

b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

c. If a self-insurer is a member of the Association for less than a full calendar year, the annual ~~standard premium~~ gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.

d. If application of the contribution rates referenced in ~~sub-subdivisions a. and b.~~ sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.

(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers

from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.

The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Be obligated to the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter. The Association shall pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this Article.

(5) After paying any claim resulting from a self-insurer's insolvency, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Assess the Fund in an amount necessary to pay only:

a. The obligations for the Association under this Article subsequent to an insolvency;

b. The expenses of handling covered claims subsequent to an insolvency;

c. The cost of examinations under G.S. 97-137; and
d. Other expenses authorized by this Article;

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Notify such persons as the Commissioner directs under G.S. 97-136;

(9) Handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association;

(11) Pay the other expenses of the Association authorized by this section; and

(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions ~~(1), (2),~~ (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association;

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post-insolvency assessment which shall be imposed as follows:

(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the

annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c) of the individual member self-insurer for the premium calendar year bears to the annual ~~standard premium~~ gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual ~~collected premium~~ gross premiums of the group member self-insurer for the premium calendar year bears to the annual ~~collected premium~~ gross premiums of all group member self-insurers for the preceding calendar year.

(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.

(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~premium collected by~~ gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year."

Section 13.5. G.S. 97-165(2) reads as rewritten:

"(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.~~ principles."

Section 13.6. G.S. 97-170(c) reads as rewritten:

"(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.~~ insurance."

Section 13.7. G.S. 97-170(d)(4) is repealed.

Section 13.8. G.S. 97-180(b) reads as rewritten:

"(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.~~ North Carolina. 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."

Section 13.9. G.S. 97-180(d) reads as rewritten:

"(d) ~~Every~~ Upon the request of the Commissioner, every self-insurer shall submit ~~within 120 days after the end of its fiscal year~~ a report of its 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."

PART XIV. EFFECT OF HEADINGS.

Section 14. 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 15. This act is effective when it becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 25, 1999

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: PCS for HB 296 – Insurance Technical Changes

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1.1 repeals G.S. 58-3-125 (revocation of license), G.S. 58-6-10 (licensing of underwriters), G.S. 58-7-150 (consolidation of insurers), and G.S. 58-71-90 (bondsmen appeal) because they are obsolete or unnecessary.

Section 1.2 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 in 1996 if it has not made its required contribution by July 1.

Sections 1.3 and 1.4 make conforming changes to statutes containing references to statutes repealed in Section 1.1.

PART II. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION.

Sections 2.1 through 2.5 amend General Statute Chapter 58, Article 64 to rename "continuing care facilities" as "continuing care retirement communities."

PART III. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Sections 3.1 through 3.12 add references in the Rate Bureau laws to the 1995 workers' compensation loss costs legislation. These references were inadvertently omitted in the 1995 legislation. They make clarifying changes in statutes concerning deviations from rates filed with the Rate Bureau. It amends G.S. 58-36-100(b)(1) to include a definition of expenses taxes "levied by the State or by any political subdivision of the State, licensing costs, fees."

PART IV. HEALTH INSURANCE CLARIFYING CHANGES.

Sections 4.1 through 4.8 make several changes to clarify provisions in the 1997 North Carolina legislation on federal health insurance changes (HB 434, 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 V. BAIL BONDS.

Section 5 amends G.S. 58-71-82 (bail bond licenses) to clarify that holding a professional bondsman's license or runner's license and a surety bondsman's license simultaneously are considered one license only for the purpose of disciplinary action involving the licenses.

PART VI. AGENT ASSOCIATIONS MERGER

On January 1, 1999, the Carolinas Association of Professional Insurance Agents, Inc., (CAPIA) merged with the Independent Insurance Agents of North Carolina, Inc. (IIANC). Sections 6.1 through 6.3 merge statutory references and responsibilities of CAPIA into IIANC. For example, where three nominees to the Public Officers and Employees Liability Insurance Commission are now made by CAPIA under G.S. 58-32-1, those nominees would come from the IIANC. Section 6.3 also renames "fire and casualty" under G.S. 58-33-135(b) as "property and liability."

PART VII. MISCELLANEOUS CORRECTIONS

Section 7.1 updates language that is no longer used ("filing face" is now "declarations page").

Section 7.2 corrects a statutory reference to conform with 1997 legislation on workers' compensation self-insurance.

PART VIII. AUTOMOBILE INSURANCE.

Sections 8.1 through 8.9 make technical amendments and corrections in laws on automobile insurance, including raising the amount of uninsured motorist and underinsured motorist coverage in a policy that can be ceded to the Reinsurance Facility to $1,000,000 – the amount that a driver can already obtain for that coverage. They repeal G.S. 58-36-75(c) (list of offenses to which facility recoupment surcharges apply) and G.S. 58-37-75 (re-allocation of facility recoupment), which both expired in 1995 and are obsolete. They amend G.S. 58-37-1 and 58-37-35(b)(2) to clarify that underinsured motorist insurance is included in the definition of motor vehicle insurance. They increase uninsured motorist coverage for property damage from $15,000 to $50,000. They amend

G.S. 58-37-35(e) to clarify that a chair of the Reinsurance Facility Board of Governors may continue to serve as chair until a successor is elected and qualified, even if it takes the chair beyond their two-year limit of service.

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Sections 9.1 through 9.3 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. RECODIFICATION CORRECTIONS.

When General Statute Chapter 58 was recodified, other General Statute chapters and provisions outside of Chapter 58 were included in the new Chapter 58. To facilitate this process, what had been Chapter 58 was included in the first sixty-four articles of new Chapter 58. Therefore, there are many places where the term, "Articles 1 through 64 of this Chapter" appears. Section 10 contains a list of statutes in which this awkward reference is unnecessary, and changes the reference to "this Chapter."

PART XI. EXAMINATION LAW – CROSS REFERENCE CORRECTIONS

In 1998, the General Assembly amended the insurance company examination law and added a new statute, G.S. 58-2-134. Sections 11.1 through 11.11 amend various statutes to reflect the 1998 law (Session Law 1998-212, Section 26B).

PART XII. MOTOR CLUBS.

Section 12.1 repeals three statutes (G.S. 58-69-1, 58-77-1, and 58-77-2), which are rewritten and improved in Sections 12.2 through 12.4.

Section 12.2 rewrites and reorganizes G.S. 58-69-1 (definitions). It also adds a definition for "branch or district office," which is needed for clarification.

Sections 12.3 and 12.4 rewrite and improve the provisions of G.S. 58-77-1 and 58-77-2, which deal with arrest bond certificates written by surety companies for motor clubs. They also include the new provisions in the motor club law (Article 69).

PART XIII. WORKERS' COMPENSATION SELF-INSURANCE.

Sections 13.1 through 13.9 make a number of technical corrections and amend G.S. 97-170(c) to remove requirements concerning employee base for applicants for self-insurance and amend G.S. 97-180(d) to provide that self-insurers must provide a report of

annual payroll information on the Commissioner's request (now, within 120 days after the end of the fiscal year).

PART XIV. EFFECT OF HEADINGS.

Section 15 provides that the headings to the parts of the act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of the act.

PART XV. EFFECTIVE DATE.

Section 16 provides that the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 306

Short Title: Insurance Amendments/AB. (Public)

Sponsors: Representatives Hardaway; and Hurley.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, AND TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES.

The General Assembly of North Carolina enacts:

PART I. HEARINGS AND FAIR AND BEACH PLANS APPEALS.

Section 1.1. G.S. 58-2-50 reads as rewritten:

"**§ 58-2-50. ~~Examinations~~ Examinations, hearings, and investigations.**

All ~~examinations~~ examinations, hearings, and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. All hearings shall, unless otherwise specially provided, be held in accordance with this Article and Article 3A of Chapter 150B of the General Statutes and at a time and place designated in a written notice given by the Commissioner to the person cited to appear. The notice shall state the subject of inquiry and the specific charges, if any."

Section 1.2. 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 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 Commissioner's 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."

Section 1.3. 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~~ after the date of ~~such~~ the ruling or decision. The Commissioner, after a 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 II. CONTINUING CARE RETIREMENT RECEIVERSHIPS.

Section 2. 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, the Department of Health

and Human Services may, notwithstanding any other provision of law, accept and approve the addition of beds for that facility if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the facility or (ii) 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."

PART III. HANDICAPPED PERSONS.

Section 3.1. 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 and other coverage provisions 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 3.2. G.S. 168-22(b) reads as rewritten:

"(b) A family care home shall be 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 IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1. 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 the provisions of G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall~~ insurance policy. This Article and Articles 65 and 67 of this Chapter and any administrative rules adopted under these 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 of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation, the provisions of Chapter 97 govern."

Section 4.2. G.S. 97-2(21) reads as rewritten:

"(21) Managed care organization. -- The term 'managed care organization' means a preferred provider organization or a health maintenance organization regulated under Chapter 58 of the General Statutes. 'Managed care organization' also means a preferred provider benefit plan of an insurance company, hospital, or medical service corporation in which utilization review or quality management programs are used to manage the provision of health care services and benefits under this Chapter."

PART V. COMMERCIAL AIRCRAFT INSURANCE.

Section 5.1. G.S. 58-7-15(19) reads as rewritten:

"(19) 'Motor vehicle ~~and aircraft~~ insurance,' meaning insurance against loss of or damage resulting from any cause to motor vehicles or ~~aircraft~~ and their equipment, and against legal liability of the insured for loss or damage to another's property resulting from the ownership, maintenance or use of motor vehicles or ~~aircraft~~ and against loss, damage or expense incident to a claim of such liability."

Section 5.2. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to ~~aviation~~ commercial aircraft insurance; to policies issued in this State covering risks with multistate locations, except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 5.3. G.S. 58-21-10(8) reads as rewritten:

"(8) 'Surplus lines insurance' means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be

placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, ~~aviation~~ commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities."

Section 5.4. G.S. 58-28-5(a) reads as rewritten:

"(a) Except as ~~hereinafter provided,~~ otherwise provided in this section, it ~~shall be~~ is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in G.S. 58-28-10, without a ~~certificate of authority~~ license issued by the Commissioner. This section ~~shall~~ does not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this ~~Chapter;~~ Chapter.

(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the ~~Commissioner;~~ Commissioner.

(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such ~~policy;~~ policy.

(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or franchise accident and health insurance where the master policy ~~of such~~ for the insurance was lawfully issued and delivered in a state ~~where~~ in which the company was authorized to transact ~~business;~~ business.

(5) Transactions in this State involving all policies of insurance issued ~~prior to~~ before July 1, ~~1967;~~ 1967.

(6) The procuring of contracts of insurance issued to a nuclear ~~insured;~~ insured. As used in this subdivision, 'nuclear insured' means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.

(7) Insurance independently procured, as specified in subsection (b) of this ~~section;~~ section.

(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.

(9) Transactions in this State involving commercial aircraft insurance, meaning insurance against (i) loss of or damage resulting from any cause to commercial aircraft and its equipment, (ii) legal liability of the insured for loss or damage to another person's property resulting from the ownership, maintenance, or use of commercial aircraft, and (iii) loss, damage, or expense incident to a liability claim."

Section 5.5. G.S. 58-1-5 reads as rewritten:

"**§ 58-1-5. Definitions.**

In this Chapter, unless the context clearly requires otherwise:

(1) 'Alien company' means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(1a) 'Commercial aircraft' means aircraft used in domestic, flag, supplemental, commuter, or on-demand operations, as defined in Federal Aviation Administration Regulations, 14 C.F.R. § 119.3, as amended.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina or an authorized designee of the Commissioner.

(3) 'Company' or 'insurance company' or 'insurer' includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations. 'Company' or 'insurance company' or 'insurer' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(4) 'Department' means the Department of Insurance of North Carolina.

(5) 'Domestic company' means a company incorporated or organized under the laws of this State.

(6) 'Foreign company' means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State.

(7) 'NAIC' means the National Association of Insurance Commissioners.

~~(8) "Nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.~~

(9) 'Person' means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert. "Person" does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(10) The singular form ~~shall include~~ includes the plural, and the masculine form ~~shall include~~ includes the feminine wherever appropriate."

PART VI. SURPLUS LINES FILINGS.

Section 6.1. G.S. 58-21-35 reads as rewritten:

"**§ 58-21-35. Duty to file ~~evidence of insurance and affidavits.~~ reports and retain affidavit.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall ~~execute and~~ file with the ~~Commissioner.~~ Commissioner a

~~(1)~~ ~~A written~~ report in a format prescribed by the Commissioner regarding the insurance and including the following information:

~~a.~~(1) The name ~~and address~~ of the ~~insured;~~ insured.

~~b.~~(2) The identity of the insurer or ~~insurers;~~ insurers.

~~c.~~(3) A description of the subject and location of the ~~risk;~~ risk.

~~d.~~(4) The amount of premium charged for the ~~insurance; and~~ insurance.

~~e. Such other pertinent information as the Commissioner may reasonably require; and~~

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

~~(2)~~ ~~An~~

(b) The licensee shall complete and retain an affidavit as to the efforts to place the coverage with admitted insurers and the results ~~thereof~~ of the efforts, in accordance with G.S. 58-21-15. The report and affidavit required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

Section 6.2. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-2. Relationship to other insurance laws.**

Unless surplus lines insurance, surplus lines licensees, or nonadmitted insurers are specifically referenced in a particular section of this Chapter, no sections contained in Articles of this Chapter other than this Article apply to surplus lines insurance, surplus lines licensees, or nonadmitted insurers."

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7. G.S. 105-259(b) is amended by adding a new subdivision to read:

"(16a) To provide the North Carolina Self-Insurance Guaranty Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of collecting the assessments authorized in G.S. 97-133(a)."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8. 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 or changes ~~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."

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9. G.S. 58-41-35 is repealed.

Section 9.1. 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 X. MORTALITY TABLE AND RESERVES UPDATE.

Section 10. G.S. 58-58-50(k) reads as rewritten:

"(k) The Commissioner shall adopt rules containing the minimum standards applicable to the valuation of health plans. The Commissioner may also adopt rules for the purpose of recognizing new annuity mortality tables for use in determining

reserve liabilities for annuities and may adopt rules that govern minimum valuation standards for reserves of life insurance companies. In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC."

PART XI. EFFECT OF HEADINGS.

Section 11. 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 12. Sections 2 through 11 of this act become effective October 1, 1999. The remainder of this act is effective when this act becomes law, but Sections 1.1, 1.2, and 1.3 of this act shall not apply to appeals pending on the date this act becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 25, 1999

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: PCS for HB 306 – Insurance Amendments

PART I. HEARINGS AND FAIR AND BEACH PLAN APPEALS

Section 1.1 amends G.S. 58-2-50 to require that all hearings provided for in General Statute Chapter 58 are to be held by the Commissioner or his designee; that all hearings be held in accordance with Article 2 of General Statute Chapter 58 and General Statute Chapter 150B, Article 3A (Administrative Procedure Act), unless otherwise provided; and that there be written notice of all hearings..

Sections 1.2 and 1.3 amend G.S. 58-45-50 and 58-46-30 to provide that FAIR and Beach Plan appeal procedures and recording and transcribing fees are to be set by the Commissioner, rather than by statute.

PART II. CONTINUING CARE RETIREMENT COMMUNITY RECEIVERSHIPS.

Section 2 adds a new G.S. 58-64-46, applicable when the Commissioner has been appointed a receiver under Article 30 of General Statute Chapter 58 for a provider or a facility subject to Article 64, allowing the N.C. Department of Health and Human Services to accept and approve the addition of beds for a facility if it appears to the court that such additional beds will best serve the best interests of the facility or the welfare of the persons who have previously contracted with the provider or who may contract with the facility.

PART III. HANDICAPPED PERSONS.

Section 3.1 amends G.S. 168-10 to extend the prohibition against discrimination against handicapped persons to hospital, medical, and dental service corporations, multiple employer welfare arrangements, and health maintenance organizations. It deletes the proviso allowing insurers to exclude by waiver or otherwise pre-existing conditions. These changes conform with present law.

Section 3.2 amends G.S. 168-22(b) to delete the provision that deems family group home as a residential use of property for insurance classification purposes.

PART IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1 amends G.S. 58-50-65 to provide in the event of any conflicts between managed care rules adopted by the Commissioner and managed care rules adopted by the Industrial Commission, the Industrial Commission's rules govern.

Section 4.2 amends the definition of "managed care organization" in the Workers' Compensation Act to reflect the types of managed care organizations there are today.

PART V. COMMERCIAL AIRCRAFT INSURANCE

Sections 5.1 through 5.5 amend various sections in General Statute Chapter 58, deregulating commercial aircraft insurance.

PART VI. SURPLUS LINES FILINGS.

Section 6.1 amends 58-21-35 to add the required material to reports filed by a surplus lines licensee.

Section 6.2 adds a G.S. 58-21-2 providing that surplus lines insurance and licensees are not subject to other articles of General Statute Chapter 58, unless specifically referenced.

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7.1 amends G.S. 105-259(b) to permit the Department of Revenue to provide the N.C. Self-Insurance Guaranty Association information on workers' compensation self-insurer's premiums, for the purpose of collecting assessments authorized in G.S. 97-133(a).

Section 7.2 amends G.S. 97-133 (powers and duties of Self-insurance Guaranty Association) to delete the duty of obtaining reports about aggregate benefits, to clarify that assessments are based on "gross premiums" rather than "standard premiums", and to require that the Secretary of Revenue provide the Association with a self-insurer premium and payroll information gathered under the specified statutes.

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8 amends G.S. 58-2-120 to delete the requirement that the Commissioner make a biennial report to General Assembly.

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9 repeals G.S. 58-41-35, which requires insurers to file, with the Commissioner, notices of cessation of commercial property and liability insurance business through insurance agencies.

PART X. MORTALITY TABLE AND RESERVES UPDATE.

Section 10 amends G.S. 58-58-50(k) to permit the Commissioner to adopt rules for recognizing new annuity mortality tables for use in determining reserve liabilities for annuities and to adopt rules that govern minimum valuation standards for reserves of life insurance companies.

PART XI. EFFECT OF HEADINGS.

Section 11 provides that the headings to the parts of the 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 DATES.

Section 12. The changes to G.S. 58-2-50, 58-45-50, and 58-46-30 become effective upon enactment; and other changes become effective October 1, 1999.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 8, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 8, 1999, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Kymberly Foster and Elizabeth Ashley Johnson from Cumberland County. The following Committee members were present: Representatives Barbee, Boyd-McIntyre, Brubaker, Cole, Dedmon, Dockham, Esposito, Grady, Hardaway, Holmes, Redwine, Saunders, Smith, Warner, and Wright. A list of visitors attending is attached (Attachment I). The following bills were considered:

House Bill 294, entitled, AN ACT TO PROVIDE MEDICARE SUPPLEMENT INSURANCE FOR PERSONS WHO DELAY MEDICARE PART B ENROLLMENT; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME ENROLLMENT; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME INSURANCE; TO CONFORM NORTH CAROLINA'S 1997 POST-MASTECTOMY RECONSTRUCTIVE SURGERY LAWS TO THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998; TO UPDATE THE LAW ON VIATICAL SETTLEMENTS; AND TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE. A committee substitute was presented and adopted for committee discussion. Changes were outlined by Bill Hale (see minutes of March 25, 1999, INSURANCE Committee meeting). Representative Redwine moved to amend the committee substitute - Part IV. Viatical Settlements - beginning on page 15, lines 19 – 20, to read "contract null and void" (Attachment II). The amendment was adopted. Representative Wright moved to roll the amendment into the committee substitute and give a favorable report to the committee substitute, unfavorable to the original bill. Motion passed.

House Bill 296, entitled, AN ACT TO REPEAL OBSOLETE OR UNNECESSARY LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES. A new committee substitute was presented and adopted for committee discussion. Additional changes were outlined as follows: Deletes Part X of the bill. Part X of the bill involves changing references to "*Articles 1 through 64 of this Chapter*" to "*this Chapter*." These changes are being removed from the bill so that they can be reviewed further. Deletes Sections 4.9, 4.10, and 4.11 of the bill. These sections involved technical changes to the law enacted two years ago concerning insurance reimbursement for diabetes coverage. It was determined that these changes are not necessary. Restore G.S. 58-7-150, which was proposed to be repealed by Section 1.1 of the bill. The Department has asked that it be restored because of its applicability to mutual insurers. This change also requires deleting Section 1.4. The change in Section 1.4 is not necessary if G.S. 58-7-150 is retained. A new Section 1.4 will be added to make a conforming change to

G.S. 58-33-45(d). This statute needs to be amended to reflect the repeal of G.S. 58-3-125 in Section 1.1 of the bill. Representative Warner moved to give the committee substitute a favorable report, unfavorable to the original bill. Motion passed.

House Bill 306, entitled, AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, AND TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES. A committee substitute was presented and adopted for committee discussion. Changes were outlined. Part II. Continuing Care Retirement Facilities – allows the Department of Health and Human Services, with court approval, to permit additional beds to be added to a continuing care facility in receivership under the Commissioner of Insurance if doing so will help "save" the facility from going under. Representative Redwine moved to amend the committee substitute - Part IV – Workers' Compensation Managed Care - beginning on page 5, line 30 through page 6, line 3 – please see amendment (Attachment III). The amendment was adopted. Representative Barbee moved to roll the amendment into the committee substitute and give a favorable report to the committee substitute, unfavorable to the original bill. Motion passed.

There being no further business, the Chair adjourned the meeting at 12:45 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

Attachment I

VISITOR REGISTRATION SHEET

Insurance 4-8-99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1.	NASW-NC
2. John McMillan	MFJS
3. Susan Valauri	National Life
4. Joe Piercy	NCALU
5. Beth Price	Jordan Price
6. Joyce Pedersen	MAMSI
7. Cathleen M Smith	Claxo
8. Betsy Cooke	Edwards Law Firm for NCSICHA
9. Ann Case	NCRMA
10. Andy Eller	NCLMA
11. Geoge Fawley	NC Ins. News Service
12. Steve Halstead	Integon Corp
13. Cindy Lamb	VCSR
14. Jerry Gno Brim	NCMS
15. Steve Theeren	NCMS
16. Steve Woodson	NCFB
17. Beth Nielsen	BCBSNC
18. W H Potter Jr	NCDS & NCPTA
19. Wade Wilson	NCHBA
20.	Mem. Va Allen
21. Dave Howard	Smith Anderson

VISITOR REGISTRATION SHEET

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Harry Kaplan	Hunton & Williams
2.	Amy Fulbright	
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Reported out 4-12-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 294 AN ACT TO PROVIDE MEDICARE SUPPLEMENT INSURANCE FOR PERSONS WHO DELAY MEDICARE PART B ENROLLMENT; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME INSURANCE; TO CONFORM NORTH CAROLINA'S 1997 POST-MASTECTOMY RECONSTRUCTIVE SURGERY LAWS TO THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998; TO UPDATE THE LAW ON VIATICAL SETTLEMENTS; AND TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE .

☐ 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).

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 294
Committee Substitute Favorable 4/12/99

Short Title: Life & Health Ins. Amendments/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING THE APPLICABILITY OF PREEXISTING CONDITION LIMITATIONS TO CERTAIN TYPES OF HEALTH INSURANCE POLICIES; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME INSURANCE; TO CONFORM NORTH CAROLINA'S 1997 POSTMASTECTOMY RECONSTRUCTIVE SURGERY LAWS TO THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998; TO UPDATE THE LAW ON VIATICAL SETTLEMENTS; AND TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE.

The General Assembly of North Carolina enacts:

PART 1. PREEXISTING CONDITIONS FOR SPECIFIED DISEASE AND HOSPITAL INDEMNITY POLICIES.

Section 1. G.S. 58-51-15(h) 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), (2), and (4)."

PART 2. DISABILITY INCOME INSURANCE.

Section 2. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-130. Standards for disability income insurance policies.**

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

(1) 'Disability income insurance policy' or 'policy' means a policy of accident and health insurance that provides payments when the insured is unable to work because of illness, disease, or injury.

(2) 'Policy' includes the certificates referred to in subsection (b) of this section.

(b) Applicability. -- This section applies to all policies used in this State, including certificates issued under group policies that are used in this State. This section also applies to a certificate issued under a policy issued and delivered to a trust or to an association outside of this State and covering persons residing in this State.

(c) Disclosure Standards. -- Every disability income insurance policy shall include provisions, where applicable, addressing:

(1) Terms of renewability.

(2) Initial and subsequent conditions of eligibility.

(3) Nonduplication of coverage.

(4) Preexisting conditions.

(5) Probationary periods.

(6) Elimination periods.

(7) Requirements for replacement.

(8) Recurrent conditions.

(9) Definitions of terms.

(d) Preexisting Conditions. -- If an insurer does not seek a prospective insured's medical history in the application or enrollment process, the insurer shall not deny a claim for disabilities that commence more than 24 months after the effective date of the insured person's coverage on the grounds the disability is caused by a preexisting condition. A policy shall not define a preexisting condition more restrictively than 'a condition for which medical advice, diagnosis, care, or treatment was received or recommended within the 24-month period immediately preceding the effective date of coverage of the insured person.'

(e) Exceptions. -- Nothing in this section prohibits an insurer from:

(1) Using an application or enrollment form designed to elicit the medical history of a prospective insured.

(2) Underwriting based on answers on the form according to the insurer's established standards.

(3) Contesting the answers in accordance with G.S. 58-51-15(a)(2)a.

(f) Required Provisions. -- Each policy shall include:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the exceptions, reductions, and limitations contained in the policy.

(3) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

(g) Other Applicable Provisions. -- G.S. 58-51-95(f) applies to individual policies and G.S. 58-51-80(g) applies to group policies.

(h) Other Income Sources. -- If a policy contains a provision that provides for integration of benefits with other income sources, it shall include a definition of what is considered other income sources and a complete description of how benefits will be reduced by other income sources, if at all. No disability income policy shall provide that the amount of any disability benefit paid to the insured shall be reduced by reason of any cost-of-living increase, designated as such under the federal Social Security Act, if the cost-of-living increase occurs during the period for which benefits are payable."

PART 3. RECONSTRUCTIVE SURGERY CONFORMING CHANGES.

Section 3.1. G.S. 58-51-62 reads as rewritten:

"**§ 58-51-62. Coverage for reconstructive breast surgery ~~resulting from~~ following mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under ~~G.S. 58-50-60~~ G.S. 58-50-56 ~~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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter."

Section 3.2. G.S. 58-65-96 reads as rewritten:

"**§ 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 benefit plan under G.S. 58-50-56 ~~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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the certificate, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter."

Section 3.3. G.S. 58-67-79 reads as rewritten:

"**§ 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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the plan upon enrollment and annually thereafter."

PART 4. VIATICAL SETTLEMENTS.

Section 4. G.S. 58-58-42 reads as rewritten:

"**§ 58-58-42. Viatical settlements.**

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

~~(1) "Broker" means a person who, for consideration and on behalf of another, offers or advertises the availability of viatical settlements, introduces viators to providers, or offers or attempts to negotiate viatical settlement contracts between a viator and one or more providers; it does not mean an attorney, accountant, or financial planner retained to represent a viator and whose compensation is not paid by a provider.~~

(1a) 'Financing entity' means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any person that may be a party to a viatical settlement contract and that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a licensed viatical settlement provider to act as a participant in a financing transaction.

(1b) 'Financing transaction' means a transaction in which a viatical settlement provider or a financing entity obtains financing for viatical settlement contracts, viaticated policies or interests therein including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering either registered or exempt from registration under federal and State securities law, or any direct purchase of interests in a policy or certificate, if the financing transaction complies with federal and State securities law.

(2) 'Policy' means an individual life insurance policy or a certificate under a group life insurance policy.

(2a) 'Viatical settlement broker' means a person that on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers. 'Viatical settlement broker' does not include an attorney, accountant, or financial planner who is retained to represent the viator and whose compensation is paid directly by or at the direction of the viator.

~~(3) "Provider" means a person who enters into a viatical settlement contract with a viator. "Provider" does not mean:~~

~~a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.~~

~~b. The issuer of a policy providing accelerated benefits under 11 NCAC 12.1200.~~

~~c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.~~

(4) 'Viatical settlement contract' or 'contract' means a written agreement entered into between a viatical settlement provider and a viator that establishes the terms under which the viatical settlement provider will pay consideration that is less than the expected death benefit of the viator's policy in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or a portion of the policy to the viatical settlement provider. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

(4a) 'Viatical settlement provider' means a person who enters into a viatical settlement contract with a viator. 'Viatical settlement provider' also means a person that obtains financing from a financing entity for the purchase, acquisition, transfer, or other assignment of one or more viatical settlement contracts, viaticated

policies, or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates, or otherwise disposes of one or more viatical settlement contracts, viaticated policies, or interests therein. 'Provider' does not mean:

a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.

b. The issuer of a policy providing accelerated benefits.

c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.

(4b) 'Viatical settlement representative' means a person who is an authorized agent of a viatical settlement provider or viatical settlement broker, as applicable, who acts in any manner in the solicitation of a viatical settlement. A viatical settlement representative is deemed to represent only the viatical settlement provider or viatical settlement broker. Viatical settlement representative does not include:

a. An attorney, accountant, or financial planner or any person exercising a power of attorney granted by a viator.

b. Any person who is retained to represent a viator and whose compensation is paid by or at the direction of the viator, regardless of whether the viatical settlement is consummated.

(4c) 'Viaticated policy' means a policy that has been acquired by a viatical settlement provider under a viatical settlement contract.

(5) "Viator" means the owner or holder of a policy insuring the life of an individual who has ~~a catastrophic or life-threatening~~ an illness or condition that is catastrophic, life-threatening, or chronic, and who enters into or seeks to enter into a viatical settlement contract.

(a1) Fiduciary Duty. -- Regardless of the manner in which a viatical settlement broker is compensated, a viatical settlement broker represents only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

(b) Registration. -- No person may act as a ~~provider~~ viatical settlement provider, viatical settlement representative, or viatical settlement broker, or enter into or solicit a contract without first registering with the Commissioner. The applicant shall register on a form prescribed by the Commissioner. The Commissioner may require the applicant to disclose fully the identity of all stockholders, partners, officers, and employees. The Commissioner may refuse registration of any partnership, corporation, or other business entity if not satisfied that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct meets the standards of this section. Registration of a partnership, corporation, or other business entity authorizes all members, officers, and designated employees to act as viatical settlement providers under the registration; all of those persons must be

named in the application and any supplements to the application. Before any registration is complete, the Commissioner shall investigate each applicant and may register the applicant if the Commissioner finds that the applicant:

(1) Has provided a detailed plan of operation.

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for.

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied.

(4) If a corporation, is incorporated under the laws of this State or is a foreign corporation authorized to transact business in this State.

No registration is complete for any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the Commissioner or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(c) Enforcement. -- The Commissioner may issue a cease and desist order upon any viatical settlement provider if the Commissioner finds that:

(1) There was any misrepresentation in the application for registration;

(2) The viatical settlement provider has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a viatical settlement provider;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to policy owners;

(4) The viatical settlement provider has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or

(5) The viatical settlement provider has violated a provision of this section.

(d) Approval of Contracts. -- No viatical settlement provider may use any viatical settlement contract in this State unless it has been filed with and approved by the Commissioner. Any contract form filed with the Commissioner is deemed to be approved if it has not been disapproved within 90 days after the filing. The Commissioner shall disapprove a contract form if, in the Commissioner's opinion, any provision of the contract is unreasonable, contrary to the public interest, or otherwise misleading or unfair to the policy owner.

(e) Reporting Requirements. -- Each viatical settlement provider shall file with the Commissioner on or before March 1 of each year a statement containing the information required by the rules adopted by the Commissioner.

(e1) Identity of Viator. -- Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement representative, viatical settlement broker, insurance company, insurance company agent, insurance broker, information bureau, rating agency or company, or any other person with actual knowledge of

viator's identity, shall not disclose that identity to any other person unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator has provided prior written consent to the disclosure.

(2) Is provided in response to an investigation by the Commissioner or any other governmental officer or agency.

(3) Is a term of or condition to the transfer of a viaticated policy by one viatical settlement provider to another viatical settlement provider.

(f) Examination. -- The Commissioner may, when the Commissioner deems it to be reasonably necessary to protect the public interest, examine the business and affairs of any ~~provider~~ viatical settlement provider, representative, or broker, or applicant for registration. The Commissioner may order any ~~provider~~ viatical settlement provider, representative, or broker, or applicant to produce records, books, files, or other information that is necessary to ascertain whether or not the ~~provider~~ viatical settlement provider, representative, or broker, or applicant is acting or has acted in violation of this section or otherwise contrary to the public interest. The ~~provider~~ viatical settlement provider, representative, or broker, or applicant shall pay the expenses incurred in conducting an examination. Names and individual identification data for all viators are confidential and shall not be disclosed by the Commissioner. The viatical settlement provider shall maintain records of all transactions of contracts and make the records available to the Commissioner for inspection during reasonable business hours. A viatical settlement provider shall maintain records of each viatical settlement until five years after the death of the insured.

(g) Disclosure. -- A viatical settlement provider shall disclose the following information to the viator no later than the date the contract is signed by all parties:

(1) Options other than the contract for a person with a catastrophic or life-threatening illness, including, but not limited to, accelerated benefits offered by the issuer of the policy.

(2) The fact that some or all of the contract consideration may be taxable, and that assistance should be sought from a personal tax advisor.

(3) The fact that the contract consideration could be subject to the claims of creditors.

(4) The fact that receipt of the contract consideration may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements; and that advice should be obtained from the appropriate government agencies.

(5) The viator's right to rescind a contract ~~within 30 days after the date it is executed by all parties or~~ within 15 days after the receipt of the contract consideration by the ~~viator, whichever is less, as provided~~ viator as provided in subsection (h) of this section.

(6) The date by which the contract consideration will be available to the viator and the source of the consideration.

(7) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator and that assistance should be sought from a financial adviser.

(g1) Disclosure Before Contract Execution. -- A viatical settlement provider shall disclose the following information to the viator before the date the viatical settlement contract is signed by all parties:

(1) The affiliation, if any, between the viatical settlement provider and the issuer of an insurance policy to be viaticated.

(2) If a policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured, the viator shall be informed of the possible loss of coverage on the other lives and be advised to consult with his or her insurance producer or the company issuing the policy for advice on the proposed viatication.

(3) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy. The viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy, and the viatical settlement provider's interest in those benefits.

(h) General Rules. -- A viatical settlement provider entering into a contract with a viator shall first obtain:

(1) A written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence.

(2) A witnessed document in which the viator (i) consents to the contract, (ii) acknowledges the catastrophic or life-threatening illness, (iii) represents that the viator has a full and complete understanding of the contract, (iv) represents that the viator has a full and complete understanding of the benefits of the policy, and (v) releases the medical records and acknowledges that the contract has been entered into freely and voluntarily.

All medical information solicited or obtained by any viatical settlement provider is subject to all State laws relating to confidentiality of medical information. All contracts entered into in this State shall contain an unconditional refund provision for at least 30 days after the date of the contract, or 15 days after the receipt of the viatical settlement proceeds, whichever is less.

(i) Contract Consideration. -- Immediately upon receipt from the viator of documents to effect the transfer of the policy, the viatical settlement provider shall direct the contract consideration to an escrow or trust account managed by a trustee or escrow agent in a ~~bank approved by the Commissioner, pending acknowledgment~~

~~of the transfer by the issuer of the policy.~~ State or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The account shall be managed by a trustee or escrow agent independent of the parties to the contract. The trustee or escrow agent shall transfer the proceeds that are due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer. Failure to tender the viatical settlement contract consideration by the date disclosed to the viator renders the contract null and void.

(j) Authority to Adopt Standards. -- The Commissioner may:

(1) Adopt rules to implement this section.

(2) Establish standards for evaluating reasonableness of payments under contracts. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy.

(3) Establish appropriate registration and other regulatory requirements for brokers.

(4) Repealed by Session Laws 1998-211, s. 32.

(k) Unfair Trade Practices. -- A violation of this section is considered an unfair trade practice under Article 63 of this Chapter."

PART 5. FAMILY LEAVE CREDIT INSURANCE.

Section 5.1. Article 57 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-57-115. Family leave credit insurance standards; policy provisions.**

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

(1) 'Foster child' means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

(2) 'Immediate family member' means a spouse, child (natural, adopted, or foster), or parent.

(3) 'Placement in the foster home' means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

(b) Coverage. -- Insurers may provide coverage for loss of income because of a voluntary, employer-approved leave of absence for specified reasons. The insured shall not be required to meet any federal requirements in order to qualify for benefits provided by this coverage. Benefits shall be paid to the creditor to reduce the insured's indebtedness.

(c) Eligibility. -- Coverage may be provided or offered to all debtors who have not yet reached their 71st birthday and have been working for wages for a minimum of 30 hours per week for the past 12 consecutive months.

(d) Qualifying Events. -- Benefits shall be paid only for the following qualifying events:

(1) An accident involving sickness of, or incapacitation of, an immediate family member that requires the insured to attend to the family member's needs.

(2) Birth of a child or children.

(3) Adoption of a child or children.

(4) Placement in the foster home of a foster child or children.

(5) The insured's principal residence is in a federally declared disaster area.

(6) The insured is called to active military duty.

(7) The insured is called to jury duty.

(e) Exclusions. -- Coverage shall not contain any exclusions except:

(1) Retirement of the insured from employment.

(2) Voluntary resignation of the insured from employment.

(3) Seasonal unemployment of the insured.

(4) Involuntary unemployment of the insured.

(5) Disability of the insured.

(6) Employment termination because of willful or criminal misconduct of the insured.

(f) Notice. -- The insurer shall send a notice to the insured at the insured's home address to inform the insured that benefits have been paid, including the dates and the amount of payment. The notice shall be sent to the insured within 60 days after the last day of the benefit period.

(g) Minimum Amounts. -- The minimum monthly benefit amount shall be level for the entire benefit period. The minimum monthly benefit amount shall equal or exceed the minimum monthly payment required by the creditor, plus the premium charge for the coverage attributable to the benefit period.

(h) Miscellaneous Provisions. -- Any waiting period for benefits shall not exceed 30 days. The insured shall provide satisfactory evidence of employer approval of qualified leave. Lump-sum benefits are prohibited. Refunds of unearned single premiums shall be equal to the pro rata unearned gross premium.

(i) Rates. -- Premium rates shall be actuarially demonstrated to generate a sixty percent (60%) loss ratio. Joint coverage rates shall be one and two-thirds (1 2/3) times the approved single rate. Rates shall be filed for approval before they can be used.

(j) Reports. -- By March 30 of each year every insurer writing family leave coverage shall file a statistical report of the past calendar year's actuarial experience for that coverage. The report shall demonstrate the actual experience loss ratio for the calendar year and shall include the: number of insureds, total premium volume, total number of claims, total claims volume, total number of claims for each eligible

leave event, average monthly benefit per claim for each event, and premium refunds."

Section 5.2. G.S. 58-57-1 reads as rewritten:

"**§ 58-57-1. Application of Article.**

All credit life insurance, all credit accident and health insurance, all credit property insurance, all credit insurance on credit card balances, all family leave credit insurance, and all credit unemployment insurance written in connection with direct loans, consumer credit installment sale contracts of whatever term permitted by G.S. 25A-33, leases, or other credit transactions shall be subject to the provisions of this Article, except credit insurance written in connection with direct loans of more than 15 years' duration. The provisions of this Article shall be controlling as to such insurance and no other provisions of Articles 1 through 64 of this Chapter shall be applicable unless otherwise specifically provided; nor shall such insurance be subject to the provisions of this Article where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor."

Section 5.3. G.S. 58-57-5 is amended by adding the following new subdivision to read:

"(6a) 'Family credit leave insurance' means insurance on a debtor in connection with a specified loan or other credit transaction to provide payment to a creditor of the debtor for the installment payments or other periodic payment becoming due when the debtor suffers a loss of income because of a voluntary, employer-approved leave of absence for qualifying events specified in G.S. 58-57-115(d)."

PART 6. EFFECT OF HEADINGS.

Section 6. 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 7. EFFECTIVE DATES.

Section 7. Sections 2, 4, 5.1, 5.2, and 5.3 of this act become effective October 1, 1999. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 294
PROPOSED COMMITTEE SUBTITUTE
H294-CSRN-001

Short Title: Life & Health Ins. Amendments/AB. (Public)

Sponsors:

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING THE APPLICABILITY OF PREEXISTING CONDITION LIMITATIONS TO CERTAIN TYPES OF HEALTH INSURANCE POLICIES; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME INSURANCE; TO CONFORM NORTH CAROLINA'S 1997 POST-MASTECTOMY RECONSTRUCTIVE SURGERY LAWS TO THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998; TO UPDATE THE LAW ON VIATICAL SETTLEMENTS; AND TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE.

The General Assembly of North Carolina enacts:

PART I. PREEXISTING CONDITIONS FOR SPECIFIED DISEASE AND HOSPITAL INDEMNITY POLICIES

Section 1. G.S. 58-51-15(h) reads as rewritten:

"(h) Preexisting Condition Exclusion Clarification. -- Subsubdivision (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), (2) and (4)."

PART 2. DISABILITY INCOME INSURANCE.

Section 2. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-51-130. Standards for disability income insurance policies.

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

(1) 'Disability income insurance policy' or 'policy' means a policy of accident and health insurance that provides payments when the insured is unable to work because of illness, disease, or injury.

(2) 'Policy' includes the certificates referred to in subsection (b) of this section.

(b) Applicability. -- This section applies to all policies used in this State, including certificates issued under group policies that are used in this State. This section also applies to a certificate issued under a policy issued and delivered to a trust or to an association outside of this State and covering persons residing in this State.

(c) Disclosure standards. -- Every disability income insurance policy shall include provisions, where applicable, addressing:

(1) Terms of renewability.

(2) Initial and subsequent conditions of eligibility.

(3) Nonduplication of coverage.

(4) Preexisting conditions.

(5) Probationary periods.

(6) Elimination periods.

(7) Requirements for replacement.

(8) Recurrent conditions.

(9) Definitions of terms.

(d) Preexisting Conditions. -- If an insurer does not seek a prospective insured's medical history in the application or enrollment process, the insurer shall not deny a claim for disabilities that commence more than 24 months after the effective date of the insured person's coverage on the grounds the disability is caused by a preexisting condition. A policy shall not define a preexisting condition more restrictively than 'a condition for which medical advice, diagnosis, care, or treatment was received or recommended within the 24-month period immediately preceding the effective date of coverage of the insured person.'

(e) Exceptions. -- Nothing in this section prohibits an insurer from:

(1) Using an application or enrollment form designed to elicit the medical history of a prospective insured.
(2) Underwriting based on answers on the form according to the insurer's established standards.
(3) Contesting the answers in accordance with G.S. 58-51-15(a)(2)a.

(f) Required Provisions. -- Each policy shall include:
(1) A description of the principal benefits and coverage provided in the policy.
(2) A statement of the exceptions, reductions, and limitations contained in the policy.
(3) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

(g) Other Applicable Provisions. -- G.S. 58-51-95(f) applies to individual policies and G.S. 58-51-80(g) applies to group policies.

(h) Other Income Sources. -- If a policy contains a provision that provides for integration of benefits with other income sources, it shall include a definition of what is considered other income sources and a complete description of how benefits will be reduced by other income sources, if at all. No disability income policy shall provide that the amount of any disability benefit paid to the insured shall be reduced by reason of any cost-of-living increase, designated as such under the federal Social Security Act, if the cost-of-living increase occurs during the period for which benefits are payable."

PART 3. RECONSTRUCTIVE SURGERY CONFORMING CHANGES.

Section 3.1. G.S. 58-51-62 reads as rewritten:

"**§ 58-51-62. Coverage for reconstructive breast surgery ~~resulting from~~ following mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under ~~G.S. 58-50-60~~ G.S. 58-50-56 ~~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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas.

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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter."

Section 3.2. G.S. 58-65-96 reads as rewritten:

"**§ 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 benefit plan under G.S. 58-50-56 ~~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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the certificate, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter."

Section 3.3. G.S. 58-67-79 reads as rewritten:

"**§ 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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the plan upon enrollment and annually thereafter."

PART 4. VIATICAL SETTLEMENTS.

Section 4. G.S. 58-58-42 reads as rewritten:

"§ 58-58-42. Viatical settlements.

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

~~(1) "Broker" means a person who, for consideration and on behalf of another, offers or advertises the availability of viatical settlements, introduces viators to providers, or offers or attempts to negotiate viatical settlement contracts between a viator and one or more providers; it does not mean an attorney, accountant, or financial planner retained to represent a viator and whose compensation is not paid by a provider.~~

(1a) 'Financing entity' means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any person that may be a party to a viatical settlement contract and that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a licensed viatical settlement provider to act as a participant in a financing transaction.

(1b) 'Financing transaction' means a transaction in which a viatical settlement provider or a financing entity obtains financing for viatical settlement contracts, viaticated policies or interests therein including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering either registered or exempt from registration under federal and State securities law, or any direct purchase of interests in a policy or certificate, if the financing transaction complies with federal and State securities law.

(2) 'Policy' means an individual life insurance policy or a certificate under a group life insurance policy.

(2a) 'Viatical settlement broker' means a person that on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlements between a viator and

one or more viatical settlement providers. 'Viatical settlement broker' does not include an attorney, accountant, or financial planner who is retained to represent the viator and whose compensation is paid directly by or at the direction of the viator.

~~(3) "Provider" means a person who enters into a viatical settlement contract with a viator. "Provider" does not mean:~~

~~a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.~~

~~b. The issuer of a policy providing accelerated benefits under 11 NCAC 12.1200.~~

~~c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.~~

(4) 'Viatical settlement contract' or 'contract' means a written agreement entered into between a viatical settlement provider and a viator that establishes the terms under which the viatical settlement provider will pay consideration that is less than the expected death benefit of the viator's policy in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or a portion of the policy to the viatical settlement provider. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

(4a) 'Viatical settlement provider' means a person who enters into a viatical settlement contract with a viator. 'Viatical settlement provider' also means a person that obtains financing from a financing entity for the purchase, acquisition, transfer, or other assignment of one or more viatical settlement contracts, viaticated policies, or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates, or otherwise disposes of one

or more viatical settlement contracts, viaticated policies, or interests therein. 'Provider' does not mean:

a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.

b. The issuer of a policy providing accelerated benefits.

c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.

(4b) 'Viatical settlement representative' means a person who is an authorized agent of a viatical settlement provider or viatical settlement broker, as applicable, who acts in any manner in the solicitation of a viatical settlement. A viatical settlement representative is deemed to represent only the viatical settlement provider or viatical settlement broker. Viatical settlement representative does not include:

a. An attorney, accountant, or financial planner or any person exercising a power of attorney granted by a viator.

b. Any person who is retained to represent a viator and whose compensation is paid by or at the direction of the viator, regardless of whether the viatical settlement is consummated.

(4c) 'Viaticated policy' means a policy that has been acquired by a viatical settlement provider under a viatical settlement contract.

(5) "Viator" means the owner or holder of a policy insuring the life of an individual who has ~~a catastrophic or life-threatening~~ an illness or condition that is catastrophic, life-threatening, or chronic, and who enters into or seeks to enter into a viatical settlement contract.

(a1) Fiduciary Duty. -- Regardless of the manner in which a viatical settlement broker is compensated, a viatical settlement broker represents only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

~~provider~~ viatical settlement provider, representative, or broker, or applicant to produce records, books, files, or other information that is necessary to ascertain whether or not the ~~provider~~ viatical settlement provider, representative, or broker, or applicant is acting or has acted in violation of this section or otherwise contrary to the public interest. The ~~provider~~ viatical settlement provider, representative, or broker, or applicant shall pay the expenses incurred in conducting an examination. Names and individual identification data for all viators are confidential and shall not be disclosed by the Commissioner. The viatical settlement provider shall maintain records of all transactions of contracts and make the records available to the Commissioner for inspection during reasonable business hours. A viatical settlement provider shall maintain records of each viatical settlement until five years after the death of the insured.

(g) Disclosure. -- A viatical settlement provider shall disclose the following information to the viator no later than the date the contract is signed by all parties:

(1) Options other than the contract for a person with a catastrophic or life-threatening illness, including, but not limited to, accelerated benefits offered by the issuer of the policy.

(2) The fact that some or all of the contract consideration may be taxable, and that assistance should be sought from a personal tax advisor.

(3) The fact that the contract consideration could be subject to the claims of creditors.

(4) The fact that receipt of the contract consideration may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements; and that advice should be obtained from the appropriate government agencies.

(5) The viator's right to rescind a contract ~~within 30 days after the date it is executed by all parties or~~ within 15 days after the receipt of the contract consideration by the ~~viator, whichever is less, as provided~~ viator as provided in subsection (h) of this section.

(6) The date by which the contract consideration will be available to the viator and the source of the consideration.

(7) Entering into a viatical settlement contract may cause other rights or benefits, including

conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator and that assistance should be sought from a financial adviser.

(g1) Disclosure Before Contract Execution. -- A viatical settlement provider shall disclose the following information to the viator before the date the viatical settlement contract is signed by all parties:

(1) The affiliation, if any, between the viatical settlement provider and the issuer of an insurance policy to be viaticated.

(2) If a policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured, the viator shall be informed of the possible loss of coverage on the other lives and be advised to consult with his or her insurance producer or the company issuing the policy for advice on the proposed viatication.

(3) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy. The viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy, and the viatical settlement provider's interest in those benefits.

(h) General Rules. -- A viatical settlement provider entering into a contract with a viator shall first obtain:

(1) A written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence.

(2) A witnessed document in which the viator (i) consents to the contract, (ii) acknowledges the catastrophic or life-threatening illness, (iii) represents that the viator has a full and complete understanding of the contract, (iv) represents that the viator has a full and complete understanding of the benefits of the policy, and (v) releases the medical records and acknowledges that the contract has been entered into freely and voluntarily.

All medical information solicited or obtained by any viatical settlement provider is subject to all State laws relating to confidentiality of medical information. All contracts entered

(b) Registration. -- No person may act as a ~~provider~~ viatical settlement provider, viatical settlement representative, or viatical settlement broker, or enter into or solicit a contract without first registering with the Commissioner. The applicant shall register on a form prescribed by the Commissioner. The Commissioner may require the applicant to disclose fully the identity of all stockholders, partners, officers, and employees. The Commissioner may refuse registration of any partnership, corporation, or other business entity if not satisfied that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct meets the standards of this section. Registration of a partnership, corporation, or other business entity authorizes all members, officers, and designated employees to act as viatical settlement providers under the registration; all of those persons must be named in the application and any supplements to the application. Before any registration is complete, the Commissioner shall investigate each applicant and may register the applicant if the Commissioner finds that the applicant:

(1) Has provided a detailed plan of operation.

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for.

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied.

(4) If a corporation, is incorporated under the laws of this State or is a foreign corporation authorized to transact business in this State.

No registration is complete for any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the Commissioner or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(c) Enforcement. -- The Commissioner may issue a cease and desist order upon any viatical settlement provider if the Commissioner finds that:

(1) There was any misrepresentation in the application for registration;

(2) The viatical settlement provider has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown

to be untrustworthy or incompetent to act as a viatical settlement provider;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to policy owners;

(4) The viatical settlement provider has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or

(5) The viatical settlement provider has violated a provision of this section.

(d) Approval of Contracts. -- No viatical settlement provider may use any viatical settlement contract in this State unless it has been filed with and approved by the Commissioner. Any contract form filed with the Commissioner is deemed to be approved if it has not been disapproved within 90 days after the filing. The Commissioner shall disapprove a contract form if, in the Commissioner's opinion, any provision of the contract is unreasonable, contrary to the public interest, or otherwise misleading or unfair to the policy owner.

(e) Reporting Requirements. -- Each viatical settlement provider shall file with the Commissioner on or before March 1 of each year a statement containing the information required by the rules adopted by the Commissioner.

(e1) Identity of Viator. -- Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement representative, viatical settlement broker, insurance company, insurance company agent, insurance broker, information bureau, rating agency or company, or any other person with actual knowledge of viator's identity, shall not disclose that identity to any other person unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator has provided prior written consent to the disclosure.

(2) Is provided in response to an investigation by the Commissioner or any other governmental officer or agency.

(3) Is a term of or condition to the transfer of a viaticated policy by one viatical settlement provider to another viatical settlement provider.

(f) Examination. -- The Commissioner may, when the Commissioner deems it to be reasonably necessary to protect the public interest, examine the business and affairs of any ~~provider~~ viatical settlement provider, representative, or broker, or applicant for registration. The Commissioner may order any

into in this State shall contain an unconditional refund provision for at least 30 days after the date of the contract, or 15 days after the receipt of the viatical settlement proceeds, whichever is less.

(i) Contract Consideration. -- Immediately upon receipt from the viator of documents to effect the transfer of the policy, the viatical settlement provider shall direct the contract consideration to an escrow or trust account managed by a trustee or escrow agent in a ~~bank approved by the Commissioner, pending acknowledgment of the transfer by the issuer of the policy.~~ State or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The account shall be managed by a trustee or escrow agent independent of the parties to the contract. The trustee or escrow agent shall transfer the proceeds that are due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer. Failure to tender the viatical settlement contract consideration by the date disclosed to the viator renders the contract ~~null and void.~~ voidable by the viator until the time consideration is tendered to and accepted by the viator.

(j) Authority to Adopt Standards. -- The Commissioner may:

(1) Adopt rules to implement this section.

(2) Establish standards for evaluating reasonableness of payments under contracts. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy.

(3) Establish appropriate registration and other regulatory requirements for brokers.

(4) Repealed by Session Laws 1998-211, s. 32.

(k) Unfair Trade Practices. -- A violation of this section is considered an unfair trade practice under Article 63 of this Chapter."

PART 5. FAMILY LEAVE CREDIT INSURANCE.

Section 5.1. Article 57 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-57-115. Family leave credit insurance standards; policy provisions.**

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

(1) 'Foster child' means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or

(ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

(2) 'Immediate family member' means a spouse, child (natural, adopted, or foster), or parent.

(3) 'Placement in the foster home' means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

(b) Coverage. -- Insurers may provide coverage for loss of income because of voluntary, employer approved, leave of absence for specified reasons. The insured shall not be required to meet any federal requirements in order to qualify for benefits provided by this coverage. Benefits shall be paid to the creditor to reduce the insured's indebtedness.

(c) Eligibility. -- Coverage may be provided or offered to all debtors who have not yet reached their 71st birthday and have been working for wages for a minimum of 30 hours per week for the past 12 consecutive months.

(d) Qualifying Events. -- Benefits shall be paid only for the following qualifying events:

(1) An accident involving sickness of, or incapacitation of an immediate family member that requires the insured to attend to the family member's needs.

(2) Birth of a child or children.

(3) Adoption of a child or children.

(4) Placement in the foster home of a foster child or children.

(5) The insured's principal residence is in a federally declared disaster area.

(6) The insured is called to active military duty.

(7) The insured is called to jury duty.

(e) Exclusions. -- Coverage shall not contain any exclusions except:

(1) Retirement of the insured from employment.

(2) Voluntary resignation of the insured from employment.

(3) Seasonal unemployment of the insured.

(4) Involuntary unemployment of the insured.

(5) Disability of the insured.
(6) Employment termination because of willful or criminal misconduct of the insured.

(f) Notice. -- The insurer shall send a notice to the insured at the insured's home address to inform the insured that benefits have been paid, including the dates and the amount of payment. The notice shall be sent to the insured within 60 days after the last day of the benefit period.

(g) Minimum Amounts. -- The minimum monthly benefit amount shall be level for the entire benefit period. The minimum monthly benefit amount shall equal or exceed the minimum monthly payment required by the creditor, plus the premium charge for the coverage attributable to the benefit period.

(h) Miscellaneous Provisions. -- Any waiting period for benefits shall not exceed 30 days. The insured shall provide satisfactory evidence of employer approval of qualified leave. Lump-sum benefits are prohibited. Refunds of unearned single premiums shall be equal to the pro rata unearned gross premium.

(i) Rates. -- Premium rates shall be actuarially demonstrated to generate a sixty percent (60%) loss ratio. Joint coverage rates shall be one and two-thirds (1 2/3) times the approved single rate. Rates shall be filed for approval before they can be used.

(j) Reports. -- By March 30 of each year every insurer writing family leave coverage shall file a statistical report of the past calendar year's actuarial experience for that coverage. The report shall demonstrate the actual experience loss ratio for the calendar year and shall include the: number of insureds, total premium volume, total number of claims, total claims volume, total number of claims for each eligible leave event, average monthly benefit per claim for each event, and premium refunds."

Section 5.2. G.S. 58-57-1 reads as rewritten:

"**§ 58-57-1. Application of Article.**

All credit life insurance, all credit accident and health insurance, all credit property insurance, all credit insurance on credit card balances, all family leave credit insurance, and all credit unemployment insurance written in connection with direct loans, consumer credit installment sale contracts of whatever term permitted by G.S. 25A-33, leases, or other credit transactions shall be subject to the provisions of this Article, except credit insurance written in connection with direct loans of more than 15 years' duration. The provisions of this Article shall be controlling as to such insurance and no other provisions of Articles 1 through 64 of this Chapter shall be applicable

unless otherwise specifically provided; nor shall such insurance be subject to the provisions of this Article where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor."

Section 5.3. G.S. 58-57-5 is amended by adding the following new subdivision to read:

"(6a) 'Family credit leave insurance' means insurance on a debtor in connection with a specified loan or other credit transaction to provide payment to a creditor of the debtor for the installment payments or other periodic payment becoming due when the debtor suffers a loss of income because of voluntary, employer-approved leave of absence for qualifying events specified in G.S. 58-57-115(d)."

PART 6. EFFECT OF HEADINGS.

Section 6. 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 7. EFFECTIVE DATES.

Section 7. Sections 2, 4, 5.1, 5.2, and 5.3 of this act become effective October 1, 1999. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

HOUSE BILL 294

Short Title: Life & Health Ins. Amendments/AB. (Public)

Sponsors: Representatives Hurley; Mosley, Edwards, and Gibson.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE MEDICARE SUPPLEMENT INSURANCE FOR PERSONS WHO DELAY MEDICARE PART B ENROLLMENT; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME INSURANCE; TO CONFORM NORTH CAROLINA'S 1997 POST-MASTECTOMY RECONSTRUCTIVE SURGERY LAWS TO THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998; TO UPDATE THE LAW ON VIATICAL SETTLEMENTS; AND TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE.

The General Assembly of North Carolina enacts:

PART I. MEDICARE SUPPLEMENT OPEN ENROLLMENT.

Section 1. Article 54 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-54-55. Open enrollment for persons who delay Medicare Part B enrollment.**

In addition to any other provision in this Article or any rule adopted under this Article that is directly or indirectly related to guaranteed issue or open enrollment, an insurer shall expand open enrollment to include those persons who have delayed Medicare Part B enrollment beyond attaining the age of 65 years because they were working and were covered by an individual or group health plan."

PART 2. DISABILITY INCOME INSURANCE.

Section 2. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-130. Standards for disability income insurance policies.**

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

(1) 'Disability income insurance policy' or 'policy' means a policy of accident and health insurance that provides payments when the insured is unable to work because of illness, disease, or injury.

(2) 'Policy' includes the certificates referred to in subsection (b) of this section.

(b) Applicability. -- This section applies to all policies used in this State, including certificates issued under group policies that are used in this State. This section also applies to a certificate issued under a policy issued and delivered to a trust or to an association outside of this State and covering persons residing in this State.

(c) Disclosure standards. -- Every disability income insurance policy shall include provisions, where applicable, addressing:

(1) Terms of renewability.

(2) Initial and subsequent conditions of eligibility.

(3) Nonduplication of coverage.

(4) Preexisting conditions.

(5) Probationary periods.

(6) Benefit limitations, exceptions, and reductions.

(7) Elimination periods.

(8) Requirements for replacement.

(9) Recurrent conditions.

(10) Definitions of terms.

(d) Preexisting Conditions. -- If an insurer does not seek a prospective insured's medical history in the application or enrollment process, the insurer shall not deny a claim for disabilities that commence more than 24 months after the effective date of coverage on the grounds the disability is caused by a preexisting condition. A policy shall not define a preexisting condition more restrictively than 'a condition for which medical advice, diagnosis, care, or treatment was received or recommended within the 24-month period immediately preceding the effective date of coverage of the insured person.'

(e) Exceptions. -- Nothing in this section prohibits an insurer from:

(1) Using an application or enrollment form designed to elicit the medical history of a prospective insured.

(2) Underwriting based on answers on the form according to the insurer's established standards.

(3) Contesting the answers in accordance with G.S. 58-51-15(a)(2)a.

(f) Required Provisions. -- Each policy shall include:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the exceptions, reductions, and limitations contained in the policy.

(3) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

(g) Other Applicable Provisions. -- G.S. 58-51-95(f) applies to individual policies and G.S. 58-51-80(g) applies to group policies.

(h) Other Income Sources. -- If a policy contains a provision that provides for integration of benefits with other income sources, it shall include a definition of what is considered other income sources and a complete description of how benefits will be reduced by other income sources, if at all. No disability income policy shall provide that the amount of any disability benefit paid to the insured shall be reduced by reason of any cost-of-living increase, designated as such under the federal Social Security Act, if the cost-of-living increase occurs during the period for which benefits are payable."

PART 3. RECONSTRUCTIVE SURGERY CONFORMING CHANGES.

Section 3.1. G.S. 58-51-62 reads as rewritten:

"**§ 58-51-62. Coverage for reconstructive breast surgery ~~resulting from~~ following mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under ~~G.S. 58-50-60~~ G.S. 58-50-56 ~~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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter."

Section 3.2. G.S. 58-65-96 reads as rewritten:

"**§ 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 benefit plan under G.S. 58-50-56 ~~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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the certificate, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter."

Section 3.3. G.S. 58-67-79 reads as rewritten:

"**§ 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~~ following 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~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. 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.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the plan upon enrollment and annually thereafter."

PART 4. VIATICAL SETTLEMENTS.

Section 4. G.S. 58-58-42 reads as rewritten:

"**§ 58-58-42. Viatical settlements.**

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

~~(1) "Broker" means a person who, for consideration and on behalf of another, offers or advertises the availability of viatical settlements, introduces viators to providers, or offers or attempts to negotiate viatical settlement contracts between a viator and one or more providers; it does not mean an attorney, accountant, or financial planner retained to represent a viator and whose compensation is not paid by a provider.~~

(1a) 'Financing entity' means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any person that may be a party to a viatical settlement contract and that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a licensed viatical settlement provider to act as a participant in a financing transaction.

(1b) 'Financing transaction' means a transaction in which a viatical settlement provider or a financing entity obtains financing for viatical settlement contracts, viaticated policies or interests therein including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering either registered or exempt from registration under federal and State securities law, or any direct purchase of interests in a policy or certificate, if the financing transaction complies with federal and State securities law.

(2) 'Policy' means an individual life insurance policy or a certificate under a group life insurance policy.

(2a) 'Viatical settlement broker' means a person that on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers. 'Viatical settlement broker' does not include an attorney, accountant, or financial planner who is retained to represent the viator and whose compensation is paid directly by or at the direction of the viator.

~~(3) "Provider" means a person who enters into a viatical settlement contract with a viator. "Provider" does not mean:~~

~~a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.~~

~~b. The issuer of a policy providing accelerated benefits under 11 NCAC 12.1200.~~

~~c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.~~

(4) 'Viatical settlement contract' or 'contract' means a written agreement entered into between a viatical settlement provider and a viator that establishes the terms under which the viatical settlement provider will pay consideration that is less than the expected death benefit of the viator's policy in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or a portion of the policy to the viatical settlement provider. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

(4a) 'Viatical settlement provider' means a person who enters into a viatical settlement contract with a viator. 'Viatical settlement provider' also means a person that obtains financing from a financing entity for the purchase, acquisition, transfer, or other assignment of one or more viatical settlement contracts, viaticated

policies, or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates, or otherwise disposes of one or more viatical settlement contracts, viaticated policies, or interests therein. 'Provider' does not mean:

a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.

b. The issuer of a policy providing accelerated benefits under 11 NCAC 12.1200.

c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.

(4b) 'Viatical settlement representative' means a person who is an authorized agent of a viatical settlement provider or viatical settlement broker, as applicable, who acts in any manner in the solicitation of a viatical settlement. A viatical settlement representative is deemed to represent only the viatical settlement provider or viatical settlement broker. Viatical settlement representative does not include:

a. An attorney, accountant, or financial planner or any person exercising a power of attorney granted by a viator.

b. Any person who is retained to represent a viator and whose compensation is paid by or at the direction of the viator, regardless of whether the viatical settlement is consummated.

(4c) 'Viaticated policy' means a policy that has been acquired by a viatical settlement provider under a viatical settlement contract.

(5) "Viator" means the owner or holder of a policy insuring the life of an individual who has ~~a catastrophic or life-threatening~~ an illness or condition that is catastrophic, life-threatening, or chronic, and who enters into or seeks to enter into a viatical settlement contract.

(a1) Fiduciary Duty. -- Regardless of the manner in which a viatical settlement broker is compensated, a viatical settlement broker represents only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

(b) Registration. -- No person may act as a ~~provider~~ viatical settlement provider, viatical settlement representative, or viatical settlement broker, or enter into or solicit a contract without first registering with the Commissioner. The applicant shall register on a form prescribed by the Commissioner. The Commissioner may require the applicant to disclose fully the identity of all stockholders, partners, officers, and employees. The Commissioner may refuse registration of any partnership, corporation, or other business entity if not satisfied that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct meets the standards of this section. Registration of a partnership, corporation, or other

business entity authorizes all members, officers, and designated employees to act as viatical settlement providers under the registration; all of those persons must be named in the application and any supplements to the application. Before any registration is complete, the Commissioner shall investigate each applicant and may register the applicant if the Commissioner finds that the applicant:

(1) Has provided a detailed plan of operation.

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for.

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied.

(4) If a corporation, is incorporated under the laws of this State or is a foreign corporation authorized to transact business in this State.

No registration is complete for any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the Commissioner or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(c) Enforcement. -- The Commissioner may issue a cease and desist order upon any viatical settlement provider if the Commissioner finds that:

(1) There was any misrepresentation in the application for registration;

(2) The viatical settlement provider has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a viatical settlement provider;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to policy owners;

(4) The viatical settlement provider has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or

(5) The viatical settlement provider has violated a provision of this section.

(d) Approval of Contracts. -- No viatical settlement provider may use any viatical settlement contract in this State unless it has been filed with and approved by the Commissioner. Any contract form filed with the Commissioner is deemed to be approved if it has not been disapproved within 90 days after the filing. The Commissioner shall disapprove a contract form if, in the Commissioner's opinion, any provision of the contract is unreasonable, contrary to the public interest, or otherwise misleading or unfair to the policy owner.

(e) Reporting Requirements. -- Each viatical settlement provider shall file with the Commissioner on or before March 1 of each year a statement containing the information required by the rules adopted by the Commissioner.

(e1) Identity of Viator. -- Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement representative, viatical settlement broker, insurance company, insurance company agent, insurance broker, information

bureau, rating agency or company, or any other person with actual knowledge of viator's identity, shall not disclose that identity to any other person unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator has provided prior written consent to the disclosure.

(2) Is provided in response to an investigation by the Commissioner or any other governmental officer or agency.

(3) Is a term of or condition to the transfer of a viaticated policy by one viatical settlement provider to another viatical settlement provider.

(f) Examination. -- The Commissioner may, when the Commissioner deems it to be reasonably necessary to protect the public interest, examine the business and affairs of any ~~provider~~ viatical settlement provider, representative, or broker, or applicant for registration. The Commissioner may order any ~~provider~~ viatical settlement provider, representative, or broker, or applicant to produce records, books, files, or other information that is necessary to ascertain whether or not the ~~provider~~ viatical settlement provider, representative, or broker, or applicant is acting or has acted in violation of this section or otherwise contrary to the public interest. The ~~provider~~ viatical settlement provider, representative, or broker, or applicant shall pay the expenses incurred in conducting an examination. Names and individual identification data for all viators are confidential and shall not be disclosed by the Commissioner. The viatical settlement provider shall maintain records of all transactions of contracts and make the records available to the Commissioner for inspection during reasonable business hours. A viatical settlement provider shall maintain records of each viatical settlement until five years after the death of the insured.

(g) Disclosure. -- A viatical settlement provider shall disclose the following information to the viator no later than the date the contract is signed by all parties:

(1) Options other than the contract for a person with a catastrophic or life-threatening illness, including, but not limited to, accelerated benefits offered by the issuer of the policy.

(2) The fact that some or all of the contract consideration may be taxable, and that assistance should be sought from a personal tax advisor.

(3) The fact that the contract consideration could be subject to the claims of creditors.

(4) The fact that receipt of the contract consideration may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements; and that advice should be obtained from the appropriate government agencies.

(5) The viator's right to rescind a contract ~~within 30 days after the date it is executed by all parties or~~ within 15 days after the receipt

of the contract consideration by the ~~viator, whichever is less, as provided~~ viator as provided in subsection (h) of this section.

(6) The date by which the contract consideration will be available to the viator and the source of the consideration.

(7) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator and that assistance should be sought from a financial adviser.

(g1) Disclosure Before Contract Execution. -- A viatical settlement provider shall disclose the following information to the viator before the date the viatical settlement contract is signed by all parties:

(1) The affiliation, if any, between the viatical settlement provider and the issuer of an insurance policy to be viaticated.

(2) If a policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured, the viator shall be informed of the possible loss of coverage on the other lives and be advised to consult with his or her insurance producer or the company issuing the policy for advice on the proposed viatication.

(3) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy. The viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy, and the viatical settlement provider's interest in those benefits.

(h) General Rules. -- A viatical settlement provider entering into a contract with a viator shall first obtain:

(1) A written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence.

(2) A witnessed document in which the viator (i) consents to the contract, (ii) acknowledges the catastrophic or life-threatening illness, (iii) represents that the viator has a full and complete understanding of the contract, (iv) represents that the viator has a full and complete understanding of the benefits of the policy, and (v) releases the medical records and acknowledges that the contract has been entered into freely and voluntarily.

All medical information solicited or obtained by any viatical settlement provider is subject to all State laws relating to confidentiality of medical information. All contracts entered into in this State shall contain an unconditional refund provision for at least 30 days after the date of the contract, or 15 days after the receipt of the viatical settlement proceeds, whichever is less.

(i) Contract Consideration. -- Immediately upon receipt from the viator of documents to effect the transfer of the policy, the viatical settlement provider shall

direct the contract consideration to an escrow or trust account managed by a trustee or escrow agent in a ~~bank approved by the Commissioner, pending acknowledgment of the transfer by the issuer of the policy.~~ State or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The account shall be managed by a trustee or escrow agent independent of the parties to the contract. The trustee or escrow agent shall transfer the proceeds that are due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer. Failure to tender the viatical settlement contract consideration by the date disclosed to the viator renders the contract ~~null and void.~~ voidable by the viator until the time consideration is tendered to and accepted by the viator.

(j) Authority to Adopt Standards. -- The Commissioner may:

(1) Adopt rules to implement this section.

(2) Establish standards for evaluating reasonableness of payments under contracts. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy.

(3) Establish appropriate registration and other regulatory requirements for brokers.

(4) Repealed by Session Laws 1998-211, s. 32.

(k) Unfair Trade Practices. -- A violation of this section is considered an unfair trade practice under Article 63 of this Chapter."

PART 5. FAMILY LEAVE CREDIT INSURANCE.

Section 5. Article 57 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-57-115. Family leave credit insurance standards; policy provisions.**

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

(1) 'Foster child' means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

(2) 'Immediate family member' means a spouse, child (natural, adopted, or foster), or parent.

(3) 'Placement in the foster home' means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

(b) Coverage. -- Insurers may provide coverage for loss of income because of voluntary, employer approved, leave of absence for specified reasons. The insured shall not be required to meet any federal requirements in order to qualify for benefits

provided by this coverage. Benefits shall be paid to the creditor to reduce the insured's indebtedness.

(c) Eligibility. -- Coverage may be provided or offered to all debtors who have not yet reached their 71st birthday and have been working for wages for a minimum of 30 hours per week for the past 12 consecutive months.

(d) Qualifying Events. -- Benefits shall be paid only for the following qualifying events:

(1) An accident involving sickness of, or incapacitation of an immediate family member that requires the insured to attend to the family member's needs.

(2) Birth of a child or children.

(3) Adoption of a child or children.

(4) Placement in the foster home of a foster child or children.

(5) The insured's principal residence is in a federally declared disaster area.

(6) The insured is called to active military duty.

(7) The insured is called to jury duty.

(e) Exclusions. -- Coverage shall not contain any exclusions except:

(1) Retirement of the insured from employment.

(2) Voluntary resignation of the insured from employment.

(3) Seasonal unemployment of the insured.

(4) Involuntary unemployment of the insured.

(5) Disability of the insured.

(6) Employment termination because of willful or criminal misconduct of the insured.

(f) Notice. -- The insurer shall send a notice to the insured at the insured's home address to inform the insured that benefits have been paid, including the dates and the amount of payment. The notice shall be sent to the insured within 60 days after the last day of the benefit period.

(g) Minimum Amounts. -- The minimum monthly benefit amount shall be level for the entire benefit period. The minimum monthly benefit amount shall equal or exceed the minimum monthly payment required by the creditor, plus the premium charge for the coverage attributable to the benefit period.

(h) Miscellaneous Provisions. -- Any waiting period for benefits shall not exceed 30 days. The insured shall provide satisfactory evidence of employer approval of qualified leave. Lump-sum benefits are prohibited. Refunds of unearned single premiums shall be equal to the pro rata unearned gross premium.

(i) Rates. -- Premium rates shall be actuarially demonstrated to generate a sixty percent (60%) loss ratio. Joint coverage rates shall be one and two-thirds (1 2/3) times the approved single rate. Rates shall be filed for approval before they can be used.

(j) Reports. -- By March 30 of each year every insurer writing family leave coverage shall file a statistical report of the past calendar year's actuarial experience for that coverage. The report shall demonstrate the actual experience loss ratio for

the calendar year and shall include the: number of insureds, total premium volume, total number of claims, total claims volume, total number of claims for each eligible leave event, average monthly benefit per claim for each event, and premium refunds."

PART 6. EFFECT OF HEADINGS.

Section 6. 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 7. EFFECTIVE DATES.

Section 7. Sections 2, 4, and 5 of this act become effective October 1, 1999. The remainder of this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoin

Attachment II

EDITION No. _____

H. B. No. 294 DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Redwine
)
Sen.)

moves to amend the bill on page 15, line s 19-20

( ) WHICH CHANGES THE TITLE

by rewriting those lines to read:

"contract null and void."

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

HOUSE BILL 294:
Life and Health Insurance Amendments

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Hurley
Date:	March 25, 1999	**Summary by:**	Linwood Jones
Version:	PCS		Committee Counsel

SUMMARY: This bill makes changes to various life and health insurance laws.

BILL ANALYSIS:

PART 1. PREEXISTING CONDITION FOR SPECIFIED DISEASE AND HOSPITAL INDEMNITY POLICIES

Section 1. The 1997 health insurance reform laws placed limits on the use of preexisting conditions in individual policies of insurance. Certain types of health insurance policies, such as disability income insurance, dental insurance, vision insurance, specified disease policies, hospital indemnity policies, and Medicare supplemental insurance policies were exempted from this requirement. Section 1 removes the exemption for specified disease policies and hospital indemnity policies. Thus, an individual seeking coverage under a specified disease policy or hospital indemnity policy would be subject to pre-existing conditions only for up to one year (or less if he or she has satisfied part or all of a pre-existing condition waiting period under prior health insurance coverage). ***Note:*** Certain types of individuals known as *eligible* individuals (essentially individuals who were previously covered for 18 months or more under a group policy) are not subject to preexisting condition limitations.

PART 2. DISABILITY INCOME INSURANCE

Section 2 sets out standards for both individual and group disability income insurance policies. A disability income insurance policy provides periodic payments to the policyholder when he or she is unable to work because of illness, injury, or disease. The law requires each disability income insurance policy to disclose, when applicable, information on the following policy terms and conditions: terms of renewability, conditions of eligibility, nonduplication of coverage, pre-existing conditions, probationary periods, benefit limitations and exceptions, elimination periods, requirements for replacement, recurrent conditions, and definitions. Disability income insurance policies must also include a description of benefits and the renewal provisions, including whether the insurer has the right to change premiums.

This section also prohibits the insurer from contesting coverage for a disability more than two years after the policy became effective on grounds that the disability was a preexisting condition. However, the insurer can underwrite individuals based on medical information elicited during the enrollment/application process. Rate increases are subject to the requirements of G.S. 58-51-95(f) for individual policies and G.S. 58-51-80(g) for group policies. These statutes restrict the frequency of rate increases, require actuarial experience supporting the increases, require 45 days advance notice to policyholders of rate changes, and in the case of individual policies, require the approval of the Commissioner of Insurance.

If the disability income insurance policy provides for integration of benefits with other sources of income, it must disclose which sources are covered and how benefits will be reduced as a result. A Social Security cost-of-living increase cannot be used as a basis to offset or reduce benefits due under the disability policy.

PART 3. RECONSTRUCTIVE SURGERY CONFORMING CHANGES

Sections 3.1, 3.2, and 3.3 amend the laws passed by the legislature in 1997 that require insurers, service corporations, and HMOs to cover the costs of breast reconstruction after a mastectomy. After the legislature passed these laws, Congress passed the Women's Health and Cancer Rights Act of 1998. That act was very similar to the law passed by the General Assembly. The federal act provides that state laws on this matter are not pre-empted if they offer at least as much coverage as the federal act. The changes proposed by Sections 3.1 through 3.3 are designed to incorporate the few provisions from the federal law that are not currently in the State law. These changes include extending coverage to *"prostheses and physical complications in all stages of mastectomy, including lymphademas"* and requiring all insureds under the health plan to be notified when they join the plan and annually thereafter that breast reconstruction following a mastectomy is a covered benefit. Any aspects of the State law that exceeded the requirements of the federal act are retained in the State law. Section 3.1 applies to commercial insurance plans, Section 3.2 applies to service corporations (Blue Cross), and Section 3.3 applies to HMOs.

PART 4. VIATICAL SETTLEMENTS

Section 4 adds more definitions and requirements to the laws regulating viatical settlements. A viatical settlement is an agreement in which the owner of a life insurance policy who has a catastrophic or life-threatening illness assigns the ownership or death benefits of the policy to a third party in exchange for money or other consideration. With certain exceptions, these third parties (known as "viatical settlement providers") must be licensed by the Commissioner of Insurance. The insurance laws also require these providers to make certain disclosures to the policyholders, have their viatical settlement contracts approved by the Commissioner, obtain certification that the policyholder is competent and acknowledges his or her life-threatening or catastrophic illness, and require the providers to pay the consideration as soon as the policyholder transfers the policy or ownership rights.

The amendments in Section 4 add definitions for a "financing entity," "financing transaction," "viatical settlement broker," and "viatical settlement representative." Section 4 also rewrites several other definitions.

Section 4 also provides the following:

- That a viatical settlement broker, no matter how he is paid, owes a fiduciary duty to the policyholder and is obligated to act in the policyholder's best interests.
- That viatical settlement representatives and viatical settlement brokers must be registered with the Commissioner of Insurance.

- That the viatical settlement provider and others in the industry cannot disclose the identity of the policyholder except when (i) the policyholder has consented and the disclosure is necessary to effectuate the agreement, (ii) provided in response to a governmental investigation, and (iii) one provider sells or transfers the assigned policy or death benefits to another provider.
- That providers retain records for 5 years after the death of the policyholder.
- That providers disclose, in addition to information already required to be disclosed under current law, that entering into a viatical settlement agreement may cause the policyholder to forfeit certain rights under the life insurance policy or that it may result in a loss of coverage for anyone else insured under the policy. A Provider must also disclose whether it is affiliated with the insurance company that issued the policy to be assigned and the amount of the death benefit payable under the policy to the provider and related benefits.
- That consideration paid by the provider be put in escrow in an FDIC-insured bank (current law says any bank approved by the Commissioner) until it is transferred to the policyholder
- That failure of the provider to pay the consideration into escrow when due renders the contract *voidable* at the option of the policyholder. The current law renders the contract *void.*

PART 5. FAMILY LEAVE CREDIT INSURANCE.

Section 5.1 specifically authorizes the sale of family credit leave insurance in North Carolina and imposes requirements and restrictions on its sale. According to the Department of Insurance, family credit leave insurance is already being offered in North Carolina pursuant to a law allowing the sale of credit unemployment insurance and *"other coverages consistent with the purposes of unemployment insurance" (G.S. 58-57-110(b)).* However, Section 5 will provide specific authority and requirements for this type of coverage.

Family credit leave insurance, which is purchased in connection with a loan, covers the loan payments if the employee who purchased the insurance loses income because of his or her voluntary, employer-approved absence from work due to sickness or injury to an immediate family member, birth or adoption, placement of a child in a foster home, a federally-declared disaster affecting the employee's home, active military duty, or jury duty. It does not cover an employee's absence due to retirement, resignation, discharge, seasonal unemployment, or disability. The employee must provide satisfactory evidence that the employer has approved leave for one of the reasons covered by this insurance.

The rates charged by insurers for this coverage must be based on a 60% loss ratio – i.e., the credit insurer should be paying out 60 cents or more for every $1 in premium collected. Rates must be approved by the Commissioner of Insurance. Benefits are paid out on a monthly basis, at a level amount. No lump-sum payments are allowed.

Section 5.2 makes a conforming change to another statute and also adds in a reference to credit insurance on credit card balances. Credit insurance on credit card balances is already authorized under G.S. 58-57-105.

Section 5.3 adds a definition of family credit leave insurance.

PART 6. EFFECT OF HEADINGS

Section 6 provides that the headings in the bill are merely a reference.

PART 7. EFFECTIVE DATE

Section 7 provides that the following provisions become effective October 1, 1999: the disability income insurance changes in Section 2, the viatical settlement changes in Section 4, and the family credit leave changes in Section 5.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 25, 1999

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: PCS for HB 294 – Life & Health Insurance Amendments

PART I. HEALTH INSURANCE.

Section 1 corrects a mistake in the 1997 Health Insurance Portability and Accountability Act. In that Act (S.L. 1997-259), an existing statute dealing with pre-existing conditions for individual health insurance policies was amended so that it would not apply to the many types of policies to which the Act did not apply. However, there were two types to which the other statute used to and still should apply. They are specified disease policies (i.e., cancer insurance) and hospital indemnity or other fixed indemnity policies (i.e., pays a fixed dollar amount for hospitalization). Section 1 would bring those policies back under the individual policy pre-existing condition law.

PART II. DISABILITY INCOME INSURANCE.

Section 2 adds a new G.S. 58-51-130 to establish standards for disability income insurance policies regarding disclosure, preexisting conditions, integration of benefits, and required provisions.

PART III. RECONSTRUCTIVE SURGERY CONFORMING CHANGES.

Sections 3.1, 3.2, and 3.3 amend the statutes regarding coverage for reconstructive breast surgery following a mastectomy to require coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas, and to require notice of the coverage to insureds, all to conform North Carolina's 1997 post-mastectomy reconstructive surgery laws to the federal Women's Health and Cancer Rights Act of 1998

PART IV. VIATICAL SETTLEMENTS.

Section 4 amends the law on viatical settlements to define or redefine "financing entity," "financing transaction," "viatical settlement broker," "viatical settlement contract," "viatical settlement provider," "viatical settlement representative," "viaticated policy," and "viator." It provides that a viatical settlement broker who represents only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the viator's best interest. It makes the viatical settlement representatives and the viatical settlement brokers (as well as the viatical settlement

providers) subject to registration and examination. It adds a provision restricting disclosure of identity of the viator. It amends the provision regarding disclosure of information by a viatical settlement provider to the viator before the execution of the viatical settlement contract. These changes are recommended by the National Association of Insurance Commissioners, which has been monitoring the viatical settlement industry over the last few years. The purpose of the changes is to update North Carolina's law to keep current with changes in that industry.

PART V. FAMILY LEAVE CREDIT INSURANCE.

Section 5.1 adds a new G.S. 58-57-115 by establishing standards for family leave credit insurance policies to provide coverage for the loss of income because of voluntary, employer approved, leave of absence for birth or adoption of a child, illness of family member, or other specified reasons. Sections 5.2 and 5.3 make conforming changes to two other credit insurance laws.

PART VI. EFFECT OF HEADINGS.

Section 6. The headings to the parts of the act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of the act.

PART VII. EFFECTIVE DATES.

Section 7. Except for the provisions regarding reconstructive surgery, the act is effective Oct. 1, 1999.

Reported out 4-14-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 296 A BILL TO BE ENTITLED AN ACT TO REPEAL OBSOLETE OR UNNECESSARY LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES.

☐ 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, unfavorable as to (original bill).

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 296
Committee Substitute Favorable 4/14/99

Short Title: Insurance Technical Changes/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE OR UNNECESSARY LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1.1. G.S. 58-3-125, 58-6-10, and 58-71-90 are repealed.

Section 1.2. 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 1.3. 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 1.4. G.S. 58-33-45(d) reads as rewritten:

"(d) For the purposes of investigation under this section, the Commissioner shall have all the power conferred upon him by G.S. ~~58-3-125.~~ 58-2-50."

PART II. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION.

Section 2.1. 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 2.2. 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 2.3. 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 2.4. 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 2.5. 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 III. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 3.1. 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 3.2. 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 3.3. 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:

(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.~~ jurisdiction. 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~~ gender 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 3.4. 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 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 3.5. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar ~~year~~ year, or later with the approval of the Commissioner, 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 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 3.6. 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 3.7. 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 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 3.8. 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 3.9. 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 3.10. 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 3.11. 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 3.12. 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 IV. HEALTH INSURANCE CLARIFYING CHANGES.

Section 4.1. G.S. 58-50-130(a) is amended by adding a new subdivision to read:

"(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 that period in the health benefit plan held at the time by the small employer."

Section 4.2. G.S. 58-51-55(d) 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 4.3. G.S. 58-65-90(d) 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 4.4. G.S. 58-67-75(d) 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 4.5. Reserved.

Section 4.6. G.S. 58-68-40(e) 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 4.7. G.S. 58-68-60(b)(2) 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 4.8. Section 3.19 of Session Law 1997-519 reads as rewritten:

"Section 3.19. Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of ~~G.S. 58-50-50 or G.S. 58-50-55~~ G.S. 58-65-140, 58-50-50, or 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.16 or Section 3.17 of this act."

PART V. BAIL BONDS.

Section 5. 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 VI. AGENT ASSOCIATIONS MERGER.

Section 6.1. G.S. 58-32-1 reads as rewritten:

"**§ 58-32-1. Commission created; membership.**

There is hereby created within the Department a Public Officers and Employees Liability Insurance Commission. The Commission shall consist of 11 members who shall be appointed as follows: the Commissioner shall appoint six members as follows: two members who are members of the insurance industry who may be chosen from a list of ~~three~~ six nominees submitted to the Commissioner by the Independent Insurance Agents of North Carolina, ~~Inc., and a list of three nominees submitted by the Carolinas Association of Professional Insurance Agents, North Carolina Division, Inc.;~~ one member who is employed by a police department who may be chosen from a list of three nominees submitted to the Commissioner jointly by the North Carolina Police Chiefs Association and North Carolina Police Executives Association, and one member who is employed by a sheriff's department who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Sheriff's Association; one member representing city government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina League of Municipalities; and one member representing county government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Association of County Commissioners; and the General Assembly shall appoint two persons, one upon the recommendation of the Speaker of the House of Representatives, and one upon the recommendation of the President Pro Tempore of the Senate. The Commissioner or ~~his~~ the Commissioner's designate shall be an ex officio member. Appointments by the General Assembly shall be made in accordance with G.S. 120-121, and vacancies in those appointments shall be filled in accordance with G.S. 120-122. The terms of the initial appointees by the General Assembly shall expire on June 30, 1983. The Secretary of the Department of Crime Control and Public Safety or ~~his~~ the Secretary's designate shall be an ex officio member. The Attorney General or ~~his~~ the Attorney General's designate shall be an ex officio member. One insurance industry member appointed by the Commissioner shall be appointed to a term of two years and one insurance industry member shall be appointed to a term of four years. The police department member shall be appointed to a term of two years and the sheriff's department member shall be appointed to a term of four years. The representative of county government shall be appointed to a term of two years and the representative of city government to a term of four years. Beginning July 1, 1983, the appointment made by the General Assembly upon the recommendation of the Speaker shall be for two years, and the appointment made by the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall be for four years. Except as provided in this section, if any vacancy occurs in the membership of the Commission, the appointing authority shall appoint another person to fill the unexpired term of the vacating member. After the initial terms established herein have expired, all appointees to the Commission shall be appointed to terms of four years.

The Commission members shall elect the ~~chairman and vice-chairman~~ chair and vice-chair of the Commission. The Commission may, by majority vote, remove any member of the Commission for chronic absenteeism, misfeasance, malfeasance or other good cause."

Section 6.2. G.S. 58-37-35(d) reads as rewritten:

"(d) The Facility shall be administered by a Board of Governors. The Board of Governors shall consist of 12 members having one vote each from the classifications hereinafter enumerated plus the Commissioner who shall serve ex officio without vote. Each Facility insurance company member serving on the Board shall be represented by a senior officer of the company. Not more than one company in a group under the same ownership or management shall be represented on the Board at the same time. Five members of the Board shall be selected by the member insurers, which members shall be fairly representative of the industry. To insure representative member insurers, one each shall be selected from the following groups: the American Insurance Association (or its successors), the Alliance of American Insurers (or its successors), the National Association of Independent Insurers (or its successors), all other stock insurers not affiliated with the above groups, and all other nonstock insurers not affiliated with the above groups. The Commissioner shall appoint two members of the Board who shall be Facility insurance company members domiciled in this State. The Commissioner shall appoint one member of the Board who shall be selected from a list of two nominees submitted by the Auto Insurance Agents of North Carolina, Inc. The Commissioner shall appoint four members of the Board who shall be fire and casualty insurance agents licensed in this State and actively engaged in writing motor vehicle insurance in this State. The Commissioner shall select ~~one agent~~ two agents from among a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina, ~~Inc., and one agent from among a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents.~~ Inc., (or its successors). The initial term of office of said Board members shall be two years. Following completion of initial terms, successors to the members of the original Board of Governors shall be selected to serve three years. All members of the Board of Governors shall serve until their successors are selected and qualified and the Commissioner may fill any vacancy on the Board from any of the aforementioned classifications until such vacancies are filled in accordance with the provisions of this Article. The Board of Governors of the Facility shall also have as nonvoting members two persons who are not employed by or affiliated with any insurance company or the Department and who are appointed by the Governor to serve at ~~his~~ the Governor's pleasure."

Section 6.3. G.S. 58-33-135(b) reads as rewritten:

"(b) The ~~fire and casualty~~ property and liability advisory committee shall comprise:

(1) Two employees of the Department of Insurance;

(2) ~~One representative~~ Two representatives from a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina;

~~(3) One representative from a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents (North Carolina Division);~~

(4) One representative of a licensed property and ~~casualty~~ liability insurance company writing business in this State that operates through an exclusive agency force;

(5) One representative from a list of two nominees submitted by the North Carolina Adjusters Association;

(6) One representative of ~~fire~~ property and ~~casualty~~ liability insurers from a list of two nominees submitted by the Association of North Carolina Property and Casualty Insurance Companies; and

(7) One representative from a list of two nominees submitted by the Department of Community Colleges."

PART VII. MISCELLANEOUS CORRECTIONS.

Section 7.1. G.S. 58-3-15 reads as rewritten:

"**§ 58-3-15. Additional or coinsurance clause.**

No insurance company or agent licensed to do business in this State may issue any policy or contract of insurance covering property in this State ~~which shall contain~~ that contains any clause or provision requiring the insured to take or maintain a larger amount of insurance than that expressed in ~~such~~ the policy, nor in any way provide that the insured shall be liable as a coinsurer with the company issuing the policy for any part of the loss or damage to the property described in ~~such~~ the policy, and any such clause or provision shall be null and void, and of no effect: Provided, the coinsurance clause or provision may be written in or attached to a policy or policies issued when there is printed or stamped on the ~~filing face~~ declarations page of ~~such~~ the policy or on the form containing ~~such~~ the clause the words 'coinsurance contract,' and the Commissioner may, in ~~his~~ the Commissioner's discretion, determine the location of the words 'coinsurance contract' and the size of the type to be used. If there ~~be~~ is a difference in the rate for the insurance with and without the coinsurance clause, the rates for each shall be furnished the insured upon request."

Section 7.2. G.S. 58-30-5 reads as rewritten:

"**§ 58-30-5. Persons covered.**

The proceedings authorized by this Article may be applied to:

(1) All insurers ~~who~~ that are doing, or have done, an insurance business in this State, and against whom claims arising from that business may exist now or in the future.

(2) All insurers ~~who~~ that purport to do an insurance business in this State.

(3) All insurers ~~who~~ that have insureds resident in this State.

(4) All persons organized or in the process of organizing with the intent to do an insurance business in this State.

(5) All persons subject to Articles 64, 65 and 66, or 67 of this Chapter; except to the extent there is a conflict between the

provisions of this Article and the provisions of those Articles, in which case those Articles will govern.

(6) Self-insured group workers' compensation funds ~~organized under G.S. 97-93(a)(2).~~ subject to Article 47 of this Chapter."

Section 7.3. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity that is or should be licensed under Articles 7, 16, 26, 47, 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).~~ or under Article 5 of Chapter 97 of the General Statutes. For the purposes of this Article, 'insurer' also includes continuing care retirement centers that are or should be licensed under Article 64 of this Chapter."

PART VIII. AUTOMOBILE INSURANCE.

Section 8.1. G.S. 58-36-75(c) is repealed.

Section 8.2. 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 8.3. 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 dollars ($100,000)~~ one million dollars ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;
Uninsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

Section 8.4. 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~~ chair and shall ~~then~~ meet ~~thereafter as often as~~ at the call of the ~~chairman shall require~~ chair or at the request of ~~three~~ four members of the Board of Governors. The ~~chairman~~ chair 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~~ chair for more than two consecutive ~~years.~~ years; provided, however, that a member may continue to serve as chair until a successor chair is elected and qualified."

Section 8.5. 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 8.6. 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 8.7. 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)~~ G.S. 58-37-40(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 8.8. 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 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 8.9. G.S. 58-37-75 is repealed.

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 9.1. 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. 58-28-15.	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.

Section 9.2. G.S. 58-43-35 reads as rewritten:

"**§ 58-43-35. Punishment for issuing fire policies contrary to law.**

Any insurance company or agent who makes, issues, or delivers a policy of fire insurance in willful violation of the provisions of Articles 1 through 64 of this Chapter ~~which~~ that prohibit a domestic insurance company from issuing policies before obtaining ~~certificate and authority~~ a license from the ~~Commissioner of Insurance;~~ Commissioner; or ~~which~~ that prohibit the issuing of a fire insurance policy for more than the fair value of the property or for a longer term than seven years; or ~~which~~ that prohibit stipulations in insurance contracts restricting the jurisdiction of courts, or limiting the time within which an action may be brought to less than one year after the cause of action accrues or to less than six months after a nonsuit by the plaintiff, shall be guilty of a Class 3 misdemeanor and shall, upon conviction, be punished only by a fine of not less than one thousand dollars ($1,000) nor more than

five thousand dollars ($5,000); but the policy shall be binding upon the company issuing it."

Section 9.3. G.S. 58-57-80 reads as rewritten:

"**§ 58-57-80. Penalties.**

In addition to any other penalty provided by law, any person, firm or corporation which willfully violates an order of the Commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of North Carolina a sum not to exceed one thousand dollars ($1,000) which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed five thousand dollars ($5,000). The Commissioner, in his discretion, may revoke or suspend the license ~~or certificate of authority~~ of the person, firm or corporation guilty of such willful violation. Such order for suspension or revocation shall be upon notice and hearing, and shall be subject to judicial review as provided in G.S. 58-57-75. Any creditor who requires credit life insurance or credit accident and health insurance, or both, in excess of the amounts set forth in G.S. 58-57-15 or who violates the provisions of G.S. 58-57-65 shall be guilty of a Class 3 misdemeanor, the penalty for which shall only be a fine of two thousand dollars ($2,000) for each such occurrence or violation."

PART X. RESERVED.

PART XI. EXAMINATION LAW -- CROSS REFERENCE CORRECTIONS.

Section 11.1. G.S. 58-3-155(c) reads as rewritten:

"(c) No licensed property or casualty insurer that has control of a broker may accept insurance from the broker in any transaction in which the broker, when the insurance is placed, is acting as such on behalf of the insured for any compensation, commission, or thing of value unless the broker, before the effective date of the coverage, delivers written notice to the prospective insured disclosing the relationship between the insurer and broker. The disclosure must be signed by the insured and must be retained in the insurer's underwriting file until the completion and release of the examination report under ~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 for the period in which the coverage is in effect. If the insurance is placed through a subbroker that is not a controlled broker, the controlling insurer shall retain in its records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has notified or will notify the insured."

Section 11.2. G.S. 58-20-30 reads as rewritten:

"**§ 58-20-30. Financial monitoring and evaluation of clubs.**

Each club shall be audited annually, at the Club's expense, by a certified public accounting firm. A copy of the audit report shall be furnished to each member, and to the Commissioner. The trustees shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expenses reserves of the Club, including estimate of losses and loss adjustment expenses incurred but not reported. The provisions of

G.S. 58-2-131 through ~~G.S. 58-2-133,~~ G.S. 58-2-134, G.S. 58-2-150, 58-2-160, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and G.S. 58-6-5 apply to each Club and to persons that administer the Clubs."

Section 11.3. G.S. 58-21-40(c) reads as rewritten:

"(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each advisory organization; in which case the provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-180, 58-2-185, 58-2-190, 58-2-195, and 58-2-200 shall apply. If the Commissioner finds the advisory organization or any member thereof to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation."

Section 11.4. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 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, 58-7-175, 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, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

Section 11.5. G.S. 58-26-10 reads as rewritten:

"**§ 58-26-10. Financial statements and licenses required.**

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The Commissioner shall annually license such companies and their agents."

Section 11.6. G.S. 58-34-2(m) reads as rewritten:

"(m) The acts of an MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined by the Commissioner under ~~G.S. 58-2-131, 58-2-132, or 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 as if it were an insurer."

Section 11.7. G.S. 58-47-100 reads as rewritten:

"**§ 58-47-100. Examinations.**

~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 apply to groups."

Section 11.8. G.S. 58-47-195 reads as rewritten:

"**§ 58-47-195. Examinations.**

TPAs and service companies may be examined under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.9. G.S. 58-64-55 reads as rewritten:

"**§ 58-64-55. Examinations; financial statements.**

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a facility offering continuing care in this State to examine its books

and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the facility examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference."

Section 11.10. G.S. 58-67-100(a) reads as rewritten:

"(a) The Commissioner may make an examination of the affairs of any health maintenance organization and the contracts, agreements or other arrangements pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years. Examinations shall otherwise be conducted under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.11. G.S. 143-215.94I(g) reads as rewritten:

"(g) Each pool shall be audited annually at the expense of the pool by a certified public accounting firm, with a copy of the report available to the governing body or chief executive officer of each member of the pool and to the Commissioner. The board of trustees of the pool shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expense reserves of the pool, including an estimate of losses and loss adjustment expenses incurred but not reported. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and 58-6-5 apply to each pool and to persons that administer the pools. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year. All financial statements required by this section shall be prepared in accordance with generally accepted statutory accounting principles."

PART XII. MOTOR CLUBS.

Section 12.1. G.S. 58-69-1, 58-77-1, and 58-77-5 are repealed.

Section 12.2. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-2. Definitions.**

As used in this Article:

(1) 'Branch or district office' means any physical location, other than a motor club's home office, where the motor club or its representatives conduct any type of business authorized under this Article.

(2) 'Motor club' means any person, whether or not residing, domiciled, or chartered in this State, that, in consideration of dues, assessments, or periodic payments of money, promises its members to assist them in matters relating to the ownership, operation, use, or maintenance of motor vehicles by rendering three or more of the following services:

a. Automobile theft reward service. -- A reward payable to any person, law enforcement agency, or officer for information leading to the recovery of a member's stolen vehicle and to

the apprehension and conviction of the person or persons unlawfully taking the vehicle.

b. Bail or cash appearance bond service. -- The furnishing of cash or a surety bond for a member accused of a violation of the motor vehicle law, or of any law of this State by reason of an automobile accident to secure the member's release and subsequent appearance in court.

c. Emergency road service. -- Roadside adjustment of a motor vehicle so that the vehicle may be operated under its own power.

d. Legal service. -- Providing for reimbursement to a member for attorneys' fees if criminal proceedings are instituted against the member as a result of the operation of a motor vehicle.

e. Map service. -- The furnishing of road maps to members without cost.

f. Personal travel and accident insurance service. -- Making available to members a personal travel and accident insurance policy issued by a duly licensed insurance company in this State.

g. Touring service. -- The furnishing of touring information to members without cost.

h. Towing service. -- Furnishing means to move a motor vehicle from one place to another under power other than its own.

(3) 'Licensee' means a motor club to which a license has been issued under this Article."

Section 12.3. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-50. Authority for qualified surety companies to guarantee certain arrest bond certificates.**

(a) Any domestic or foreign surety company that is authorized to do business in this State may become a surety, by filing with the Department an undertaking to become a surety, in an amount not to exceed one thousand five hundred dollars ($1,500) with respect to each guaranteed arrest bond certificate issued by a motor club.

(b) The undertaking shall be in a form to be prescribed by the Department and shall state:

(1) The name and address of the motor club or clubs with respect to which the surety company undertakes to guarantee the arrest bond certificates.

(2) The unqualified obligation of the surety company to pay the fine or forfeiture, in an amount not to exceed one thousand five hundred dollars ($1,500) of any person who, after posting a

guaranteed arrest bond certificate which the surety has undertaken to guarantee, fails to make the appearance for which the guaranteed arrest bond certificate was posted."

Section 12.4. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-55. Guaranteed arrest bond certificates accepted.**

(a) Any guaranteed arrest bond certificate guaranteed by a surety company under G.S. 58-69-50 shall be accepted in lieu of cash bail or other bond in an amount not to exceed one thousand five hundred dollars ($1,500) as a bail bond, when signed by the person whose signature appears on the certificate, to guarantee the appearance of that person in any court in this State at the time set by the court when the person is arrested for the violation of any motor vehicle law of this State or any motor vehicle ordinance of any municipality of this State. The guaranteed arrest bond certificate shall not apply to, and shall not be accepted in lieu of, cash bail or bond when the person has been arrested for any impaired driving offense or for any felony.

(b) A guaranteed arrest bond certificate that is posted as a bail bond in any court shall be subject to the forfeiture and enforcement provisions with respect to bail bonds in criminal cases as provided by law."

PART XIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 13.1. G.S. 58-47-65(f)(3) reads as rewritten:

"(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~~ each member. The financial statements are confidential, but the Commissioner may use them in any judicial or administrative proceeding."

Section 13.2. G.S. 58-47-85(2)c. reads as rewritten:

"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, which, at a minimum, is 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."

Section 13.3. G.S. 58-47-120(f)(11) reads as rewritten:

"(11) Qualifications for group membership, including underwriting guidelines and procedures to identify ~~members~~ any member that ~~are~~ is in a hazardous financial ~~conditions.~~ condition."

Section 13.4. Reserved.

Section 13.5. G.S. 97-165(2) reads as rewritten:

"(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.~~ principles."

Section 13.6. G.S. 97-170(c) reads as rewritten:

"(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.~~ insurance."

Section 13.7. G.S. 97-170(d)(4) is repealed.

Section 13.8. G.S. 97-180(b) reads as rewritten:

"(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.~~ North Carolina. 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."

Section 13.9. G.S. 97-180(d) reads as rewritten:

"(d) ~~Every~~ Upon the request of the Commissioner, every self-insurer shall submit ~~within 120 days after the end of its fiscal year~~ a report of its 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."

PART XIV. EFFECT OF HEADINGS.

Section 14. 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 15. This act is effective when it becomes law, except for Part III of this act, which becomes effective September 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 296
Proposed Committee Substitute H296-PCS1164-RN

Short Title: Insurance Technical Changes/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE OR UNNECESSARY LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1.1. G.S. 58-3-125, 58-6-10, and 58-71-90 are repealed.

Section 1.2. 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 1.3. 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 1.4. G.S. 58-33-45(d) reads as rewritten:

"(d) For the purposes of investigation under this section, the Commissioner shall have all the power conferred upon him by G.S. ~~58-3-125.~~ 58-2-50."

PART II. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION.

Section 2.1. 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 2.2. 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 2.3. 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 2.4. 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 2.5. 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 III. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 3.1. 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 3.2. 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 3.3. 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:

(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.~~ jurisdiction. 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~~ gender 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 3.4. 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 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 3.5. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar ~~year~~ year, or later with the approval of the Commissioner, 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 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 3.6. 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 3.7. 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 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 3.8. 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 3.9. 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 3.10. 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 3.11. 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 3.12. 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 IV. HEALTH INSURANCE CLARIFYING CHANGES.

Section 4.1. G.S. 58-50-130(a) is amended by adding a new subdivision to read:

"(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 that period in the health benefit plan held at the time by the small employer."

Section 4.2. G.S. 58-51-55(d) 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 4.3. G.S. 58-65-90(d) 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 4.4. G.S. 58-67-75(d) 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 4.5. Reserved.

Section 4.6. G.S. 58-68-40(e) 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 4.7. G.S. 58-68-60(b)(2) 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 4.8. Section 3.19 of Session Law 1997-519 reads as rewritten:

"Section 3.19. Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of ~~G.S. 58-50-50 or G.S. 58-50-55~~ G.S. 58-65-140, 58-50-50, or 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.16 or Section 3.17 of this act."

PART V. BAIL BONDS.

Section 5. 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 VI. AGENT ASSOCIATIONS MERGER.

Section 6.1. G.S. 58-32-1 reads as rewritten:

"**§ 58-32-1. Commission created; membership.**

There is hereby created within the Department a Public Officers and Employees Liability Insurance Commission. The Commission shall consist of 11 members who shall be appointed as follows: the Commissioner shall appoint six members as follows: two members who are members of the insurance industry who may be chosen from a list of ~~three~~ six nominees submitted to the Commissioner by the Independent Insurance Agents of North Carolina, ~~Inc., and a list of three nominees submitted by the Carolinas Association of Professional Insurance Agents, North Carolina Division, Inc.;~~ one member who is employed by a police department who may be chosen from a list of three nominees submitted to the Commissioner jointly by the North Carolina Police Chiefs Association and North Carolina Police Executives Association, and one member who is employed by a sheriff's department who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Sheriff's Association; one member representing city government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina League of Municipalities; and one member representing county government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Association of County Commissioners; and the General Assembly shall appoint two persons, one upon the recommendation of the Speaker of the House of Representatives, and one upon the recommendation of the President Pro Tempore of the Senate. The Commissioner or ~~his~~ the Commissioner's designate shall be an ex officio member. Appointments by the General Assembly shall be made in accordance with G.S. 120-121, and vacancies in those appointments shall be filled in accordance with G.S. 120-122. The terms of the initial appointees by the General Assembly shall expire on June 30, 1983. The Secretary of the Department of Crime Control and Public Safety or ~~his~~ the Secretary's designate shall be an ex officio member. The Attorney General or ~~his~~ the Attorney General's designate shall be an ex officio member. One insurance industry member appointed by the Commissioner shall be appointed to a term of two years and one insurance industry member shall be appointed to a term of four years. The police department member shall be appointed to a term of two years and the sheriff's department member shall be appointed to a term of four years. The representative of county government shall be appointed to a term of two years and the representative of city government to a term of four years. Beginning July 1, 1983, the appointment made by the General Assembly upon the recommendation of the Speaker shall be for two years, and the appointment made by the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall be for four years. Except as provided in this section, if any vacancy occurs in the membership of the Commission, the appointing authority shall appoint another person to fill the unexpired term of the vacating member. After the initial terms established herein have expired, all appointees to the Commission shall be appointed to terms of four years.

The Commission members shall elect the ~~chairman and vice-chairman~~ chair and vice-chair of the Commission. The Commission may, by majority vote, remove any member of the Commission for chronic absenteeism, misfeasance, malfeasance or other good cause."

Section 6.2. G.S. 58-37-35(d) reads as rewritten:

"(d) The Facility shall be administered by a Board of Governors. The Board of Governors shall consist of 12 members having one vote each from the classifications hereinafter enumerated plus the Commissioner who shall serve ex officio without vote. Each Facility insurance company member serving on the Board shall be represented by a senior officer of the company. Not more than one company in a group under the same ownership or management shall be represented on the Board at the same time. Five members of the Board shall be selected by the member insurers, which members shall be fairly representative of the industry. To insure representative member insurers, one each shall be selected from the following groups: the American Insurance Association (or its successors), the Alliance of American Insurers (or its successors), the National Association of Independent Insurers (or its successors), all other stock insurers not affiliated with the above groups, and all other nonstock insurers not affiliated with the above groups. The Commissioner shall appoint two members of the Board who shall be Facility insurance company members domiciled in this State. The Commissioner shall appoint one member of the Board who shall be selected from a list of two nominees submitted by the Auto Insurance Agents of North Carolina, Inc. The Commissioner shall appoint four members of the Board who shall be fire and casualty insurance agents licensed in this State and actively engaged in writing motor vehicle insurance in this State. The Commissioner shall select ~~one agent~~ two agents from among a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina, ~~Inc., and one agent from among a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents.~~ Inc., (or its successors). The initial term of office of said Board members shall be two years. Following completion of initial terms, successors to the members of the original Board of Governors shall be selected to serve three years. All members of the Board of Governors shall serve until their successors are selected and qualified and the Commissioner may fill any vacancy on the Board from any of the aforementioned classifications until such vacancies are filled in accordance with the provisions of this Article. The Board of Governors of the Facility shall also have as nonvoting members two persons who are not employed by or affiliated with any insurance company or the Department and who are appointed by the Governor to serve at ~~his~~ the Governor's pleasure."

Section 6.3. G.S. 58-33-135(b) reads as rewritten:

"(b) The ~~fire and casualty~~ property and liability advisory committee shall comprise:

(1) Two employees of the Department of Insurance;

(2) ~~One representative~~ Two representatives from a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina;

~~(3) One representative from a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents (North Carolina Division);~~

(4) One representative of a licensed property and ~~casualty~~ liability insurance company writing business in this State that operates through an exclusive agency force;

(5) One representative from a list of two nominees submitted by the North Carolina Adjusters Association;

(6) One representative of ~~fire~~ property and ~~casualty~~ liability insurers from a list of two nominees submitted by the Association of North Carolina Property and Casualty Insurance Companies; and

(7) One representative from a list of two nominees submitted by the Department of Community Colleges."

PART VII. MISCELLANEOUS CORRECTIONS.

Section 7.1. G.S. 58-3-15 reads as rewritten:

"**§ 58-3-15. Additional or coinsurance clause.**

No insurance company or agent licensed to do business in this State may issue any policy or contract of insurance covering property in this State ~~which shall contain~~ that contains any clause or provision requiring the insured to take or maintain a larger amount of insurance than that expressed in ~~such~~ the policy, nor in any way provide that the insured shall be liable as a coinsurer with the company issuing the policy for any part of the loss or damage to the property described in ~~such~~ the policy, and any such clause or provision shall be null and void, and of no effect: Provided, the coinsurance clause or provision may be written in or attached to a policy or policies issued when there is printed or stamped on the ~~filing face~~ declarations page of ~~such~~ the policy or on the form containing ~~such~~ the clause the words 'coinsurance contract,' and the Commissioner may, in ~~his~~ the Commissioner's discretion, determine the location of the words 'coinsurance contract' and the size of the type to be used. If there ~~be~~ is a difference in the rate for the insurance with and without the coinsurance clause, the rates for each shall be furnished the insured upon request."

Section 7.2. G.S. 58-30-5 reads as rewritten:

"**§ 58-30-5. Persons covered.**

The proceedings authorized by this Article may be applied to:

(1) All insurers ~~who~~ that are doing, or have done, an insurance business in this State, and against whom claims arising from that business may exist now or in the future.

(2) All insurers ~~who~~ that purport to do an insurance business in this State.

(3) All insurers ~~who~~ that have insureds resident in this State.

(4) All persons organized or in the process of organizing with the intent to do an insurance business in this State.

(5) All persons subject to Articles 64, 65 and 66, or 67 of this Chapter; except to the extent there is a conflict between the

provisions of this Article and the provisions of those Articles, in which case those Articles will govern.

(6) Self-insured group workers' compensation funds ~~organized under G.S. 97-93(a)(2).~~ subject to Article 47 of this Chapter."

Section 7.3. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity that is or should be licensed under Articles 7, 16, 26, 47, 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).~~ or under Article 5 of Chapter 97 of the General Statutes. For the purposes of this Article, 'insurer' also includes continuing care retirement centers that are or should be licensed under Article 64 of this Chapter."

PART VIII. AUTOMOBILE INSURANCE.

Section 8.1. G.S. 58-36-75(c) is repealed.

Section 8.2. 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 8.3. 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 dollars ($100,000)~~ one million dollars ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;
Uninsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

Section 8.4. 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~~ chair and shall ~~then~~ meet ~~thereafter as often as~~ at the call of the ~~chairman shall require~~ chair or at the request of ~~three~~ four members of the Board of Governors. The ~~chairman~~ chair 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~~ chair for more than two consecutive ~~years.~~ years; provided, however, that a member may continue to serve as chair until a successor chair is elected and qualified."

Section 8.5. 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 8.6. 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 8.7. 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)~~ G.S. 58-37-40(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 8.8. 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 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 8.9. G.S. 58-37-75 is repealed.

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 9.1. 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. 58-28-15.	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.

Section 9.2. G.S. 58-43-35 reads as rewritten:

"**§ 58-43-35. Punishment for issuing fire policies contrary to law.**

Any insurance company or agent who makes, issues, or delivers a policy of fire insurance in willful violation of the provisions of Articles 1 through 64 of this Chapter ~~which~~ that prohibit a domestic insurance company from issuing policies before obtaining ~~certificate and authority~~ a license from the ~~Commissioner of Insurance;~~ Commissioner; or ~~which~~ that prohibit the issuing of a fire insurance policy for more than the fair value of the property or for a longer term than seven years; or ~~which~~ that prohibit stipulations in insurance contracts restricting the jurisdiction of courts, or limiting the time within which an action may be brought to less than one year after the cause of action accrues or to less than six months after a nonsuit by the plaintiff, shall be guilty of a Class 3 misdemeanor and shall, upon conviction, be punished only by a fine of not less than one thousand dollars ($1,000) nor more than

five thousand dollars ($5,000); but the policy shall be binding upon the company issuing it."

Section 9.3. G.S. 58-57-80 reads as rewritten:

"**§ 58-57-80. Penalties.**

In addition to any other penalty provided by law, any person, firm or corporation which willfully violates an order of the Commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of North Carolina a sum not to exceed one thousand dollars ($1,000) which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed five thousand dollars ($5,000). The Commissioner, in his discretion, may revoke or suspend the license ~~or certificate of authority~~ of the person, firm or corporation guilty of such willful violation. Such order for suspension or revocation shall be upon notice and hearing, and shall be subject to judicial review as provided in G.S. 58-57-75. Any creditor who requires credit life insurance or credit accident and health insurance, or both, in excess of the amounts set forth in G.S. 58-57-15 or who violates the provisions of G.S. 58-57-65 shall be guilty of a Class 3 misdemeanor, the penalty for which shall only be a fine of two thousand dollars ($2,000) for each such occurrence or violation."

PART X. RESERVED.

PART XI. EXAMINATION LAW -- CROSS REFERENCE CORRECTIONS.

Section 11.1. G.S. 58-3-155(c) reads as rewritten:

"(c) No licensed property or casualty insurer that has control of a broker may accept insurance from the broker in any transaction in which the broker, when the insurance is placed, is acting as such on behalf of the insured for any compensation, commission, or thing of value unless the broker, before the effective date of the coverage, delivers written notice to the prospective insured disclosing the relationship between the insurer and broker. The disclosure must be signed by the insured and must be retained in the insurer's underwriting file until the completion and release of the examination report under ~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 for the period in which the coverage is in effect. If the insurance is placed through a subbroker that is not a controlled broker, the controlling insurer shall retain in its records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has notified or will notify the insured."

Section 11.2. G.S. 58-20-30 reads as rewritten:

"**§ 58-20-30. Financial monitoring and evaluation of clubs.**

Each club shall be audited annually, at the Club's expense, by a certified public accounting firm. A copy of the audit report shall be furnished to each member, and to the Commissioner. The trustees shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expenses reserves of the Club, including estimate of losses and loss adjustment expenses incurred but not reported. The provisions of

G.S. 58-2-131 through ~~G.S. 58-2-133,~~ G.S. 58-2-134, G.S. 58-2-150, 58-2-160, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and G.S. 58-6-5 apply to each Club and to persons that administer the Clubs."

Section 11.3. G.S. 58-21-40(c) reads as rewritten:

"(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each advisory organization; in which case the provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-180, 58-2-185, 58-2-190, 58-2-195, and 58-2-200 shall apply. If the Commissioner finds the advisory organization or any member thereof to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation."

Section 11.4. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 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, 58-7-175, 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, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

Section 11.5. G.S. 58-26-10 reads as rewritten:

"**§ 58-26-10. Financial statements and licenses required.**

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The Commissioner shall annually license such companies and their agents."

Section 11.6. G.S. 58-34-2(m) reads as rewritten:

"(m) The acts of an MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined by the Commissioner under ~~G.S. 58-2-131, 58-2-132, or 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 as if it were an insurer."

Section 11.7. G.S. 58-47-100 reads as rewritten:

"**§ 58-47-100. Examinations.**

~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 apply to groups."

Section 11.8. G.S. 58-47-195 reads as rewritten:

"**§ 58-47-195. Examinations.**

TPAs and service companies may be examined under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.9. G.S. 58-64-55 reads as rewritten:

"**§ 58-64-55. Examinations; financial statements.**

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a facility offering continuing care in this State to examine its books

and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the facility examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference."

Section 11.10. G.S. 58-67-100(a) reads as rewritten:

"(a) The Commissioner may make an examination of the affairs of any health maintenance organization and the contracts, agreements or other arrangements pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years. Examinations shall otherwise be conducted under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.11. G.S. 143-215.94I(g) reads as rewritten:

"(g) Each pool shall be audited annually at the expense of the pool by a certified public accounting firm, with a copy of the report available to the governing body or chief executive officer of each member of the pool and to the Commissioner. The board of trustees of the pool shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expense reserves of the pool, including an estimate of losses and loss adjustment expenses incurred but not reported. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and 58-6-5 apply to each pool and to persons that administer the pools. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year. All financial statements required by this section shall be prepared in accordance with generally accepted statutory accounting principles."

PART XII. MOTOR CLUBS.

Section 12.1. G.S. 58-69-1, 58-77-1, and 58-77-5 are repealed.

Section 12.2. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-2. Definitions.**

As used in this Article:

(1) 'Branch or district office' means any physical location, other than a motor club's home office, where the motor club or its representatives conduct any type of business authorized under this Article.

(2) 'Motor club' means any person, whether or not residing, domiciled, or chartered in this State, that, in consideration of dues, assessments, or periodic payments of money, promises its members to assist them in matters relating to the ownership, operation, use, or maintenance of motor vehicles by rendering three or more of the following services:

a. Automobile theft reward service. -- A reward payable to any person, law enforcement agency, or officer for information leading to the recovery of a member's stolen vehicle and to

the apprehension and conviction of the person or persons unlawfully taking the vehicle.

b. Bail or cash appearance bond service. -- The furnishing of cash or a surety bond for a member accused of a violation of the motor vehicle law, or of any law of this State by reason of an automobile accident to secure the member's release and subsequent appearance in court.

c. Emergency road service. -- Roadside adjustment of a motor vehicle so that the vehicle may be operated under its own power.

d. Legal service. -- Providing for reimbursement to a member for attorneys' fees if criminal proceedings are instituted against the member as a result of the operation of a motor vehicle.

e. Map service. -- The furnishing of road maps to members without cost.

f. Personal travel and accident insurance service. -- Making available to members a personal travel and accident insurance policy issued by a duly licensed insurance company in this State.

g. Touring service. -- The furnishing of touring information to members without cost.

h. Towing service. -- Furnishing means to move a motor vehicle from one place to another under power other than its own.

(3) 'Licensee' means a motor club to which a license has been issued under this Article."

Section 12.3. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-50. Authority for qualified surety companies to guarantee certain arrest bond certificates.**

(a) Any domestic or foreign surety company that is authorized to do business in this State may become a surety, by filing with the Department an undertaking to become a surety, in an amount not to exceed one thousand five hundred dollars ($1,500) with respect to each guaranteed arrest bond certificate issued by a motor club.

(b) The undertaking shall be in a form to be prescribed by the Department and shall state:

(1) The name and address of the motor club or clubs with respect to which the surety company undertakes to guarantee the arrest bond certificates.

(2) The unqualified obligation of the surety company to pay the fine or forfeiture, in an amount not to exceed one thousand five hundred dollars ($1,500) of any person who, after posting a

guaranteed arrest bond certificate which the surety has undertaken to guarantee, fails to make the appearance for which the guaranteed arrest bond certificate was posted."

Section 12.4. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-55. Guaranteed arrest bond certificates accepted.**

(a) Any guaranteed arrest bond certificate guaranteed by a surety company under G.S. 58-69-50 shall be accepted in lieu of cash bail or other bond in an amount not to exceed one thousand five hundred dollars ($1,500) as a bail bond, when signed by the person whose signature appears on the certificate, to guarantee the appearance of that person in any court in this State at the time set by the court when the person is arrested for the violation of any motor vehicle law of this State or any motor vehicle ordinance of any municipality of this State. The guaranteed arrest bond certificate shall not apply to, and shall not be accepted in lieu of, cash bail or bond when the person has been arrested for any impaired driving offense or for any felony.

(b) A guaranteed arrest bond certificate that is posted as a bail bond in any court shall be subject to the forfeiture and enforcement provisions with respect to bail bonds in criminal cases as provided by law."

PART XIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 13.1. G.S. 58-47-65(f)(3) reads as rewritten:

"(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~~ each member. The financial statements are confidential, but the Commissioner may use them in any judicial or administrative proceeding."

Section 13.2. G.S. 58-47-85(2)c. reads as rewritten:

"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, which, at a minimum, is 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."

Section 13.3. G.S. 58-47-120(f)(11) reads as rewritten:

"(11) Qualifications for group membership, including underwriting guidelines and procedures to identify ~~members~~ any member that ~~are~~ is in a hazardous financial ~~conditions.~~ condition."

Section 13.4. Reserved.

Section 13.5. G.S. 97-165(2) reads as rewritten:

"(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.~~ principles."

Section 13.6. G.S. 97-170(c) reads as rewritten:

"(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.~~ insurance."

Section 13.7. G.S. 97-170(d)(4) is repealed.

Section 13.8. G.S. 97-180(b) reads as rewritten:

"(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.~~ North Carolina. 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."

Section 13.9. G.S. 97-180(d) reads as rewritten:

"(d) ~~Every~~ Upon the request of the Commissioner, every self-insurer shall submit ~~within 120 days after the end of its fiscal year~~ a report of its 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."

PART XIV. EFFECT OF HEADINGS.

Section 14. 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 15. This act is effective when it becomes law, except for Part III of this act, which becomes effective September 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 296
PROPOSED COMMITTEE SUBSTITUTE
H296-CSRN-001

Short Title: Insurance Technical Changes/AB. (Public)

Sponsors:

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE OR UNNECESSARY LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1.1. G.S. 58-3-125, 58-6-10, 58-7-150, and 58-71-90 are repealed.

Section 1.2. 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 1.3. 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 1.4. 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."

PART II. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION.

Section 2.1. 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 2.2. 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 2.3. 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 2.4. 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 2.5. 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 III. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 3.1. 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 3.2. 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 sufficien

grounds for ~~the Bureau to authorize~~ the termination of the policy of that employer."

Section 3.3. 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:

(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.~~ jurisdiction. 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~~ gender 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 3.4. 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 the date the filing is received by the Commissioner: Provided that (1) rate or loss costs filings for workers' compensation insurance and employers' liabilit

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 3.5. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar ~~year~~ year, or later with the approval of the Commissioner, 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 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 3.6. 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 3.7. 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 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 3.8. 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 3.9. 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 3.10. 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 3.11. 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 3.12. 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 IV. HEALTH INSURANCE CLARIFYING CHANGES.

Section 4.1. G.S. 58-50-130(a) is amended by adding a new subdivision to read:

"(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 that period in the health

benefit plan held at the time by the small employer."

Section 4.2. G.S. 58-51-55(d) 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 4.3. G.S. 58-65-90(d) 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 4.4. G.S. 58-67-75(d) 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 4.5. Reserved.

Section 4.6. G.S. 58-68-40(e) 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 4.7. G.S. 58-68-60(b)(2) 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 4.8. Section 3.19 of Session Law 1997-519 reads as rewritten:

"Section 3.19. Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of ~~G.S. 58-50-50 or G.S. 58-50-55~~ G.S. 58-65-140, 58-50-50, or 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.16 or Section 3.17 of this act.

Section 4.9. G.S. 58-51-61(b) reads as rewritten:

"(b) For the purposes of this ~~section,~~ section:

(1) ~~"physician"~~ 'Physician' is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes.

(2) 'Medication' includes oral agents for controlling blood sugar, including all drugs approved by the United States Food and Drug Administration."

Section 4.10. G.S. 58-65-91(b) reads as rewritten:

"(b) For the purposes of this ~~section,~~ section:

(1) ~~"physician"~~ 'Physician' is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes.

(2) 'Medication' includes oral agents for controlling blood sugar, including all drugs approved by the United States Food and Drug Administration."

Section 4.11. G.S. 58-67-74(b) reads as rewritten:

"(b) For the purposes of this ~~section,~~ section:

(1) ~~"physician"~~ 'Physician' is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes.

(2) 'Medication' includes oral agents for controlling blood sugar, including all drugs approved by the United States Food and Drug Administration."

PART V. BAIL BONDS.

Section 5. 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 VI. AGENT ASSOCIATIONS MERGER.

Section 6.1. G.S. 58-32-1 reads as rewritten:
"§ 58-32-1. Commission created; membership.
There is hereby created within the Department a Public Officers and Employees Liability Insurance Commission. The Commission shall consist of 11 members who shall be appointed as follows: the Commissioner shall appoint six members as follows: two members who are members of the insurance industry who may be chosen from a list of ~~three~~ six nominees submitted to the Commissioner by the Independent Insurance Agents of North Carolina, ~~Inc., and a list of three nominees submitted by the Carolinas Association of Professional Insurance Agents, North Carolina Division;~~ Inc.; one member who is employed by a police department who may be chosen from a list of three nominees submitted to the Commissioner jointly by the North Carolina Police Chiefs Association and North Carolina Police Executives Association, and one member who is employed by a sheriff's department who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Sheriff's Association; one member representing city government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina League of Municipalities; and one member representing county government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Association of County Commissioners; and the General Assembly shall appoint two persons, one upon the recommendation of the Speaker of the House of Representatives, and one upon the recommendation of the President Pro Tempore of the Senate. The Commissioner or ~~his~~ the Commissioner's designate shall be an ex officio member. Appointments by the General Assembly shall be made in accordance with G.S. 120-121, and vacancies in those appointments shall be filled in accordance with G.S. 120-122. The terms of the initial appointees by the General Assembly shall expire on June 30, 1983. The Secretary of the Department of Crime Control and Public Safety or ~~his~~ the Secretary's designate shall be an ex officio member. The Attorney General or ~~his~~ the Attorney General's designate shall be an ex officio member. One insurance industry member appointed by the Commissioner shall be appointed to a term of two years and one insurance industry member shall be appointed to a term of four years. The police department member shall be appointed to a term of two years and the sheriff's department member shall be appointed to a term of four years. The representative of county government shall be appointed to a term of two years and the representative of city government to a term of four years.

Beginning July 1, 1983, the appointment made by the General Assembly upon the recommendation of the Speaker shall be for two years, and the appointment made by the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall be for four years. Except as provided in this section, if any vacancy occurs in the membership of the Commission, the appointing authority shall appoint another person to fill the unexpired term of the vacating member. After the initial terms established herein have expired, all appointees to the Commission shall be appointed to terms of four years.

The Commission members shall elect the ~~chairman and vice-chairman~~ chair and vice-chair of the Commission. The Commission may, by majority vote, remove any member of the Commission for chronic absenteeism, misfeasance, malfeasance or other good cause."

Section 6.2. G.S. 58-37-35(d) reads as rewritten:

"(d) The Facility shall be administered by a Board of Governors. The Board of Governors shall consist of 12 members having one vote each from the classifications hereinafter enumerated plus the Commissioner who shall serve ex officio without vote. Each Facility insurance company member serving on the Board shall be represented by a senior officer of the company. Not more than one company in a group under the same ownership or management shall be represented on the Board at the same time. Five members of the Board shall be selected by the member insurers, which members shall be fairly representative of the industry. To insure representative member insurers, one each shall be selected from the following groups: the American Insurance Association (or its successors), the Alliance of American Insurers (or its successors), the National Association of Independent Insurers (or its successors), all other stock insurers not affiliated with the above groups, and all other nonstock insurers not affiliated with the above groups. The Commissioner shall appoint two members of the Board who shall be Facility insurance company members domiciled in this State. The Commissioner shall appoint one member of the Board who shall be selected from a list of two nominees submitted by the Auto Insurance Agents of North Carolina, Inc. The Commissioner shall appoint four members of the Board who shall be fire and casualty insurance agents licensed in this State and actively engaged in writing motor vehicle insurance in this State. The Commissioner shall select ~~one agent~~ two agents from among a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina, ~~Inc., and one agent from among a list of two nominees~~

~~submitted by the Carolinas Association of Professional Insurance Agents.~~ Inc., (or its successors). The initial term of office of said Board members shall be two years. Following completion of initial terms, successors to the members of the original Board of Governors shall be selected to serve three years. All members of the Board of Governors shall serve until their successors are selected and qualified and the Commissioner may fill any vacancy on the Board from any of the aforementioned classifications until such vacancies are filled in accordance with the provisions of this Article. The Board of Governors of the Facility shall also have as nonvoting members two persons who are not employed by or affiliated with any insurance company or the Department and who are appointed by the Governor to serve at ~~his~~ the Governor's pleasure."

Section 6.3. G.S. 58-33-135(b) reads as rewritten:

"(b) The ~~fire and casualty~~ property and liability advisory committee shall comprise:

(1) Two employees of the Department of Insurance;

(2) ~~One representative~~ Two representatives from a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina;

~~(3) One representative from a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents (North Carolina Division);~~

(4) One representative of a licensed property and ~~casualty~~ liability insurance company writing business in this State that operates through an exclusive agency force;

(5) One representative from a list of two nominees submitted by the North Carolina Adjusters Association;

(6) One representative of ~~fire~~ property and ~~casualty~~ liability insurers from a list of two nominees submitted by the Association of North Carolina Property and Casualty Insurance Companies; and

(7) One representative from a list of two nominees submitted by the Department of Community Colleges."

PART VII. MISCELLANEOUS CORRECTIONS.

Section 7.1. G.S. 58-3-15 reads as rewritten:

"**§ 58-3-15. Additional or coinsurance clause.**

No insurance company or agent licensed to do business in this State may issue any policy or contract of insurance covering property in this State ~~which shall contain~~ that contains any clause or provision requiring the insured to take or maintain a larger amount of insurance than that expressed in ~~such~~ the policy, nor in any way provide that the insured shall be liable as a coinsurer with the company issuing the policy for any part of the loss or damage to the property described in ~~such~~ the policy, and any such clause or provision shall be null and void, and of no effect: Provided, the coinsurance clause or provision may ~~be~~ written in or attached to a policy or policies issued when there is printed or stamped on the ~~filing face~~ declarations page of ~~such~~ the policy or on the form containing ~~such~~ the clause the words 'coinsurance contract,' and the Commissioner may, in ~~his~~ the Commissioner's discretion, determine the location of the words 'coinsurance contract' and the size of the type to be used. If there ~~be~~ is a difference in the rate for the insurance with and without the coinsurance clause, the rates for each shall be furnished the insured upon request."

Section 7.2. G.S. 58-30-5 reads as rewritten:

"**§ 58-30-5. Persons covered.**

The proceedings authorized by this Article may be applied to:

(1) All insurers ~~who~~ that are doing, or have done, an insurance business in this State, and against whom claims arising from that business may exist now or in the future.

(2) All insurers ~~who~~ that purport to do an insurance business in this State.

(3) All insurers ~~who~~ that have insureds resident in this State.

(4) All persons organized or in the process of organizing with the intent to do an insurance business in this State.

(5) All persons subject to Articles 64, 65 and 66, or 67 of this Chapter; except to the extent there is a conflict between the provisions of this Article and the provisions of those Articles, in which case those Articles will govern.

(6) Self-insured group workers' compensation funds ~~organized under G.S. 97-93(a)(2).~~ subject to Article 47 of this Chapter."

Section 7.3. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity that is or should be licensed under Articles 7, 16, 26, 47, 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).~~ or under Article 5 of Chapter 97 of the General Statutes. For the purposes of this Article, 'insurer' also includes continuing care retirement centers that are or should be licensed under Article 64 of this Chapter."

PART VIII. AUTOMOBILE INSURANCE.

Section 8.1. G.S. 58-36-75(c) is repealed.

Section 8.2. 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 8.3. 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 dollars ($100,000)~~ one million dollars ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;
Uninsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

Section 8.4. 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~~ chair and shall ~~then~~ meet ~~thereafter as often as~~ at the call of the ~~chairman shall require~~ chair or at the request of ~~three~~ four members of the Board of Governors. The ~~chairman~~ chair 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~~ chair for more than two consecutive ~~years.~~ years; provided, however, that a member may continue to serve as chair until a successor chair is elected and qualified."

Section 8.5. 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;~~ losses; (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 8.6. 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 8.7. 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)~~ G.S. 58-37-40(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 8.8. G.S. 58-37-35(1) reads as rewritten:

"(1) 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 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 8.9. G.S. 58-37-75 is repealed.

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 9.1. 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. 58-28-15. 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.

Section 9.2. G.S. 58-43-35 reads as rewritten:

"**§ 58-43-35. Punishment for issuing fire policies contrary to law.**

Any insurance company or agent who makes, issues, or delivers a policy of fire insurance in willful violation of the provisions of ~~Articles 1 through 64 of~~ this Chapter ~~which~~ that prohibit a domestic insurance company from issuing policies before obtaining ~~certificate and authority~~ a license from the ~~Commissioner of Insurance;~~ Commissioner; or ~~which~~ that prohibit the issuing of a fire insurance policy for more than the fair value of the property or for a longer term than seven years; or ~~which~~ that

prohibit stipulations in insurance contracts restricting the jurisdiction of courts, or limiting the time within which an action may be brought to less than one year after the cause of action accrues or to less than six months after a nonsuit by the plaintiff, shall be guilty of a Class 3 misdemeanor and shall, upon conviction, be punished only by a fine of not less than one thousand dollars ($1,000) nor more than five thousand dollars ($5,000); but the policy shall be binding upon the company issuing it."

Section 9.3. G.S. 58-57-80 reads as rewritten:

"**§58-~~57~~-80. Penalties.**

In addition to any other penalty provided by law, any person, firm or corporation which willfully violates an order of the Commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of North Carolina a sum not to exceed one thousand dollars ($1,000) which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed five thousand dollars ($5,000). The Commissioner, in his discretion, may revoke or suspend the license ~~or certificate of authority~~ of the person, firm or corporation guilty of such willful violation. Such order for suspension or revocation shall be upon notice and hearing, and shall be subject to judicial review as provided in G.S. 58-57-75. Any creditor who requires credit life insurance or credit accident and health insurance, or both, in excess of the amounts set forth in G.S. 58-57-15 or who violates the provisions of G.S. 58-57-65 shall be guilty of a Class 3 misdemeanor, the penalty for which shall only be a fine of two thousand dollars ($2,000) for each such occurrence or violation."

PART X. RECODIFICATION CORRECTIONS.

Section 10. The phrase "Articles 1 through 64 of this Chapter" is deleted and replaced by the words "this Chapter" wherever it occurs in each of the following sections of the General Statutes:

G.S. 58-1-1.	Title of the Chapter.
G.S. 58-1-15.	Warranties by manufacturers, distributors, or sellers of goods or services.
G.S. 58-2-40.	Powers and duties of Commissioner.
G.S. 58-2-45.	Orders of Commissioner; when writing required.
G.S. 58-2-90.	Extent of review under § 58-2-80.
G.S. 58-2-150.	Oath required for compliance with law.

G.S. 58-2-155.	Investigation of charges.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-5.	No insurance contracts except under Articles 1 through 64 of this Chapter.
G.S. 58-3-30.	Meaning of terms "accidental injury", and "accidental means".
G.S. 58-3-35.	Stipulations as to jurisdiction and limitation of actions.
G.S. 58-3-85.	Corporation or association maintaining office in State required to qualify and secure license.
G.S. 58-3-105.	Limitation of risk.
G.S. 58-3-130.	Agent, adjuster, etc., acting without a license or violating insurance law.
G.S. 58-3-145.	Solicitation, negotiation, or payment of premiums on insurance policies through credit card facilities prohibited; exceptions.
G.S. 58-5-50.	Deposits of foreign life insurance companies.
G.S. 58-5-55.	Deposits of capital and surplus by domestic insurance companies.
G.S. 58-5-90.	Deposits held in trust by Commissioner or Treasurer.
G.S. 58-5-100.	Deposits by alien companies required and regulated.
G.S. 58-6-5.	Schedule of fees and charges.
G.S. 58-6-15.	Licenses run from July 1.
G.S. 58-7-1.	Application of Articles 1 through 64 of this Chapter and general laws.
G.S. 58-7-15.	Kinds of insurance authorized.
G.S. 58-7-75.	Amount of capital and/or surplus required; impairment of capital or surplus.
G.S. 58-7-115.	Increase of capital stock.
G.S. 58-8-20.	Mutual companies with a guaranty capital.
G.S. 58-13-15.	Definitions.
G.S. 58-13-20.	Exception.
G.S. 58-15-15.	Risk limitations.
G.S. 58-15-30.	License, surplus, and deposit requirements.
G.S. 58-15-35.	Continuation of business under prior requirements.
G.S. 58-15-45.	Attorney's domicile.
G.S. 58-16-1.	Admitted to do business.
G.S. 58-16-5.	Conditions of admission.
G.S. 58-16-15.	Foreign companies; requirements for admission.
G.S. 58-16-40.	Alternative service of process on insurers.
G.S. 58-16-50.	Action to enforce compliance with this Chapter.

G.S. 58-19-10.	Subsidiaries of insurers.
G.S. 58-19-35.	Examination.
G.S. 58-20-10.	Commercial Fishermen Hull Insurance, and Protection and Indemnity Clubs authorized.
G.S. 58-22-30.	Countersignature not required.
G.S. 58-22-50.	Administrative and procedural authority regarding risk retention groups and purchasing groups.
G.S. 58-24-130.	Annual license.
G.S. 58-24-140.	Foreign or alien society admission.
G.S. 58-25-25.	Conditions precedent to doing business.
G.S. 58-28-1.	Purpose of Article.
G.S. 58-30-75.	Grounds for rehabilitation.
G.S. 58-33-120.	Agent, adjuster, etc., acting without a license or violating insurance law.
G.S. 58-34-5.	Retrospective compensation agreements.
G.S. 58-40-65.	Insurers authorized to act in concert.
G.S. 58-40-130.	Financial disclosure; rate modifications; reporting requirements.
G.S. 58-41-10.	Scope.
G.S. 58-43-1.	Performance of contracts as to devices not prohibited.
G.S. 58-50-25.	Nurses' services.
G.S. 58-50-30.	[Note: Effective until July 1, 1999.] Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, or advanced practice registered nurse.
G.S. 58-51-20.	Renewability of individual and blanket hospitalization and accident and health insurance policies.
G.S. 58-51-35.	Insurers and others to afford coverage to mentally retarded and physically handicapped children.
G.S. 58-51-40.	Insurers and others to afford coverage for active medical treatment in tax-supported institutions.
G.S. 58-51-45.	Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.
G.S. 58-52-1.	Definitions.
G.S. 58-52-5.	Joint action to insure persons 65 years of age or over and their spouses permitted; associations of insurers; individual and group policies.
G.S. 58-52-15.	Forms and rate manuals subject to § 58-51-1; disapproval of rates.

G.S. 58-54-1. Definitions.
G.S. 58-57-1. Application of Article.
G.S. 58-58-25. Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.
G.S. 58-58-55. Standard nonforfeiture provisions.
G.S. 58-58-160. Voting power under policies of group life insurance.
G.S. 58-60-1. Purpose of Article.
G.S. 58-65-130. Amendments to certificate of incorporation.
G.S. 58-69-45. Insurance licensing provisions not affected.

PART XI. EXAMINATION LAW -- CROSS REFERENCE CORRECTIONS.

Section 11.1. G.S. 58-3-155(c) reads as rewritten:

"(c) No licensed property or casualty insurer that has control of a broker may accept insurance from the broker in any transaction in which the broker, when the insurance is placed, is acting as such on behalf of the insured for any compensation, commission, or thing of value unless the broker, before the effective date of the coverage, delivers written notice to the prospective insured disclosing the relationship between the insurer and broker. The disclosure must be signed by the insured and must be retained in the insurer's underwriting file until the completion and release of the examination report under ~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 for the period in which the coverage is in effect. If the insurance is placed through a subbroker that is not a controlled broker, the controlling insurer shall retain in its records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has notified or will notify the insured."

Section 11.2. G.S. 58-20-30 reads as rewritten:

"**§ 58-20-30. Financial monitoring and evaluation of clubs.**

Each club shall be audited annually, at the Club's expense, by a certified public accounting firm. A copy of the audit report shall be furnished to each member, and to the Commissioner. The trustees shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expenses reserves of the Club, including estimate of losses and loss adjustment expenses incurred but not reported. The provisions of G.S. 58-2-131 through ~~G.S. 58-2-133,~~ G.S. 58-2-134, G.S. 58-2-150, 58-2-160, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and G.S. 58-6-5 apply to each Club and to persons that administer the Clubs."

Section 11.3. G.S. 58-21-40(c) reads as rewritten:

"(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each advisory organization; in which case the provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-180, 58-2-185, 58-2-190, 58-2-195, and 58-2-200 shall apply. If the Commissioner finds the advisory organization or any member thereof to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation."

Section 11.4. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, G.S. 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 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, 58-7-175, 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, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

Section 11.5. G.S. 58-26-10 reads as rewritten:

"**§ 58-26-10. Financial statements and licenses required.**

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The Commissioner shall annually license such companies and their agents."

Section 11.6. G.S. 58-34-2(m) reads as rewritten:

"(m) The acts of an MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined by the Commissioner under ~~G.S. 58-2-131, 58-2-132, or 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 as if it were an insurer."

Section 11.7. G.S. 58-47-100 reads as rewritten:

"**§ 58-47-100. Examinations.**

~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 apply to groups."

Section 11.8. G.S. 58-47-195 reads as rewritten:

"**§ 58-47-195. Examinations.**

TPAs and service companies may be examined under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.9. G.S. 58-64-55 reads as rewritten:

"**§ 58-64-55. Examinations; financial statements.**

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a facility offering continuing care in this State to examine its books and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the facility examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference."

Section 11.10. G.S. 58-67-100(a) reads as rewritten:

"(a) The Commissioner may make an examination of the affairs of any health maintenance organization and the contracts, agreements or other arrangements pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years. Examinations shall otherwise be conducted under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.11. G.S. 143-215.94I(g) reads as rewritten:

"(g) Each pool shall be audited annually at the expense of the pool by a certified public accounting firm, with a copy of the report available to the governing body or chief executive officer of each member of the pool and to the Commissioner. The board of trustees of the pool shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expense reserves of the pool, including an estimate of losses and loss adjustment expenses incurred but not reported. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and 58-6-5 apply to each pool and to persons that administer the pools. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year. All financial statements required by this section shall be prepared in accordance with generally accepted statutory accounting principles."

PART XII. MOTOR CLUBS.

Section 12.1. G.S. 58-69-1, 58-77-1, and 58-77-5 are repealed.

Section 12.2. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-2. Definitions.**

As used in this Article:

(1) 'Branch or district office' means any physical location, other than a motor club's home office,

where the motor club or its representatives conduct any type of business authorized under this Article.

(2) 'Motor club' means any person, whether or not residing, domiciled, or chartered in this State, that, in consideration of dues, assessments, or periodic payments of money, promises its members to assist them in matters relating to the ownership, operation, use, or maintenance of motor vehicles by rendering three or more of the following services:

a. Automobile theft reward service. -- A reward payable to any person, law enforcement agency, or officer for information leading to the recovery of a member's stolen vehicle and to the apprehension and conviction of the person or person's unlawfully taking the vehicle.

b. Bail or cash appearance bond service. -- The furnishing of cash or a surety bond for a member accused of a violation of the motor vehicle law, or of any law of this State by reason of an automobile accident to secure the member's release and subsequent appearance in court.

c. Emergency road service. -- Roadside adjustment of a motor vehicle so that the vehicle may be operated under its own power.

d. Legal service. -- Providing for reimbursement to a member for attorneys' fees if criminal proceedings are instituted against the member as a result of the operation of a motor vehicle.

e. Map service. -- The furnishing of road maps to members without cost.

f. Personal travel and accident insurance service. -- Making available to members a personal travel and accident insurance policy issued by a duly licensed insurance company in this State.

g. Touring service. -- The furnishing of touring information to members without cost.

h. Towing service. -- Furnishing means to move a motor vehicle from one place to another under power other than its own.

(3) 'Licensee' means a motor club to which a license has been issued under this Article."

Section 12.3. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-69-50. Authority for qualified surety companies to guarantee certain arrest bond certificates.

(a) Any domestic or foreign surety company that is authorized to do business in this State may become a surety, by filing with the Department an undertaking to become a surety, in an amount not to exceed one thousand five hundred dollars ($1,500) with respect to each guaranteed arrest bond certificate issued by a motor club.

(b) The undertaking shall be in a form to be prescribed by the Department and shall state:

(1) The name and address of the motor club or clubs with respect to which the surety company undertakes to guarantee the arrest bond certificates.

(2) The unqualified obligation of the surety company to pay the fine or forfeiture, in an amount not to exceed one thousand five hundred dollars ($1,500) of any person who, after posting a guaranteed arrest bond certificate which the surety has undertaken to guarantee, fails to make the appearance for which the guaranteed arrest bond certificate was posted."

Section 12.4. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-69-55. Guaranteed arrest bond certificates accepted.

(a) Any guaranteed arrest bond certificate guaranteed by a surety company under G.S. 58-69-50 shall be accepted in lieu of cash bail or other bond in an amount not to exceed one thousand five hundred dollars ($1,500) as a bail bond, when signed by the person whose signature appears on the certificate, to guarantee the appearance of that person in any court in this State at the time set by the court when the person is arrested for the violation of any motor vehicle law of this State or any motor vehicle ordinance of any municipality of this State. The guaranteed arrest bond certificate shall not apply to, and shall not be accepted in lieu of, cash bail or bond when the person has been arrested for any impaired driving offense or for any felony.

(b) A guaranteed arrest bond certificate that is posted as a bail bond in any court shall be subject to the forfeiture and enforcement provisions with respect to bail bonds in criminal cases as provided by law."

PART XIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 13.1. G.S. 58-47-65(f)(3) reads as rewritten:

"(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~~ each member. The financial statements are confidential, but the Commissioner may use them in any judicial or administrative proceeding."

Section 13.2. G.S. 58-47-85(2)c. reads as rewritten:

"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, which, at a minimum, is 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."

Section 13.3. G.S. 58-47-120(f)(11) reads as rewritten:

"(11) Qualifications for group membership, including underwriting guidelines and procedures to identify ~~members~~ any member that ~~are~~ is in a hazardous financial ~~conditions.~~ condition."

Section 13.4. Reserved.

Section 13.5. G.S. 97-165(2) reads as rewritten:

"(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.~~ principles."

Section 13.6. G.S. 97-170(c) reads as rewritten:

"(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.~~ insurance."

Section 13.7. G.S. 97-170(d)(4) is repealed.

Section 13.8. G.S. 97-180(b) reads as rewritten:

"(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.~~ North Carolina. 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."

Section 13.9. G.S. 97-180(d) reads as rewritten:

"(d) ~~Every~~ Upon the request of the Commissioner, every self-insurer shall submit ~~within 120 days after the end of its fiscal year~~ a report of its 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."

PART XIV. EFFECT OF HEADINGS.

Section 14. 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 15. This act is effective when it becomes law.

HOUSE BILL 296

Short Title: Insurance Technical Changes/AB. (Public)

Sponsors: Representatives Hurley; Gibson and Melton.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REPEAL OBSOLETE OR UNNECESSARY LAWS AND MAKE TECHNICAL AND CLARIFYING AMENDMENTS AND CORRECTIONS IN VARIOUS INSURANCE STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1.1. G.S. 58-3-125, 58-6-10, 58-7-150, and 58-71-90 are repealed.

Section 1.2. 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 1.3. 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 1.4. 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."

PART II. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION.

Section 2.1. 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 2.2. 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 2.3. 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 2.4. 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 2.5. 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 III. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Section 3.1. 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 3.2. 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 3.3. 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:

(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.~~ jurisdiction. 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~~ gender 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 3.4. 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 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 3.5. G.S. 58-36-15(f) reads as rewritten:

"(f) On or before September 1 of each calendar ~~year~~ year, or later with the approval of the Commissioner, 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 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 3.6. 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 3.7. 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 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 3.8. 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 3.9. 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 3.10. 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 3.11. 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 3.12. 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 IV. HEALTH INSURANCE CLARIFYING CHANGES.

Section 4.1. G.S. 58-50-130(a) is amended by adding a new subdivision to read:

"(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 that period in the health benefit plan held at the time by the small employer."

Section 4.2. G.S. 58-51-55(d) 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 4.3. G.S. 58-65-90(d) 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 4.4. G.S. 58-67-75(d) 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 4.5. G.S. 58-51-15(h) 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 4.6. G.S. 58-68-40(e) 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 4.7. G.S. 58-68-60(b)(2) 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 4.8. Section 3.19 of Session Law 1997-519 reads as rewritten:

"Section 3.19. Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of

~~G.S. 58-50-50 or G.S. 58-50-55~~ G.S. 58-65-140, 58-50-50, or 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.16 or Section 3.17 of this act."

PART V. BAIL BONDS.

Section 5. 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 VI. AGENT ASSOCIATIONS MERGER.

Section 6.1. G.S. 58-32-1 reads as rewritten:

"**§ 58-32-1. Commission created; membership.**

There is hereby created within the Department a Public Officers and Employees Liability Insurance Commission. The Commission shall consist of 11 members who shall be appointed as follows: the Commissioner shall appoint six members as follows: two members who are members of the insurance industry who may be chosen from a list of ~~three~~ six nominees submitted to the Commissioner by the Independent Insurance Agents of North Carolina, ~~Inc., and a list of three nominees submitted by the Carolinas Association of Professional Insurance Agents, North Carolina Division, Inc.;~~ one member who is employed by a police department who may be chosen from a list of three nominees submitted to the Commissioner jointly by the North Carolina Police Chiefs Association and North Carolina Police Executives Association, and one member who is employed by a sheriff's department who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Sheriff's Association; one member representing city government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina League of Municipalities; and one member representing county government who may be chosen from a list of three nominees submitted to the Commissioner by the North Carolina Association of County Commissioners; and the General Assembly shall appoint two persons, one upon the recommendation of the Speaker of the House of Representatives, and one upon the recommendation of the President Pro Tempore of the Senate. The Commissioner or ~~his~~ the Commissioner's designate shall be an ex officio member. Appointments by the General Assembly shall be made in accordance with G.S. 120-121, and vacancies in those appointments shall be filled in accordance with G.S. 120-122. The terms of the initial appointees by the General Assembly shall expire on June 30, 1983. The Secretary of the Department of Crime Control and Public Safety or ~~his~~ the Secretary's designate shall be an ex officio member. The Attorney General or ~~his~~ the Attorney General's designate shall be an ex officio member. One insurance industry member appointed by the Commissioner shall be appointed to a term of two years and one insurance industry member shall be

appointed to a term of four years. The police department member shall be appointed to a term of two years and the sheriff's department member shall be appointed to a term of four years. The representative of county government shall be appointed to a term of two years and the representative of city government to a term of four years. Beginning July 1, 1983, the appointment made by the General Assembly upon the recommendation of the Speaker shall be for two years, and the appointment made by the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall be for four years. Except as provided in this section, if any vacancy occurs in the membership of the Commission, the appointing authority shall appoint another person to fill the unexpired term of the vacating member. After the initial terms established herein have expired, all appointees to the Commission shall be appointed to terms of four years.

The Commission members shall elect the ~~chairman and vice-chairman~~ chair and vice-chair of the Commission. The Commission may, by majority vote, remove any member of the Commission for chronic absenteeism, misfeasance, malfeasance or other good cause."

Section 6.2. G.S. 58-37-35(d) reads as rewritten:

"(d) The Facility shall be administered by a Board of Governors. The Board of Governors shall consist of 12 members having one vote each from the classifications hereinafter enumerated plus the Commissioner who shall serve ex officio without vote. Each Facility insurance company member serving on the Board shall be represented by a senior officer of the company. Not more than one company in a group under the same ownership or management shall be represented on the Board at the same time. Five members of the Board shall be selected by the member insurers, which members shall be fairly representative of the industry. To insure representative member insurers, one each shall be selected from the following groups: the American Insurance Association (or its successors), the Alliance of American Insurers (or its successors), the National Association of Independent Insurers (or its successors), all other stock insurers not affiliated with the above groups, and all other nonstock insurers not affiliated with the above groups. The Commissioner shall appoint two members of the Board who shall be Facility insurance company members domiciled in this State. The Commissioner shall appoint one member of the Board who shall be selected from a list of two nominees submitted by the Auto Insurance Agents of North Carolina, Inc. The Commissioner shall appoint four members of the Board who shall be fire and casualty insurance agents licensed in this State and actively engaged in writing motor vehicle insurance in this State. The Commissioner shall select ~~one agent~~ two agents from among a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina, ~~Inc., and one agent from among a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents.~~ Inc., (or its successors). The initial term of office of said Board members shall be two years. Following completion of initial terms, successors to the members of the original Board of Governors shall be selected to serve three years. All members of the Board of Governors shall serve until their successors are selected and qualified and the Commissioner may fill any vacancy on the Board from any of

the aforementioned classifications until such vacancies are filled in accordance with the provisions of this Article. The Board of Governors of the Facility shall also have as nonvoting members two persons who are not employed by or affiliated with any insurance company or the Department and who are appointed by the Governor to serve at ~~his~~ the Governor's pleasure."

Section 6.3. G.S. 58-33-135(b) reads as rewritten:

"(b) The ~~fire and casualty~~ property and liability advisory committee shall comprise:

(1) Two employees of the Department of Insurance;

(2) ~~One representative~~ Two representatives from a list of ~~two~~ four nominees submitted by the Independent Insurance Agents of North Carolina;

~~(3) One representative from a list of two nominees submitted by the Carolinas Association of Professional Insurance Agents (North Carolina Division);~~

(4) One representative of a licensed property and ~~casualty~~ liability insurance company writing business in this State that operates through an exclusive agency force;

(5) One representative from a list of two nominees submitted by the North Carolina Adjusters Association;

(6) One representative of ~~fire~~ property and ~~casualty~~ liability insurers from a list of two nominees submitted by the Association of North Carolina Property and Casualty Insurance Companies; and

(7) One representative from a list of two nominees submitted by the Department of Community Colleges."

PART VII. MISCELLANEOUS CORRECTIONS.

Section 7.1. G.S. 58-3-15 reads as rewritten:

"§ 58-3-15. Additional or coinsurance clause.

No insurance company or agent licensed to do business in this State may issue any policy or contract of insurance covering property in this State ~~which shall contain~~ that contains any clause or provision requiring the insured to take or maintain a larger amount of insurance than that expressed in ~~such~~ the policy, nor in any way provide that the insured shall be liable as a coinsurer with the company issuing the policy for any part of the loss or damage to the property described in ~~such~~ the policy, and any such clause or provision shall be null and void, and of no effect: Provided, the coinsurance clause or provision may be written in or attached to a policy or policies issued when there is printed or stamped on the ~~filing face~~ declarations page of ~~such~~ the policy or on the form containing ~~such~~ the clause the words 'coinsurance contract,' and the Commissioner may, in ~~his~~ the Commissioner's discretion, determine the location of the words 'coinsurance contract' and the size of the type to be used. If there ~~be~~ is a difference in the rate for the insurance with and without the coinsurance clause, the rates for each shall be furnished the insured upon request."

Section 7.2. G.S. 58-30-5 reads as rewritten:

"**§ 58-30-5. Persons covered.**

The proceedings authorized by this Article may be applied to:

(1) All insurers ~~who~~ that are doing, or have done, an insurance business in this State, and against whom claims arising from that business may exist now or in the future.

(2) All insurers ~~who~~ that purport to do an insurance business in this State.

(3) All insurers ~~who~~ that have insureds resident in this State.

(4) All persons organized or in the process of organizing with the intent to do an insurance business in this State.

(5) All persons subject to Articles 64, 65 and 66, or 67 of this Chapter; except to the extent there is a conflict between the provisions of this Article and the provisions of those Articles, in which case those Articles will govern.

(6) Self-insured group workers' compensation funds ~~organized under G.S. 97-93(a)(2).~~ subject to Article 47 of this Chapter."

Section 7.3. G.S. 58-30-10(14) reads as rewritten:

"(14) 'Insurer' means any entity that is or should be licensed under Articles 7, 16, 26, 47, 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).~~ or under Article 5 of Chapter 97 of the General Statutes. For the purposes of this Article, 'insurer' also includes continuing care retirement centers that are or should be licensed under Article 64 of this Chapter."

PART VIII. AUTOMOBILE INSURANCE.

Section 8.1. G.S. 58-36-75(c) is repealed.

Section 8.2. 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 8.3. 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 dollars ($100,000)~~ one million dollars ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;

Uninsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

Section 8.4. 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~~ chair and shall ~~then~~ meet ~~thereafter as often as~~ at the call of the ~~chairman shall require~~ chair or at the request of ~~three~~ four members of the Board of Governors. The ~~chairman~~ chair 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~~ chair for more than two consecutive ~~years.~~ years; provided, however, that a member may continue to serve as chair until a successor chair is elected and qualified."

Section 8.5. 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;~~ losses; (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 8.6. 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 8.7. 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)~~ G.S. 58-37-40(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 8.8. 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 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 8.9. G.S. 58-37-75 is repealed.

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Section 9. 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. RECODIFICATION CORRECTIONS.

Section 10. The phrase "Articles 1 through 64 of this Chapter" is deleted and replaced by the words "this Chapter" wherever it occurs in each of the following sections of the General Statutes:

G.S. 58-1-1. Title of the Chapter.
G.S. 58-1-15. Warranties by manufacturers, distributors, or sellers of goods or services.
G.S. 58-2-40. Powers and duties of Commissioner.
G.S. 58-2-45. Orders of Commissioner; when writing required.
G.S. 58-2-90. Extent of review under § 58-2-80.
G.S. 58-2-150. Oath required for compliance with law.
G.S. 58-2-155. Investigation of charges.
G.S. 58-2-200. Books and papers required to be exhibited.
G.S. 58-3-5. No insurance contracts except under Articles 1 through 64 of this Chapter.
G.S. 58-3-30. Meaning of terms "accidental injury", and "accidental means".
G.S. 58-3-35. Stipulations as to jurisdiction and limitation of actions.
G.S. 58-3-85. Corporation or association maintaining office in State required to qualify and secure license.
G.S. 58-3-105. Limitation of risk.
G.S. 58-3-130. Agent, adjuster, etc., acting without a license or violating insurance law.
G.S. 58-3-145. Solicitation, negotiation, or payment of premiums on insurance policies through credit card facilities prohibited; exceptions.
G.S. 58-5-50. Deposits of foreign life insurance companies.
G.S. 58-5-55. Deposits of capital and surplus by domestic insurance companies.
G.S. 58-5-90. Deposits held in trust by Commissioner or Treasurer.
G.S. 58-5-100. Deposits by alien companies required and regulated.
G.S. 58-6-5. Schedule of fees and charges.
G.S. 58-6-15. Licenses run from July 1.
G.S. 58-7-1. Application of Articles 1 through 64 of this Chapter and general laws.
G.S. 58-7-15. Kinds of insurance authorized.
G.S. 58-7-75. Amount of capital and/or surplus required; impairment of capital or surplus.
G.S. 58-7-115. Increase of capital stock.
G.S. 58-8-20. Mutual companies with a guaranty capital.
G.S. 58-13-15. Definitions.
G.S. 58-13-20. Exception.
G.S. 58-15-15. Risk limitations.

G.S. 58-15-30.	License, surplus, and deposit requirements.
G.S. 58-15-35.	Continuation of business under prior requirements.
G.S. 58-15-45.	Attorney's domicile.
G.S. 58-16-1.	Admitted to do business.
G.S. 58-16-5.	Conditions of admission.
G.S. 58-16-15.	Foreign companies; requirements for admission.
G.S. 58-16-40.	Alternative service of process on insurers.
G.S. 58-16-50.	Action to enforce compliance with this Chapter.
G.S. 58-19-10.	Subsidiaries of insurers.
G.S. 58-19-35.	Examination.
G.S. 58-20-10.	Commercial Fishermen Hull Insurance, and Protection and Indemnity Clubs authorized.
G.S. 58-22-30.	Countersignature not required.
G.S. 58-22-50.	Administrative and procedural authority regarding risk retention groups and purchasing groups.
G.S. 58-24-130.	Annual license.
G.S. 58-24-140.	Foreign or alien society admission.
G.S. 58-25-25.	Conditions precedent to doing business.
G.S. 58-28-1.	Purpose of Article.
G.S. 58-30-75.	Grounds for rehabilitation.
G.S. 58-33-120.	Agent, adjuster, etc., acting without a license or violating insurance law.
G.S. 58-34-5.	Retrospective compensation agreements.
G.S. 58-40-65.	Insurers authorized to act in concert.
G.S. 58-40-130.	Financial disclosure; rate modifications; reporting requirements.
G.S. 58-41-10.	Scope.
G.S. 58-43-1.	Performance of contracts as to devices not prohibited.
G.S. 58-43-35.	Punishment for issuing fire policies contrary to law.
G.S. 58-50-25.	Nurses' services.
G.S. 58-50-30.	[Note: Effective until July 1, 1999.] Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, or advanced practice registered nurse.
G.S. 58-51-20.	Renewability of individual and blanket hospitalization and accident and health insurance policies.
G.S. 58-51-35.	Insurers and others to afford coverage to mentally retarded and physically handicapped children.
G.S. 58-51-40.	Insurers and others to afford coverage for active medical treatment in tax-supported institutions.
G.S. 58-51-45.	Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.
G.S. 58-52-1.	Definitions.

G.S. 58-52-5.	Joint action to insure persons 65 years of age or over and their spouses permitted; associations of insurers; individual and group policies.
G.S. 58-52-15.	Forms and rate manuals subject to § 58-51-1; disapproval of rates.
G.S. 58-54-1.	Definitions.
G.S. 58-57-1.	Application of Article.
G.S. 58-58-25.	Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.
G.S. 58-58-55.	Standard nonforfeiture provisions.
G.S. 58-58-160.	Voting power under policies of group life insurance.
G.S. 58-60-1.	Purpose of Article.
G.S. 58-65-130.	Amendments to certificate of incorporation.
G.S. 58-69-45.	Insurance licensing provisions not affected.

PART XI. EXAMINATION LAW -- CROSS REFERENCE CORRECTIONS.

Section 11.1. G.S. 58-3-155(c) reads as rewritten:

"(c) No licensed property or casualty insurer that has control of a broker may accept insurance from the broker in any transaction in which the broker, when the insurance is placed, is acting as such on behalf of the insured for any compensation, commission, or thing of value unless the broker, before the effective date of the coverage, delivers written notice to the prospective insured disclosing the relationship between the insurer and broker. The disclosure must be signed by the insured and must be retained in the insurer's underwriting file until the completion and release of the examination report under ~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 for the period in which the coverage is in effect. If the insurance is placed through a subbroker that is not a controlled broker, the controlling insurer shall retain in its records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has notified or will notify the insured."

Section 11.2. G.S. 58-20-30 reads as rewritten:

"**§ 58-20-30. Financial monitoring and evaluation of clubs.**

Each club shall be audited annually, at the Club's expense, by a certified public accounting firm. A copy of the audit report shall be furnished to each member, and to the Commissioner. The trustees shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expenses reserves of the Club, including estimate of losses and loss adjustment expenses incurred but not reported. The provisions of G.S. 58-2-131 through ~~G.S. 58-2-133,~~ G.S. 58-2-134, G.S. 58-2-150, 58-2-160, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and G.S. 58-6-5 apply to each Club and to persons that administer the Clubs."

Section 11.3. G.S. 58-21-40(c) reads as rewritten:

"(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each advisory organization; in which case the provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-180, 58-2-185, 58-

2-190, 58-2-195, and 58-2-200 shall apply. If the Commissioner finds the advisory organization or any member thereof to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation."

Section 11.4. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, G.S. 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 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, 58-7-175, 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, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

Section 11.5. G.S. 58-26-10 reads as rewritten:

"**§ 58-26-10. Financial statements and licenses required.**

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The Commissioner shall annually license such companies and their agents."

Section 11.6. G.S. 58-34-2(m) reads as rewritten:

"(m) The acts of an MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined by the Commissioner under ~~G.S. 58-2-131, 58-2-132, or 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 as if it were an insurer."

Section 11.7. G.S. 58-47-100 reads as rewritten:

"**§ 58-47-100. Examinations.**

~~G.S. 58-2-131, 58-2-132, and 58-2-133~~ G.S. 58-2-131 through G.S. 58-2-134 apply to groups."

Section 11.8. G.S. 58-47-195 reads as rewritten:

"**§ 58-47-195. Examinations.**

TPAs and service companies may be examined under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.9. G.S. 58-64-55 reads as rewritten:

"**§ 58-64-55. Examinations; financial statements.**

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a facility offering continuing care in this State to examine its books and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the facility examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference."

Section 11.10. G.S. 58-67-100(a) reads as rewritten:

"(a) The Commissioner may make an examination of the affairs of any health maintenance organization and the contracts, agreements or other arrangements

pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years. Examinations shall otherwise be conducted under ~~G.S. 58-2-131, 58-2-132, and 58-2-133.~~ G.S. 58-2-131 through G.S. 58-2-134."

Section 11.11. G.S. 143-215.94I(g) reads as rewritten:

"(g) Each pool shall be audited annually at the expense of the pool by a certified public accounting firm, with a copy of the report available to the governing body or chief executive officer of each member of the pool and to the Commissioner. The board of trustees of the pool shall obtain an appropriate actuarial evaluation of the loss and loss adjustment expense reserves of the pool, including an estimate of losses and loss adjustment expenses incurred but not reported. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, and 58-6-5 apply to each pool and to persons that administer the pools. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year. All financial statements required by this section shall be prepared in accordance with generally accepted statutory accounting principles."

PART XII. MOTOR CLUBS.

Section 12.1. G.S. 58-69-1, 58-77-1, and 58-77-5 are repealed.

Section 12.2. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-2. Definitions.**

As used in this Article:

(1) 'Branch or district office' means any physical location, other than a motor club's home office, where the motor club or its representatives conduct any type of business authorized under this Article.

(2) 'Motor club' means any person, whether or not residing, domiciled, or chartered in this State, that, in consideration of dues, assessments, or periodic payments of money, promises its members to assist them in matters relating to the ownership, operation, use, or maintenance of motor vehicles by rendering three or more of the following services:

a. Automobile theft reward service. -- A reward payable to any person, law enforcement agency, or officer for information leading to the recovery of a member's stolen vehicle and to the apprehension and conviction of the person or person's unlawfully taking the vehicle.

b. Bail or cash appearance bond service. -- The furnishing of cash or a surety bond for a member accused of a violation of the motor vehicle law, or of any law of this State by reason of an automobile accident to secure the member's release and subsequent appearance in court.

c. Emergency road service. -- Roadside adjustment of a motor vehicle so that the vehicle may be operated under its own power.

d. Legal service. -- Providing for reimbursement to a member for attorneys' fees if criminal proceedings are instituted against the member as a result of the operation of a motor vehicle.

e. Map service. -- The furnishing of road maps to members without cost.

f. Personal travel and accident insurance service. -- Making available to members a personal travel and accident insurance policy issued by a duly licensed insurance company in this State.

g. Touring service. -- The furnishing of touring information to members without cost.

h. Towing service. -- Furnishing means to move a motor vehicle from one place to another under power other than its own.

(3) 'Licensee' means a motor club to which a license has been issued under this Article."

Section 12.3. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-50. Authority for qualified surety companies to guarantee certain arrest bond certificates.**

(a) Any domestic or foreign surety company that is authorized to do business in this State may become a surety, by filing with the Department an undertaking to become a surety, in an amount not to exceed one thousand five hundred dollars ($1,500) with respect to each guaranteed arrest bond certificate issued by a motor club.

(b) The undertaking shall be in a form to be prescribed by the Department and shall state:

(1) The name and address of the motor club or clubs with respect to which the surety company undertakes to guarantee the arrest bond certificates.

(2) The unqualified obligation of the surety company to pay the fine or forfeiture, in an amount not to exceed one thousand five hundred dollars ($1,500) of any person who, after posting a guaranteed arrest bond certificate which the surety has undertaken to guarantee, fails to make the appearance for which the guaranteed arrest bond certificate was posted."

Section 12.4. Article 69 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-55. Guaranteed arrest bond certificates accepted.**

(a) Any guaranteed arrest bond certificate guaranteed by a surety company under G.S. 58-69-50 shall be accepted in lieu of cash bail or other bond in an amount not to exceed one thousand five hundred dollars ($1,500) as a bail bond, when signed by the person whose signature appears on the certificate, to guarantee the appearance of that person in any court in this State at the time set by the court when the person is arrested for the violation of any motor vehicle law of this State or any motor vehicle ordinance of any municipality of this State. The guaranteed arrest bond certificate shall not apply to, and shall not be accepted in lieu of, cash bail or bond when the person has been arrested for any impaired driving offense or for any felony.

(b) A guaranteed arrest bond certificate that is posted as a bail bond in any court shall be subject to the forfeiture and enforcement provisions with respect to bail bonds in criminal cases as provided by law."

PART XIII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 13.1. G.S. 58-47-65(f)(3) reads as rewritten:

"(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~~ each member. The financial statements are confidential, but the Commissioner may use them in any judicial or administrative proceeding."

Section 13.2. G.S. 58-47-85(2)c. reads as rewritten:

"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, which, at a minimum, is 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."

Section 13.3. G.S. 58-47-120(f)(11) reads as rewritten:

"(11) Qualifications for group membership, including underwriting guidelines and procedures to identify ~~members~~ any member that ~~are~~ is in a hazardous financial ~~conditions.~~ condition."

Section 13.4. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

~~(1) Obtain from each member self-insurer and file with the Commissioner individual reports specifying the aggregate benefits each member paid during the previous calendar year, and the annual standard premium that would have been paid by the individual member self-insurer during the previous calendar year, pursuant to manual rates established by the North Carolina Rate Bureau and using the experience rating procedure approved by the Commissioner for that member self-insurer or the annual premium collected by each group member self-insurer during the prior calendar year. These reports shall be due on or before July 15 following the close of that calendar year, except that this deadline may be extended by the Commissioner for up to three additional months for good cause shown.~~

(2) Assess each member of the Association as follows:

a. Each individual member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual ~~standard premium~~ gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual ~~standard premium.~~ gross premiums. Each group member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~premium collected by~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this one-quarter of one percent (0.25%) assessment. Assessments paid by members pursuant to this

subdivision shall be credited toward the tax paid by self-insurers under Article 8B of Chapter 105 of the General Statutes. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll information as determined under G.S. 105-228.5(b), (b1), and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.

b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

c. If a self-insurer is a member of the Association for less than a full calendar year, the annual ~~standard premium~~ gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.

d. If application of the contribution rates referenced in ~~sub-subdivisions a. and b.~~ sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.

(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers

from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.

The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Be obligated to the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter. The Association shall pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this Article.

(5) After paying any claim resulting from a self-insurer's insolvency, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Assess the Fund in an amount necessary to pay only:

a. The obligations for the Association under this Article subsequent to an insolvency;

b. The expenses of handling covered claims subsequent to an insolvency;

c. The cost of examinations under G.S. 97-137; and
d. Other expenses authorized by this Article;

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Notify such persons as the Commissioner directs under G.S. 97-136;

(9) Handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association;

(11) Pay the other expenses of the Association authorized by this section; and

(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions ~~(1), (2),~~ (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association;

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post-insolvency assessment which shall be imposed as follows:

(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the

annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c) of the individual member self-insurer for the premium calendar year bears to the annual ~~standard premium~~ gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual ~~collected premium~~ gross premiums of the group member self-insurer for the premium calendar year bears to the annual ~~collected premium~~ gross premiums of all group member self-insurers for the preceding calendar year.

(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.

(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~premium collected by~~ gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year."

Section 13.5. G.S. 97-165(2) reads as rewritten:

"(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.~~ principles."

Section 13.6. G.S. 97-170(c) reads as rewritten:

"(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.~~ insurance."

Section 13.7. G.S. 97-170(d)(4) is repealed.

Section 13.8. G.S. 97-180(b) reads as rewritten:

"(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.~~ North Carolina. 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."

Section 13.9. G.S. 97-180(d) reads as rewritten:

"(d) ~~Every~~ Upon the request of the Commissioner, every self-insurer shall submit ~~within 120 days after the end of its fiscal year~~ a report of its 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."

PART XIV. EFFECT OF HEADINGS.

Section 14. 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 15. This act is effective when it becomes law.

HOUSE BILL 296:
Insurance Technical Amendments

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Hurley
Date:	March 25, 1999	**Summary by:**	Linwood Jones
Version:	PCS		Committee Counsel

SUMMARY: ***House Bill 296 makes several technical and clarification changes in the insurance laws.***

BILL ANALYSIS:

Section 1.1 repeals the following four statutes:

- G.S. 58-3-125, which provides for revocation of an insurer's license for violating certain laws. There is another provision of the law, G.S. 58-3-100, that already provides for suspension or revocation of an insurer's license for violating any applicable law.
- GS 59-6-10, which refers to underwriting agencies consisting of two or more insurers doing only reinsurance business in this State. This statute was originally enacted in 1919. According to the Department, there are no such entities.
- GS 58-7-150, which governs consolidation by a domestic insurer with another insurer. Mergers, consolidations, and acquisitions of insurance companies are now covered (and have been for some time) under the Insurance Holding Company System Regulatory Act (Article 19 of Chapter 58).
- GS 58-71-90, which provides that appeals by bail bondsmen and runners of denials, suspension, or revocation of their licenses are governed by the appeals procedures of the APA. With G.S. 58-71-90 repealed, those appeals will come under the general insurance appeals statute (G.S. 58-2-75).

Section 1.2. The State Fire and Rescue Commission provides workers' compensation coverage for volunteer fire departments and rescue units that wish to participate. The money to the pay the premiums for this coverage comes from a combination of State appropriations and contributions by the participating units. Section 1.2 eliminates the prohibition on a unit getting coverage for a particular year if it fails to make its contribution by July 1st.

Section 1.3 conforms G.S. 58-3-115 to the change made by Section 1.1 of this bill, which repeals G.S. 58-3-125.

Section 1.4 eliminates a reference to G.S. 58-7-150, which is repealed by Section 1.1 of the bill.

Sections 2.1 through 2.5 change the reference to "continuing care facilities" to "continuing care retirement communities" and references to "continuing care facilities" to "facilities." The term "facility" is already defined in Article 64 of Chapter 58 as a facility that provides continuing care.

Sections 3.1 through 3.12 make various changes concerning workers' compensation insurance, and a couple of changes relating to insurance generally under the Rate Bureau. A few years ago, the General Assembly authorized moving the rating system for workers' compensation insurance from a rate system to a loss cost system. Under the rate system, the North Carolina Rate Bureau determined standard rates for each of several hundred job classifications, and those rates were used by all insurers unless they offered discounts ("deviations") from those rates. Under the loss costs system, the Rate Bureau only develops the part of the rate that reflects the industry-wide losses from workers' compensation claims in each job category, and the companies individually modify these base loss cost amounts with their own expense factors to come up with the rates.

Sections 3.1 through 3.12 add the words "loss costs" in several places in the statutes that were overlooked in the original conversion from the rate system to the loss cost system a few years ago. In addition, the following changes are made:

- Section 3.5 allows the Rate Bureau to file its loss cost filing with the Commissioner later in the year than September 1st if the Commissioner approves.
- Section 3.7 makes changes concerning insurance rate deviations. In practice, a deviation is a discount off of the standard insurance rate. Currently, a rate deviation is allowed if it applies uniformly to all risks in the State of the class to which it is apply and does not result in a rate being excessive, inadequate, or unfairly discriminatory. Section 3.7 deletes this requirement and replaces it with one that says the deviation must be based on sound actuarial principles. As is the case under the current law, rate deviations will still have to be approved by the Commissioner.

Section 4.1 restores language that provides that late enrollees in small employer group health plans (plans offered by employers with 50 or fewer employees) are subject to pre-existing condition limitations for up to 18 months. Section 4.1 is designed to eliminate potential concerns that late enrollees could be completely excluded from coverage. The language being addedd by Section 4.1 was in the Small Employer Group Reform law prior to 1997 and was inadvertently repealed during the major rewrite of the health insurance laws in 1997. The intent of the 1997 rewrite was to leave all of the then exisitng protections for employee insurance in place except to the extent necessary to comply with federal law.

Sections 4.2, 4.3, and 4.4 make clear that the limited mental parity provisions that were enacted in 1997 apply only to true group health insurance policies, not other types of special health policies such as disability income insurance, cancer policies, etc.

Section 4.5. Reserved.

Section 4.6. This section makes clear that two types of plans – the basic and standard plans – issued by insurance companies to self-employed individuals will remain guaranteed-issue plans.

Section 4.7 corrects the definition of an "eligible individual" for purposes of the insurance laws that determine when individuals are eligible for guaranteed issuance of individual health insurance coverage.

Section 4.8. In 1997, the legislature rewrote the laws on managed care, including the laws governing PPO plans. The 1997 bill including a "savings" clause to ensure that the existing Department rules on commercial insurance company PPO plans remained intact, except to the extent that the bill itself modified those rules. However, the savings clause inadvertently omitted a reference to existing rules

governing service corporation PPO plans. Section 4.8 amends the savings clause to pick up the rules that govern service corporation's PPO plans (except to the extent that the bill itself modified those rules).

Sections 4.9 through 4.11 make clear that diabetes "medications," which are already covered under the recently-passd law on diabetes insurance reimbursement, include oral medications for controlling blood sugar, including all drugs approved by the FDA for that purpose.

Section 5 makes clear that a bail bondsmen/runner license held simultaneously with a surety bond license is considered one license for purposes of disciplinary actions involving suspension, revocation, or nonrenewal of the licenses.

Sections 6.1, 6.2, and 6.3 recognize the recent merger of the Carolinas Association of Professional Insurance Agents with the Independent Insurance Agents of North Carolina in several statutes that refer to those associations by name.

Section 7.1 replaces the outdated term "filing face" of the policy with the term "declarations page."

Section 7.2 corrects the statutory reference to self-insured group workers' compensation funds (now Article 47 of Chapter 58) and redefines "insurer" under the insurance rehabilitation and liquidation law to pick up entities that were conducting insurance business unlawfully without a license (i.e., those that "should be licensed") and employers that individually self-insure their workers' compensation liability (Article 5 of Chapter 97). (These employers are required to be licensed pursuant to Article 5 of Chapter 97).

Section 8.1 repeals the list of 22 traffic offenses for which *facility recoupment surcharges* are authorized. From 1977 through 1987, losses in the Motor Vehicle Reinsurance Facility (the pool for drivers unable to find coverage in the voluntary market) were recouped by surcharging auto insurance policyholders with insurance points. Eventually, the surcharge was levied just on those with points for these 22 listed offenses. (These surcharges were in addition to the regular *insurance point surcharges* assessed for moving violations and at-fault accidents). In 1988, the legislature enacted a law (G.S. 58-37-75) to gradually shift the cost of these losses from policyholders with insurance points to all policyholders. This gradual shift was completed in 1995. Since 1995, Facility losses have been assessed against all policyholders. Thus, there is no longer a need for a list of offenses to determine which policyholders should pay Facility recoupment surcharges. [***Note:*** The Facility charges rates that are designed to make the Facility self-supporting. However, there are still two types of recoupment from all policyholders: (i) recoupment surcharges for losses of the Facility above and beyond the projected losses and (ii) "clean risk allocation" recoupment surcharges, which are surcharges reflecting the actuarial losses the Facility sustains from charging drivers in the Facility with no insurance points the same rates they would have paid in the voluntary market.]

Section 8.2 makes a conforming change to the definition of "motor vehicle insurance" in the Reinsurance Facility laws to include "underinsured motorist coverage." Those laws already apply to undersinured motorist coverage (see, for example, G.S. 58-37-35, which is amended in Section 8.3).

Section 8.3 amends the law governing the types of auto insurance coverages and the amounts of those coverages that an insurer can cede to the Reinsurance Facility. These changes recognize the 1991 increase in the amount of uninsured and underinsured motorist coverage that a policyholder can purchase ($1 million) and the amount of uninsured motorist property damage coverage that the Facility already recognizes as cedeable ($50,000).

Section 8.4 eliminates outdated language about the initial (1973) governing board of the Reinsuran Facility. This section also increases the quorum of the board from 5 to 7 members, increases the numb of members required to call a special meeting from 3 to 4, and allows the chair to serve until a successor chair is elected and qualified. (The Board has 12 members).

Sections 8.5, 8.6, 8.7, and 8.8 make further conforming changes to reflect the repeal of G.S. 58-36-75(c) in Section 8.1. Section 8.5 also recognizes the existing authority of the Reinsurance Facility to recoup losses through policy surcharges (see 58-37-40(f)).

Section 8.9 repeals G.S. 58-37-75, the statute that provided for the gradual shift, from 1988 to 1995, in how Facility losses were recouped *(see Section 8.1 above for additional discussion)*. This statute is no longer necessary.

Section 9.1 changes all references to "certificates of authority" to "licenses" throughout the insurance laws.

Section 10 deletes references to "Articles 1 through 64 of this Chapter" and replaces it with "this Chapter."

Sections 11.1 through 11.11 update cross-references to the insurance company examination laws. Those laws were amended late last year in the budget to add a new section, GS 58-2-134, which governs when insurers can be assessed the cost of examinations.

Section 12.1 repeals three statutes on motor clubs. Sections 12.2 through 12.4 then rewrite these statutes. All of the new statutes are incorporated into the primary law governing motor clubs (Article 69 of Chapter 58).

Sections 13.1 and 13.3 make grammatical clarifications. Section 13.2 amends the current languag requiring members of self-insured workers compensation pools to annually submit balance sheets to the pool administrators that are *at a minimum* compiled by CPAs.

Section 13.4. Reserved.

Section 13.5 changes the definition of a "certified audit" under the laws requiring self-insured employers (workers compensation) to be licensed by the Commissioner of Insurance. The current law defines the audit as being in conformity with "generally accepted accounting principles *as considered necessary by the auditor under the circumstances."* The italicized language would be deleted.

Section 13.6 redefines the criteria for an employer to self-insure for workers' compensation. Although this section deletes language requiring the employer to have a sufficient number of employees over which it can actuarially spread its risk of workers compensation losses, the number of employees is still one of the factors the Commissioner reviews in determining whether the employer is capable of self-insuring *(see G.S. 97-170(c)(6))*.

Section 13.7 repeals in another part of G.S. 97-170 the same language that was deleted in Section 13.6.

Section 13.8 provides that each self-insured employer needs to submit an actuarial report on its losses and loss expense reserves only for its workers compensation experience in North Carolina.

Section 13.9 eliminates the annual requirement for the submission of a payroll report by self-insured employers to the Commissioner. The report will be required when requested by the Commissioner.

Section 14 provides that the headings in the bill are for reference only.

Section 15 makes this act effective when it becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 25, 1999

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: PCS for HB 296 – Insurance Technical Changes

PART I. REPEALS OF OBSOLETE OR UNNECESSARY PROVISIONS.

Section 1.1 repeals G.S. 58-3-125 (revocation of license), G.S. 58-6-10 (licensing of underwriters), G.S. 58-7-150 (consolidation of insurers), and G.S. 58-71-90 (bondsmen appeal) because they are obsolete or unnecessary.

Section 1.2 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 in 1996 if it has not made its required contribution by July 1.

Sections 1.3 and 1.4 make conforming changes to statutes containing references to statutes repealed in Section 1.1.

PART II. CONTINUING CARE RETIREMENT COMMUNITY NAME CORRECTION.

Sections 2.1 through 2.5 amend General Statute Chapter 58, Article 64 to rename "continuing care facilities" as "continuing care retirement communities."

PART III. WORKERS' COMPENSATION LOSS COSTS CONFORMING CHANGES.

Sections 3.1 through 3.12 add references in the Rate Bureau laws to the 1995 workers' compensation loss costs legislation. These references were inadvertently omitted in the 1995 legislation. They make clarifying changes in statutes concerning deviations from rates filed with the Rate Bureau. It amends G.S. 58-36-100(b)(1) to include a definition of expenses taxes "levied by the State or by any political subdivision of the State, licensing costs, fees."

PART IV. HEALTH INSURANCE CLARIFYING CHANGES.

Sections 4.1 through 4.8 make several changes to clarify provisions in the 1997 North Carolina legislation on federal health insurance changes (HB 434, S.L. 1997-259).

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 V. BAIL BONDS.

Section 5 amends G.S. 58-71-82 (bail bond licenses) to clarify that holding a professional bondsman's license or runner's license and a surety bondsman's license simultaneously are considered one license only for the purpose of disciplinary action involving the licenses.

PART VI. AGENT ASSOCIATIONS MERGER

On January 1, 1999, the Carolinas Association of Professional Insurance Agents, Inc., (CAPIA) merged with the Independent Insurance Agents of North Carolina, Inc. (IIANC). Sections 6.1 through 6.3 merge statutory references and responsibilities of CAPIA into IIANC. For example, where three nominees to the Public Officers and Employees Liability Insurance Commission are now made by CAPIA under G.S. 58-32-1, those nominees would come from the IIANC. Section 6.3 also renames "fire and casualty" under G.S. 58-33-135(b) as "property and liability."

PART VII. MISCELLANEOUS CORRECTIONS

Section 7.1 updates language that is no longer used ("filing face" is now "declarations page").

Section 7.2 corrects a statutory reference to conform with 1997 legislation on workers' compensation self-insurance.

PART VIII. AUTOMOBILE INSURANCE.

Sections 8.1 through 8.9 make technical amendments and corrections in laws on automobile insurance, including raising the amount of uninsured motorist and underinsured motorist coverage in a policy that can be ceded to the Reinsurance Facility to $1,000,000 – the amount that a driver can already obtain for that coverage. They repeal G.S. 58-36-75(c) (list of offenses to which facility recoupment surcharges apply) and G.S. 58-37-75 (re-allocation of facility recoupment), which both expired in 1995 and are obsolete. They amend G.S. 58-37-1 and 58-37-35(b)(2) to clarify that underinsured motorist insurance is included in the definition of motor vehicle insurance. They increase uninsured motorist coverage for property damage from $15,000 to $50,000. They amend

G.S. 58-37-35(e) to clarify that a chair of the Reinsurance Facility Board of Governors may continue to serve as chair until a successor is elected and qualified, even if it takes the chair beyond their two-year limit of service.

PART IX. CERTIFICATE OF AUTHORITY CONFORMING NAME CHANGE.

Sections 9.1 through 9.3 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. RECODIFICATION CORRECTIONS.

When General Statute Chapter 58 was recodified, other General Statute chapters and provisions outside of Chapter 58 were included in the new Chapter 58. To facilitate this process, what had been Chapter 58 was included in the first sixty-four articles of new Chapter 58. Therefore, there are many places where the term, "Articles 1 through 64 of this Chapter" appears. Section 10 contains a list of statutes in which this awkward reference is unnecessary, and changes the reference to "this Chapter."

PART XI. EXAMINATION LAW – CROSS REFERENCE CORRECTIONS

In 1998, the General Assembly amended the insurance company examination law and added a new statute, G.S. 58-2-134. Sections 11.1 through 11.11 amend various statutes to reflect the 1998 law (Session Law 1998-212, Section 26B).

PART XII. MOTOR CLUBS.

Section 12.1 repeals three statutes (G.S. 58-69-1, 58-77-1, and 58-77-2), which are rewritten and improved in Sections 12.2 through 12.4.

Section 12.2 rewrites and reorganizes G.S. 58-69-1 (definitions). It also adds a definition for "branch or district office," which is needed for clarification.

Sections 12.3 and 12.4 rewrite and improve the provisions of G.S. 58-77-1 and 58-77-2, which deal with arrest bond certificates written by surety companies for motor clubs. They also include the new provisions in the motor club law (Article 69).

PART XIII. WORKERS' COMPENSATION SELF-INSURANCE.

Sections 13.1 through 13.9 make a number of technical corrections and amend G.S. 97-170(c) to remove requirements concerning employee base for applicants for self-insurance and amend G.S. 97-180(d) to provide that self-insurers must provide a report of

annual payroll information on the Commissioner's request (now, within 120 days after the end of the fiscal year).

PART XIV. EFFECT OF HEADINGS.

Section 15 provides that the headings to the parts of the act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of the act.

PART XV. EFFECTIVE DATE.

Section 16 provides that the act is effective when it becomes law.

Reported out 4-12-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 306 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, AND TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES.

☐ 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, unfavorable as to (original bill).

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

☐ 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.

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 3

HOUSE BILL 306
Committee Substitute Favorable 4/12/99
Third Edition Engrossed 4/13/99

Short Title: Insurance Amendments/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, AND TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES.

The General Assembly of North Carolina enacts:

PART I. HEARINGS AND FAIR AND BEACH PLANS APPEALS.

Section 1.1. G.S. 58-2-50 reads as rewritten:

"**§ 58-2-50. ~~Examinations~~ Examinations, hearings, and investigations.**

All ~~examinations~~ examinations, hearings, and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. All hearings shall, unless otherwise specially provided, be held in accordance with this Article and Article 3A of Chapter 150B of the General Statutes and at a time and place designated in a written notice given by the Commissioner to the person cited to appear. The notice shall state the subject of inquiry and the specific charges, if any."

Section 1.2. 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 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 Commissioner's 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."

Section 1.3. 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~~ after the date of ~~such~~ the ruling or decision. The Commissioner, after a 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 II. CONTINUING CARE RETIREMENT RECEIVERSHIPS.

Section 2. 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, the Department of Health and Human Services may, notwithstanding any other provision of law, accept and approve the addition of adult care home beds for that facility if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the facility or (ii) 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."

PART III. HANDICAPPED PERSONS.

Section 3.1. 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 and other coverage provisions 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 3.2. G.S. 168-22(b) reads as rewritten:

"(b) A family care home shall be 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 IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1. G.S. 58-50-65(a) reads as rewritten:

"(a) Nothing in Articles 50 through 55 of this Chapter ~~shall apply~~ applies to or ~~affect~~ affects any policy of liability or workers' compensation insurance, except that the provisions of ~~G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55~~ G.S. 58-

50-56(g) and (h) ~~shall~~ apply to policies of workers' compensation ~~insurance.~~ insurance and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care provisions of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation insurance, the provisions of Chapter 97 govern."

Section 4.2. G.S. 97-2(21) reads as rewritten:

"(21) Managed care organization. -- The term 'managed care organization' means a preferred provider organization or a health maintenance organization regulated under Chapter 58 of the General Statutes. 'Managed care organization' also means a preferred provider benefit plan of an insurance company, hospital, or medical service corporation in which utilization review or quality management programs are used to manage the provision of health care services and benefits under this Chapter."

PART V. COMMERCIAL AIRCRAFT INSURANCE.

Section 5.1. G.S. 58-7-15(19) reads as rewritten:

"(19) 'Motor vehicle ~~and~~ or aircraft insurance,' meaning insurance against loss of or damage resulting from any cause to motor vehicles or aircraft and their equipment, and against legal liability of the insured for loss or damage to another's property resulting from the ownership, maintenance or use of motor vehicles or aircraft and against loss, damage or expense incident to a claim of such liability. This subdivision does not apply to commercial aircraft as defined in G.S. 58-1-5."

Section 5.2. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to ~~aviation~~ commercial aircraft insurance; to policies issued in this State covering risks with multistate locations, except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 5.3. G.S. 58-21-10(8) reads as rewritten:

"(8) 'Surplus lines insurance' means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, ~~aviation~~

commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities."

Section 5.4. G.S. 58-28-5(a) reads as rewritten:

"(a) Except as ~~hereinafter provided,~~ otherwise provided in this section, it ~~shall be~~ is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in G.S. 58-28-10, without a ~~certificate of authority~~ license issued by the Commissioner. This section ~~shall~~ does not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this ~~Chapter;~~ Chapter.

(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the ~~Commissioner;~~ Commissioner.

(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such ~~policy;~~ policy.

(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or franchise accident and health insurance where the master policy ~~of such~~ for the insurance was lawfully issued and delivered in a state ~~where~~ in which the company was authorized to transact ~~business;~~ business.

(5) Transactions in this State involving all policies of insurance issued ~~prior to~~ before July 1, ~~1967;~~ 1967.

(6) The procuring of contracts of insurance issued to a nuclear ~~insured;~~ insured. As used in this subdivision, 'nuclear insured' means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.

(7) Insurance independently procured, as specified in subsection (b) of this ~~section;~~ section.

(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.

(9) Transactions in this State involving commercial aircraft insurance, meaning insurance against (i) loss of or damage resulting from any

cause to commercial aircraft and its equipment, (ii) legal liability of the insured for loss or damage to another person's property resulting from the ownership, maintenance, or use of commercial aircraft, and (iii) loss, damage, or expense incident to a liability claim."

Section 5.5. G.S. 58-1-5 reads as rewritten:

"**§ 58-1-5. Definitions.**

In this Chapter, unless the context clearly requires otherwise:

(1) 'Alien company' means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(1a) 'Commercial aircraft' means aircraft used in domestic, flag, supplemental, commuter, or on-demand operations, as defined in Federal Aviation Administration Regulations, 14 C.F.R. § 119.3, as amended.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina or an authorized designee of the Commissioner.

(3) 'Company' or 'insurance company' or 'insurer' includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations. 'Company' or 'insurance company' or 'insurer' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(4) 'Department' means the Department of Insurance of North Carolina.

(5) 'Domestic company' means a company incorporated or organized under the laws of this State.

(6) 'Foreign company' means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State.

(7) 'NAIC' means the National Association of Insurance Commissioners.

~~(8) "Nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.~~

(9) 'Person' means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert. "Person" does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(10) The singular form ~~shall include~~ includes the plural, and the masculine form ~~shall include~~ includes the feminine wherever appropriate."

PART VI. SURPLUS LINES FILINGS.

Section 6.1. G.S. 58-21-35 reads as rewritten:

"**§ 58-21-35. Duty to file ~~evidence of insurance and affidavits.~~ reports and retain affidavits.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall ~~execute and~~ file with the ~~Commissioner.~~ Commissioner a

~~(1)~~ ~~A written~~ report in a format prescribed by the Commissioner regarding the insurance and including the following information:

~~a.~~(1) The name ~~and address~~ of the ~~insured;~~ insured.

~~b.~~(2) The identity of the insurer or ~~insurers;~~ insurers.

~~c.~~(3) A description of the subject and location of the ~~risk;~~ risk.

~~d.~~(4) The amount of premium charged for the ~~insurance; and~~ insurance.

~~e. Such other pertinent information as the Commissioner may reasonably require; and~~

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

~~(2)~~ ~~An~~

(b) The licensee shall complete and retain an affidavit as to the efforts to place the coverage with admitted insurers and the results ~~thereof~~ of the efforts, in accordance with G.S. 58-21-15. The report and affidavit required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

Section 6.2. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-2. Relationship to other insurance laws.**

Unless surplus lines insurance, surplus lines licensees, or nonadmitted insurers are specifically referenced in a particular section of this Chapter, no sections contained in Articles of this Chapter other than this Article apply to surplus lines insurance, surplus lines licensees, or nonadmitted insurers."

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7.1. G.S. 105-259(b) is amended by adding a new subdivision to read:

"(16a) To provide the North Carolina Self-Insurance Guaranty Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of collecting the assessments authorized in G.S. 97-133(a)."

Section 7.2. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

~~(1) Obtain from each member self-insurer and file with the Commissioner individual reports specifying the aggregate benefits each member paid during the previous calendar year, and the annual standard premium that would have been paid by the individual member self-insurer during the previous calendar year, pursuant to manual rates established by the North Carolina Rate Bureau and using the experience rating procedure approved by the Commissioner for that member self-insurer or the annual premium collected by each group member self-insurer during the prior calendar year. These reports shall be due on or before July 15 following the close of that calendar year, except that this deadline may be extended by the Commissioner for up to three additional months for good cause shown.~~

(2) Assess each member of the Association as follows:

a. Each individual member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual ~~standard premium~~ gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual ~~standard premium.~~ gross premiums. Each group member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~premium collected by~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this one-quarter of one percent (0.25%)

assessment. Assessments paid by members pursuant to this subdivision shall be credited toward the tax paid by self-insurers under Article 8B of Chapter 105 of the General Statutes. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll information as determined under G.S. 105-228.5(b), (b1), and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.

b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

c. If a self-insurer is a member of the Association for less than a full calendar year, the annual ~~standard premium~~ gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.

d. If application of the contribution rates referenced in ~~sub-subdivisions a. and b.~~ sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.

(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall

thereafter pay covered claims against group member self-insurers from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.

The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Be obligated to the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter. The Association shall pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this Article.

(5) After paying any claim resulting from a self-insurer's insolvency, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Assess the Fund in an amount necessary to pay only:

a. The obligations for the Association under this Article subsequent to an insolvency;

b. The expenses of handling covered claims subsequent to an insolvency;
c. The cost of examinations under G.S. 97-137; and
d. Other expenses authorized by this Article;

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Notify such persons as the Commissioner directs under G.S. 97-136;

(9) Handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association;

(11) Pay the other expenses of the Association authorized by this section; and

(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions ~~(1), (2),~~ (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association;

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post-insolvency assessment which shall be imposed as follows:

(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-

insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the individual member self-insurer for the premium calendar year bears to the annual ~~standard premium~~ gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual ~~collected premium~~ gross premiums of the group member self-insurer for the premium calendar year bears to the annual ~~collected premium~~ gross premiums of all group member self-insurers for the preceding calendar year.

(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.

(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~premium collected by~~ gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8. 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 or changes ~~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."

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9. G.S. 58-41-35 is repealed.

Section 9.1. 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 X. MORTALITY TABLE AND RESERVES UPDATE.

Section 10. G.S. 58-58-50(k) reads as rewritten:

"(k) The Commissioner shall adopt rules containing the minimum standards applicable to the valuation of health plans. The Commissioner may also adopt rules for the purpose of recognizing new annuity mortality tables for use in determining reserve liabilities for annuities and may adopt rules that govern minimum valuation standards for reserves of life insurance companies. In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC."

PART XI. EFFECT OF HEADINGS.

Section 11. 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 12. Sections 2 through 11 of this act become effective October 1, 1999. The remainder of this act is effective when it becomes law, but Sections 1.1, 1.2, and 1.3 of this act shall not apply to appeals pending on the date this act becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 306
Committee Substitute Favorable 4/12/99

Short Title: Insurance Amendments/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, AND TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES.

The General Assembly of North Carolina enacts:

PART I. HEARINGS AND FAIR AND BEACH PLANS APPEALS.

Section 1.1. G.S. 58-2-50 reads as rewritten:

"**§ 58-2-50. ~~Examinations~~ Examinations, hearings, and investigations.**

All ~~examinations~~ examinations, hearings, and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. All hearings shall, unless otherwise specially provided, be held in accordance with this Article and Article 3A of Chapter 150B of the General Statutes and at a time and place designated in a written notice given by the Commissioner to the person cited to appear. The notice shall state the subject of inquiry and the specific charges, if any."

Section 1.2. 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 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 Commissioner's 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."

Section 1.3. 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~~ after the date of ~~such~~ the ruling or decision. The Commissioner, after a 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 II. CONTINUING CARE RETIREMENT RECEIVERSHIPS.

Section 2. 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, the Department of Health and Human Services may, notwithstanding any other provision of law, accept and approve the addition of beds for that facility if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the facility or (ii) 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."

PART III. HANDICAPPED PERSONS.

Section 3.1. 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 and other coverage provisions 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 3.2. G.S. 168-22(b) reads as rewritten:

"(b) A family care home shall be 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 IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1. G.S. 58-50-65(a) reads as rewritten:

"(a) Nothing in Articles 50 through 55 of this Chapter ~~shall apply~~ applies to or ~~affect~~ affects any policy of liability or workers' compensation insurance, except that the provisions of ~~G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55~~ G.S. 58-

50-56(g) and (h) ~~shall~~ apply to policies of workers' compensation ~~insurance.~~ insurance and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care provisions of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation insurance, the provisions of Chapter 97 govern."

Section 4.2. G.S. 97-2(21) reads as rewritten:

"(21) Managed care organization. -- The term 'managed care organization' means a preferred provider organization or a health maintenance organization regulated under Chapter 58 of the General Statutes. 'Managed care organization' also means a preferred provider benefit plan of an insurance company, hospital, or medical service corporation in which utilization review or quality management programs are used to manage the provision of health care services and benefits under this Chapter."

PART V. COMMERCIAL AIRCRAFT INSURANCE.

Section 5.1. G.S. 58-7-15(19) reads as rewritten:

"(19) 'Motor vehicle ~~and~~ or aircraft insurance,' meaning insurance against loss of or damage resulting from any cause to motor vehicles or aircraft and their equipment, and against legal liability of the insured for loss or damage to another's property resulting from the ownership, maintenance or use of motor vehicles or aircraft and against loss, damage or expense incident to a claim of such liability. This subdivision does not apply to commercial aircraft as defined in G.S. 58-1-5."

Section 5.2. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to ~~aviation~~ commercial aircraft insurance; to policies issued in this State covering risks with multistate locations, except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 5.3. G.S. 58-21-10(8) reads as rewritten:

"(8) 'Surplus lines insurance' means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, ~~aviation~~

commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities."

Section 5.4. G.S. 58-28-5(a) reads as rewritten:

"(a) Except as ~~hereinafter provided,~~ otherwise provided in this section, it ~~shall be~~ is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in G.S. 58-28-10, without a ~~certificate of authority~~ license issued by the Commissioner. This section ~~shall~~ does not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this ~~Chapter;~~ Chapter.

(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the ~~Commissioner;~~ Commissioner.

(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such ~~policy;~~ policy.

(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or franchise accident and health insurance where the master policy ~~of such~~ for the insurance was lawfully issued and delivered in a state ~~where~~ in which the company was authorized to transact ~~business;~~ business.

(5) Transactions in this State involving all policies of insurance issued ~~prior to~~ before July 1, ~~1967;~~ 1967.

(6) The procuring of contracts of insurance issued to a nuclear ~~insured;~~ insured. As used in this subdivision, 'nuclear insured' means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.

(7) Insurance independently procured, as specified in subsection (b) of this ~~section;~~ section.

(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.

(9) Transactions in this State involving commercial aircraft insurance, meaning insurance against (i) loss of or damage resulting from any

cause to commercial aircraft and its equipment, (ii) legal liability of the insured for loss or damage to another person's property resulting from the ownership, maintenance, or use of commercial aircraft, and (iii) loss, damage, or expense incident to a liability claim."

Section 5.5. G.S. 58-1-5 reads as rewritten:

"**§ 58-1-5. Definitions.**

In this Chapter, unless the context clearly requires otherwise:

(1) 'Alien company' means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(1a) 'Commercial aircraft' means aircraft used in domestic, flag, supplemental, commuter, or on-demand operations, as defined in Federal Aviation Administration Regulations, 14 C.F.R. § 119.3, as amended.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina or an authorized designee of the Commissioner.

(3) 'Company' or 'insurance company' or 'insurer' includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations. 'Company' or 'insurance company' or 'insurer' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(4) 'Department' means the Department of Insurance of North Carolina.

(5) 'Domestic company' means a company incorporated or organized under the laws of this State.

(6) 'Foreign company' means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State.

(7) 'NAIC' means the National Association of Insurance Commissioners.

~~(8) "Nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.~~

(9) 'Person' means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert. "Person" does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(10) The singular form ~~shall include~~ includes the plural, and the masculine form ~~shall include~~ includes the feminine wherever appropriate."

PART VI. SURPLUS LINES FILINGS.

Section 6.1. G.S. 58-21-35 reads as rewritten:

"**§ 58-21-35. Duty to file ~~evidence of insurance and affidavits.~~ reports and retain affidavits.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall ~~execute and~~ file with the ~~Commissioner.~~ Commissioner a

~~(1)~~ ~~A written~~ report in a format prescribed by the Commissioner regarding the insurance and including the following information:

~~a.~~(1) The name ~~and address~~ of the ~~insured;~~ insured.

~~b.~~(2) The identity of the insurer or ~~insurers;~~ insurers.

~~c.~~(3) A description of the subject and location of the ~~risk;~~ risk.

~~d.~~(4) The amount of premium charged for the ~~insurance; and~~ insurance.

~~e. Such other pertinent information as the Commissioner may reasonably require; and~~

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

~~(2)~~ ~~An~~

(b) The licensee shall complete and retain an affidavit as to the efforts to place the coverage with admitted insurers and the results ~~thereof~~ of the efforts, in accordance with G.S. 58-21-15. The report and affidavit required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

Section 6.2. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-2. Relationship to other insurance laws.**

Unless surplus lines insurance, surplus lines licensees, or nonadmitted insurers are specifically referenced in a particular section of this Chapter, no sections contained in Articles of this Chapter other than this Article apply to surplus lines insurance, surplus lines licensees, or nonadmitted insurers."

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7.1. G.S. 105-259(b) is amended by adding a new subdivision to read:

"(16a) To provide the North Carolina Self-Insurance Guaranty Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of collecting the assessments authorized in G.S. 97-133(a)."

Section 7.2. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

~~(1) Obtain from each member self-insurer and file with the Commissioner individual reports specifying the aggregate benefits each member paid during the previous calendar year, and the annual standard premium that would have been paid by the individual member self-insurer during the previous calendar year, pursuant to manual rates established by the North Carolina Rate Bureau and using the experience rating procedure approved by the Commissioner for that member self-insurer or the annual premium collected by each group member self-insurer during the prior calendar year. These reports shall be due on or before July 15 following the close of that calendar year, except that this deadline may be extended by the Commissioner for up to three additional months for good cause shown.~~

(2) Assess each member of the Association as follows:

a. Each individual member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual ~~standard premium~~ gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual ~~standard premium.~~ gross premiums. Each group member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~premium collected by~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this one-quarter of one percent (0.25%)

assessment. Assessments paid by members pursuant to this subdivision shall be credited toward the tax paid by self-insurers under Article 8B of Chapter 105 of the General Statutes. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll information as determined under G.S. 105-228.5(b), (b1), and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.

b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

c. If a self-insurer is a member of the Association for less than a full calendar year, the annual ~~standard premium~~ gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.

d. If application of the contribution rates referenced in ~~sub-subdivisions a. and b.~~ sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.

(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall

thereafter pay covered claims against group member self-insurers from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.

The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Be obligated to the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter. The Association shall pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this Article.

(5) After paying any claim resulting from a self-insurer's insolvency, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Assess the Fund in an amount necessary to pay only:

a. The obligations for the Association under this Article subsequent to an insolvency;

b. The expenses of handling covered claims subsequent to an insolvency;
c. The cost of examinations under G.S. 97-137; and
d. Other expenses authorized by this Article;

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Notify such persons as the Commissioner directs under G.S. 97-136;

(9) Handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association;

(11) Pay the other expenses of the Association authorized by this section; and

(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions ~~(1), (2),~~ (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association;

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post-insolvency assessment which shall be imposed as follows:

(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-

insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the individual member self-insurer for the premium calendar year bears to the annual ~~standard premium~~ gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual ~~collected premium~~ gross premiums of the group member self-insurer for the premium calendar year bears to the annual ~~collected premium~~ gross premiums of all group member self-insurers for the preceding calendar year.

(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.

(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~premium collected by~~ gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8. 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 or changes ~~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."

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9. G.S. 58-41-35 is repealed.

Section 9.1. 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 X. MORTALITY TABLE AND RESERVES UPDATE.

Section 10. G.S. 58-58-50(k) reads as rewritten:

"(k) The Commissioner shall adopt rules containing the minimum standards applicable to the valuation of health plans. The Commissioner may also adopt rules for the purpose of recognizing new annuity mortality tables for use in determining reserve liabilities for annuities and may adopt rules that govern minimum valuation standards for reserves of life insurance companies. In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC."

PART XI. EFFECT OF HEADINGS.

Section 11. 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 12. Sections 2 through 11 of this act become effective October 1, 1999. The remainder of this act is effective when it becomes law, but Sections 1.1, 1.2, and 1.3 of this act shall not apply to appeals pending on the date this act becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 306
PROPOSED COMMITTEE SUBSTITUTE
H306-CSRN-001

Short Title: Insurance Amendments/AB. (Public)

Sponsors:

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, AND TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES.

The General Assembly of North Carolina enacts:

PART I. HEARINGS AND FAIR AND BEACH PLANS APPEALS.

Section 1.1. G.S. 58-2-50 reads as rewritten:

"§ 58-2-50. ~~Examinations~~ Examinations, hearings, and investigations.

All ~~examinations~~ examinations, hearings, and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. All hearings shall, unless otherwise specially provided, be held in accordance with this Article and Article 3A of Chapter 150B of the General Statutes and at a time and place designated in a written notice given by the Commissioner to the person cited to appear. The notice shall state the subject of inquiry and the specific charges, if any."

Section 1.2. 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 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 Commissioner's 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."

Section 1.3. 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~~ after the date of ~~such~~ the ruling or decision. The Commissioner, after a 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 II. CONTINUING CARE RETIREMENT RECEIVERSHIPS.

Section 2. 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, the Department of Health and Human Services may, notwithstanding any other provision of law, accept and approve the addition of beds for that facility if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the facility or (ii) 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."

PART III. HANDICAPPED PERSONS.

Section 3.1. 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 and other coverage provisions 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 3.2. G.S. 168-22(b) reads as rewritten:

"(b) A family care home shall be 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 IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1. 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 the provisions of G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall~~ insurance policy. This Article and Articles 65 and 67 of this Chapter and any administrative rules adopted under these 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 of this Chapter and

managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation, the provisions of Chapter 97 govern."

Section 4.2. G.S. 97-2(21) reads as rewritten:

"(21) Managed care organization. -- The term 'managed care organization' means a preferred provider organization or a health maintenance organization regulated under Chapter 58 of the General Statutes. 'Managed care organization' also means a preferred provider benefit plan of an insurance company, hospital, or medical service corporation in which utilization review or quality management programs are used to manage the provision of health care services and benefits under this Chapter."

PART V. COMMERCIAL AIRCRAFT INSURANCE.

Section 5.1. G.S. 58-7-15(19) reads as rewritten:

"(19) 'Motor vehicle ~~and~~ or aircraft insurance,' meaning insurance against loss of or damage resulting from any cause to motor vehicles or aircraft and their equipment, and against legal liability of the insured for loss or damage to another's property resulting from the ownership, maintenance or use of motor vehicles or aircraft and against loss, damage or expense incident to a claim of such liability. This subdivision does not apply to commercial aircraft as defined in G.S. 58-1-5."

Section 5.2. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to ~~aviation~~ commercial aircraft insurance; to policies issued in this State covering risks with multistate locations, except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association

restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 5.3. G.S. 58-21-10(8) reads as rewritten:

"(8) 'Surplus lines insurance' means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, ~~aviation~~ commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities."

Section 5.4. G.S. 58-28-5(a) reads as rewritten:

"(a) Except as ~~hereinafter provided,~~ otherwise provided in this section, it ~~shall be~~ is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in G.S. 58-28-10, without a ~~certificate of authority~~ license issued by the Commissioner. This section ~~shall~~ does not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this ~~Chapter;~~ Chapter.

(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the ~~Commissioner;~~ Commissioner.

(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such ~~policy;~~ policy.

(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or

franchise accident and health insurance where the master policy ~~of such~~ for the insurance was lawfully issued and delivered in a state ~~where~~ in which the company was authorized to transact ~~business;~~ business.

(5) Transactions in this State involving all policies of insurance issued ~~prior to~~ before July 1, ~~1967;~~ 1967.

(6) The procuring of contracts of insurance issued to a nuclear ~~insured;~~ insured. As used in this subdivision, 'nuclear insured' means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.

(7) Insurance independently procured, as specified in subsection (b) of this ~~section;~~ section.

(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.

(9) Transactions in this State involving commercial aircraft insurance, meaning insurance against (i) loss of or damage resulting from any cause to commercial aircraft and its equipment, (ii) legal liability of the insured for loss or damage to another person's property resulting from the ownership, maintenance, or use of commercial aircraft, and (iii) loss, damage, or expense incident to a liability claim."

Section 5.5. G.S. 58-1-5 reads as rewritten:

"**§ 58-1-5. Definitions.**

In this Chapter, unless the context clearly requires otherwise:

(1) 'Alien company' means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(1a) 'Commercial aircraft' means aircraft used in domestic, flag, supplemental, commuter, or on-demand operations, as defined in Federal Aviation Administration Regulations, 14 C.F.R. § 119.3, as amended.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina or an authorized designee of the Commissioner.

(3) 'Company' or 'insurance company' or 'insurer' includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations. 'Company' or 'insurance company' or 'insurer' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(4) 'Department' means the Department of Insurance of North Carolina.

(5) 'Domestic company' means a company incorporated or organized under the laws of this State.

(6) 'Foreign company' means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State.

(7) 'NAIC' means the National Association of Insurance Commissioners.

~~(8) "Nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.~~

(9) 'Person' means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert. "Person" does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(10) The singular form ~~shall include~~ includes the plural, and the masculine form ~~shall include~~ includes the feminine wherever appropriate."

PART VI. SURPLUS LINES FILINGS.

Section 6.1. G.S. 58-21-35 reads as rewritten:

"**§ 58-21-35. Duty to file ~~evidence of insurance and affidavits.~~ reports and retain affidavit.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall ~~execute and~~ file with the ~~Commissioner:~~ Commissioner a

~~(1)~~ ~~A written~~ report in a format prescribed by the Commissioner regarding the insurance and including the following information:

~~a.~~(1) The name ~~and address~~ of the ~~insured;~~ insured.

~~b.~~(2) The identity of the insurer or ~~insurers;~~ insurers.

~~c.~~(3) A description of the subject and location of the ~~risk;~~ risk.

~~d.~~(4) The amount of premium charged for the ~~insurance; and~~ insurance.

~~e. Such other pertinent information as the Commissioner may reasonably require; and~~

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

~~(2)~~ ~~An~~

(b) The licensee shall complete and retain an affidavit as to the efforts to place the coverage with admitted insurers and the results ~~thereof~~ of the efforts, in accordance with G.S. 58-21-15. The report and affidavit required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

Section 6.2. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-2. Relationship to other insurance laws.**

Unless surplus lines insurance, surplus lines licensees, or nonadmitted insurers are specifically referenced in a particular section of this Chapter, no sections contained in Articles of this Chapter other than this Article apply to surplus lines insurance, surplus lines licensees, or nonadmitted insurers."

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7.1. G.S. 105-259(b) is amended by adding a new subdivision to read:

"(16a) To provide the North Carolina Self-Insurance Guaranty Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of

collecting the assessments authorized in G.S. 97-133(a)."

Section 7.2. G.S. 97-133 reads as rewritten:

"§ 97-133. Powers and duties of the Association.

(a) The Association shall:

~~(1) Obtain from each member self-insurer and file with the Commissioner individual reports specifying the aggregate benefits each member paid during the previous calendar year, and the annual standard premium that would have been paid by the individual member self-insurer during the previous calendar year, pursuant to manual rates established by the North Carolina Rate Bureau and using the experience rating procedure approved by the Commissioner for that member self-insurer or the annual premium collected by each group member self-insurer during the prior calendar year. These reports shall be due on or before July 15 following the close of that calendar year, except that this deadline may be extended by the Commissioner for up to three additional months for good cause shown.~~

(2) Assess each member of the Association as follows:

a. Each individual member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual ~~standard premium~~ gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual ~~standard premium.~~ gross premiums. Each group member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~premium collected by~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and

(c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this one-quarter of one percent (0.25%) assessment. Assessments paid by members pursuant to this subdivision shall be credited toward the tax paid by self-insurers under Article 8B of Chapter 105 of the General Statutes. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll information as determined under G.S. 105-228.5(b), (b1), and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.

b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

c. If a self-insurer is a member of the Association for less than a full calendar year, the annual ~~standard premium~~ gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.

d. If application of the contribution rates referenced in ~~sub-subdivisions a. and b.~~ sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.

(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.

The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section

herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Be obligated to the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter. The Association shall pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this Article.

(5) After paying any claim resulting from a self-insurer's insolvency, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Assess the Fund in an amount necessary to pay only:

a. The obligations for the Association under this Article subsequent to an insolvency;

b. The expenses of handling covered claims subsequent to an insolvency;

c. The cost of examinations under G.S. 97-137; and

d. Other expenses authorized by this Article;

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the

insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Notify such persons as the Commissioner directs under G.S. 97-136;

(9) Handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association;

(11) Pay the other expenses of the Association authorized by this section; and

(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions ~~(1), (2),~~ (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association;

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post-insolvency assessment which shall be imposed as follows:

(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b),

(b1), and (c), that would have been paid by that member self-insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c) of the individual member self-insurer for the premium calendar year bears to the annual ~~standard premium~~ gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual ~~collected premium~~ gross premiums of the group member self-insurer for the premium calendar year bears to the annual ~~collected premium~~ gross premiums of all group member self-insurers for the preceding calendar year.

(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.

(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would

have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~premium collected by~~ gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8. 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 or changes ~~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."

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9. G.S. 58-41-35 is repealed.

Section 9.1. 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 X. MORTALITY TABLE AND RESERVES UPDATE.

Section 10. G.S. 58-58-50(k) reads as rewritten:

"(k) The Commissioner shall adopt rules containing the minimum standards applicable to the valuation of health plans. The Commissioner may also adopt rules for the purpose of recognizing new annuity mortality tables for use in determining reserve liabilities for annuities and may adopt rules that govern minimum valuation standards for reserves of life insurance companies. In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC."

PART XI. EFFECT OF HEADINGS.

Section 11. 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 12. Sections 2 through 11 of this act become effective October 1, 1999. The remainder of this act is effective when this act becomes law, but Sections 1.1, 1.2, and 1.3 of this act shall not apply to appeals pending on the date this act becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 306

Short Title: Insurance Amendments/AB. (Public)

Sponsors: Representatives Hardaway; and Hurley.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, AND TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES.

The General Assembly of North Carolina enacts:

PART I. HEARINGS AND FAIR AND BEACH PLANS APPEALS.

Section 1.1. G.S. 58-2-50 reads as rewritten:

"**§ 58-2-50. ~~Examinations~~ Examinations, hearings, and investigations.**

All ~~examinations~~ examinations, hearings, and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. All hearings shall, unless otherwise specially provided, be held in accordance with this Article and Article 3A of Chapter 150B of the General Statutes and at a time and place designated in a written notice given by the Commissioner to the person cited to appear. The notice shall state the subject of inquiry and the specific charges, if any."

Section 1.2. 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 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 Commissioner's 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."

Section 1.3. 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~~ after the date of ~~such~~ the ruling or decision. The Commissioner, after a 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 II. CONTINUING CARE RETIREMENT RECEIVERSHIPS.

Section 2. 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, the Department of Health

and Human Services may, notwithstanding any other provision of law, accept and approve the addition of beds for that facility if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the facility or (ii) 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."

PART III. HANDICAPPED PERSONS.

Section 3.1. 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 and other coverage provisions 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 3.2. G.S. 168-22(b) reads as rewritten:

"(b) A family care home shall be 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 IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1. 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 the provisions of G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall~~ insurance policy. This Article and Articles 65 and 67 of this Chapter and any administrative rules adopted under these 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 of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation, the provisions of Chapter 97 govern."

Section 4.2. G.S. 97-2(21) reads as rewritten:

"(21) Managed care organization. -- The term 'managed care organization' means a preferred provider organization or a health maintenance organization regulated under Chapter 58 of the General Statutes. 'Managed care organization' also means a preferred provider benefit plan of an insurance company, hospital, or medical service corporation in which utilization review or quality management programs are used to manage the provision of health care services and benefits under this Chapter."

PART V. COMMERCIAL AIRCRAFT INSURANCE.

Section 5.1. G.S. 58-7-15(19) reads as rewritten:

"(19) 'Motor vehicle ~~and aircraft~~ insurance,' meaning insurance against loss of or damage resulting from any cause to motor vehicles or ~~aircraft~~ and their equipment, and against legal liability of the insured for loss or damage to another's property resulting from the ownership, maintenance or use of motor vehicles or ~~aircraft~~ and against loss, damage or expense incident to a claim of such liability."

Section 5.2. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to ~~aviation~~ commercial aircraft insurance; to policies issued in this State covering risks with multistate locations, except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 5.3. G.S. 58-21-10(8) reads as rewritten:

"(8) 'Surplus lines insurance' means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be

placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, ~~aviation~~ commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities."

Section 5.4. G.S. 58-28-5(a) reads as rewritten:

"(a) Except as ~~hereinafter provided,~~ otherwise provided in this section, it ~~shall be~~ is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in G.S. 58-28-10, without a ~~certificate of authority~~ license issued by the Commissioner. This section ~~shall~~ does not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this ~~Chapter;~~ Chapter.

(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the ~~Commissioner;~~ Commissioner.

(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such ~~policy;~~ policy.

(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or franchise accident and health insurance where the master policy ~~of such~~ for the insurance was lawfully issued and delivered in a state ~~where~~ in which the company was authorized to transact ~~business;~~ business.

(5) Transactions in this State involving all policies of insurance issued ~~prior to~~ before July 1, ~~1967;~~ 1967.

(6) The procuring of contracts of insurance issued to a nuclear ~~insured;~~ insured. As used in this subdivision, 'nuclear insured' means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.

(7) Insurance independently procured, as specified in subsection (b) of this ~~section;~~ section.

(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.

(9) Transactions in this State involving commercial aircraft insurance, meaning insurance against (i) loss of or damage resulting from any cause to commercial aircraft and its equipment, (ii) legal liability of the insured for loss or damage to another person's property resulting from the ownership, maintenance, or use of commercial aircraft, and (iii) loss, damage, or expense incident to a liability claim."

Section 5.5. G.S. 58-1-5 reads as rewritten:

"**§ 58-1-5. Definitions.**

In this Chapter, unless the context clearly requires otherwise:

(1) 'Alien company' means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(1a) 'Commercial aircraft' means aircraft used in domestic, flag, supplemental, commuter, or on-demand operations, as defined in Federal Aviation Administration Regulations, 14 C.F.R. § 119.3, as amended.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina or an authorized designee of the Commissioner.

(3) 'Company' or 'insurance company' or 'insurer' includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations. 'Company' or 'insurance company' or 'insurer' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(4) 'Department' means the Department of Insurance of North Carolina.

(5) 'Domestic company' means a company incorporated or organized under the laws of this State.

(6) 'Foreign company' means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State.

(7) 'NAIC' means the National Association of Insurance Commissioners.

~~(8) "Nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.~~

(9) 'Person' means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert. "Person" does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(10) The singular form ~~shall include~~ includes the plural, and the masculine form ~~shall include~~ includes the feminine wherever appropriate."

PART VI. SURPLUS LINES FILINGS.

Section 6.1. G.S. 58-21-35 reads as rewritten:

"**§ 58-21-35. Duty to file ~~evidence of insurance and affidavits.~~ reports and retain affidavit.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall ~~execute and~~ file with the ~~Commissioner.~~ Commissioner a

~~(1)~~ ~~A written~~ report in a format prescribed by the Commissioner regarding the insurance and including the following information:

~~a.~~(1) The name ~~and address~~ of the ~~insured;~~ insured.

~~b.~~(2) The identity of the insurer or ~~insurers;~~ insurers.

~~c.~~(3) A description of the subject and location of the ~~risk;~~ risk.

~~d.~~(4) The amount of premium charged for the ~~insurance; and~~ insurance.

~~e. Such other pertinent information as the Commissioner may reasonably require; and~~

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

~~(2)~~ ~~An~~

(b) The licensee shall complete and retain an affidavit as to the efforts to place the coverage with admitted insurers and the results ~~thereof~~ of the efforts, in accordance with G.S. 58-21-15. The report and affidavit required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

Section 6.2. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-2. Relationship to other insurance laws.**

Unless surplus lines insurance, surplus lines licensees, or nonadmitted insurers are specifically referenced in a particular section of this Chapter, no sections contained in Articles of this Chapter other than this Article apply to surplus lines insurance, surplus lines licensees, or nonadmitted insurers."

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7. G.S. 105-259(b) is amended by adding a new subdivision to read:

"(16a) To provide the North Carolina Self-Insurance Guaranty Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of collecting the assessments authorized in G.S. 97-133(a)."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8. 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 or changes ~~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."

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9. G.S. 58-41-35 is repealed.

Section 9.1. 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 X. MORTALITY TABLE AND RESERVES UPDATE.

Section 10. G.S. 58-58-50(k) reads as rewritten:

"(k) The Commissioner shall adopt rules containing the minimum standards applicable to the valuation of health plans. The Commissioner may also adopt rules for the purpose of recognizing new annuity mortality tables for use in determining

reserve liabilities for annuities and may adopt rules that govern minimum valuation standards for reserves of life insurance companies. In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC."

PART XI. EFFECT OF HEADINGS.

Section 11. 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 12. Sections 2 through 11 of this act become effective October 1, 1999. The remainder of this act is effective when this act becomes law, but Sections 1.1, 1.2, and 1.3 of this act shall not apply to appeals pending on the date this act becomes law.

HOUSE BILL 306:
Insurance Amendments

BILL ANALYSIS

Committee: House Insurance
Date: March 25, 1999
Version: PCS

Introduced by: Representative Hardaway
Summary by: Linwood Jones
Committee Counsel

SUMMARY: This bill makes substantive changes to various insurance laws.

BILL ANALYSIS:

PART I. HEARINGS AND FAIR AND BEACH PLAN APPEALS

Section 1.1 provides that all hearings before the Department of Insurance will be held in accordance with both Article 2 of Chapter 58 of the General Statutes and Article 3A of Chapter 150B of the General Statutes (APA), unless a particular insurance statute provides otherwise. The time and place of the hearing will be designated by the Department in a written notice sent to the person that is required to appear at the hearing, and the notice must state the subject of the hearing and any charges against the person.

Sections 1.2 and 1.3 provide that appeals under the Beach and FAIR Plans will be heard by the Department pursuant to rules adopted by the Department. The current law provides that these appeals are to be heard under the general hearing statute of the Department – G.S. 58-2-50. These sections also provide that the Commissioner will by rule determine the procedures governing how these appeal hearings are recorded and transcribed and how fees will be assessed for copies of the recordings and transcripts. The law currently requires the appeal hearing to be recorded and transcribed, with each side sharing the costs, although the prevailing side recovers those costs back once the appeal reaches "final adjudication." The Beach and FAIR Plans are statutorily-created joint underwriting associations that provide property insurance coverage to homeowners and business owners unable to obtain that coverage in the voluntary insurance market.

PART II. CONTINUNG CARE RETIREMENT RECEIVERSHIPS

Section 2 allows DHHS to authorize additional beds for a continuing care retirement facility that is in receivership under the Commissioner of Insurance if the court finds that this is in the best interests of the facility or it will best serve the welfare of persons already under contract or who may contract with the facility.

PART III. HANDICAPPED PERSONS

Section 3.1. Currently, the State Handicapped Protection Act prohibits commercial insurance companies and service corporations from denying individual insurance coverage to a handicapped person solely because of his or her handicap, although they can refuse to cover preexisting conditions. Section 3.1 deletes the language allowing pre-existing conditions to be excluded. However, it appears that the general insurance laws on the use of preexisting conditions would still apply, which would mean that an "eligible" individual (essentially an individual who previously had 18 months or more of creditable coverage under a group health plan) would not be subject to preexisting conditions and any other individual would be subject to preexisting conditions for up to 12 months.

Section 3.2. Currently, a family care home is deemed a "residential" use of property for a number of purposes, including for insurance classification purposes. However, group homes are reportedly having difficulty in finding insurers willing to cover those risks under "residential" coverages. This change is designed to encourage insurers to write property and liability coverages for family care homes.

PART IV. WORKERS' COMPENSATION INSURANCE

Section 4.1 specifies that the PPO laws and utilization review laws and Department of Insurance rules apply to workers' compensation insurance plans (including those of self-insured employer and employer groups) that utilize PPO and utilization review. If the PPO or utilization rules adopted by the Department conflict with those of the Industrial Commission, the rules of the Industrial Commission prevail with respect to workers' compensation plans.

Section 4.2 redefines the definition of "managed care organization," as that term is used in the workers' compensation laws, to make clear that it picks up all preferred provider benefit plans.

PART V. COMMERCIAL AIRCRAFT INSURANCE

Sections 5.1 through 5.5 make several changes concerning aircraft insurance. Commercial aircraft means aircraft used commercially (for hire) for passengers or cargo. Commercial aircraft insurance is insurance covering the aircraft and liability coverage for passengers and cargo. These sections essentially provide that commercial aircraft insurance is not regulated as are other forms of insurance. These sections also specify that the term "company," when used in the insurance laws, does not include the State or a local unit of government and provide a definition of "nuclear insured," a term already used in the insurance laws.

PART VI. SURPLUS LINE FILINGS

Section 6.1 provides for additional information to be provided by surplus lines licensees to the Department of Insurance beyond what they already are required by law to provide. The new information required includes the policy number and policy period for each policy, the premium tax amount, and the address of the licensee. In addition, the information is no longer required to be filed in writing, but will instead be filed in a format "prescribed by the Commissioner," which may allow for electronic filings in addition to written filings.

Section 6.2 provides that the insurance laws applicable to insurance companies admitted to do business in North Carolina do not apply to surplus lines insurance companies except for Article 21 of Chapter 58 of the General Statutes (the Surplus Lines Act) and any other statute that specifically references surplus lines insurance or nonadmitted insurers.

PART VII. WORKERS COMPENSATION SELF-INSURANCE

Section 7.1 amends the State tax confidentiality statute to enable the Department of Revenue to provide the Self Insurance Guaranty Association with information on self-insurers' "premiums" so that the Association can collect assessments authorized by G.S. 97-133(a).

Section 7.2 directs the Secretary of Revenue to provide this information to the Association on individually self-insured employers and directs the Commissioner to provide the same information for group self-insured employers. This section also replaces the term "standard premium" with the term "gross premium."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT

Section 8 repeals the requirement that the Commissioner of Insurance file a biennial report with the legislature (through the Governor) of his official acts and rulings and a biennial report of his recommendations. The Commissioner would still be required to report recommended changes to the insurance laws to the Governor and the General Assembly from time to time.

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW

Section 9 repeals the agency business cessation law. This law was enacted in the 1986-87 liability insurance shortage to require insurers to report detailed information to the Commissioner about commercial property and liability insurance coverages that were cancelled or nonrenewed as a result of the company ceasing to do business through an insurance agency. The purpose of the law was to allow the Commissioner to track commercial property and liability insurance availability problems throughout the State. The Department no longer considers these reports necessary.

Section 9.1 makes a conforming change to reflect the change in Section 9.1.

PART X. MORTALITY TABLE AND RESERVE UPDATE

Section 10 amends the Standard Valuation Law (G.S. 58-58-50) to provide that the Commissioner of Insurance can, through rules, recognize new mortality tables to determine reserve liabilities for annuities and minimum valuation standards for reserves of life insurance companies. The Commissioner may consider model rules recommended by the National Association of Insurance Commissioners (NAIC).

PART XI. HEADINGS

Section 11. This section provides that the headings in the bill are for reference only.

PART XII. EFFECTIVE DATE

Section 12 provides that most of this act takes effect October 1, 1999. Sections 1.1, 1.2, and 1.3, all of which relate to hearings and appeals under the FAIR and Beach Plans, take effect when this bill becomes law but do not apply to appeals pending at that time.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 25, 1999

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: PCS for HB 306 – Insurance Amendments

PART I. HEARINGS AND FAIR AND BEACH PLAN APPEALS

Section 1.1 amends G.S. 58-2-50 to require that all hearings provided for in General Statute Chapter 58 are to be held by the Commissioner or his designee; that all hearings be held in accordance with Article 2 of General Statute Chapter 58 and General Statute Chapter 150B, Article 3A (Administrative Procedure Act), unless otherwise provided; and that there be written notice of all hearings..

Sections 1.2 and 1.3 amend G.S. 58-45-50 and 58-46-30 to provide that FAIR and Beach Plan appeal procedures and recording and transcribing fees are to be set by the Commissioner, rather than by statute.

PART II. CONTINUING CARE RETIREMENT COMMUNITY RECEIVERSHIPS.

Section 2 adds a new G.S. 58-64-46, applicable when the Commissioner has been appointed a receiver under Article 30 of General Statute Chapter 58 for a provider or a facility subject to Article 64, allowing the N.C. Department of Health and Human Services to accept and approve the addition of beds for a facility if it appears to the court that such additional beds will best serve the best interests of the facility or the welfare of the persons who have previously contracted with the provider or who may contract with the facility.

PART III. HANDICAPPED PERSONS.

Section 3.1 amends G.S. 168-10 to extend the prohibition against discrimination against handicapped persons to hospital, medical, and dental service corporations, multiple employer welfare arrangements, and health maintenance organizations. It deletes the proviso allowing insurers to exclude by waiver or otherwise pre-existing conditions. These changes conform with present law.

Section 3.2 amends G.S. 168-22(b) to delete the provision that deems family group home as a residential use of property for insurance classification purposes.

PART IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1 amends G.S. 58-50-65 to provide in the event of any conflicts between managed care rules adopted by the Commissioner and managed care rules adopted by the Industrial Commission, the Industrial Commission's rules govern.

Section 4.2 amends the definition of "managed care organization" in the Workers' Compensation Act to reflect the types of managed care organizations there are today.

PART V. COMMERCIAL AIRCRAFT INSURANCE

Sections 5.1 through 5.5 amend various sections in General Statute Chapter 58, deregulating commercial aircraft insurance.

PART VI. SURPLUS LINES FILINGS.

Section 6.1 amends 58-21-35 to add the required material to reports filed by a surplus lines licensee.

Section 6.2 adds a G.S. 58-21-2 providing that surplus lines insurance and licensees are not subject to other articles of General Statute Chapter 58, unless specifically referenced.

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7.1 amends G.S. 105-259(b) to permit the Department of Revenue to provide the N.C. Self-Insurance Guaranty Association information on workers' compensation self-insurer's premiums, for the purpose of collecting assessments authorized in G.S. 97-133(a).

Section 7.2 amends G.S. 97-133 (powers and duties of Self-insurance Guaranty Association) to delete the duty of obtaining reports about aggregate benefits, to clarify that assessments are based on "gross premiums" rather than "standard premiums", and to require that the Secretary of Revenue provide the Association with a self-insurer premium and payroll information gathered under the specified statutes.

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8 amends G.S. 58-2-120 to delete the requirement that the Commissioner make a biennial report to General Assembly.

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9 repeals G.S. 58-41-35, which requires insurers to file, with the Commissioner, notices of cessation of commercial property and liability insurance business through insurance agencies.

PART X. MORTALITY TABLE AND RESERVES UPDATE.

Section 10 amends G.S. 58-58-50(k) to permit the Commissioner to adopt rules for recognizing new annuity mortality tables for use in determining reserve liabilities for annuities and to adopt rules that govern minimum valuation standards for reserves of life insurance companies.

PART XI. EFFECT OF HEADINGS.

Section 11 provides that the headings to the parts of the 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 DATES.

Section 12. The changes to G.S. 58-2-50, 58-45-50, and 58-46-30 become effective upon enactment; and other changes become effective October 1, 1999.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoir

Attachment III

EDITION No. _____

H. B. No. 306 DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

moves to amend the bill on page 5, line 30 thru p. 6, line 3

( ) WHICH CHANGES THE TITLE

by rewriting those lines to read:

"(a) Nothing in Articles 50 through 55 of this Chapter shall apply to or affect any policy of liability or workers' compensation insurance, except that the provisions of ~~G.S. 58-50-50~~ and subsections (b) and (c) ~~of G.S. 58-50-55~~ shall 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 provisions of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to worker's compensation, the provisions of Chapter 97 govern."

GS 58-50-56 (g) and (h)

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 15, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 15, 1999, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Melissa Barnett (Rowan County) and Charlie Chrisawin (Wake County). The following Committee members were present: Representatives Barbee, Boyd-McIntyre, Brubaker, Cole, Dockham, Earle, Esposito, Grady, Hardaway, Holmes, Howard, Miller, Redwine, Saunders, Smith, Wainwright, Warner, and C. Wilson. A list of visitors attending is attached. The Chair indicated the following bills would be considered, but would not be voted on at this meeting:

House Bill 678, entitled, AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT. Representative Sherrill was recognized to explain the bill (see attached handout presented). Acupuncturists would be added to the list of providers under the anti-discrimination laws. If a health insurance plan does cover an acupuncture service performed by a physician, the plan would be required to cover the same service when performed by a licensed acupuncturist. Section 1 applies to commercial insurance companies, and Section 2 applies to service corporations (Blue Cross). Governmental health plans would not be able to deny their beneficiaries the right to choose an acupuncturist as the provider of care or services within the scope of the practice of acupuncture. Representative Luebke, Co-Sponsor, was recognized to further explain the bill and introduce three individuals speaking in favor of HB 678: Joe Pfister and M. Cissy Majebi, licensed acupuncturists, and Mack Bonner, M.D, Emergency Medical Services. All three indicated the majority of the time services provided by licensed acupuncturists are upon a physician's recommendation. The Chair recognized Dr. Robert Seymour who indicated only physicians should be able to make referrals to acupuncturists.

House Bill 713, entitled, AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY TREATMENT. Representative Alexander was recognized to explain the bill (see attached handouts presented). Group health plans would be mandated to cover chemical dependency and mental illness benefits, and the benefits would be required to be in full parity with benefits for physical illness generally under the policy. John Tote, Executive Director of the Mental Health Association, and Al Mooney, M.D., family physician practicing in Cary, were recognized to speak in favor of this bill. Mr. Tote discussed the large number of individuals presently not able to receive these types of services and noted that the definition of mental illness would be tightened. Dr. Mooney discussed the morbidity and mortality (death and sickness) from chemical dependency. He thinks that treating these diseases would be cost effective because often a problem requires treatment when it could have been prevented.

The Chair recognized Perri Morgan, National Federation of Independent Business, and Nancy Thompson, NC Citizens for Business and Industry, who spoke in opposition to the bill. The primary principle of basic standard health care insurance is to furnish the most coverage possible for the greatest number of people. When mandates for a limited type of care are added, the price goes up for everyone. There is a concern that employers will not be able to afford the coverage and will either discontinue providing health care or pass additional costs on to employees. They thought the bill would discriminate against small businesses and possibly some insurance companies would be forced out of the health care market.

Questions and concerns raised by Committee members are as follows: Would like to receive cost indicators, especially as it relates to the State Health Plan, which currently include these services. Is this coverage available in the market place as an endorsement to an existing policy? Concern over the fact that so many bills are being introduced that, taken individually, would not cost a large amount; however, added all together could be monumental. Would like to see them considered in some totality. The Chair indicated he would take these questions/concerns under advisement. Sam Byrd with Fiscal Research indicated he would provide fiscal information.

There being no further business, the Chair adjourned the meeting at 12:47 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Forms
HB 678 & HB 713
Handouts
Bill Summaries

VISITOR REGISTRATION SHEET

Insurance — 4-15-99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS 28201
M E Mauldin	Clean Air Clin 369 Montford Av NC
C. Porter	Bone & Associates
Becky Carver	Alcohol/Drug Council of NC
Sandra A. Miles	Alcohol/Drug Council of NC
Tim Krebs	NC Mental Health Consumer's Organization
Joy Turner	NC Mental Health Consumer Organization
NT Burnette	GACPD
Jesse J. Sell	Addiction Professionals NC
Tony Melvin	Alcohol/Drug Council of NC
Bob Goodale	Alcohol/Drug Council of NC
R. Van Voorhees	Coalition Against SB 90
[illegible]	Coalition Against Senate Bill 90
George Reed	NC Council of Churches
Jamie Norton	Addiction Professionals of NC
Al Mooney	Carolina Family Medicine/American Society of Addiction Medicine
Phil Hilbman	~~North Raleigh Psychiatry~~ North Carolina Society of Addiction Medicine

VISITOR REGISTRATION SHEET

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Patti McCutchen	100 Woodsorrel Way Cary 27511
Nelle Riegel	102 Woodsorrel Way Cary 27511
Terry Stelle	DMHDDSAS
Ted Fitzgerald	Program Resource Institute Inc., Lillington
Jan Ramquist	NCANA
Robin Huffman	NC Coalition for Mental Health Care / Charter Behaviors
Mary Carmilia	Mecklenburg County
Jim Mata	Transitions Hospitals -
Joyce Bates	HP Assoc
ART ECCLESTON	NC DIV. MH/DD/SAS
Carolyn Titus	Durham Area MH/DD/SAS
Barrett Brewer	Capital Strategies
Bonnie Dhweny	acupuncture Center of Cary
Dagmar Ebling	Acupuncture & Herbal Health Center
Amy Fullbright	Hunton & Williams

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
PERRI MORGAN	NFIB
Nancy Thompson	NCCBD
John Cyrus	N.C. State Grange
Gail Pruett	NCNA
Ann Case	NCRMA
Bonnie Morell	Dir MH/DD/SAS
Spence Clark	DMH/DD/SAS, SA Section
MICHELLE COTTON	DMH/DD/SAS
Dick Hatch	AARP
Lato Rutgers	CYPC
Adam Searing	NCHAC
Tommy Watts	Carolinas HealthCare System
Mac Barkley	Licensed Professional Counselors
B. Michael Herman	Health Insurance Association of America
Robert Paschal	Young, Moore & Henderson

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Ann Faust	M Alexander's La., NCDA
[illegible]	NC Equity
Andy Ellen	NC Retail Merchants
Wilmer C. Betts, MD	ASAM
Raleigh E. Ward	Raleigh E. Ward & Assoc.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

HOUSE BILL 678

Short Title: Acupuncturist Reimbursement. (Public)

Sponsors: Representatives Sherrill, Luebke (Primary Sponsors); Braswell, Clary, Earle, Michaux, Morris, and Nesbitt.

Referred to: Insurance.

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. (Effective July 1, 1999) Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, or advanced practice registered ~~nurse:~~ nurse, or acupuncturist.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly

certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 or a duly licensed acupuncturist acting within the scope of the acupuncturist's practice as defined in Article 30 of Chapter 90 of the General Statutes unless a comparable limitation is imposed on such medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) Expired.

(c2) For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;
(2) The policy currently provides benefits for identical services performed by other licensed health care providers;
(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;
(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service."

Section 2. G.S. 58-65-1 reads as rewritten:

"§ 58-65-1. (Effective July 1, 1999) Regulation and definitions; application of other laws; profit and foreign corporations prohibited.

(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care,

laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter, or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article

and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State."

Section 3. Article 30 of Chapter 90 of the General Statutes is amended by adding the following new section:

"**§ 90-460. Free choice by patient guaranteed.**

No agency of the State, county, or municipality, nor any commission or clinic, nor any board administering relief, social security, health insurance, or health service under the laws of the State of North Carolina shall deny to the recipients or beneficiaries of their aid or services the freedom to choose a duly licensed acupuncturist as the provider of care or services which are within the scope of practice of the profession of acupuncture as defined in this Article."

Section 4. G.S. 90-459 is repealed.

Section 5. G.S. 135-40.6(8) is amended by adding a new sub-subdivision to read:

"u. Acupuncture: Allowable charges for the practice of acupuncture when performed by a doctor of medicine or an acupuncturist licensed pursuant to Article 30 of Chapter 90 of the General Statutes."

Section 6. This act becomes effective January 1, 2000. Sections 1, 2, and 3 apply to plans issued, amended, or renewed on or after that date. Section 5 applies to treatment and services provided on or after January 1, 2000.

HB 678:
Acupuncturist Reimbursement

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Sherill
Date:	April 15, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

Sections 1 and 2 of House Bill 678 add acupuncturists to the list of providers under the anti-discrimination laws. The anti-discrimination laws prohibit insurance companies and service corporations from refusing to reimburse the listed providers when they perform a service for which a physician would be reimbursed under the insurance plan. These changes would not require health insurance plans to cover acupuncture. However, if a health insurance plan does cover an acupuncture service performed by a physician, the plan would also be required to cover the same acupuncture service when performed by a licensed acupuncturist. Section 1 applies to commercial insurance companies, and Section 2 applies to service corporations (Blue Cross). By virtue of G.S. 58-50-56, these changes would also apply to preferred provider plans offered by insurance companies or service corporations. In addition, if an insurance plan does cover acupuncture services, any restrictions it places on that treatment must be the same for physicians as it is for acupuncturists.

Section 3 of the bill provides that governmental health plans cannot deny to their beneficiaries the right to choose an acupuncturist as the provider of care or services within the scope of practice of acupuncture.

Section 4 of the bill repeals a provision in the acupuncture licensing law that says that nothing in the acupuncture licensing law requires third-party reimbursement of acupuncturists.

Section 5 requires the Teachers and State Employees Health Plan to cover acupuncture when performed by a physician or an acupuncturist licensed by the North Carolina Acupuncture Licensing Board.

Section 6 makes this act effective January 1, 2000, and applicable to policies issued, renewed, or amended on or after that date or to treatment or services provided under the State Health Plan on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 713*

Short Title: Mental Health/Chem. Dep. Parity. (Public)

Sponsors: Representatives Alexander; Adams, Allen, Baddour, Barefoot, Bonner, Boyd-McIntyre, Braswell, Bridgeman, Church, Crawford, Cunningham, Davis, Earle, Easterling, Edwards, Fitch, Goodwin, Hackney, Hardaway, Hensley, Hill, Hunter, Insko, Jarrell, Jeffus, Kinney, Luebke, McAllister, Melton, Michaux, Miller, Moore, Mosley, Nesbitt, Oldham, Owens, Saunders, Sherrill, Sutton, Tolson, Tucker, Wainwright, Warner, Warren, G. Wilson, Womble, Wright, and Yongue.

Referred to: Insurance.

March 30, 1999

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-51-50 reads as rewritten:

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

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

(1) '~~chemical~~ 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.

(2) 'Health benefit plan' has the same meaning as in G.S. 58-3-220.

(3) 'Insurer' has the same meaning as in G.S. 58-3-220.

(b) Chemical Dependency Parity Requirement. -- ~~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 to its insureds~~ Every health insurer shall provide in each group health

benefit plan 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~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. -- If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance 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 insurer may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. -- An insurer may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. -- Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

~~(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:~~ Chapter 131E of the General Statutes:
   a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~ licensed facilities;
   b. Medical units;
   c. Psychiatric units; and
(2) The following facilities or programs licensed ~~after July 1, 1984,~~ under Article 2 of Chapter 122C of the General Statutes: ~~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.~~ Chapter 122C of the General Statutes.

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.

~~(c) 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 2. G.S. 58-51-55 reads as rewritten:

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

(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~~ 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.
(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~ 58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

~~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 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 requires an insurer to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-51-50.~~

~~(d) Applicability. -- 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 3. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Parity Requirement. -- A health insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Average. -- If the plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance 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 insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Case Management. -- An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules may only ensure that case management programs are not designed to avoid the requirements of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Medical Necessity. -- Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary.

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

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' includes a blanket health policy or blanket accident and health policy. '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.
k. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance.
l. Hospital income or indemnity.

(2) '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.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes."

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

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

(a) Definition. -- 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) Chemical Dependency Parity Requirement. -- 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~~ shall 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 for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. -- If a hospital or medical plan governed by this Article contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance 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 group insurance certificate or group subscriber contract may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. -- A group insurance certificate or group subscriber contract may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. -- Nothing in this section prohibits a hospital or medical plan governed by this Article from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

~~(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:~~ Chapter 131E of the General Statutes:

a. Chemical dependency units in licensed facilities; ~~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:~~ Chapter 122C of the General Statutes:

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.~~ Chapter 122C of the General Statutes. ~~After January 1, 1995, 'duly~~ 'Duly licensed psychologists' ~~shall be~~ are 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.

~~(e) 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.~~ dependent individuals.**

(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~~ 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or

a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-65-75~~ 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

~~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 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 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 requires a service corporation to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-65-75.~~

~~(d) Applicability. -- 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 6. G.S. 58-67-70 reads as rewritten:

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

(a) Definition. -- 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~~ Chemical Dependency Parity Requirement. -- 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~~ limits as are benefits under the health care plan generally. For purposes of this subsection 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. -- If a group health plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance 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 health maintenance organization may

impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. -- A health maintenance organization may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. -- Nothing in this section prohibits a health maintenance organization from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

~~(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:~~ Chapter 131E of the General Statutes:

a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~ licensed facilities;

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:~~ Chapter 122C of the General Statutes:

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.~~ under Article 2 of Chapter 122C of the General Statutes.

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.

~~(c) 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.~~ dependent individuals.**

(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~~ 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-67-70~~ 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

~~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 requires an HMO to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-67-70.~~

~~(d) Applicability. — 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 8. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) 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. 58-3-220, respectively. The Plan may use a case management program in accordance with G.S. 58-51-50 and G.S. 58-3-220, respectively.

(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 9. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

HB 713:
Mental Health/Chemical Dependency Parity

BILL ANALYSIS

Committee: House Insurance
Date: April 15, 1999
Version: 1st

Introduced by: Rep. Alexander
Summary by: Linwood Jones
Committee Counsel

CURRENT LAW

Chemical Dependency: Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. An employer or other group policyholder is not required to accept the offered coverage. If the group policyholder does accept the coverage, the chemical dependency benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than $8,000 in total annual benefits under the policy, it must also provide chemical dependency coverage of at least $8,000 *per year* and at least $16,000 over the *lifetime* of the policy.

Mental illness: Until 1997, there were no requirements concerning mental health coverage. In 1997, the legislature, in response to federal requirements, enacted a law requiring *limited* parity in mental health benefits. Under this law, insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans. However, if the plan does provide mental health benefits, it must ensure that any lifetime and annual limits on that coverage are in parity with (i.e., no less favorable than) the benefits provided for physical benefits generally under the plan. There are exceptions to this requirement: any plan that can show a 1% increase in costs as a result of the parity requirement can opt out of the requirement, and any plan that has 50 or fewer employees is exempt. This law expires October 1, 2001.

Note – Self-funded plans: It is estimated that as many as one-half of all persons insured under group employer health plans are in plans self-funded by employers. Self-funded plans cannot be regulated by the State. They can only be regulated by Congress because of federal ERISA preemption of State regulation. Congress did impose the *limited* mental parity requirement on self-funded plans. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement

BILL ANALYSIS

House Bill 713 requires group health plans to cover chemical dependency benefits and mental illness benefits, and the benefits are required to be in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual or lifetime limits or different deductibles, coinsurance, copayments, out-of-pocket maximums, or durational limits for mental illness and chemical dependency benefits than it provides for physical benefits generally under the policy. If the policy

provides limits on only some physical benefits, a weighted average, developed in accordance with rules adopted by the Commissioner of Insurance, will be used to determine what limits the policy can use for mental illness and chemical dependency.

Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case.

Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as 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."* Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines "chemically dependent" in the same manner, but the bill adds a requirement that he dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions).

Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MHDDSA Act defines "mental illness" as follows: *"(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment."(GS 122C-3(21)).*

However, the bill specifically excludes from the mental illness coverage requirement the following disorders:

- Mental disorders coded in the DSM-IV as substance-abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders, phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.
- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

The mental parity requirement is contained primarily in Section 3 of the bill, which applies to insurers, service corporations, and HMOs. The chemical dependency requirement is set out in Sections 1, 4, and 6. The same language is set out several times in the bill because the State has separate laws for insurers, service corporations, and HMOs. Sections 1 and 2 apply to insurers, Sections 4 and 5 apply to service corporations, and Sections 6 and 7 apply to HMOs. Section 8 makes both the mental illness and chemical dependency requirements applicable to the standard health plan offered in the small employer group market. The standard health plan is one of two types of plans that insurers competing in the small employer market (50 or fewer employees) must offer to small employers. The other plan – a "basic" plan – is not intended to provide the same coverage as the standard plan and is not subject to the mental illness and chemical dependency requirements.

The current provisions on limited mental parity are repealed in the bill. Thus, the bill applies to all group policyholders, not just those with more than 50 employees. Also repealed are the 1% cost opt-out provision and the October 1, 2001 sunset discussed under the Current Law section of this analysis.

This bill would take effect January 1, 2000, and would apply to policies issued or renewed on or after that date. A policy is presumed to be renewed on the anniversary date on which coverage was first effective on the person or persons covered under the plan.

NC Comprehensive Major Medical Plan for Teachers and State Employees

Data on the **Mental Health Benefit**

Since 1992, the State Health Plan has provided mental health benefits at the same levels as physical health benefits in a managed environment through a contract with Value Behavioral Health. Using the current structure, a very affordable and cost-contained mental health benefit has been achieved. All data about the State Health Plan has to be framed within the broader benefit structure, i.e. that a very affordable and cost-contained mental health benefit has been achieved:

1. with full coverage **parity** with non-mental health conditions (since 1992),
2. with **no separate additional deductible** for mental health services,
3. with **full freedom-of-choice** of mental health providers,
4. with **only moderate management** of generous benefits when compared to other typical mental health plans, and
5. with a **broad demographic** and **large number** of covered lives (390,000).

KEY DATA POINTS INCLUDE:

1. **Contrary to broad insurance industry attributions** about "skyrocketing" mental health costs relative to the overall health benefit payments (e.g. double-digit 10-15% of payouts), **the State Health Plan has consistently had mental health expenses considerably lower.** Figures since 1989 have ranged from 7.1% downward for mental health as a portion of total payouts.
2. Since parity was established (1992) and a single insurance deductible implemented in 1992, **mental health payments** as a portion of total health payments **decreased from 6.4% to 3.1%** which is a 52% cumulative reduction for the fiscal year ending June, 1998.
3. **Utilization patterns remain constant** and at a very modest level for outpatient over the years:
   - 6-7% seek out-patient services in any year
   - Half of the people using services go for only 3-4 sessions and three-quarters of the people seeking services complete treatment within 11 sessions
   - Over the span of several years, the percentage of people utilizing more extended outpatient services (utilization > 26) has consistently been low and progressively decreasing (0.38-0.75%)
4. Since 1992, **hospital days** paid by the Plan have been **reduced by 70%.**
5. Within a parity benefit, mental health payments, expressed as a monthly cost per covered life, have been extremely reasonable and very well cost contained. The **cost per life per month** for the year ending June, 1998, **was $4.11.** This figure is lower than in June, 1990, even without adjustment for inflation.
6. These actual utilization/cost **figures compare favorably** with actuarial projected figures generated by Coopers and Lybrand for the NC Health Planning Commission for a variety of benefits structure scenarios including versions similar to the State Health Plan. Coopers and Lybrand mental health cost data was itself viewed quite favorably by the Benefits Committee, which included members from the business sector.

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office 4/99

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Experience (Excluding Substance Abuse)
Inpatient/Outpatient Data

Fiscal Year Ending

	FY 98	FY 6/97	FY 6/96	FY 6/95	FY 6/94	FY 6/93	FY 6/92	FY 6/91
Inpatient (Actives & Dependents Only)								
# of Admissions	738	781	876	971	1,092	1,142	1,276	1,403
Adm/10,000	25.8	26.7	28.6	30.3	34.1	35.5	38.2	39.5
Days/10,000	238.6	271.9	308.5	318.9	391.6	484.9	807.1	859.6
ALOS	9.2	8.1	8.3	9.2	10.8	13.7	21.1	21.7
Outpatient (ALL)								
# Patients	20,405	20,113	20,519	20,562	19,674	19,659	20,520	21,092
Patients as %	7.1%	6.8%	6.7%	6.4%	6.1%	6.1%	6.1%	6.0%
# Visits	159,351	160,666	170,225	172,664	185,866	193,601	217,944	212,612
# Visits/1000 members	553.2	551.4	550.5	539	557	602	653	609
# Visits/Patient								
— Median	3.0	4.0	4.0	4.0	4.0	4.0	5.0	5.0
— 75th Percentile	11.0	11.0	11.0	12.0	13.0	13.0	13.0	14.0
— Mean	7.8	8.0	8.3	8.5	9.2	9.8	10.6	10.1
Utilization > 26 Visits								
— # of patients	1096	1,203	1,216	1,508	1,642	1,842	2,482	2,499
— % of patients	5.4	6.0%	5.9%	7.3%	8.3%	9.4%	12.1%	11.8%
— % of covered lives	0.38%	0.41%	0.40%	0.47%	0.51%	0.57%	0.75%	0.71%

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office

3/99

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Costs

Fiscal Year Ending

	June 98	June-97	June-96	June-95	June-94	June-93 (Full MH Mgmt)	June-92 (No Outpatient Cap or MH Mgmt)	June-91
TOTAL: Actives & Dependents	285,902	292,572	305,924	322,627	322,900	322,088	330,613	351,189
TOTAL: Covered Lives	390,363	393,965	404,210	415,225	412,529	409,302	415,302	433,069
Total Mental Health Payments	$19,262,363	$19,185,00	$19,936,678	$20,424,916	$23,138,778	$25,612,004	$32,361,152	$30,830,831
--- Total Payments PMPY*	$49.35	$48.70	$49.32	$49.19	$56.09	$62.57	$77.92	$71.19
--- Total Payments PMPM*	$4.11	$4.06	$4.11	$4.10	$4.67	$5.21	$6.49	$5.93
--- % of Total of all Medical Claims Paid	3.1%	3.3%	3.4%	3.7%	4.5%	5.2%	6.4%	6.1%

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office

3/99

Parity *for* Mental Health and Substance Abuse

Bill Introduced by:
Rep. Martha Alexander (H713)

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

What the Bill does:
Benefits for 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 the 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 the 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 is subjected to higher deductibles, co-payments, and limits. Mental illness and substance abuse should not be treated differently than physical illnesses. The federal legislation on mental illness only provides parity for annual and lifetime limits. That does not assure adequate care.

What about the cost?
Currently, the State Employees Health Plan provides full parity for mental health treatment. Since parity was established in 1992 (including a single deductible for all care), mental health payments as a portion of total health payments have decreased from 6.4% to 3.1% for the fiscal year ending June, 1998. That is a 52% reduction — not a rise in cost. Since 1992, hospital days paid by the Plan for mental illness have been reduced by 70%. The plan added parity for substance abuse treatment in 1998.

Independent Actuarial Study:
Coopers and Lybrand has done an independent actuarial analysis based on implementation of the bill which states, "Therefore, the expected employer contributions for health insurance will raise about 1.2% per month."

What about other states?
Nineteen states have some degree of mental health parity. None of these states is reporting significant premium increases related to parity.

Minnesota passed full parity effective August 1, 1995. The Minnesota Department of Commerce, the state agency that regulates indemnity insurance, estimated cost of 1% of total premium dollars for mental health parity. Maryland reported a 0.2% decrease after implementation of full parity, and Rhode Island has a 0.33% increase.

It's the Right Thing to Do:
Mental illness and substance abuse are treatable. Treatment success rates are comparable to other major physical illnesses. With parity, people's ability to access early and appropriate treatment will reduce long-term costs.

Organizations Supporting This Parity Bill

Addiction Professionals of North Carolina
Alcohol and Drug Council of North Carolina
American Association of Retired Persons
Coalition for Persons Disabled by Mental Illness
Families CAN
Licensed Professional Counselors Association of NC
Mental Health Association in North Carolina
NAMI North Carolina
National Association of Social Workers, NC Chapter
North Carolina Academy of Family Physicians
North Carolina Association for Behavioral Health Care
North Carolina Association of County Commissioners
North Carolina Behavioral Health Care Association
North Carolina Coalition for Mental Health Care
North Carolina Counseling Association
North Carolina Council of Community MH/DD/SA Programs
North Carolina Depressive Manic Depressive Association
North Carolina Employee Assistance Professionals Association
North Carolina Health Access Coalition
North Carolina Medical Society
North Carolina Mental Health Consumers Organization
North Carolina Nurses Association
North Carolina Pediatric Society
North Carolina Psychiatric Association
North Carolina Psychological Association
North Carolina Psychological Foundation
PAIMI Committee, Governor's Advocacy Council for Persons with Disabilities
Senior Tarheel Legislature
Substance Abuse Federation

4/99

AIM for Health
Hugh Chatham HealthCare Services
Parkwood Drive
Elkin, NC 28621
336/ 526-0077

April 14, 1999

Representative George Holmes
North Carolina State Legislature
Member, Insurance Committee

Representative Holmes:

I am writing today in regard to House Bill #678, which was recently introduced by Rep. Sherrill. As you may be aware, it is difficult for many people to access acupuncture services because of the lack of insurance coverage. Most insurance companies require that an M.D. administer the acupuncture treatment. Unfortunately, we do not have any M.D./Acupuncturists in our area. It is my understanding that this bill would require insurance companies that cover acupuncture to reimburse Licensed Acupuncturists for these services, as well as M.D.s. Our program, AIM for Health, is supportive of House Bill #678.

Alternative and Integrative Medicine [AIM] for Health is a model health program developed by Hugh Chatham HealthCare Services to increase options for people seeking greater personal involvement in their own healthcare and to foster better understanding of these options by health care professionals. We have developed a series of programs, including hospital-based acupuncture, to meet the needs of staff and patients. A licensed acupuncturist (L.Ac.) is credentialled by the Department of Surgery and is available in the Outpatient Department, by referral from the patient's physician. To learn more about our innovative program, go to our website at http://www.hughchatham.com or call us for more information.

Our acupuncture program is currently funded by a grant from The Duke Endowment and by patient fees. We are unable to bill most insurance companies at this time. House Bill #678 will allow us to bill insurance companies whose policies cover acupuncture services provided by our Licensed Acupuncturist, thus allowing us to continue to offer these services to our patients. It only seems reasonable that services provided by licensed health care professionals should be reimbursed equally by insurance companies.

Please do not hesitate to call me if you have any questions about this matter.

Yours in Health!

Patrick Hanaway, M.D.
Director, AIM for Health

JOSEPH L. SITNICK, M.D.
PRACTICE OF RADIOLOGY
P. O. BOX 568
SPRUCE PINE, N. C. 28777
(704) 765-9138

4/14/98

Dear Ms. Sherrill:

I am in support of Bill # 618. Acupuncture has been shown to be helpful in many conditions. I believe that it is important to allow it to be administered by licensed Acupuncturists to make it more accessible to the public.

Thank you for your assistance in this regard.

Sincerely,

J Sitnick MD

MAHEC

Family Practice Residency Program

April 14, 1999

Representative Wilma Sherrill

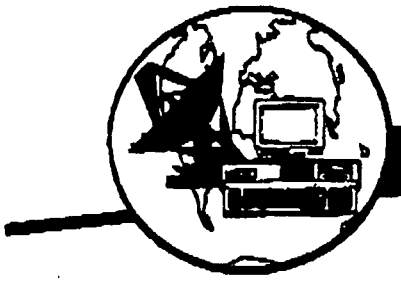
Dear Ms Sherrill:

I am a Family Physician and I am writing in support of your bill #678 to provide insurance coverage for Acupuncture performed by licensed Acupuncturists. I see no reason why coverage should be limited to physicians, given that there are relatively few physicians who are trained in this technique, and there are many others with the training that can provide the service professionally.

Sincerely,

John F. Rowe, M.D.

118 Weaver Boulevard Asheville, NC 28804-3415 VOICE: (828) 258-0670 FAX: (828) 257-4738



THE CIELO INSTITUTE

486 Sunset Dr., Asheville, NC 28804-3727 USA
Phone: 828-251-9794
Fax: 828-254-4431
Email: cieloinst@aol.com

Representative Wilma Sherrill
State of North Carolina
919-715-5815

April 12, 1999

RE: House Bill # 678

Dear Ms. Sherrill,

As a neurologist and psychiatrist and a supporter of "alternative medicine" approaches to health of a reputable kind, Chinese Medicine being a major one, I write in support of your House Bill requiring those insurance plans that cover acupuncture do so without the requirement of medical licensure from the acupuncturist. Given the implicit differences in theory and practice between these two schools, it is almost oxymoronic for insurance companies to require medical licensure of this treatment, particularly in a State that has acupuncture licensure laws.

As a former professor and chairman of a medical school department in California (UCSD, La Jolla, CA), I can say that this paradoxical problem does not exist there.

Your sincerely,

Arnold J. Mandell, M.D.
Professor
Emory University School of Medicine

RICHARD J. HOUSE, M.D., P.A.
AND ASSOCIATES
1008 EAST ASH STREET • GOLDSBORO, NC 27530
Telephone (919) 734-7772 • Annex (919) 734-4373

April 14, 1999.

Dear Representative Sherrill:

The NIH report on acupuncture is a very interesting read.

One of the conclusions it reaches is that many citizens are unable to access acupuncture services. Further, it recommends that insurance companies and federal programs expand coverage to underwrite acupuncture; that it is a valuable health care option worthy of universal access.

I would encourage you to support Bill #678 which introduces third-party reimbursement for licensed acupuncturists in North Carolina. This will greatly hasten availability of this paradigm to our citizens.

Kindly,

Richard J. House, M.D., L.Ac.
Member North Carolina Acupuncture Licensing Board

RJH/vk

FAX: M. Cissy Majebe 828-254-9720

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 20, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 20, 1999, at 2:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Adam Hurley (Cumberland County) and Isaac Wingfield (Buncombe County). The following Committee members were present: Representatives Barbee, Brubaker, Cole, Cunningham, Dedmon, Dockham, Earle, Esposito, Hackney, Holmes, Howard, Miller, Redwine, Saunders, Smith, Warner, C. Wilson, and Wright. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

House Bill 713, entitled, AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY TREATMENT. Representative Alexander was recognized to explain the bill. Group health plans would be mandated to cover chemical dependency and mental illness benefits, and the benefits would be required to be in full parity with benefits for physical illness generally under the policy. Sam Byrd, Fiscal Research, indicated they were unable to determine the impact of this bill. A committee substitute was presented by Representative Warner and adopted for committee discussion. The bill would be changed to allow a Legislative Research Commission to study parity in health insurance coverage for mental illness and chemical dependency treatment and report any findings and recommendations to the General Assembly prior to the convening of the 2000 Regular Session. The Chair moved to give the committee substitute a favorable report, unfavorable to the original bill. Motion passed.

House Bill 678, entitled, AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT. Representative Sherrill was recognized to explain the bill. Representative Howard presented an amendment which would rewrite the lines 33 – 36 on page 6, to read: "u. Acupuncture: Allowable charges for the treatment of pain and the production of regional anesthesia when performed by a medical doctor or an acupuncturist licensed or certified in the state in which he or she practices." (Amendment attached). The Chair called for adoption of the amendment. Division was called and a hand count required. The vote was 8 in favor, 7 opposed, with the Chair breaking the tie. The amendment was adopted. Representative Earle made a motion to roll the amendment into a committee substitute and give a favorable report to the committee substitute, unfavorable to the original bill. The Chair was unable to determine the vote and a hand count was required. Seven votes were in favor of the motion, nine were against. Motion failed.

HB 714, entitled, AN ACT TO PROVIDE FOR DIRECT PAYMENT OF CERTIFIED SUBSTANCE ABUSE PROFESSIONALS UNDER HEALTH INSURANCE POLICIES AND PLANS. Representative Martha Alexander was recognized to present and explain the bill. This bill amends the insurance anti-discrimination laws to require health plans to reimburse certified substance abuse

professionals when they provide services within their scope of practice (assuming the type of service is covered by the plan). Mr. Ed Ward representing the Addiction Professionals of North Carolina and Mr. Jesse Seld, a Certified Substance Abuse Counselor, spoke in favor of the bill. Representative Dockham made a motion for an unfavorable report. The motion did not pass.

There being no further business, the Chair adjourned the meeting at 3:15 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Forms
HB 678, HB 713, & HB 714
Amendment & Committee Substitute
Bill Summaries
Handout

VISITOR REGISTRATION SHEET

Insurance
Name of Committee

4/20/99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Priscilla Surratt	AARP
Polly Williams	AARP
Becky Carver	Alcohol/Drug Council of NC
Thomas Eckman MD	Freedom House Rec Center - CH
Paul Mahoney	NC ASSN OF HEALTH PLANS
MICHAEL ZAUCH	NC ASAP
SUE KEITH	NC ADVOCATES FOR SUBSTANCE ABUSE PROGRAMMING
Sandra Mills	Alcohol/Drug Council of NC
Helen J. Twomey	CADAAC - California accreditation
David M Twomey	
Spence Clark	DMH/DD/SAS - CAS
Marleen Scott Robbins	DMH/DD/SAS
Franklin Ingram	South Right of Substance Abuse Raleigh, NC 27607
Trish Hussey	Freedom House Recovery Center Chapel Hill, NC
Joe Donovan	NAMI - NC
Mac Boxley	N.C. Pediatric Medical Society

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

4/20/99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
MARK ARNELL	Progressive Ins. Co.
Michael Harrold	NAII
Tony McIntosh	Alcohol/Drug Council
Tom Tolle	NHAIVC
DON WILLIS	DMHDDSAS
Steve Keene	NC Med Soc.
Lori Ann Harris	LA HARRIS & ASSOC
Mary Ciany Mayle	Chinese Acupuncture Clinic
Bonnie Hussey	Acupuncture Center of Cary
Myrna Miller	NASW-NC
Ted Fitzgerald	APNC
Ernest Gore	PRI
Eric Daum	APNC
Dave Markey	NCPEN
Mary Jane McGill	APIC

VISITOR REGISTRATION SHEET

Insurance
Name of Committee

4/20/99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jacqueline E. Donnelly	Chinese Acupuncture Clinic - Asheville
Sarah Weber	" " Asheville
Aulma Pulley	" " Rale
Amy Jo Bain	NC Medical Society
[illegible]	
[illegible]	NCMHP
Loyal Lutes	[illegible]
Ethel Hennessee	BHC - Melrose center Fayetteville, NC. (Psychiatry)
Lisa Abernethy	Blue Ridge Dermatology, Assoc. Raleigh, NC
[illegible]	NCPS for CCHN
Jim Mettry	
Jamie Norton	Addiction Professionals of NC
J. Allen Adams	Charter Behavioral
Ed F. Ward	Addiction Professionals of NC
Jesse J. Sell	Addictim Professionals NC

VISITOR REGISTRATION SHEET

Insurance
Name of Committee

4/20/99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Robert Pasichal	Young, Moore & Henderson, P.A.
[signature]	Integrated Mktg, NC
DAVID TURPIN	SOUTHLIGHT SUBSTANCE ABUSE SERVICES
JANICE PETERSEN	COMMISSION ON SUBSTANCE ABUSE
Barrett Brewer	Capital Strategies
Yvonne Thompson	VICCRAD
[signature]	NC Equity
Betty Wiser	NC Div Public Health
Janie Ramquist	NCSOS
[signature]	CCEMC, Mhd City
Dee C. Barnes	CCEMC, MH City, N.C.
David M. Chadwick	CCEMC MOREHEAD CITY N.C.
Thom Styron	CCEMC Morehead City, NC
Ken Wright	RBBSNC
W. Allard	WCSA

VISITOR REGISTRATION SHEET

Insurance — 4-30-99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Mac Sturgis	NSSA
Glenn Jernigan	Property & Casualty Assn. of N.C.
Dirk Hale	NC Dept of Insurance
Sam Byrd	Gen. Assembly Fiscal Res

Reported out 4-21-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 713 A BILL TO BE ENTITLED AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 713*
Committee Substitute Favorable 4/21/99

Short Title: Mental Health Parity Study. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY TREATMENT.

The General Assembly of North Carolina enacts:

Section 1. The Legislative Research Commission may study the issue of requiring mental health benefits and chemical dependency benefits in health benefit plans in parity with physical illness benefits provided under those plans. The study may review other states' mental parity and chemical dependency parity laws, the cost-effectiveness of parity requirements, the use of case management and medical necessity standards, the health benefits and potential cost savings of treatment, and related issues.

Section 2. The Legislative Research Commission shall report any findings and recommendations to the General Assembly prior to the convening of the 2000 Regular Session of the 1999 General Assembly.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 713*
Proposed Committee Substitute
H713-CSRN-001

Short Title: Mental Health Parity Study (Public)

Sponsors:

Referred to: Insurance.

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY TREATMENT.

The General Assembly of North Carolina enacts:

Section 1. The Legisative Research Commission may study the issue of requiring mental health benefits and chemical dependency benefits in health benefit plans in parity with physical illness benefits provided under those plans. The study may review other states' mental parity and chemical dependency parity laws, the cost effectiveness of parity requirements, the use of case management and medical necessity standards, the health benefits and potential cost savings of treatment, and related issues.

Section 2. The Legislative Research Commission shall report any findings and recommendations to the General Assembly prior to the convening of the 2000 Regular Sesion of the 1999 General Assembly.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 713*

Short Title: Mental Health/Chem. Dep. Parity. (Public)

Sponsors: Representatives Alexander; Adams, Allen, Baddour, Barefoot, Bonner, Boyd-McIntyre, Braswell, Bridgeman, Church, Crawford, Cunningham, Davis, Earle, Easterling, Edwards, Fitch, Goodwin, Hackney, Hardaway, Hensley, Hill, Hunter, Insko, Jarrell, Jeffus, Kinney, Luebke, McAllister, Melton, Michaux, Miller, Moore, Mosley, Nesbitt, Oldham, Owens, Saunders, Sherrill, Sutton, Tolson, Tucker, Wainwright, Warner, Warren, G. Wilson, Womble, Wright, and Yongue.

Referred to: Insurance.

March 30, 1999

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-51-50 reads as rewritten:

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

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

(1) '~~chemical~~ 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.

(2) 'Health benefit plan' has the same meaning as in G.S. 58-3-220.

(3) 'Insurer' has the same meaning as in G.S. 58-3-220.

(b) Chemical Dependency Parity Requirement. -- ~~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 to its insureds~~ Every health insurer shall provide in each group health

benefit plan 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~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. -- If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance 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 insurer may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. -- An insurer may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. -- Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

~~(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:~~ Chapter 131E of the General Statutes:
   a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~ licensed facilities;
   b. Medical units;
   c. Psychiatric units; and
(2) The following facilities or programs licensed ~~after July 1, 1984,~~ under Article 2 of Chapter 122C of the General Statutes: ~~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.~~ Chapter 122C of the General Statutes.

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.

~~(c) 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 2. G.S. 58-51-55 reads as rewritten:

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

(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~~ 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.
(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~ 58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

~~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 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 requires an insurer to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-51-50.~~

~~(d) Applicability. -- 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 3. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Parity Requirement. -- A health insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Average. -- If the plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance 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 insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Case Management. -- An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules may only ensure that case management programs are not designed to avoid the requirements of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Medical Necessity. -- Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary.

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

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' includes a blanket health policy or blanket accident and health policy. '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.
k. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance.
l. Hospital income or indemnity.

(2) '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.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes."

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

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

(a) Definition. -- 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) Chemical Dependency Parity Requirement. -- 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~~ shall 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 for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. -- If a hospital or medical plan governed by this Article contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance 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 group insurance certificate or group subscriber contract may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. -- A group insurance certificate or group subscriber contract may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. -- Nothing in this section prohibits a hospital or medical plan governed by this Article from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

~~(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.~~ Chapter 131E of the General Statutes:

a. Chemical dependency units in licensed facilities; ~~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.~~ Chapter 122C of the General Statutes:

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.~~ Chapter 122C of the General Statutes. ~~After January 1, 1995, 'duly~~ 'Duly licensed psychologists' ~~shall be~~ are 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.

~~(e) 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.~~ dependent individuals.**

(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~~ 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or

a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-65-75~~ 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

~~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 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 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 requires a service corporation to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-65-75.~~

~~(d) Applicability. -- 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 6. G.S. 58-67-70 reads as rewritten:

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

(a) Definition. -- 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~~ Chemical Dependency Parity Requirement. -- 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~~ limits as are benefits under the health care plan generally. For purposes of this subsection 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. -- If a group health plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance 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 health maintenance organization may

impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. -- A health maintenance organization may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. -- Nothing in this section prohibits a health maintenance organization from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

~~(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.~~ Chapter 131E of the General Statutes:

a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~ licensed facilities;

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.~~ Chapter 122C of the General Statutes:

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.~~ under Article 2 of Chapter 122C of the General Statutes.

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.~~ dependent individuals.**

(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~~ 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-67-70~~ 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

~~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 requires an HMO to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-67-70.~~

~~(d) Applicability. -- 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 8. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) 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. 58-3-220, respectively. The Plan may use a case management program in accordance with G.S. 58-51-50 and G.S. 58-3-220, respectively.

(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 9. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

HB 713:
Mental Health/Chemical Dependency Parity

BILL ANALYSIS

Committee: House Insurance
Date: April 15, 1999
Version: 1st

Introduced by: Rep. Alexander
Summary by: Linwood Jones
Committee Counsel

CURRENT LAW

Chemical Dependency: Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. An employer or other group policyholder is not required to accept the offered coverage. If the group policyholder does accept the coverage, the chemical dependency benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than $8,000 in total annual benefits under the policy, it must also provide chemical dependency coverage of at least $8,000 *per year* and at least $16,000 over the *lifetime* of the policy.

Mental illness: Until 1997, there were no requirements concerning mental health coverage. In 1997, the legislature, in response to federal requirements, enacted a law requiring *limited* parity in mental health benefits. Under this law, insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans. However, if the plan does provide mental health benefits, it must ensure that any lifetime and annual limits on that coverage are in parity with (i.e., no less favorable than) the benefits provided for physical benefits generally under the plan. There are exceptions to this requirement: any plan that can show a 1% increase in costs as a result of the parity requirement can opt out of the requirement, and any plan that has 50 or fewer employees is exempt. This law expires October 1, 2001.

Note -- Self-funded plans: It is estimated that as many as one-half of all persons insured under group employer health plans are in plans self-funded by employers. Self-funded plans cannot be regulated by the State. They can only be regulated by Congress because of federal ERISA preemption of State regulation. Congress did impose the *limited* mental parity requirement on self-funded plans. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement

BILL ANALYSIS

House Bill 713 requires group health plans to cover chemical dependency benefits and mental illness benefits, and the benefits are required to be in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual or lifetime limits or different deductibles, coinsurance, copayments, out-of-pocket maximums, or durational limits for mental illness and chemical dependency benefits than it provides for physical benefits generally under the policy. If the policy

provides limits on only some physical benefits, a weighted average, developed in accordance with rules adopted by the Commissioner of Insurance, will be used to determine what limits the policy can use for mental illness and chemical dependency.

Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case.

Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as 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."* Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines "chemically dependent" in the same manner, but the bill adds a requirement that he dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions).

Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MHDDSA Act defines "mental illness" as follows: *"(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment."(GS 122C-3(21)).*

However, the bill specifically excludes from the mental illness coverage requirement the following disorders:

- Mental disorders coded in the DSM-IV as substance-abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders, phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.
- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

The mental parity requirement is contained primarily in Section 3 of the bill, which applies to insurers, service corporations, and HMOs. The chemical dependency requirement is set out in Sections 1, 4, and 6. The same language is set out several times in the bill because the State has separate laws for insurers, service corporations, and HMOs. Sections 1 and 2 apply to insurers, Sections 4 and 5 apply to service corporations, and Sections 6 and 7 apply to HMOs. Section 8 makes both the mental illness and chemical dependency requirements applicable to the standard health plan offered in the small employer group market. The standard health plan is one of two types of plans that insurers competing in the small employer market (50 or fewer employees) must offer to small employers. The other plan – a "basic" plan – is not intended to provide the same coverage as the standard plan and is not subject to the mental illness and chemical dependency requirements.

The current provisions on limited mental parity are repealed in the bill. Thus, the bill applies to all group policyholders, not just those with more than 50 employees. Also repealed are the 1% cost opt-out provision and the October 1, 2001 sunset discussed under the Current Law section of this analysis.

This bill would take effect January 1, 2000, and would apply to policies issued or renewed on or after that date. A policy is presumed to be renewed on the anniversary date on which coverage was first effective on the person or persons covered under the plan.

Mental Health Association
in North Carolina, Inc.

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HOUSE BILL 713 – MENTAL HEALTH/CHEMICAL DEPENDENCE PARITY KEY POINTS AND SUMMARY INFORMATION

I. Insurance programs discriminate against individuals seeking mental health and chemical dependency treatment.

II. House Bill 713 seeks to end this discrimination by providing mental health and chemical dependency insurance in all group plans subject to North Carolina law.

III. House Bill 713 will provide equal coverage with regard to co-payments, deductibles and number of visits.

IV. The North Carolina State Employee and Teacher Health Plan has had parity for mental health coverage since 1992 and chemical dependency coverage since 1998.

V. Since 1992, mental health payments have decreased in the State Health Plan from 6.4% of all payments to 3.1% with a real dollar decrease of over $13 million per year having been realized.

VI. Treatment success rates for mental health and chemical dependency are extraordinarily high.

VII. House Bill 713 seeks to end the cost shifting to the public sector that occurs when limited insurance benefits for mental health and chemical dependency are used up.

VIII. Nearly 20 states across the nation have an enacted some form of mental health/chemical dependency parity. Extensive studies from these states have shown that a cost saving does occur when parity is enacted.

IX. The typical health plan sees costs rise by approximately one dollar per member per month.

X. Data has shown that when this type of parity is provided in insurance plans that individuals receive more effective and appropriate treatment earlier in their illness thus preventing higher long-term care costs.

XI. Studies in states where parity is been enacted indicate that no employer has dropped their coverage due to parity being provided.

NC Comprehensive Major Medical Plan for Teachers and State Employees

Data on the **Mental Health Benefit**

Since 1992, the State Health Plan has provided mental health benefits at the same levels as physical health benefits in a managed environment through a contract with Value Behavioral Health. Using the current structure, a very affordable and cost-contained mental health benefit has been achieved. All data about the State Health Plan has to be framed within the broader benefit structure, i.e. that a very affordable and cost-contained mental health benefit has been achieved:

1. with full coverage **parity** with non-mental health conditions (since 1992),
2. with **no separate additional deductible** for mental health services,
3. with **full freedom-of-choice** of mental health providers,
4. with **only moderate management** of generous benefits when compared to other typical mental health plans, and
5. with a **broad demographic** and **large number** of covered lives (390,000).

KEY DATA POINTS INCLUDE:

1. **Contrary to broad insurance industry attributions** about "skyrocketing" mental health costs relative to the overall health benefit payments (e.g. double-digit 10-15% of payouts), **the State Health Plan has consistently had mental health expenses considerably lower.** Figures since 1989 have ranged from 7.1% downward for mental health as a portion of total payouts.
2. Since parity was established (1992) and a single insurance deductible implemented in 1992, **mental health payments** as a portion of total health payments **decreased from 6.4% to 3.1%** which is a 52% cumulative reduction for the fiscal year ending June, 1998.
3. **Utilization patterns remain constant** and at a very modest level for outpatient over the years:
   - 6-7% seek out-patient services in any year
   - Half of the people using services go for only 3-4 sessions and three-quarters of the people seeking services complete treatment within 11 sessions
   - Over the span of several years, the percentage of people utilizing more extended outpatient services (utilization > 26) has consistently been low and progressively decreasing (0.38-0.75%)
4. Since 1992, **hospital days** paid by the Plan have been **reduced by 70%.**
5. Within a parity benefit, mental health payments, expressed as a monthly cost per covered life, have been extremely reasonable and very well cost contained. The **cost per life per month** for the year ending June, 1998, **was $4.11.** This figure is lower than in June, 1990, even without adjustment for inflation.
6. These actual utilization/cost **figures compare favorably** with actuarial projected figures generated by Coopers and Lybrand for the NC Health Planning Commission for a variety of benefits structure scenarios including versions similar to the State Health Plan. Coopers and Lybrand mental health cost data was itself viewed quite favorably by the Benefits Committee, which included members from the business sector.

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office 4/99

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Experience (Excluding Substance Abuse)
Inpatient/Outpatient Data

Fiscal Year Ending

	FY 98	FY 6/97	FY 6/96	FY 6/95	FY 6/94	FY 6/93	FY 6/92	FY 6/91
Inpatient (Actives & Dependents Only)								
# of Admissions	738	781	876	971	1,092	1,142	1,276	1,403
Adm/10,000	25.8	26.7	28.6	30.3	34.1	35.5	38.2	39.5
Days/10,000	238.6	271.9	308.5	318.9	391.6	484.9	807.1	859.6
ALOS	9.2	8.1	8.3	9.2	10.8	13.7	21.1	21.7
Outpatient (ALL)								
# Patients	20,405	20,113	20,519	20,562	19,674	19,659	20,520	21,092
Patients as %	7.1%	6.8%	6.7%	6.4%	6.1%	6.1%	6.1%	6.0%
# Visits	159,351	160,666	170,225	172,664	185,866	193,601	217,944	212,612
# Visits/1000 members	553.2	551.4	550.5	539	557	602	653	609
# Visits/Patient								
– Median	3.0	4.0	4.0	4.0	4.0	4.0	5.0	5.0
– 75th Percentile	11.0	11.0	11.0	12.0	13.0	13.0	13.0	14.0
– Mean	7.8	8.0	8.3	8.5	9.2	9.8	10.6	10.1
Utilization > 26 Visits								
– # of patients	1096	1,203	1,216	1,508	1,642	1,842	2,482	2,499
– % of patients	5.4	6.0%	5.9%	7.3%	8.3%	9.4%	12.1%	11.8%
– % of covered lives	0.38%	0.41%	0.40%	0.47%	0.51%	0.57%	0.75%	0.71%

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office

3/99

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Costs

Fiscal Year Ending

	June 98	June-97	June-96	June-95	June-94	June-93 (Full MH Mgmt)	June-92 (No Outpatient Cap or MH Mgmt)	June-91
TOTAL: Actives & Dependents	285,902	292,572	305,924	322,627	322,900	322,088	330,613	351,189
TOTAL: Covered Lives	390,363	393,965	404,210	415,225	412,529	409,302	415,302	433,069
Total Mental Health Payments	$19,262,363	$19,185,00	$19,936,678	$20,424,916	$23,138,778	$25,612,004	$32,361,152	$30,830,831
— Total Payments PMPY*	$49.35	$48.70	$49.32	$49.19	$56.09	$62.57	$77.92	$71.19
— Total Payments PMPM*	$4.11	$4.06	$4.11	$4.10	$4.67	$5.21	$6.49	$5.93
— % of Total of all Medical Claims Paid	3.1%	3.3%	3.4%	3.7%	4.5%	5.2%	6.4%	6.1%

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office

3/99

Parity *for* Mental Health and Substance Abuse

Bill Introduced by:
Rep. Martha Alexander (H713)

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

What the Bill does:
Benefits for 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 the 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 the 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 is subjected to higher deductibles, co-payments, and limits. Mental illness and substance abuse should not be treated differently than physical illnesses. The federal legislation on mental illness only provides parity for annual and lifetime limits. That does not assure adequate care.

What about the cost?
Currently, the State Employees Health Plan provides full parity for mental health treatment. Since parity was established in 1992 (including a single deductible for all care), mental health payments as a portion of total health payments have decreased from 6.4% to 3.1% for the fiscal year ending June, 1998. That is a 52% reduction — not a rise in cost. Since 1992, hospital days paid by the Plan for mental illness have been reduced by 70%. The plan added parity for substance abuse treatment in 1998.

Independent Actuarial Study:
Coopers and Lybrand has done an independent actuarial analysis based on implementation of the bill which states, "Therefore, the expected employer contributions for health insurance will raise about 1.2% per month."

What about other states?
Nineteen states have some degree of mental health parity. None of these states is reporting significant premium increases related to parity.

Minnesota passed full parity effective August 1, 1995. The Minnesota Department of Commerce, the state agency that regulates indemnity insurance, estimated cost of 1% of total premium dollars for mental health parity. Maryland reported a 0.2% decrease after implementation of full parity, and Rhode Island has a 0.33% increase.

It's the Right Thing to Do:
Mental illness and substance abuse are treatable. Treatment success rates are comparable to other major physical illnesses. With parity, people's ability to access early and appropriate treatment will reduce long-term costs.

Organizations Supporting This Parity Bill

Addiction Professionals of North Carolina
Alcohol and Drug Council of North Carolina
American Association of Retired Persons
Coalition for Persons Disabled by Mental Illness
Families CAN
Licensed Professional Counselors Association of NC
Mental Health Association in North Carolina
NAMI North Carolina
National Association of Social Workers, NC Chapter
North Carolina Academy of Family Physicians
North Carolina Association for Behavioral Health Care
North Carolina Association of County Commissioners
North Carolina Behavioral Health Care Association
North Carolina Coalition for Mental Health Care
North Carolina Counseling Association
North Carolina Council of Community MH/DD/SA Programs
North Carolina Depressive Manic Depressive Association
North Carolina Employee Assistance Professionals Association
North Carolina Health Access Coalition
North Carolina Medical Society
North Carolina Mental Health Consumers Organization
North Carolina Nurses Association
North Carolina Pediatric Society
North Carolina Psychiatric Association
North Carolina Psychological Association
North Carolina Psychological Foundation
PAIMI Committee, Governor's Advocacy Council for Persons with Disabilities
Senior Tarheel Legislature
Substance Abuse Federation

4/99

Two Legislative Studies of the Costs and Benefits of Substance Abuse Treatment

In 1992, the California Legislature authorized $2 million for a landmark study to determine the effectiveness, costs, and benefits of substance abuse treatment in California. It is one of the most rigorous outcome studies ever conducted on substance abuse treatment. The results determined three main points:

- Treatment is very cost beneficial to taxpayers. California determined that there is an average return of $7 to every dollar invested.
- Criminal activities significantly decline. Reductions in crime represented a $1.5 BILLION savings to California taxpayers.
- *Health care costs are reduced.* There are significant reductions in health care and hospitalization. Emergency room admissions were reduced by 33% both during and after treatment.

Source: California Department of Alcohol and Drug Programs. (1994). Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment.

The State of Oregon in 1994 commissioned an extensive study of treatment outcomes in their state. The findings indicate that Oregon citizens who received and completed treatment:

- Increased wage earning by 65%.
- Reduced drug crimes and total arrests by 34%.
- Reduced property crimes by 40% and violent crimes by 23%.
- Only 6% of those who completed treatment were later incarcerated in the state prison system compared to 12% of those who did not complete treatment.
- Had 51% fewer hospital claims after treatment resulting in a 30% savings. Emergency room admissions decreased by 53%.
- Child abuse fell by 51%.

Source: Michael Finigan, Ph.D. (1995). *Societal Outcomes of Drug and Alcohol Treatment in the State of Oregon.*. Oregon Department of Human Resources.

Compiled by: Ted C. Fitzgerald, Executive Director - Program Resource Institute, Inc. Lillington, N.C.

Presented by Dr. Al Mooney-April 15,1999

Who Bears the Cost of Alcohol Abuse and Alcoholism?

- 45.1% of costs are incurred by the alcoholic/addict and/or their family.
- 38.6% is paid for by the government (taxpayers).
- Only 10.2% of the cost is paid by private insurance.
- 6.0% by the innocent victims of alcohol/drug related accidents or crime.

Source: Harwood, Fountain, and Livermore. (1998). The Economic Costs of Alcohol Abuse and Alcoholism. *Recent Developments in Alcoholism*, Vol. 14.

Compiled by: Ted C. Fitzgerald, Executive Director - Program Resource Institute, Inc. Lillington, N.C.

Addictions Fact Sheet

Addiction is very costly to our society

- Total economic cost to America in 1992: $245.7 billion (latest figures available)
- Alcohol and other drugs are responsible for a large fraction of health care costs; for example, 20 to 40 percent of hospital patients have drug or alcohol problems. Liver disease, trauma, and HIV are a few examples.
- Alcohol and other drugs are involved in 45.1 percent of fatal automobile crashes, and alcohol is involved in the majority of adult drownings and fatal falls.
- Suicide, the fifth leading cause of death, is associated with drug or alcohol use 20 to 35 percent of the time.
- Violent crime is associated with alcohol or drug use: 68 percent of manslaughters, 62 percent of assaults, 54 percent of murders or attempted murders, 48 percent off robberies, 44 percent of burglaries, 42 percent of rapes and 64 percent of reported child abuse and neglect cases.
- Alcohol and drug users in the workplace are more likely to injure themselves or someone else, use three times as many sick days, are five times more likely to file workers compensation claims, and are far less productive.

Alcoholics and drug addicts suffer from a brain disorder

Though the behavior of addicts and alcoholics causes much suffering to them, their families and our society, this behavior is only superficially voluntary. The addict or alcoholic is unable to stop using drugs or drinking permanently on his or her own without help, no matter how severe the consequences. A reward circuit in the brain has been turned on, and that part of the brain believes that the use of drugs or alcohol is necessary for life, no matter how illogical that may seem. The alcoholic or drug-addicted brain also believes, paradoxically, that there is no real problem, though everyone around the addict or alcoholic can see a terrible problem. In many cases, intensive treatment can lead the addicted person into remission from the addiction.

Treatment of addiction effectively reduces the costs to society

Five years after treatment for addiction, addicted individuals showed a 21 percent reduction in illicit drug use, 29 percent reduction in alcohol use, 43 percent reduction in suicide attempts, 30 percent decline in loss of child custody, 40 percent drop in time spent on the street and a 23 to 38 percent reduction in criminal activity (including breaking and entering, drug sales, prostitution, driving under the influence and weapons use). A large study in California (CALDATA) showed that illegal activity dropped 43.3 percent after treatment, and that for every $1 spent on treatment, California residents saved $7.

Insurance benefits for addiction treatment have been cut drastically in recent years

In the managed care era, the dollar value of general health care benefits of 1,043 employers surveyed dropped by 7 percent from 1988 to 1997. However, benefits provided for addiction treatment dropped by 71 percent in the same period. Treatment is very cost-effective, but unavailable to many who need it.

North Carolina Society of Addiction Medicine
April 1999

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 678

Short Title: Acupuncturist Reimbursement. (Public)

Sponsors: Representatives Sherrill, Luebke (Primary Sponsors); Braswell, Clary, Earle, Michaux, Morris, and Nesbitt.

Referred to: Insurance.

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. (Effective July 1, 1999) Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, or advanced practice registered ~~nurse.~~ nurse, or acupuncturist.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly

certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 or a duly licensed acupuncturist acting within the scope of the acupuncturist's practice as defined in Article 30 of Chapter 90 of the General Statutes unless a comparable limitation is imposed on such medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) Expired.

(c2) For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;
(2) The policy currently provides benefits for identical services performed by other licensed health care providers;
(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;
(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service."

Section 2. G.S. 58-65-1 reads as rewritten:

"§ 58-65-1. (Effective July 1, 1999) Regulation and definitions; application of other laws; profit and foreign corporations prohibited.

(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care,

laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter, or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article

and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State."

Section 3. Article 30 of Chapter 90 of the General Statutes is amended by adding the following new section:

"**§ 90-460. Free choice by patient guaranteed.**

No agency of the State, county, or municipality, nor any commission or clinic, nor any board administering relief, social security, health insurance, or health service under the laws of the State of North Carolina shall deny to the recipients or beneficiaries of their aid or services the freedom to choose a duly licensed acupuncturist as the provider of care or services which are within the scope of practice of the profession of acupuncture as defined in this Article."

Section 4. G.S. 90-459 is repealed.

Section 5. G.S. 135-40.6(8) is amended by adding a new sub-subdivision to read:

"u. Acupuncture: Allowable charges for the practice of acupuncture when performed by a doctor of medicine or an acupuncturist licensed pursuant to Article 30 of Chapter 90 of the General Statutes."

Section 6. This act becomes effective January 1, 2000. Sections 1, 2, and 3 apply to plans issued, amended, or renewed on or after that date. Section 5 applies to treatment and services provided on or after January 1, 2000.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 678

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

H678-ARN-001

Date_____,1999

Comm. Sub. [YES]
Amends Title []
1st Edition

Rep. _____

moves to amend the bill on page 6, lines 33-36, by rewriting those lines to read:

"u. Acupuncture: Allowable charges for the treatment of pain and the production of regional anesthesia when performed by a medical doctor or an acupuncturist licensed or certified in the state in which he or she practices."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if **Senate** Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 714

Short Title: Substance Abuse/Direct Pay. (Public)

Sponsors: Representatives Alexander; Earle, Easterling, Luebke, Melton, Miller, and Wainwright.

Referred to: Insurance.

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR DIRECT PAYMENT OF CERTIFIED SUBSTANCE ABUSE PROFESSIONALS UNDER HEALTH INSURANCE POLICIES AND PLANS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, certified substance abuse professional, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, or advanced practice registered nurse.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint which is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be

performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(c2) For purposes of this section, a 'duly certified substance abuse professional' is a person certified by the North Carolina Substance Abuse Professionals Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service."

Section 2. G.S. 58-65-1 reads as rewritten:

"**§ 58-65-1. Regulation and definitions; application of other laws; profit and foreign corporations prohibited.**

(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this

Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified substance abuse professional, a duly certified fee-based practicing pastoral counselor, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified substance abuse professional, a duly certified fee-based practicing pastoral counselor, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

For purposes of this section, a 'duly certified substance abuse professional' is a person certified by the North Carolina Substance Abuse Professionals Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter,

or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State."

Section 3. G.S. 135-40.7B(c1) reads as rewritten:

"(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary 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;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors; ~~and~~
j. Certified fee-based practicing pastoral counselors until July 1, ~~1999.~~ 1999; and
k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes.

(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 Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors 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;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Licensed fee-based practicing pastoral counselors until July 1, 1999; ~~and~~

k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; and

~~k.~~l. 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."

Section 4. This act becomes effective October 1, 1999, and applies to claims for payment or reimbursement for services rendered on or after that date.

HB 714:
Substance Abuse/Direct Pay

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Alexander
Date:	April 20, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

House Bill 714 amends the insurance anti-discrimination laws to require health plans to reimburse certified substance abuse professionals when they provide services within their scope of practice (assuming the type of service is covered by the plan). Section 1 of the bill places this requirement on insurance companies. Section 2 of the bill places the requirement on service corporations (Blue Cross). This requirement would also apply to preferred provider benefit plans offered by insurers or service corporations. A certified substance abuse professional is a person certified by the North Carolina Substance Abuse Professionals Certification Board.

Section 3 of the bill amends the State Health Plan laws to add certified substance abuse professionals to the list of providers eligible for reimbursement by the State Health Plan for providing chemical dependency treatment and services.

Section 4 makes the bill effective October 1, 1999, and applicable to claims for payment or reimbursement for services rendered on or after that date.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 21, 1999

The House Committee on Insurance met in Room 1425 of the Legislative Building on April 21, 1999, at 2:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Adam Hurley (Cumberland County) and Tyler McLawhorn (Pitt County). The following Committee members were present: Representatives Baddour, Barbee, Brubaker, Cole, Cunningham, Dedmon, Dockham, Esposito, Grady, Hackney, Hardaway, Holmes, Howard, Miller, Saunders, Smith, Warner, C. Wilson, and Wright. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 714, entitled, AN ACT TO PROVIDE FOR DIRECT PAYMENT OF CERTIFIED SUBSTANCE ABUSE PROFESSIONALS UNDER HEALTH INSURANCE POLICIES AND PLANS. Representative Alexander was recognized to explain the bill. This bill amends the insurance anti-discrimination laws to require health plans to reimburse certified substance abuse professionals when they provide services within their scope of practice (assuming the type of service is covered by the plan). Representative Cunningham moved to give the bill a favorable report. Division was called, and a show of hands was required. Nine were in favor of the bill, six were opposed. Motion passed.

HB 991, entitled, AN ACT TO CLARIFY THAT LIABILITY, UNINSURED, AND UNDERINSURED COVERAGE IS NOT REDUCED BY RECEIPT OF SUBROGATED WORKERS' COMPENSATION BENEFITS. Representative Baddour was recognized to explain the bill, and present a handout. After much discussion, it was determined to hold the bill over until the April 23rd committee meeting.

HB 715, entitled, AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM). Representative Alexander was recognized to explain the bill. Representative Saunders offered an oral amendment, which would amend the bill on lines 11 – 14 with a new sentence being added. The amendment was adopted. The Chair recognized Mr. Paul Mahoney with the North Carolina Association of Health Plans who spoke against the original bill (see attached handout). Dr. Phillip Hillsman, psychiatrist and addiction specialist, and Dr. Vanderberry were recognized to speak in favor of the bill.

There being no further business, the Chair adjourned the meeting at 3:00 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
HB 714, HB 715, & HB 991
Handouts
Bill Summary

VISITOR REGISTRATION SHEET

Insurance — 4-21-99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Paul Mahoney	NC ASSN of HEALTH PLANS
Alan Miller	Bailey & Dixon LLP
Susan Valauri	Nationwide
Dave Horne	Smith Anderson
Tommy Herndon	Enterprise Rent a Car
Richard O'Brien	PFFPNC
David Anders	PFFPNC
Bobby Riddle	PFFPNC
Alan Lloyd	State Farm Ins. Cos.
Robert Pasichal	Young, Moore & Henderson, P.A.
Fran Preston	NCRMA
Andy Ellen	NCRMA
Lori Bradley	NC DOI
Jerry B. Lewis	Forsyth County Fire Marshal
Mark Arnell	Progressive
Michael Harrold	NAII

VISITOR REGISTRATION SHEET

Insurance
Name of Committee

4-21-99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Crissy Porter	Bone and Associates
Steve Woodson	NC Farm Bureau
Scott Hammack	NCATL
Charles Cramer	NCATL
Jim LORE	LORE & McClearen
Ted Fitzgerald	APNIC
Tom Mulvihill	Alcohol/Drug Council of NC
Rebecca J. Carver	Alcohol/Drug Council of NC
Sandra A. Miles	Alcohol/Drug Council of NC
Wilmer C. Betts, MD	ASAM
Jesse J. Sell, Ph.D	Addiction Profs. of NC
Jamie Norton	Addiction Prof. of NC
Ed Ward	Addiction Professionals of NC
Phil Hillsman	American Soc. Addiction Medicine
Bob Vanderberry	ASAM
Marion Smith	NCSA

VISITOR REGISTRATION SHEET

Name of Committee

Date 4/21/99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	Automotive Parts Assoc.
[signature]	Bona Assoc.
[signature]	NC Chamber Council
[signature]	Moore & Van Allen
[signature]	Jordan Price Wall
[signature]	LA Harris & Assoc

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 714 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR DIRECT PAYMENT OF CERTIFIED SUBSTANCE ABUSE PROFESSIONALS UNDER HEALTH INSURANCE POLICIES AND 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 714

Short Title: Substance Abuse/Direct Pay. (Public)

Sponsors: Representatives Alexander; Earle, Easterling, Luebke, Melton, Miller, and Wainwright.

Referred to: Insurance.

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR DIRECT PAYMENT OF CERTIFIED SUBSTANCE ABUSE PROFESSIONALS UNDER HEALTH INSURANCE POLICIES AND PLANS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, certified substance abuse professional, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, or advanced practice registered nurse.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint which is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be

performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(c2) For purposes of this section, a 'duly certified substance abuse professional' is a person certified by the North Carolina Substance Abuse Professionals Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service."

Section 2. G.S. 58-65-1 reads as rewritten:

"**§ 58-65-1. Regulation and definitions; application of other laws; profit and foreign corporations prohibited.**

(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this

Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified substance abuse professional, a duly certified fee-based practicing pastoral counselor, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified substance abuse professional, a duly certified fee-based practicing pastoral counselor, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

For purposes of this section, a 'duly certified substance abuse professional' is a person certified by the North Carolina Substance Abuse Professionals Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter,

or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State."

Section 3. G.S. 135-40.7B(c1) reads as rewritten:

"(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary 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;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors; ~~and~~
j. Certified fee-based practicing pastoral counselors until July 1, ~~1999.~~ 1999; and
k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes.

(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 Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors 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;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Licensed fee-based practicing pastoral counselors until July 1, 1999; ~~and~~

k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; and

~~k.~~l. 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."

Section 4. This act becomes effective October 1, 1999, and applies to claims for payment or reimbursement for services rendered on or after that date.

HB 714:
Substance Abuse/Direct Pay

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Alexander
Date:	April 20, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

House Bill 714 amends the insurance anti-discrimination laws to require health plans to reimburse certified substance abuse professionals when they provide services within their scope of practice (assuming the type of service is covered by the plan). Section 1 of the bill places this requirement on insurance companies. Section 2 of the bill places the requirement on service corporations (Blue Cross). This requirement would also apply to preferred provider benefit plans offered by insurers or service corporations. A certified substance abuse professional is a person certified by the North Carolina Substance Abuse Professionals Certification Board.

Section 3 of the bill amends the State Health Plan laws to add certified substance abuse professionals to the list of providers eligible for reimbursement by the State Health Plan for providing chemical dependency treatment and services.

Section 4 makes the bill effective October 1, 1999, and applicable to claims for payment or reimbursement for services rendered on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 991

Short Title: Workers' Comp. and UIM Insurance. (Public)

Sponsors: Representative Baddour.

Referred to: Insurance.

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT LIABILITY, UNINSURED, AND UNDERINSURED COVERAGE IS NOT REDUCED BY RECEIPT OF SUBROGATED WORKERS' COMPENSATION BENEFITS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-279.21(e) reads as rewritten:

"(e) ~~Such~~ A motor vehicle liability policy need not insure against loss from ~~any liability for which benefits are in whole or in part either payable or required to be provided under any workers' compensation law nor~~ any liability for damage to property owned by, rented to, in charge of or transported by the insured."

Section 2. This act is effective when it becomes law.

H.B. 991 – Explanation Example

Present Status: N.C.G.S. §20-279.21(e) allows an uninsured or underinsured motorist (UM/UIM) carrier contractually to reduce its coverage by the amount a claimant has received for his injuries from workers' compensation.[1] When combined with an employer's right to assert a lien pursuant to N.C.G.S. §97-10.2, a claimant is prevented from even a single recovery.

Objective: To eliminate a "double reduction" with respect to a claimant's third party recovery by disallowing a UM/UIM carrier to reduce its coverage by the amount a claimant has received from workers' compensation.

Proposed Change: The proposed amendment would prohibit a motor vehicle liability policy from including a provision which allows it to reduce the amount of its coverage by the amount a claimant has received for his injuries from workers' compensation. A claimant would still be subject to an employer's lien with respect to any third party recovery. However, a claimant would no longer by subject to a "double reduction".

For example, suppose a claimant has received $10,000.00 in workers' compensation benefits and receives a third party recovery of $20,000.00 payable by UM/UIM coverage. Under existing law, the UM/UIM carrier is entitled to a reduction for the $10,000 that the claimant has received from workers' compensation. Accordingly, the UM/UIM carrier owes only the difference of $10,000.00. The workers' compensation carrier has a lien with respect to the $10,000.00 that it has previously paid. Accordingly, the claimant would receive no further benefits from the third party recovery. The *total* benefits that the claimant would receive under this fact situation from workers' compensation and the third party recovery is $10,000.00 despite having received a verdict of $20,000.00. The claimant would actually be $10,000.00 "better off" having never pursued his workers' compensation claim. To require a claimant to forgo workers' compensation benefits during the period of time when he or she is out of work and may not be able to afford medical treatment is certainly not the logical result intended by our legislature.

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[1] McMillan v. North Carolina Farm Bureau Mutual Insurance Company, 347 N.C. 560, 495 S.E.2d 352.

Benefits:

(1) It allows a claimant a single recovery and avoids a "double reduction" as exists under the present system where a UM/UIM carrier is allowed to reduce its coverage by the amount claimant has received from workers' compensation and the workers' compensation carrier is allowed to be reimbursed for these same payments pursuant to N.C.G.S. §97-10.2(j).

(2) It avoids placing claimant in the precarious position of having to decline workers' compensation benefits in order to avoid this "double reduction" and obtain a single recovery.

(3) It allows the UM/UIM coverage to benefit the claimant as should be the intention. This is particularly true where the claimant purchases these benefits for his protection but is unable to benefit from them because he was injured in the course and scope of his employment.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 715

Short Title: Utilization Review/ASAM Criteria. (Public)

Sponsors: Representatives Alexander; Earle, Easterling, Luebke, Melton, Miller, Wainwright, and G. Wilson.

Referred to: Insurance.

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM).

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-61(d) reads as rewritten:

"(d) Program Operations. -- In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders. Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to

ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section."

Section 2. This act becomes effective October 1, 1999, and applies to utilization reviews conducted on and after that date.

ERNEST RABA, MD

FACSIMILE TRANSMITTAL SHEET

TO: Joel Kostin, PhD	FROM: Ernest Raba, MD
COMPANY: Magellan Behavioral	DATE: 4/20/99
FAX NUMBER: 919-379-9595	TOTAL NO. OF PAGES INCLUDING COVER: 2
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
RE: ASAM Criteria & proposed legislation	YOUR REFERENCE NUMBER:

X URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

I have been shown a legislative proposal pending for NC that involves a legislative mandate to require the use of ASAM criteria for placement and utilization decisions relating to substance abuse and I have been asked to comment on this proposal.

By way of background, I have been a psychiatrist since 1972 (residency at Duke 1972-1975), have practiced in NC since 1975 and I am certified by ASAM and in General Psychiatry. I have been a Medical Director of a free standing substance abuse facility (Charter Northridge, Raleigh NC), Clinical Director of a Dual Diagnosis program (Holly Hills Hospital, Raleigh NC) and Medical Director of a free standing Out-Patient Treatment Program (Westhaven, Raleigh NC). I was one of the founding members of the Psychiatry Department at Durham Regional and I have had a clinical adjunct appointment at Duke for many years. In my current practice I see out patients at my office in Raleigh and hospital patients on my service at Charter/Holly Hills Hospital. I am also the Medical Director for the Magellan Behavioral NC Regional Service Center in Morrisville, NC.

The ASAM criteria set, like most criteria sets, suffers from a lack of outcomes or efficacy data. This lack of data is important because we already know that passionately held opinions about what works in substance abuse treatment have often found no support after scientific study. I can provide several examples. First, the earlier standard of care for 28-day treatment of all cases of alcohol dependency or abuse was not supported in outcomes research showing that other treatments were equally as effective. Second, in another important study recent research has shown that out patient detoxification is as effective as in patient detoxification for a large number of patients. Despite this data, facilities and practitioners continue to demand in patient services and have refused to develop programs offering the appropriate level of care. Third, the National Institute of Health has issued a position statement that identifies methadone maintenance as the

standard of care for opiate dependency (because substance free approaches have such a truly dismal outcome), yet facilities and providers continue to treat opiate addicts using a model of acute detoxification without referral to methadone programs. Finally, research data has clearly shown that the addition of the prescription drug Revia markedly improves outcomes for alcoholics yet providers fail to provide this intervention because they cling to an earlier standard of care that did not include it.

Emphasis on intensive out patient treatment, ambulatory detoxification and other innovative treatments has been supported by third party payors, despite the objections of providers and facilities, because these interventions have been shown to be effective. There were no out patient intensive programs or ambulatory detoxification programs available in Raleigh before those programs were demanded and supported by third party payors.

It has been my experience that facilities and providers usually formulate case presentations and make level of care recommendations that coincide with the programs that are available at the site where the patient is evaluated. For example, despite the availability of out patient detoxification in a particular area, if a facility does not offer that service then in patient detoxification is routinely recommended rather than the more appropriate level of care which is available down the road. I am concerned that a legislatively mandated criteria set would be used to force certification of the available level of care at a particular facility rather than the most appropriate level of care because the level of care assessment at the facility would be naturally biased toward the services that the facility actually could provide.

I am also concerned that a legislative mandate would lead to less flexibility and less local control of services despite outcomes experience. ASAM criteria contain level of care criteria for a wide range of services. The general experience at Westhaven (on the out patient intensive side) and at other treatment programs (on the in patient side) is that the probability of a successful outcome from some of the levels of care in the ASAM set are very low. It is possible or even likely that legislative adoption of a mandated criteria set would result in a legal requirement to certify an expensive service that has little probability of success either in local experience or in published studies. The obvious implications for wasting scarce health care dollars is clear.

I was unable to determine if the proposed legislation would also encumber the public sector, but I assume that the legislature would not impose two different standards of care. My general experience from the perspective of a psychiatrist in private practice who has patients enter private care from the public sector and leave private care to enter the public sector is that the public sector would be unable to meet the ASAM criteria for level of care decisions because adequate resources do not exist. The implications should be explored.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 22, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 22, 1999, at 12:00 P.M. (noon). Representative Hurley called the meeting to order and introduced the pages, Adam Hurley (Cumberland County) and Emily Cook (Rowan County). The following Committee members were present: Representatives Barbee, Boyd-McIntyre, Brubaker, Cole, Dockham, Esposito, Hardaway, Holmes, Howard, Redwine, Saunders, Warner, and C. Wilson. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 1089, entitled, AN ACT TO REQUIRE THE NORTH CAROLINA RATE BUREAU TO RECLASSIFY SWEET POTATOES FOR THE PURPOSE OF WORKERS' COMPENSATION INSURANCE. Representative Arnold was recognized to explain the bill. House Bill 1089 requires the Rate Bureau to reclassify the job of sweet potato harvesting (by hand) into the same class as other vegetable hand harvesting. After much discussion, this bill was to be placed on the agenda for the April 23rd INSURANCE Committee meeting.

HB 715, entitled, AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM). Representative Alexander was recognized to explain the bill and distribute a proposed committee substitute. Upon motion made by Representative C. Wilson, the committee adopted the committee substitute for discussion. Representative C. Wilson moved to amend the bill on page 1, line 17, by deleting the word "similar" and inserting the following between the words "criteria" and "adopted": "for determining when a patient needs to be placed in a substance abuse treatment program". Upon motion made by the Chair, the amendment was adopted. Representative C. Wilson moved to roll the amendment into a new committee substitute and give a favorable report to the committee substitute, unfavorable to the original bill. Motion passed.

HB 1025, entitled, AN ACT TO ALLOW SMALL EMPLOYERS TO CHARGE THE SAME ADMINISTRATIVE FEE UNDER THE STATE GROUP HEALTH CONTINUATION LAW AS LARGER EMPLOYERS CHARGE UNDER THE FEDERAL COBRA GROUP HEALTH CONTINUATION LAW. Representative Gardner was recognized to explain the bill. Upon motion made by Representative Cole, the bill received a favorable report.

There being no further business, the Chair adjourned the meeting at 12:30 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
HB 715, HB 1025, HB 1089
Proposed Committee Substitute
Amendment
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — 4/22/99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Charles Cromer	NCATL
Scott Hammack	NCATL
Liz Kuminolm	NCATL
Becky Carver	Alcohol/Drug Council of NC
SUE KEITH	NC ADVOCATES FOR SUBSTANCE ABUSE PROGRAMMING
Trish Hussey	Freedom House Recovery Center
Sandra Miles	Alcohol/Drug Council of NC
MICHAEL WHALEY	FELLOWSHIP HALL / APNC
Robert VANDERBERRY	NC. Medical Society
Randall McCormick	Lee-Harnett Mental Health / APNC
Steve Woodson	NC Farm Bureau
Sue Johnson-Langford	NC Sweet Potato Commission
Michelle McPherson	NC Attygen
Charlie Diell	NC Outdoor Adv. Association
LISA REEVES	THE INSIDER

VISITOR REGISTRATION SHEET

INSURANCE — 4/2/95
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Tim McDonald	NCAICU
Jo Steni	DMH/DD/SAS
John Palisano	AT&T
Johnnie McLean	St. Bd. of Elections
Larry O. Bartlett	" " " "
[illegible] JR	NCDS & NCPTA

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

HOUSE BILL 1089

Short Title: Sweet Potato Insurance Reclassification. (Public)

Sponsors: Representative Arnold.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE NORTH CAROLINA RATE BUREAU TO RECLASSIFY SWEET POTATOES FOR THE PURPOSE OF WORKERS' COMPENSATION INSURANCE.

Whereas, the potato is a tuber and is planted and harvested with the use of mechanical equipment; and

Whereas, the potato is classified by the North Carolina Rate Bureau as "0037 field crops & drivers" for purposes of determining workers' compensation insurance rates; and

Whereas, other vegetables such as cucumbers, squash, and peppers are planted and harvested using hand labor and are therefore classifed by the North Carolina Rate Bureau as "0008 vegetable & driver" for purposes of determining workers' compensation insurance rates, with lower rates than potatoes; and

Whereas, sweet potatoes are root vegetables and are planted and harvested using hand labor rather than mechanized equipment; and

Whereas, the North Carolina Rate Bureau currently classifies sweet potatoes with other potatoes for purposes of determining workers' compensation insurance rates, with a higher rate than other vegetables harvested by hand; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. The North Carolina Rate Bureau shall reclassify sweet potatoes as "0008 vegetable & driver" for purposes of determing workers' compensation insurance rates and shall adjust all rates accordingly.

Section 2. This act becomes effective July 1, 1999.

HB 1089:
Sweet Potato Insurance Reclassification

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Arnold
Date:	April 22, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

The North Carolina Rate Bureau has developed several hundred job classifications for workers' compensation purposes. The classifications are designed to recognize the differences in hazards and risks among the different jobs. Generally, the higher the risk of injury in the job, the higher the workers' compensation premium for that particular job classification. For example, the workers' compensation premium for a roofer is far greater than that for an office employee.

House Bill 1089 requires the Rate Bureau to reclassify the job of sweet potato harvesting (by hand, according to the bill's preamble) into the same class as other vegetable hand-harvesting.

This act would take effect July 1, 1999.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 715 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM).

☐ 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 715
Committee Substitute Favorable 4/23/99

Short Title: Utilization Review/ASAM Criteria. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA FOR SUBSTANCE ABUSE TREATMENT BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) OR SIMILAR CRITERIA.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-61(d) reads as rewritten:

"(d) Program Operations. -- In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or criteria for determining when a patient needs to be placed in a substance abuse treatment program adopted by the insurer or its URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect

incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section."

Section 2. This act becomes effective October 1, 1999, and applies to utilization reviews conducted on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 715
Proposed Committee Substitute H715-PCS1227-RN

Short Title: Utilization Review/ASAM Criteria. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA FOR SUBSTANCE ABUSE TREATMENT BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) OR SIMILAR CRITERIA.

The General Assembly of North Carolina enacts:

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Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect

incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section."

Section 2. This act becomes effective October 1, 1999, and applies to utilization reviews conducted on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 715

Short Title: Utilization Review/ASAM Criteria. (Public)

Sponsors: Representatives Alexander; Earle, Easterling, Luebke, Melton, Miller, Wainwright, and G. Wilson.

Referred to: Insurance.

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM).

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-61(d) reads as rewritten:

"(d) Program Operations. -- In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders. Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to

ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section."

Section 2. This act becomes effective October 1, 1999, and applies to utilization reviews conducted on and after that date.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 715 DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓ CSRN-002

Rep.)
) _____
Sen.)

moves to amend the bill on page 1, lines 17

( ) WHICH CHANGES THE TITLE

by deleting the word "similar" and inserting the following between the words "criteria" and "adopted": "for determining when a patient needs to be placed in a substance abuse treatment program"

SIGNED Connie Wilson

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 1025 A BILL TO BE ENTITLED AN ACT TO ALLOW SMALL EMPLOYERS TO CHARGE THE SAME ADMINISTRATIVE FEE UNDER THE STATE GROUP HEALTH CONTINUATION LAW AS LARGER EMPLOYERS CHARGE UNDER THE FEDERAL COBRA GROUP HEALTH CONTINUATION 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1025

Short Title: Group Health Continuation Insurance. (Public)

Sponsors: Representative Gardner.

Referred to: Insurance.

April 14, 1999

A BILL TO BE ENTITLED

AN ACT TO ALLOW SMALL EMPLOYERS TO CHARGE THE SAME ADMINISTRATIVE FEE UNDER THE STATE GROUP HEALTH CONTINUATION LAW AS LARGER EMPLOYERS CHARGE UNDER THE FEDERAL COBRA GROUP HEALTH CONTINUATION LAW.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-53-30 reads as rewritten:

"**§ 58-53-30. Payment of premiums.**

An employee or member electing continuation must pay to the group policyholder or his employer, in advance, the amount of contribution required by the policyholder or employer, but not more than one hundred two percent (102%) of the full group rate for the insurance applicable under the group policy on the due date of each payment. The employee or member may not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member must make a written election of continuation, on a form furnished by the group policyholder, and pay the first contribution, in advance, to the policyholder or employer on or before the date on which employee's or member's insurance would otherwise terminate."

Section 2. This act becomes effective September 1, 1999, and applies to group health insurance continuation that commences on or after that date.

HB 1025:
Grooup Health Continuation Insurance

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Gardner
Date:	April 22, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

Currently, both federal and State law require employers to offer continued coverage for 18 months (longer in some cases under federal law) under the employer's group health plan to employees whose coverage under the plan ends because of termination of employment (subject to certain exceptions). The federal law, known as COBRA continuation coverage, applies to employers with 20 or more employees. COBRA allows these employers to charge the employee the full group rate premium plus a two percent administrative fee.

The State group health continuation law applies to employers with less than 20 employees. This law also allows the employer to charge the former employee the full group rate premium, but it does not allow for the charging of an administrative fee.

House Bill 1025 will allow the employers under the State law to charge the same 2% administrative fee that employers under the federal COBRA law are allowed to charge

This bill would take effect September 1, 1999, and would apply only to persons who begin their continuation coverage on or after that date. Thus, a person who is already on continuation coverage as of that date would not be affected by the 2% administrative fee.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 23, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 23, 1999, at 10:00 A.M. Representative Hurley called the meeting to order and introduced the pages, Adam Hurley (Cumberland County), Tyler McLawhorn (Pitt County), and Isaac Wingfield (Buncombe County). The following Committee members were present: Representatives Baddour, Barbee, Boyd-McIntyre, Cole, Cunningham, Dedmon, Dockham, Earle, Esposito, Hackney, Hardaway, Holmes, Howard, Redwine, Saunders, Wainwright, and C. Wilson. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 1089, entitled, AN ACT TO REQUIRE THE NORTH CAROLINA RATE BUREAU TO RECLASSIFY SWEET POTATOES FOR THE PURPOSE OF WORKERS' COMPENSATION INSURANCE. Jerry Hamrick, Workers' Compensation Manager with the North Carolina Rate Bureau, was recognized to indicate the Rate Bureau is going to work with the Sweet Potato Association to resolve this issue. No action was taken on this bill.

HB 991, entitled, AN ACT TO CLARIFY THAT LIABILITY, UNINSURED, AND UNDERINSURED COVERAGE IS NOT REDUCED BY RECEIPT OF SUBROGATED WORKERS' COMPENSATION BENEFITS. Representative Baddour was recognized to present the bill and a proposed committee substitute. Representative Cunningham moved to give a favorable report to the committee substitute, unfavorable to the original bill. Motion passed.

HB 1186, entitled, AN ACT TO REVISE THE LAW GOVERNING THE UNEARNED PREMIUM RESERVE OF DOMESTIC TITLE COMPANIES. Representative Miner was recognized to present and explain the bill and a proposed committee substitute. The Chair called on Mr. Dascheil Propes, Department of Insurance, who indicated the Department is in agreement with this bill. Representative Saunders made a motion to give a favorable report to the committee substitute, unfavorable to the original bill. Motion passed.

House Bill 678, entitled, AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT. Representative Sherrill was recognized to explain the bill along with the amendment which was approved at the April 20, 1999, INSURANCE Committee meeting. Representative Cunningham made a motion to roll the amendment into a committee substitute and give a favorable report to the committee substitute, unfavorable to the original bill. Representative Dockham moved that HB 678 be postponed indefinitely. Representative C. Wilson seconded the motion. Division was called and a hand count

required. Seven votes were in favor of the motion, nine were opposed. The motion failed. The Chair called for a vote on the original motion made by Representative Cunningham. Division was called and a hand count required. The motion passed by a vote of eleven to seven.

There being no further business, the Chair adjourned the meeting at 10:45 A.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
House Bills 678, 991, 1089, 1186
Proposed Committee Substitutes
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE - 4-23-94

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Julie Pulley	Arcys — M/J
2.	Wendy Jennings	N.C. Insurance Commission
3.	[illegible]	[illegible]
4.	Jim McNeal	NC Department of Commerce
5.	Wendy Mills	SEANC
6.	Darlene Annas	SEANC
7.	Evelyn Hammond	UNC-CH
8.	LISA REYES	THE INSIDER
9.	Charles Case	Austin + Williams
10.	FRAN PRESNELL	NCRMA
11.	Ann Case	NCRMA
12.	Margaret Thompson	NCCBD
13.	Andrea Ellen	NCRMA
14.	John Polumbo	AT&T
15.	Joyce Rogers	JP Assoc
16.	Jennie Dorsett	NCAHA
17.	Mary Jane	NCSA
18.	Lynn Summers	NC Equity
19.		
20.		
21.		

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

HOUSE BILL 1089

Short Title: Sweet Potato Insurance Reclassification. (Public)

Sponsors: Representative Arnold.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE NORTH CAROLINA RATE BUREAU TO RECLASSIFY SWEET POTATOES FOR THE PURPOSE OF WORKERS' COMPENSATION INSURANCE.

Whereas, the potato is a tuber and is planted and harvested with the use of mechanical equipment; and

Whereas, the potato is classified by the North Carolina Rate Bureau as "0037 field crops & drivers" for purposes of determining workers' compensation insurance rates; and

Whereas, other vegetables such as cucumbers, squash, and peppers are planted and harvested using hand labor and are therefore classifed by the North Carolina Rate Bureau as "0008 vegetable & driver" for purposes of determining workers' compensation insurance rates, with lower rates than potatoes; and

Whereas, sweet potatoes are root vegetables and are planted and harvested using hand labor rather than mechanized equipment; and

Whereas, the North Carolina Rate Bureau currently classifies sweet potatoes with other potatoes for purposes of determining workers' compensation insurance rates, with a higher rate than other vegetables harvested by hand; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. The North Carolina Rate Bureau shall reclassify sweet potatoes as "0008 vegetable & driver" for purposes of determing workers' compensation insurance rates and shall adjust all rates accordingly.

Section 2. This act becomes effective July 1, 1999.

HB 1089:
Sweet Potato Insurance Reclassification

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Arnold
Date:	April 22, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

The North Carolina Rate Bureau has developed several hundred job classifications for workers' compensation purposes. The classifications are designed to recognize the differences in hazards and risks among the different jobs. Generally, the higher the risk of injury in the job, the higher the workers' compensation premium for that particular job classification. For example, the workers' compensation premium for a roofer is far greater than that for an office employee.

House Bill 1089 requires the Rate Bureau to reclassify the job of sweet potato harvesting (by hand, according to the bill's preamble) into the same class as other vegetable hand-harvesting.

This act would take effect July 1, 1999.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 991 A BILL TO BE ENTITLED AN ACT TO CLARIFY THAT LIABILITY, UNINSURED, AND UNDERINSURED COVERAGE IS NOT REDUCED BY RECEIPT OF SUBROGATED WORKERS' COMPENSATION BENEFITS.

☐ 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, unfavorable as to original bill.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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 _____.

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____ 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 991
Committee Substitute Favorable 4/26/99

Short Title: Workers' Comp. and UIM Insurance. (Public)

Sponsors:

Referred to:

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT LIABILITY, UNINSURED, AND UNDERINSURED COVERAGE IS NOT REDUCED BY RECEIPT OF SUBROGATED WORKERS' COMPENSATION BENEFITS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-279.21(e) reads as rewritten:

"(e) ~~Such~~ Uninsured or underinsured motorist coverage that is provided as part of a motor vehicle liability policy need not insure ~~against~~ against:

(1) A loss ~~from any liability~~ for which benefits ~~are in whole or in part either payable or required to be provided~~ have been paid under any workers' compensation law except as to the amount of an employer's lien determined pursuant to G.S. 97-10.2(h) or (j), in no event to exceed the applicable uninsured or underinsured coverage limits of the motor vehicle policy; nor

(2) ~~any~~ A loss from any liability for damage to property owned by, rented to, in charge of or transported by the insured."

Section 2. This act becomes effective October 1, 1999, and applies to policies issued or renewed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 991
Proposed Committee Substitute H991-PCS7211-RN

Short Title: Workers' Comp. and UIM Insurance. (Public)

Sponsors:

Referred to:

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT LIABILITY, UNINSURED, AND UNDERINSURED COVERAGE IS NOT REDUCED BY RECEIPT OF SUBROGATED WORKERS' COMPENSATION BENEFITS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-279.21(e) reads as rewritten:

"(e) ~~Such~~ Uninsured or underinsured motorist coverage that is provided as part of a motor vehicle liability policy need not insure ~~against~~ against:

(1) A loss ~~from any liability~~ for which benefits ~~are in whole or in part either payable or required to be provided~~ have been paid under any workers' compensation law except as to the amount of an employer's lien determined pursuant to G.S. 97-10.2(h) or (j), in no event to exceed the applicable uninsured or underinsured coverage limits of the motor vehicle policy; nor

(2) ~~any~~ A loss from any liability for damage to property owned by, rented to, in charge of or transported by the insured."

Section 2. This act becomes effective October 1, 1999, and applies to policies issued or renewed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 991

Short Title: Workers' Comp. and UIM Insurance. (Public)

Sponsors: Representative Baddour.

Referred to: Insurance.

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT LIABILITY, UNINSURED, AND UNDERINSURED COVERAGE IS NOT REDUCED BY RECEIPT OF SUBROGATED WORKERS' COMPENSATION BENEFITS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-279.21(e) reads as rewritten:

"(e) ~~Such~~ A motor vehicle liability policy need not insure against loss from ~~any liability for which benefits are in whole or in part either payable or required to be provided under any workers' compensation law nor~~ any liability for damage to property owned by, rented to, in charge of or transported by the insured."

Section 2. This act is effective when it becomes law.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1186 A BILL TO BE ENTITLED AN ACT TO REVISE THE LAW GOVERNING THE UNEARNED PREMIUM RESERVE OF DOMESTIC TITLE COMPANIES.

☐ 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, unfavorable as to original bill.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1186
Committee Substitute Favorable 4/23/99

Short Title: Unearned Premium Reserves. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REVISE THE LAW GOVERNING THE UNEARNED PREMIUM RESERVE OF DOMESTIC TITLE COMPANIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-26-25 reads as rewritten:

"**§ 58-26-25. Amount of unearned premium reserve.**

(a) The unearned premium reserve of every domestic title insurance company shall consist of the aggregate of:

(1) The amount of the unearned premium reserve held as of ~~January 1, 1974.~~ December 31, 1998.

(2) The amount of all additions required to be made to such reserve by this section, less the reduction of such aggregate amount required hereby.

(b) ~~On each contract of title insurance issued by a~~ A domestic title insurance company on and after ~~January 1, 1974, there shall be reserved~~ January 1, 1999, shall reserve initially as an unearned premium reserve a sum equal to ten per centum (10%) of the ~~original risk premium charged therefor.~~ following items set forth in the title insurer's most recent annual statement on file with the Commissioner:

(1) Direct premiums written; and

(2) Premiums for reinsurance assumed less premiums for reinsurance ceded during the year.

(c) The aggregate of the amounts set aside in unearned premium reserves in any calendar year, pursuant to subsection (b) of this section, shall be reduced annually at

the end of each calendar year following the year in which the policy is issued, ~~at the annual rate of one twentieth of the aggregate of such amounts.~~ over a period of 20 years, pursuant to the following: twenty percent (20%) the first year; ten percent (10%) for years two and three; five percent (5%) for years four through 10; three percent (3%) for years 11 through 15; and two percent (2%) for years 16 through 20.

(d) The entire amount of the unearned premium reserve held as of ~~January 1, 1974,~~ December 31, 1998, shall be accorded a fresh start ~~added to the reserve as of that date~~ and shall be released from said reserve and restored to net profits ~~at the annual rate of one twentieth of the said entire amount, beginning in the next ensuing calendar year.~~ in accordance with the percentages set forth in subsection (c) of this section.

(e) ~~If substantially the entire outstanding liability under all policies, contracts of title insurance or reinsurance agreements of any such title insurance company shall be reinsured, the value of the consideration received by a reinsuring title insurance company authorized to transact the business of title insurance in this State, shall constitute, in its entirety, unearned portions of original premiums and be added to its unearned premium reserve and deemed, for recovery purposes, to have been provided for liabilities assumed during the year of such reinsurance. The amount of such addition to the unearned premium reserve of such assuming title insurance company shall be not less, however, than two thirds of the amount of the unearned premium reserve required to be maintained by the ceding title insurance company at the time of such reinsurance.~~ A supplemental reserve shall be established in accordance with the instructions of the annual statement required by G.S. 58-2-165 and G.S. 58-26-10 consisting of the reserves necessary, when taken in combination with the reserves required by subsections (a) through (d) of this section to cover the company's liabilities with respect to all losses, claims, and loss adjustment expenses.

(f) Each title insurer subject to the provisions of this Article shall file with its annual statement required by G.S. 58-2-165 and G.S. 58-26-10 a certification of a member in good standing of the American Academy of Actuaries. The actuarial certification required of a title insurer must conform to the annual statement instructions for title insurers of the National Association of Insurance Commissioners."

Section 2. This act becomes effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1186
Proposed Committee Substitute H1186-PCS1231-RN

Short Title: Unearned Premium Reserves. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REVISE THE LAW GOVERNING THE UNEARNED PREMIUM RESERVE OF DOMESTIC TITLE COMPANIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-26-25 reads as rewritten:

"**§ 58-26-25. Amount of unearned premium reserve.**

(a) The unearned premium reserve of every domestic title insurance company shall consist of the aggregate of:

(1) The amount of the unearned premium reserve held as of ~~January 1, 1974.~~ December 31, 1998.

(2) The amount of all additions required to be made to such reserve by this section, less the reduction of such aggregate amount required hereby.

(b) ~~On each contract of title insurance issued by a~~ A domestic title insurance company on and after ~~January 1, 1974, there shall be reserved~~ January 1, 1999, shall reserve initially as an unearned premium reserve a sum equal to ten per centum (10%) of the ~~original risk premium charged therefor.~~ following items set forth in the title insurer's most recent annual statement on file with the Commissioner:

(1) Direct premiums written; and

(2) Premiums for reinsurance assumed less premiums for reinsurance ceded during the year.

(c) The aggregate of the amounts set aside in unearned premium reserves in any calendar year, pursuant to subsection (b) of this section, shall be reduced annually at

the end of each calendar year following the year in which the policy is issued, ~~at the annual rate of one twentieth of the aggregate of such amounts.~~ over a period of 20 years, pursuant to the following: twenty percent (20%) the first year; ten percent (10%) for years two and three; five percent (5%) for years four through 10; three percent (3%) for years 11 through 15; and two percent (2%) for years 16 through 20.

(d) The entire amount of the unearned premium reserve held as of ~~January 1, 1974,~~ December 31, 1998, shall be accorded a fresh start ~~added to the reserve as of that date~~ and shall be released from said reserve and restored to net profits ~~at the annual rate of one twentieth of the said entire amount, beginning in the next ensuing calendar year.~~ in accordance with the percentages set forth in subsection (c) of this section.

(e) ~~If substantially the entire outstanding liability under all policies, contracts of title insurance or reinsurance agreements of any such title insurance company shall be reinsured, the value of the consideration received by a reinsuring title insurance company authorized to transact the business of title insurance in this State, shall constitute, in its entirety, unearned portions of original premiums and be added to its unearned premium reserve and deemed, for recovery purposes, to have been provided for liabilities assumed during the year of such reinsurance. The amount of such addition to the unearned premium reserve of such assuming title insurance company shall be not less, however, than two thirds of the amount of the unearned premium reserve required to be maintained by the ceding title insurance company at the time of such reinsurance.~~ A supplemental reserve shall be established in accordance with the instructions of the annual statement required by G.S. 58-2-165 and G.S. 58-26-10 consisting of the reserves necessary, when taken in combination with the reserves required by subsections (a) through (d) of this section to cover the company's liabilities with respect to all losses, claims, and loss adjustment expenses.

(f) Each title insurer subject to the provisions of this Article shall file with its annual statement required by G.S. 58-2-165 and G.S. 58-26-10 a certification of a member in good standing of the American Academy of Actuaries. The actuarial certification required of a title insurer must conform to the annual statement instructions for title insurers of the National Association of Insurance Commissioners."

Section 2. This act becomes effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1186

Short Title: Unearned Premium Reserves. (Public)

Sponsors: Representative Miner.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REVISE THE LAW GOVERNING THE UNEARNED PREMIUM RESERVE OF DOMESTIC TITLE COMPANIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-26-25 reads as rewritten:

"**§ 58-26-25. Amount of unearned premium reserve.**

(a) The unearned premium reserve of every domestic title insurance company shall consist of the aggregate of:

(1) The amount of the unearned premium reserve held as of ~~January 1, 1974.~~ January 1, 1999.

(2) The amount of all additions required to be made to such reserve by this section, less the reduction of such aggregate amount required hereby.

(b) ~~On each contract of title insurance issued by a~~ A domestic title insurance company on and after ~~January 1, 1974, there shall be reserved~~ January 1, 1999, shall reserve initially as an unearned premium reserve a sum equal to ten per centum (10%) of the ~~original risk premium charged therefor.~~ following items set forth in the title insurer's most recent annual statement on file with the Commissioner:

(1) Direct premiums written; and

(2) Premiums for reinsurance assumed less premiums for reinsurance ceded during the year.

(c) The aggregate of the amounts set aside in unearned premium reserves in any calendar year, pursuant to subsection (b) of this section, shall be reduced annually at the end of each calendar year following the year in which the policy is issued, ~~at the~~

~~annual rate of one twentieth of the aggregate of such amounts.~~ over a period of 20 years, pursuant to the following: twenty percent (20%) the first year; ten percent (10%) for years two and three; five percent (5%) for years four through ten; three percent (3%) for years 11 through 15; and two percent (2%) for years 16 through 20.

(d) The entire amount of the unearned premium reserve held as of ~~January 1, 1974,~~ January 1, 1999, shall be added to the reserve as of ~~that date~~ December 31, 1998 and shall be released from said reserve and restored to net profits ~~at the annual rate of one twentieth of the said entire amount, beginning in the next ensuing calendar year.~~ in accordance with the percentages set forth in subsection (c) of this section.

(e) ~~If substantially the entire outstanding liability under all policies, contracts of title insurance or reinsurance agreements of any such title insurance company shall be reinsured, the value of the consideration received by a reinsuring title insurance company authorized to transact the business of title insurance in this State, shall constitute, in its entirety, unearned portions of original premiums and be added to its unearned premium reserve and deemed, for recovery purposes, to have been provided for liabilities assumed during the year of such reinsurance. The amount of such addition to the unearned premium reserve of such assuming title insurance company shall be not less, however, than two thirds of the amount of the unearned premium reserve required to be maintained by the ceding title insurance company at the time of such reinsurance.~~ A supplemental reserve shall be established in accordance with the instructions of the annual statement required by G.S. 58-2-165 and G.S. 58-26-10 consisting of the reserves necessary, when taken in combination with the reserves required by subsections (a) through (d) of this section to cover the company's liabilities with respect to all losses, claims, and loss adjustment expenses.

(f) Each title insurer subject to the provisions of this Article shall file with its annual statement required by G.S. 58-2-165 and G.S. 58-26-10 a certification of a member in good standing of the American Academy of Actuaries. The actuarial certification required of a title insurer must conform to the annual statement instructions for title insurers of the National Association of Insurance Commissioners."

Section 2. This act becomes effective October 1, 1999.

Reported Out 4-26-99

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 678 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT.

☐ 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, unfavorable as to original bill.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 678
Committee Substitute Favorable 4/26/99

Short Title: Acupuncturist Reimbursement. (Public)

Sponsors:

Referred to:

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. (Effective July 1, 1999) Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, ~~or~~ advanced practice registered ~~nurse.~~ nurse, or acupuncturist.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly

certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 or a duly licensed acupuncturist acting within the scope of the acupuncturist's practice as defined in Article 30 of Chapter 90 of the General Statutes unless a comparable limitation is imposed on such medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) Expired.

(c2) For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;
(2) The policy currently provides benefits for identical services performed by other licensed health care providers;
(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;
(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service."

Section 2. G.S. 58-65-1 reads as rewritten:

"**§ 58-65-1. (Effective July 1, 1999) Regulation and definitions; application of other laws; profit and foreign corporations prohibited.**

(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care,

laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter, or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article

and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State."

Section 3. Article 30 of Chapter 90 of the General Statutes is amended by adding the following new section:

"**§ 90-460. Free choice by patient guaranteed.**

No agency of the State, county, or municipality, nor any commission or clinic, nor any board administering relief, social security, health insurance, or health service under the laws of the State of North Carolina shall deny to the recipients or beneficiaries of their aid or services the freedom to choose a duly licensed acupuncturist as the provider of care or services which are within the scope of practice of the profession of acupuncture as defined in this Article."

Section 4. G.S. 90-459 is repealed.

Section 5. G.S. 135-40.6(8) is amended by adding a new sub-subdivision to read:

"u. Acupuncture: Allowable charges for the treatment of pain and the production of regional anesthesia when performed by a medical doctor or an acupuncturist licensed or certified in the state in which he or she practices."

Section 6. This act becomes effective January 1, 2000. Sections 1, 2, and 3 apply to plans issued, amended, or renewed on or after that date. Section 5 applies to treatment and services provided on or after January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 678
Proposed Committee Substitute H678-PCS3375-RN

Short Title: Acupuncturist Reimbursement. (Public)

Sponsors:

Referred to:

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. (Effective July 1, 1999) Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, or advanced practice registered ~~nurse:~~ nurse, or acupuncturist.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly

certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 or a duly licensed acupuncturist acting within the scope of the acupuncturist's practice as defined in Article 30 of Chapter 90 of the General Statutes unless a comparable limitation is imposed on such medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) Expired.

(c2) For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;
(2) The policy currently provides benefits for identical services performed by other licensed health care providers;
(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;
(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service."

Section 2. G.S. 58-65-1 reads as rewritten:

"§ 58-65-1. (Effective July 1, 1999) Regulation and definitions; application of other laws; profit and foreign corporations prohibited.

(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care,

laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter, or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article

and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State."

Section 3. Article 30 of Chapter 90 of the General Statutes is amended by adding the following new section:

"**§ 90-460. Free choice by patient guaranteed.**

No agency of the State, county, or municipality, nor any commission or clinic, nor any board administering relief, social security, health insurance, or health service under the laws of the State of North Carolina shall deny to the recipients or beneficiaries of their aid or services the freedom to choose a duly licensed acupuncturist as the provider of care or services which are within the scope of practice of the profession of acupuncture as defined in this Article."

Section 4. G.S. 90-459 is repealed.

Section 5. G.S. 135-40.6(8) is amended by adding a new sub-subdivision to read:

"u. Acupuncture: Allowable charges for the treatment of pain and the production of regional anesthesia when performed by a medical doctor or an acupuncturist licensed or certified in the state in which he or she practices."

Section 6. This act becomes effective January 1, 2000. Sections 1, 2, and 3 apply to plans issued, amended, or renewed on or after that date. Section 5 applies to treatment and services provided on or after January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 678

Short Title: Acupuncturist Reimbursement. (Public)

Sponsors: Representatives Sherrill, Luebke (Primary Sponsors); Braswell, Clary, Earle, Michaux, Morris, and Nesbitt.

Referred to: Insurance.

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR EQUAL TREATMENT FOR ACUPUNCTURISTS WITH RESPECT TO INSURANCE REIMBURSEMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. (Effective July 1, 1999) Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, ~~or~~ advanced practice registered ~~nurse.~~ nurse, or acupuncturist.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly

certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, ~~or~~ an advanced practice registered nurse, or a duly licensed acupuncturist, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 or a duly licensed acupuncturist acting within the scope of the acupuncturist's practice as defined in Article 30 of Chapter 90 of the General Statutes unless a comparable limitation is imposed on such medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) Expired.

(c2) For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;
(2) The policy currently provides benefits for identical services performed by other licensed health care providers;
(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;
(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service."

Section 2. G.S. 58-65-1 reads as rewritten:

"**§ 58-65-1. (Effective July 1, 1999) Regulation and definitions; application of other laws; profit and foreign corporations prohibited.**

(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care,

laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly licensed acupuncturist, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(b1) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(c) For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a "duly certified clinical social worker" is a "certified clinical social worker" as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For the purposes of this section, a "duly licensed psychologist" shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

For purposes of this section, a "duly licensed acupuncturist" means an acupuncturist licensed by the Acupuncture Licensing Board pursuant to Article 30 of Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every "medical service plan" and of every "dental service plan," as those terms are used in this Article and Article 66 of this Chapter, or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article

and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State."

Section 3. Article 30 of Chapter 90 of the General Statutes is amended by adding the following new section:

"**§ 90-460. Free choice by patient guaranteed.**

No agency of the State, county, or municipality, nor any commission or clinic, nor any board administering relief, social security, health insurance, or health service under the laws of the State of North Carolina shall deny to the recipients or beneficiaries of their aid or services the freedom to choose a duly licensed acupuncturist as the provider of care or services which are within the scope of practice of the profession of acupuncture as defined in this Article."

Section 4. G.S. 90-459 is repealed.

Section 5. G.S. 135-40.6(8) is amended by adding a new sub-subdivision to read:

"u. Acupuncture: Allowable charges for the practice of acupuncture when performed by a doctor of medicine or an acupuncturist licensed pursuant to Article 30 of Chapter 90 of the General Statutes."

Section 6. This act becomes effective January 1, 2000. Sections 1, 2, and 3 apply to plans issued, amended, or renewed on or after that date. Section 5 applies to treatment and services provided on or after January 1, 2000.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 678

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

H678-ARN-001

Page 1 of __

Date_____,1999

Comm. Sub. [YES]
Amends Title []
1st Edition

Rep. _____

moves to amend the bill on page 6, lines 33-36, by rewriting those lines to read:

"u. Acupuncture: Allowable charges for the treatment of pain and the production of regional anesthesia when performed by a medical doctor or an acupuncturist licensed or certified in the state in which he or she practices."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HB 678:
Acupuncturist Reimbursement

BILL ANALYSIS

Committee: House Insurance
Date: April 15, 1999
Version: 1st

Introduced by: Rep. Sherill
Summary by: Linwood Jones
Committee Counsel

Sections 1 and 2 of House Bill 678 add acupuncturists to the list of providers under the anti-discrimination laws. The anti-discrimination laws prohibit insurance companies and service corporations from refusing to reimburse the listed providers when they perform a service for which a physician would be reimbursed under the insurance plan. These changes would not require health insurance plans to cover acupuncture. However, if a health insurance plan does cover an acupuncture service performed by a physician, the plan would also be required to cover the same acupuncture service when performed by a licensed acupuncturist. Section 1 applies to commercial insurance companies, and Section 2 applies to service corporations (Blue Cross). By virtue of G.S. 58-50-56, these changes would also apply to preferred provider plans offered by insurance companies or service corporations. In addition, if an insurance plan does cover acupuncture services, any restrictions it places on that treatment must be the same for physicians as it is for acupuncturists.

Section 3 of the bill provides that governmental health plans cannot deny to their beneficiaries the right to choose an acupuncturist as the provider of care or services within the scope of practice of acupuncture.

Section 4 of the bill repeals a provision in the acupuncture licensing law that says that nothing in the acupuncture licensing law requires third-party reimbursement of acupuncturists.

Section 5 requires the Teachers and State Employees Health Plan to cover acupuncture when performed by a physician or an acupuncturist licensed by the North Carolina Acupuncture Licensing Board.

Section 6 makes this act effective January 1, 2000, and applicable to policies issued, renewed, or amended on or after that date or to treatment or services provided under the State Health Plan on or after that date.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 26, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 26, 1999, at 3:00 P.M. Representative Hurley called the meeting to order. The following Committee members were present: Representatives Barbee, Boyd-McIntyre, Brubaker, Cole, Howard, Miller, Saunders, Smith, and C. Wilson. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 1119, entitled, AN ACT TO ENSURE THAT HEALTH BENEFIT PLANS IN NORTH CAROLINA PROVIDE COVERAGE FOR ANESTHESIA AND HOSPITAL CHARGES IN CERTAIN CASES INVOLVING YOUNG CHILDREN, PERSONS WITH SERIOUS MENTAL OR PHYSICAL CONDITIONS, AND PERSONS WITH SIGNIFICANT BEHAVIORAL PROBLEMS, WHERE THE AGE OR CONDITION OR PROBLEM REQUIRES HOSPITALIZATION OR GENERAL ANESTHESIA IN ORDER TO SAFELY AND EFFECTIVELY PERFORM DENTAL PROCEDURES ON THE PATIENT INVOLVED. Representative C. Wilson was recognized to explain the bill for Representative Wright and present a technical amendment. Upon a motion by Representative C. Wilson the amendment was adopted. Mr. William Potter, who represents the North Carolina Dental Society, indicated Blue Cross does not oppose the bill with the amendment included. The amendment was agreed to with the managed care industry. Representative Smith made a motion to roll the amendment into a committee substitute with a favorable report to the committee substitute, unfavorable to the original bill. Motion passed.

HB 1206, entitled, AN ACT PERTAINING TO HEALTH INSURANCE PLAN PRECERTIFICATION REQUIREMENTS FOR MENTAL HEALTH BENEFITS. Representative Insko was recognized to explain the bill. Representative Smith moved to amend HB 1206 to send it to a study commission. The amendment was adopted. Representative Smith made a motion to roll the amendment into a committee substitute with a favorable report to the committee substitute, unfavorable to the original bill, and a recommendation that the committee substitute bill be re-referred to the Committee on RULES, CALENDAR & OPERATIONS OF THE HOUSE. Motion passed.

HB 1126, entitled, AN ACT TO PROHIBIT NONCOMPETITION CLAUSES IN MEDICAL PROVIDER CONTRACTS. Representative Hackney was recognized to present the bill and a proposed committee substitute. Representative Brubaker moved to adopt the committee substitute. Motion passed. Representative Saunders moved to amend HB 1126 from when it becomes law to become effective October 1. The amendment was adopted. The Chair moved to roll the amendment into a committee substitute with a favorable report to the committee substitute, unfavorable to the original bill. Motion passed.

HB 314, entitled, AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICES PLANS, AND HMO PLANS TO PROVIDE COVERAGE FOR BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS.
Representative Boyd-McIntyre was recognized to present the bill and a proposed committee substitute. Representative Brubaker moved to adopt the committee substitute. Motion passed. The bill was tabled until the April 27th INSURANCE Committee meeting.

There being no further business, the Chair adjourned the meeting at 4:03 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
House Bills 314, 1126, 1119, 1206
Amendment
Proposed Committee Substitutes
Bill Summaries

VISITOR REGISTRATION SHEET

Insurance — 4-26-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valauri	National
Dr. Ronald Venezie	NC Academy of Pediatric Dentistry
Dr. Martha Ann Ical	Duke Children's Hospital
Michael W. Roberts, DDS	UNC School of Dentistry, Dept of Pediatric Dentistry
Glenn Wells	DHHS/Public Health
Marcy Ellis	NCMS
Crissy Porter	Bone & Associates
Mark Nitcavage	NC Assoc. of Non-Profit Homes for Aging
Mark Arnold	Progressive
Michael Harrold	NAII
Donna Leaman	USAA
Perri Morgan	NFIB
Nancy Thompson	NCAHD
Linda Suggs	NCASA
Sally Cameron	NC Psychological Assoc
Dan Hunt	Smith
Jeff Keegan	Mercer & Van Allen
Bob Price	Jordan Price Wall
Robert Bashaw	Young, Moore & Henderson
Glenn Jernigan	N.C. Professional Counselors Assn
Sheila McInnes	NC DOT
Bill Hale	NC DOI
Karen Carpenter	PCS
Doug Dunn	Hatch
Andy Ellen	NCRMA
Fran Preston	NCRMA
Susan Schmidt	NC Justice Center
Amy Fullbright	Hunton & Williams

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 1119 A BILL TO BE ENTITLED AN ACT TO ENSURE THAT HEALTH BENEFIT PLANS IN NORTH CAROLINA PROVIDE COVERAGE FOR ANESTHESIA AND HOSPITAL CHARGES IN CERTAIN CASES INVOLVING YOUNG CHILDREN, PERSONS WITH SERIOUS MENTAL OR PHYSICAL CONDITIONS, AND PERSONS WITH SIGNIFICANT BEHAVIORAL PROBLEMS, WHERE THE AGE OR CONDITION OR PROBLEM REQUIRES HOSPITALIZATION OR GENERAL ANESTHESIA IN ORDER TO SAFELY AND EFFECTIVELY PERFORM DENTAL PROCEDURES ON THE PATIENT INVOLVED.

☐ 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, unfavorable as to original bill.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1119
Committee Substitute Favorable 4/27/99

Short Title: Children/Disable Anesth. Dental Care. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT HEALTH BENEFIT PLANS IN NORTH CAROLINA PROVIDE COVERAGE FOR ANESTHESIA AND HOSPITAL CHARGES IN CERTAIN CASES INVOLVING YOUNG CHILDREN, PERSONS WITH SERIOUS MENTAL OR PHYSICAL CONDITIONS, AND PERSONS WITH SIGNIFICANT BEHAVIORAL PROBLEMS, WHERE THE AGE OR CONDITION OR PROBLEM REQUIRES HOSPITALIZATION OR GENERAL ANESTHESIA IN ORDER TO SAFELY AND EFFECTIVELY PERFORM DENTAL PROCEDURES ON THE PATIENT INVOLVED.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-122. Anesthesia and hospital charges necessary for safe and effective administration of dental procedures for young children, persons with serious mental or physical conditions, and persons with significant behavioral problems; coverage in health benefit plans.**

(a) All health benefit plans shall provide coverage for payment of anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The

same deductibles, coinsurance, network requirements, medical necessity provisions, and other limitations as apply to physical illness benefits under the health benefit plan shall apply to coverage for anesthesia and hospital or facility charges required to be covered under this section.

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

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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.

(2) 'Insurer' includes 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."

Section 2. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

HOUSE BILL 1119

Short Title: Children/Disable Anesth. Dental Care. (Public)

Sponsors: Representatives Wright, Edwards, Baddour, Cansler (Primary Sponsors), Horn; Bowie, Hardaway, Luebke, McMahan, Miner, Sherrill, and Smith.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT HEALTH BENEFIT PLANS IN NORTH CAROLINA PROVIDE COVERAGE FOR ANESTHESIA AND HOSPITAL CHARGES IN CERTAIN CASES INVOLVING YOUNG CHILDREN, PERSONS WITH SERIOUS MENTAL OR PHYSICAL CONDITIONS, AND PERSONS WITH SIGNIFICANT BEHAVIORAL PROBLEMS, WHERE THE AGE OR CONDITION OR PROBLEM REQUIRES HOSPITALIZATION OR GENERAL ANESTHESIA IN ORDER TO SAFELY AND EFFECTIVELY PERFORM DENTAL PROCEDURES ON THE PATIENT INVOLVED.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-167.5. Anesthesia and hospital charges necessary for safe and effective administration of dental procedures for young children, persons with serious mental or physical conditions, and persons with significant behavioral problems; coverage in health benefit plans.**

(a) All health benefit plans shall provide coverage for payment of anesthesia and hospital charges for services in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the

procedures. The same deductibles, coinsurance, and other limitations as apply to physical illness benefits under the health benefit plan shall apply to coverage for anesthesia and hospital charges required to be covered under this section.

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

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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.

(2) 'Insurer' includes 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."

Section 2. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 1119 DATE 4/26/99

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
)
Sen.)

moves to amend the bill on page 1, line 18, after "hospital",
( ) WHICH CHANGES THE TITLE
by ~~inserting the following:~~

"or facility";

TO FURTHER AMEND, ON PAGE 1, LINE 18, After "for services",
by inserting the following:

"performed in a hospital or
ambulatory surgical facility";

TO FURTHER AMEND, ON PAGE 2, LINE 1, After "coinsurance",
by inserting the following:

"network requirements, medical
necessity provisions,";

~~TO FURTHER AMEND, ON PAGE 2, LINE 3, After "hospital",~~
by inserting: "or facility". SIGNED Connie Wilson

and on page 1, line 13 by deleting "169.5" and inserting "122."

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

HB 1119:
Children/Disabled Anesthesia Dental Care

BILL ANALYSIS

Committee: House Insurance
Date: April 26, 1999
Version: 1st

Introduced by: Rep. Wright
Summary by: Linwood Jones
Committee Counsel

House Bill 1119 requires health plans to cover hospital care and general anesthesia for certain persons who need to be hospitalized in order to safely and effectively undergo a needed dental procedure. The plan must provide coverage if the patient is less than 9 years old or has a serious mental or physical condition or behavioral problem that necessitates hospitalization or the use of general anesthesia. The coverage is subject to the same deductibles, coinsurance requirements, and other limitations that apply to physical benefits coverage under the plan.

This requirement applies to health plans offered by insurers, HMOs, multiple employer welfare arrangements, and service corporations, but does not apply to self-funded plans that are exempt under ERISA, the State Health Plan, or specialized health plans such as accident-only, specified disease, Med-Supp policies, and similar types of limited health plans.

The act would take effect January 1, 2000, and would apply to plans issued or renewed on or after that date.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 1206 A BILL TO BE ENTITLED AN ACT PERTAINING TO HEALTH INSURANCE PLAN PRECERTIFICATION REQUIREMENTS FOR MENTAL HEALTH BENEFITS.

☐ 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, and recommendation that the committee substitute bill be re-referred to the Committee on RULES, CALENDAR & OPERATIONS OF THE HOUSE.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1206
Committee Substitute Favorable 4/27/99

Short Title: Mental Health Precert. Study. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A STUDY ON MENTAL HEALTH PRECERTIFICATION REQUIREMENTS.

The General Assembly of North Carolina enacts:

Section 1. The Legislative Research Commission may study the issue of mental health insurance precertification, including whether a certain number of visits per year without precertification should be required.

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

HOUSE BILL 1206

Short Title: Health Ins./Mental Hlth Precert. (Public)

Sponsors: Representative Insko.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT PERTAINING TO HEALTH INSURANCE PLAN PRECERTIFICATION REQUIREMENTS FOR MENTAL HEALTH BENEFITS.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-225. Mental health benefits precertification.**

(a) Every insurer providing a health benefit plan that provides coverage for physical illness and injury and mental illness that is subject to case management for medical necessity and medical appropriateness shall provide coverage without precertification for not fewer than 26 outpatient mental health visits per plan year.

(b) As used in this section, the terms 'health benefit plan' and 'insurer' have the same meaning as applies under G.S. 58-50-61."

Section 2. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit plan 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.

H1206:
Health Ins./Mental Hlth Precert

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Insko
Date:	April 23, 1999	**Summary by:**	Ed Rossi
Version:	1st Ed.		Committee Co-Counsel

SUMMARY: House bill 1206 requires insurers who use a case management approach for medical necessity and appropriateness and provide coverage for physical illness and injury and mental illness to provide coverage for "no fewer than 26 outpatient mental health visits" without precertification.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 1126 A BILL TO BE ENTITLED AN ACT TO PROHIBIT NONCOMPETITION CLAUSES IN MEDICAL PROVIDER CONTRACTS.

☐ 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, unfavorable as to original bill.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1126
Committee Substitute Favorable 4/27/99

Short Title: Phys. Contracts/Noncompete Prohibited. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT NONCOMPETITION CLAUSES IN MEDICAL PROVIDER CONTRACTS.

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:

"**§ 58-3-250. Restrictive covenants and agreements not to compete are not enforceable.**

Any covenant or agreement not to compete within an agreement that creates or establishes the terms of a partnership, employment, or any other form of professional relationship with a physician licensed to practice medicine in this State, which includes any restriction of the right of the physician to practice medicine in any geographical area for any period of time after the termination of the partnership, employment, or other professional relationship, is unenforceable with respect to the restriction. All other provisions of the agreement are enforceable at law, including provisions that require the payment of damages in an amount that is reasonably related to the injury suffered by reason of termination of the principal agreement. Provisions that require the payment of damages upon termination of the principal agreement may include damages related to competition."

Section 2. This act becomes effective October 1, 1999, and applies to covenants or agreements executed on and after that date. For purposes of this act, renewal of an existing covenant or agreement shall not be deemed to be the execution of a new covenant or agreement.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1126
Proposed Committee Substitute H1126-PCS6193-RN

Short Title: Phys. Contracts/Noncompete Prohibited. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT NONCOMPETITION CLAUSES IN MEDICAL PROVIDER CONTRACTS.

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:

"**§ 58-3-250. Restrictive covenants and agreements not to compete are not enforceable.**

Any covenant or agreement not to compete within an agreement that creates or establishes the terms of a partnership, employment, or any other form of professional relationship with a physician licensed to practice medicine in this State, which includes any restriction of the right of the physician to practice medicine in any geographical area for any period of time after the termination of the partnership, employment, or other professional relationship, is unenforceable with respect to the restriction. All other provisions of the agreement are enforceable at law, including provisions that require the payment of damages in an amount that is reasonably related to the injury suffered by reason of termination of the principal agreement. Provisions that require the payment of damages upon termination of the principal agreement may include damages related to competition."

Section 2. This act becomes effective October 1, 1999, and applies to covenants or agreements executed on and after that date. For purposes of this act, renewal of an existing covenant or agreement shall not be deemed to be the execution of a new covenant or agreement.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1126

Short Title: Phys. Contracts/Noncompete Prohibited. (Public)

Sponsors: Representative Hackney.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT NONCOMPETITION CLAUSES IN MEDICAL PROVIDER CONTRACTS.

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:

"**§ 58-3-250. Restrictive covenants and agreements not to compete are not enforceable.**

Any covenant or agreement not to compete within an agreement that creates or establishes the terms of a partnership, employment, or any other form of professional relationship with a physician licensed to practice medicine in this State, which includes any restriction of the right of the physician to practice medicine in any geographical area for any period of time after the termination of the partnership, employment, or other professional relationship, is void ab initio and unenforceable with respect to the restriction. All other provisions of the agreement are enforceable at law, including provisions that require the payment of damages in an amount that is reasonably related to the injury suffered by reason of termination of the principal agreement. Provisions that require the payment of damages upon termination of the principal agreement may include damages related to competition."

Section 2. This act is effective when it becomes law and applies to covenants or agreements executed or renewed on and after that date.

HB 1126:
Physician Contracts/Noncompete Prohibited

BILL ANALYSIS

Committee: House Insurance
Date: April 24, 1999
Version: 1st

Introduced by: Rep. Hackney
Summary by: Linwood Jones
Committee Counsel

House Bill 1126 provides that covenants not to compete by physicians, in which the physician agrees in the partnership agreement, employment agreement or similar agreement not to compete in a particular geographical area for a specified duration after leaving the partnership, employment, or other professional relationship, are not enforceable. The remaining provisions of the agreement, including any requirement for payment of damages reasonably related to the termination of the agreement and damages related to competition, are enforceable.

This act would take effect when it becomes law and would apply to covenants or agreements executed or renewed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 314
Proposed Committee Substitute H314-PCS1230-LN

Short Title: Insurance Covg./Bone Mass Msmt. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICES PLANS, AND HMO PLANS TO PROVIDE COVERAGE FOR BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS.

Whereas, osteoporosis or low bone mass is a public health hazard to over one million North Carolinians age 50 and over; and

Whereas, each year more than 13,000 North Carolinians are hospitalized for hip fractures alone resulting in more than $57 million in direct medical costs; and

Whereas, osteoporosis or low bone mass is a silent disease, typically undiagnosed until a fracture occurs, and once a fracture occurs, osteoporosis or low bone mass is already substantially advanced and has a high risk of additional fractures; and

Whereas, one of two women over age 50 and one of eight men over age 50 will suffer at least one osteoporotic fracture during late life; and

Whereas, osteoporosis or low bone mass has no cure, pharmaceutical or otherwise, but prevention, early diagnosis, and treatment can be key to reducing the prevalence of this disease as well as its negative impact on individuals; and

Whereas, osteoporosis or low bone mass not only increases the likelihood of fracture and nursing home placement but also increases the risk of depression, loss of self-esteem, anxiety, chronic pain, poor social relationships, and loss of employment; and

Whereas, it is cost-effective to mandate coverage of bone mass measurement because it leads to early diagnosis, intervention, and prevention of fracture and, therefore, reduces unnecessary health care expenditures; and

Whereas, bone mass measurement reliably detects low bone mass and helps to ascertain the extent of bone loss to determine an individual's future fracture risk which helps individuals and health care professionals to select appropriate therapies and interventions; and

Whereas, conventional X rays cannot accurately diagnose osteoporosis or low bone mass in the absence of fracture; and

Whereas, scientifically proven technologies for bone mass measurement and other services related to the diagnosis and treatment of osteoporosis or low bone mass can be used effectively to reduce the physical, emotional, social, and financial burden that this disease inflicts upon its victims; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass.**

(a) Every entity providing a health benefit plan shall provide coverage for a qualified individual for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for bone mass measurement.

(b) A health benefit plan may provide that bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that a plan must provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is medically necessary. Conditions under which more frequent bone mass measurement coverage may be medically necessary include, but are not limited to:

(1) Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months.

(2) Allowing for a central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

(c) Nothing in this section shall be construed to require health benefit plans to cover screening for nonqualified individuals.

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

(1) 'Bone mass measurement' means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

(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 by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Short-term limited duration coverage
i. Coverage issued as a supplement to liability insurance
j. Workers' compensation
k. Medical payments under automobile or homeowners
l. Hospital income or indemnity
m. 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' includes 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.

(4) 'Qualified individual' means any one or more of the following:

a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
b. An individual with radiographic osteopenia anywhere in the skeleton.
c. An individual who is receiving long-term glucocorticoid (steroid) therapy.
d. An individual with primary hyperparathyroidism.

e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.

f. An individual who has a history of low-trauma fractures.

g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass."

Section 2. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(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 3. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 314

Short Title: Insurance Covg./Bone Mass Msmt. (Public)

Sponsors: Representatives Boyd-McIntyre; Mosley, Wainwright, and Jeffus.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICES PLANS, AND HMO PLANS TO PROVIDE COVERAGE FOR BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS.

Whereas, osteoporosis or low bone mass is a public health hazard to over one million North Carolinians age 50 and over; and

Whereas, each year more than 13,000 North Carolinians are hospitalized for hip fractures alone resulting in more than $57 million in direct medical costs; and

Whereas, osteoporosis or low bone mass is a silent disease, typically undiagnosed until a fracture occurs and, once a fracture occurs, osteoporosis or low bone mass is already substantially advanced and has a high risk of additional fractures; and

Whereas, one of two women over age 50 and one of eight men over age 50 will suffer at least one osteoporotic fracture during late life; and

Whereas, osteoporosis or low bone mass has no cure, pharmaceutical or otherwise, but prevention, early diagnosis, and treatment can be key to reducing the prevalence of this disease as well as its negative impact on individuals; and

Whereas, osteoporosis or low bone mass not only increases the likelihood of fracture and nursing home placement but also increases the risk of depression, loss of self-esteem, anxiety, chronic pain, poor social relationships, and loss of employment; and

Whereas, it is cost-effective to mandate coverage of bone mass measurement because it leads to early diagnosis, intervention, and prevention of fracture and, therefore, reduces unnecessary health care expenditures; and

Whereas, bone mass measurement reliably detects low bone mass and helps to ascertain the extent of bone loss to determine an individual's future fracture risk which helps individuals and health care professionals to select appropriate therapies and interventions; and

Whereas, conventional X rays cannot accurately diagnose osteoporosis or low bone mass in the absence of fracture; and

Whereas, scientifically proven technologies for bone mass measurement and other services related to the diagnosis and treatment of osteoporosis or low bone mass can be used effectively to reduce the physical, emotional, social, and financial burden that this disease inflicts upon its victims; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass.**

(a) Every entity providing a health benefit plan shall provide coverage for a qualified individual for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for bone mass measurement.

(b) A health benefit plan may provide that bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that a plan must provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is medically necessary. Conditions under which more frequent bone mass measurement coverage may be medically necessary include, but are not limited to:

(1) Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months.

(2) Allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of beneficiaries in the future if the initial test was performed with a technique that is different from the proposed monitoring method.

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

(1) 'Bone mass measurement' means a radiological, sonographic procedure or other scientifically proven technology performed on an individual in order to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

(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 by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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.

(3) 'Insurer' includes 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.

(4) 'Qualified individual' means any one or more of the following:

a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
b. An individual with radiographic osteopenia anywhere in the skeleton.
c. An individual who is receiving long-term glucocorticoid (steroid) therapy.
d. An individual with primary hyperparathyroidism.
e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.
f. An individual who has a history of low trauma fractures.
g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

(d) Insurers subject to this section shall identify and use the most current scientifically accurate educational materials to increase awareness and knowledge by their insureds of osteoporosis or low bone mass and methods of diagnosing osteoporosis or low bone mass, including bone mass measurement, and to encourage the treatment and prevention of osteoporosis."

Section 2. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(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 3. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit plan 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.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 27, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 27, 1999, at 2:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Bobbi J. Oxendine (Robeson County) and Adrianne Krauss (Wake County). The following Committee members were present: Representatives Barbee, Boyd-McIntyre, Brubaker, Cole, Dedmon, Dockham, Esposito, Grady, Holmes, Saunders, Smith, Warner, C. Wilson, and Wright. Linwood Jones and Ed Rossi, Staff Counselors, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 314, entitled, AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICES PLANS, AND HMO PLANS TO PROVIDE COVERAGE FOR BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS. Representative Boyd-McIntyre was recognized to present the bill and a proposed committee substitute. Representative Barbee presented an amendment to rewrite HB314 to become a study bill. The motion did not pass with a vote of three in favor, six opposed. Representative Dedmon moved for a favorable report to the committee substitute, unfavorable to the original bill. The motion passed.

HB 922, entitled, AN ACT TO REGULATE THE USE OF AFTERMARKET PARTS IN THE REPAIR OF MOTOR VEHICLES. Representative Hunter was recognized to explain the bill. No action was taken on this bill.

Representative Dedmon moved to adjourn the meeting. Motion passed. The Chair adjourned the meeting at 2:58 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Sheets
HB 314 and HB 922
Proposed Committee Substitute & Amendment
Bill Summaries

VISITOR REGISTRATION SHEET

Insurance — 4-27-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valauri	Nationwide
Eileen Sothill	Northstar - Carolina Bonper
Teresa J. Mason	Robert's Wholesale Body Parts, Inc.
JACK Gillis	Certified Automotive Parts Association
Glenn Wells	DHHS / Public Health
Bill Trott	Young Moore + Henderson, PA
Mark Arnell	Progressive
Donna Leaman	USAA
Bill Janvier	Northstar Plating / Caro Bumper
Mecar D	Carolina Automotive Group
Michael Harrold	NAII
Chante Cromer	NCATL
David Feffell	H, Mc CCTC P.A.
	NCSSA
	Auto. Parts Assn.
	NC Medical Society
David Simmons	ZDA PA
Larry Heckner	Household Financial Group
Crissy Porter	Bone and Associates
Ron Aycock	County Com Assn
Nancy Thompson	NCCBD
Hannah	NCATL
Tommy Harrelson	Enterprise Rent a Car
Lee Dail	DHHS
Tommy Worth	Carolinas Healthcare System
Tama Reed	State Farm Ins.
Mark Taylor	State Farm Ins.
Mari Sutton	NCSA

VISITOR REGISTRATION SHEET

4-27-99

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Starla McHenry	NC DOI
Bill Hale	NC DOI
Dascrill Pipes	NC DOI

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 314 A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICES PLANS, AND HMO PLANS TO PROVIDE COVERAGE FOR BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS.

☐ 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, unfavorable as to original bill.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 314
Committee Substitute Favorable 4/27/99

Short Title: Insurance Covg./Bone Mass Msmt. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICES PLANS, AND HMO PLANS TO PROVIDE COVERAGE FOR BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS.

Whereas, osteoporosis or low bone mass is a public health hazard to over one million North Carolinians age 50 and over; and

Whereas, each year more than 13,000 North Carolinians are hospitalized for hip fractures alone resulting in more than $57 million in direct medical costs; and

Whereas, osteoporosis or low bone mass is a silent disease, typically undiagnosed until a fracture occurs, and once a fracture occurs, osteoporosis or low bone mass is already substantially advanced and has a high risk of additional fractures; and

Whereas, one of two women over age 50 and one of eight men over age 50 will suffer at least one osteoporotic fracture during late life; and

Whereas, osteoporosis or low bone mass has no cure, pharmaceutical or otherwise, but prevention, early diagnosis, and treatment can be key to reducing the prevalence of this disease as well as its negative impact on individuals; and

Whereas, osteoporosis or low bone mass not only increases the likelihood of fracture and nursing home placement but also increases the risk of depression, loss of self-esteem, anxiety, chronic pain, poor social relationships, and loss of employment; and

Whereas, it is cost-effective to mandate coverage of bone mass measurement because it leads to early diagnosis, intervention, and prevention of fracture and, therefore, reduces unnecessary health care expenditures; and

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e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Short-term limited duration coverage
i. Coverage issued as a supplement to liability insurance
j. Workers' compensation
k. Medical payments under automobile or homeowners
l. Hospital income or indemnity
m. 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' includes 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.

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d. An individual with primary hyperparathyroidism.

e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.

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(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(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 3. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 314
Proposed Committee Substitute H314-PCS1230-LN

Short Title: Insurance Covg./Bone Mass Msmt. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICES PLANS, AND HMO PLANS TO PROVIDE COVERAGE FOR BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS.

Whereas, osteoporosis or low bone mass is a public health hazard to over one million North Carolinians age 50 and over; and

Whereas, each year more than 13,000 North Carolinians are hospitalized for hip fractures alone resulting in more than $57 million in direct medical costs; and

Whereas, osteoporosis or low bone mass is a silent disease, typically undiagnosed until a fracture occurs, and once a fracture occurs, osteoporosis or low bone mass is already substantially advanced and has a high risk of additional fractures; and

Whereas, one of two women over age 50 and one of eight men over age 50 will suffer at least one osteoporotic fracture during late life; and

Whereas, osteoporosis or low bone mass has no cure, pharmaceutical or otherwise, but prevention, early diagnosis, and treatment can be key to reducing the prevalence of this disease as well as its negative impact on individuals; and

Whereas, osteoporosis or low bone mass not only increases the likelihood of fracture and nursing home placement but also increases the risk of depression, loss of self-esteem, anxiety, chronic pain, poor social relationships, and loss of employment; and

Whereas, it is cost-effective to mandate coverage of bone mass measurement because it leads to early diagnosis, intervention, and prevention of fracture and, therefore, reduces unnecessary health care expenditures; and

Whereas, bone mass measurement reliably detects low bone mass and helps to ascertain the extent of bone loss to determine an individual's future fracture risk which helps individuals and health care professionals to select appropriate therapies and interventions; and

Whereas, conventional X rays cannot accurately diagnose osteoporosis or low bone mass in the absence of fracture; and

Whereas, scientifically proven technologies for bone mass measurement and other services related to the diagnosis and treatment of osteoporosis or low bone mass can be used effectively to reduce the physical, emotional, social, and financial burden that this disease inflicts upon its victims; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass.**

(a) Every entity providing a health benefit plan shall provide coverage for a qualified individual for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for bone mass measurement.

(b) A health benefit plan may provide that bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that a plan must provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is medically necessary. Conditions under which more frequent bone mass measurement coverage may be medically necessary include, but are not limited to:

(1) Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months.

(2) Allowing for a central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

(c) Nothing in this section shall be construed to require health benefit plans to cover screening for nonqualified individuals.

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

(1) 'Bone mass measurement' means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

(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 by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Short-term limited duration coverage
i. Coverage issued as a supplement to liability insurance
j. Workers' compensation
k. Medical payments under automobile or homeowners
l. Hospital income or indemnity
m. 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' includes 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.

(4) 'Qualified individual' means any one or more of the following:

a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
b. An individual with radiographic osteopenia anywhere in the skeleton.
c. An individual who is receiving long-term glucocorticoid (steroid) therapy.
d. An individual with primary hyperparathyroidism.

e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.

f. An individual who has a history of low-trauma fractures.

g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass."

Section 2. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(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 3. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

HOUSE BILL 314

Short Title: Insurance Covg./Bone Mass Msmt. (Public)

Sponsors: Representatives Boyd-McIntyre; Mosley, Wainwright, and Jeffus.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH AND ACCIDENT INSURANCE POLICIES, HOSPITAL OR MEDICAL SERVICES PLANS, AND HMO PLANS TO PROVIDE COVERAGE FOR BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS.

Whereas, osteoporosis or low bone mass is a public health hazard to over one million North Carolinians age 50 and over; and

Whereas, each year more than 13,000 North Carolinians are hospitalized for hip fractures alone resulting in more than $57 million in direct medical costs; and

Whereas, osteoporosis or low bone mass is a silent disease, typically undiagnosed until a fracture occurs and, once a fracture occurs, osteoporosis or low bone mass is already substantially advanced and has a high risk of additional fractures; and

Whereas, one of two women over age 50 and one of eight men over age 50 will suffer at least one osteoporotic fracture during late life; and

Whereas, osteoporosis or low bone mass has no cure, pharmaceutical or otherwise, but prevention, early diagnosis, and treatment can be key to reducing the prevalence of this disease as well as its negative impact on individuals; and

Whereas, osteoporosis or low bone mass not only increases the likelihood of fracture and nursing home placement but also increases the risk of depression, loss of self-esteem, anxiety, chronic pain, poor social relationships, and loss of employment; and

Whereas, it is cost-effective to mandate coverage of bone mass measurement because it leads to early diagnosis, intervention, and prevention of fracture and, therefore, reduces unnecessary health care expenditures; and

Whereas, bone mass measurement reliably detects low bone mass and helps to ascertain the extent of bone loss to determine an individual's future fracture risk which helps individuals and health care professionals to select appropriate therapies and interventions; and

Whereas, conventional X rays cannot accurately diagnose osteoporosis or low bone mass in the absence of fracture; and

Whereas, scientifically proven technologies for bone mass measurement and other services related to the diagnosis and treatment of osteoporosis or low bone mass can be used effectively to reduce the physical, emotional, social, and financial burden that this disease inflicts upon its victims; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass.**

(a) Every entity providing a health benefit plan shall provide coverage for a qualified individual for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for bone mass measurement.

(b) A health benefit plan may provide that bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that a plan must provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is medically necessary. Conditions under which more frequent bone mass measurement coverage may be medically necessary include, but are not limited to:

(1) Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months.

(2) Allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of beneficiaries in the future if the initial test was performed with a technique that is different from the proposed monitoring method.

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

(1) 'Bone mass measurement' means a radiological, sonographic procedure or other scientifically proven technology performed on an individual in order to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

(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 by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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.

(3) 'Insurer' includes 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.

(4) 'Qualified individual' means any one or more of the following:

a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
b. An individual with radiographic osteopenia anywhere in the skeleton.
c. An individual who is receiving long-term glucocorticoid (steroid) therapy.
d. An individual with primary hyperparathyroidism.
e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.
f. An individual who has a history of low trauma fractures.
g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

(d) Insurers subject to this section shall identify and use the most current scientifically accurate educational materials to increase awareness and knowledge by their insureds of osteoporosis or low bone mass and methods of diagnosing osteoporosis or low bone mass, including bone mass measurement, and to encourage the treatment and prevention of osteoporosis."

Section 2. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(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 3. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit plan 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.

H 314

Failed

Date _____, 1999

Comm. Sub. [X]
Amends Title [YES]
PCS Edition

Representative

moves to amend the bill on page 1, line 2 through page 4, line 39 by rewriting those lines to read:

"AN ACT TO PROVIDE FOR A STUDY OF INSURANCE COVERAGE FOR ~~OSTEOPOROSIS AND LOW~~ BONE MASS MEASUREMENT.

The General Assembly of North Carolina enacts:

Section 1. The Legislative Research Commission may study the issue of insurance coverage for bone mass measurement for osteoporosis or low bone mass.

Section 2. The Commission may reports its findings and recommendations to the 2000 Regular Session of the 1999-2000 General Assembly.

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

SIGNED Bobby H Barbee
Amendment Sponsor

SIGNED _____
Committee Chair if **Senate** Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HB 314:
Insurance Coverage/Bone Mass Measurement

BILL ANALYSIS

Committee: House Insurance
Date: April 20, 1999
Version: 1st

Introduced by: Rep. Boyd-McIntyre
Summary by: Linwood Jones
Committee Counsel

House Bill 314 would require health insurance plans to cover certain bone mass measurement procedures for the diagnosis and evaluation of osteoporosis or low bone mass. The same deductibles and other limitations applicable to similar services provided under the health benefit plan would also apply. The coverage is required when the following conditions are met:

- The bone mass measurement procedure is a radiological, sonographic procedure or other scientifically-proven and approved technology used to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.
- The individual undergoing the bone mass measurement is one of the following types of "qualified individuals:"
    - A person who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass
    - A person with radiographic osteopenia in the skeleton
    - A person receiving radiographic long-term glucocorticoid (steroid) therapy
    - A person with primary hyperparathyroidism
    - A person who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies
    - A person who has a history of low trauma fractures
    - A person with other conditions or on medical therapies known to cause osteoporosis or low bone mass
- The test has not been performed within the past 23 months, except that the health plan must cover medically-necessary follow-up tests more frequently than once every 23 months. Follow-up tests are considered medically necessary when (1) monitoring beneficiaries on long-term glucocorticoid therapy of more than 3 months, (2) conducting a confirmatory baseline test to allow monitoring in the future if the initial test was conducted with a different technique, or (3) when otherwise determined to be medically necessary.

'IN THE REPAIR OF YOUR COVERED AUTO UNDER THE PHYSICAL DAMAGE COVERAGE PROVISIONS OF THIS POLICY, WE MAY REQUIRE OR SPECIFY THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. THESE PARTS ARE REQUIRED TO BE AT LEAST EQUAL IN TERMS OF FIT, QUALITY, PERFORMANCE, AND WARRANTY TO THE ORIGINAL MANUFACTURER PARTS THEY REPLACE. UNDER THE LAWS OF THIS STATE, IN THE REPAIR OF A VEHICLE LESS THAN THREE YEARS OLD, YOU HAVE A CHOICE TO USE ORIGINAL MANUFACTURER PARTS OR NONORIGINAL MANUFACTURER PARTS.'

An insurer must disclose to a claimant in writing, either on the estimate or on a separate document attached to the estimate, the following information in no smaller print than ten point type:

'THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUAL IN TERMS OF FIT, QUALITY, PERFORMANCE, AND WARRANTY TO THE ORIGINAL MANUFACTURER PARTS THEY ARE REPLACING.'

All aftermarket parts installed on a motor vehicle shall be clearly identified on the estimate and invoice for the repair.

An automobile part not made by the original manufacturer shall have affixed or inscribed on the part the logo or name of the manufacturer and, when practicable, the logo or name of the manufacturer shall be visible.

(d) As used in this section:

(1) 'Aftermarket part' means a part made by a nonoriginal manufacturer.

(2) 'Claimant' means a first-party claimant or a third-party claimant.

(3) 'Insurer' includes any person authorized to represent the insurer with respect to a claim and who is acting within the scope of the person's authority.

(4) 'New motor vehicle' means a motor vehicle manufactured no longer than three years prior to the date the claim is made for repair of the motor vehicle.

(5) 'Nonoriginal manufacturer' means any manufacturer other than the original manufacturer of a part.

(6) 'Part' means a sheet metal or plastic part that generally is a component of the exterior of a motor vehicle, including an inner or outer panel.

(e) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and G.S. 58-33-45."

Section 2. This act becomes effective October 1, 1999, and applies to insurance policies made or renewed on or after that date.

H922:
Regualte Used Motor Vehicle Parts

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Hunter
Date:	April 19, 1999	**Summary by:**	Ed Rossi
Version:	1st. Ed.		Committee Co-Counsel

SUMMARY: House bill 922 provides the following:

- *An insurer cannot require that aftermarket parts be used to repair vehicles that are at least 3 years old, nor can it require additional payment for the use of original equipment parts on such vehicles.*
- *An insurer may require the use of aftermarket parts for vehicles that are more than 3 years old if the parts are at least equal to the original part in fit, quality, performance, and warranty.*
- *If an insurer requires the use of aftermarket parts on vehicles that are more than three years old it must (1) disclose its parts policy; (2) disclose whether a repair estimate is based on aftermarket parts.*

CURRENT LAW: There are two current provisions in the law that are relevant to this bill. One is the Department of Insurance' rule on disclosure requirements.[1] That rule would is found on page 2 lines 1 through 9 and 13 through 18 of the bill.

The other relevant provision of law can be found in G.S. § 58-3-180. It provides in pertinent part:

> *§ 58-3-180. Motor vehicle repairs; selection by claimant.*
>
> *(a) A policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage.*
>
> *(b) The amount determined by the insurer to be payable under a policy covering damage to a motor vehicle shall be paid regardless of the repair service or source selected by the claimant.* [Emphasis added]

The word "source" is not defined in the statute and has not been defined by a court. That notwithstanding, it is conceivable that the word could be interpreted to refer to a "source" of parts.

BILL ANALYSIS: House bill 922 codifies the Department rule and makes the following changes:

1. Owners of vehicles that are at least 3 years old can have a choice of using repair parts made by a vehicle's original manufacturer.
2. Whenever aftermarket parts are used to repair a vehicle, the manufacturer's name or logo must be affixed or inscribed on the part and when practicable that name or logo should also be visible.
3. Provides for penalties.

[1] 11-4.0427

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 13, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 13, 1999, at 12:00 P.M. (noon). Representative Hurley called the meeting to order and introduced the pages, Melissa Clements (Granville County) and Laura Douglas (Watauga County). The following Committee members were present: Representatives Barbee, Boyd-McIntyre, Cole, Dedmon, Dockham, Earle, Esposito, Grady, Hackney, Hardaway, Holmes, Howard, Miller, Saunders, Smith, Wainwright, Warner, C. Wilson, and Wright. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 165, entitled, AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, TO EXTEND THE BEACH PLAN RATE CAP ON WIND POLICIES ISSUED IN THE COASTAL AREA FOR TWO YEARS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS. Mr. Bill Hale, Department of Insurance, was recognized to explain the bill and Senate change. Representative Smith made a motion for a recommendation that the House concur with the Senate Committee Substitute. Motion passed.

SB 90, entitled, AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES. The Chair indicated discussion would pertain to insurance issues only on SB 90. Representative Insko and Senator Forrester were recognized to explain the bill and answer questions. Representative Miller moved for a favorable report. Representative Saunders presented an amendment (see attachment). The Chair moved for adoption of the amendment. Motion passed. Representative Miller amended his motion to roll the amendment into a House committee substitute with a favorable report to the House committee substitute (#2), unfavorable to the House committee substitute bill (#1). Representative C. Wilson asked for a roll call vote. Motion passed with ten voting in favor and eight opposed.

There being no further business, the Chair adjourned the meeting at 12:46 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

Attachments: Visitor Registration Form, HB 165, SB 90, Amendment, Summaries

VISITOR REGISTRATION SHEET

INSURANCE — 5-13-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barry Smith	Freedom Newspapers
[illegible]	NOW
DWIGHT EISENHOWER	MILITARY INDUSTRIAL COMPLEX
T Crosby	Real
Scott Jenkins	Dept of General
Faith Lawrence	DHHS
[illegible]	DHHS
[illegible]	BCBSNC
[illegible]	DHHS / Public Health
[illegible]	PEJ
[illegible]	NCMS
SARA NETZER	Student
Marlene Short	Planned Parenthood
Regina Chadwick	CSB
[illegible]	IHM
Betty Wickham	citizen
Nancy Lischwe	
Jack Brennan	legislative intern
SARAH ARNOTT	ACLU
Stephanie Mann	NCAR
Joann Shaw	NC Nurses Assoc
Buffy Helber	Interact
Margaret Perry	UNC Law
Robert Brown	Jordan Price Wall
Robert PASchal	Young, Moore & Henderson
C Davis	Pope & Associates
[illegible]	NC Insurance News Service
[illegible]	

VISITOR REGISTRATION SHEET

Insurance — Name of Committee

5-13-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Hunt	NCFPC
Art Nelson	AP
Joyce Peters	Attorney / Moore St.
Charles Cramer	NCATL
John Bowdich	Zeb Alley P.A.
Adam Searing	NCKAC
Robert Martin	Mayor Scotland Neck
Barbara Hoot	NCRTL
[illegible]	NCMHP
Thomas Henderson	CALNC
[illegible]	
Sheila McKenrick	NCDOT
[illegible]	"
Ron Aycock	NC Assn County Com
Ed Regan	" " " "
Dave Horne	Smith Anderson
[illegible] Bode	Bode Call & Stroupe
Kay Michaels	PPOD
[illegible]	[illegible]

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☒ Senate Committee Substitute for
H.B. 165 A BILL TO BE ENTITLED AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, TO EXTEND THE BEACH PLAN RATE CAP ON WIND POLICIES ISSUED IN THE COASTAL AREA FOR TWO YEARS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS.

☐ 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 3

HOUSE BILL 165
Committee Substitute Favorable 3/29/99
Senate Insurance Committee Substitute Adopted 4/8/99

Short Title: JUA Reauthorization. (Public)

Sponsors:

Referred to:

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO REENACT THE 1986 LAW PROVIDING FOR RISK-SHARING PLANS, TO AMEND THE IMMUNITY STATUTES FOR THE FAIR AND BEACH PLANS, TO EXTEND THE BEACH PLAN RATE CAP ON WIND POLICIES ISSUED IN THE COASTAL AREA FOR TWO YEARS, AND TO MAKE A TECHNICAL AMENDMENT IN THE BEACH PLAN LAWS.

The General Assembly of North Carolina enacts:

Section 1. Article 42 of Chapter 58 of the General Statutes, which expired July 1, 1997, is reenacted.

Section 2. G.S. 58-42-1, as reenacted in Section 1 of this act, reads as rewritten:

"**§ 58-42-1. Establishment of plans.**

(a) If the Commissioner finds, after a hearing held in accordance with ~~G.S. 58-2-50,~~ Article 3A of Chapter 150B of the General Statutes, 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 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 approval.

(b) Consistent with G.S. 58-42-5(a)(2), the Commissioner shall at least annually reevaluate a plan promulgated pursuant to this section and shall terminate the plan upon determining that the insurance coverage is readily available in the voluntary market or that the public interest no longer requires the operation of the plan."

Section 2.1. G.S. 58-42-20, as reenacted by Section 1 of this act, reads as rewritten:

"**§ 58-42-20. Classification and rates.**

Each plan shall provide for:

(1) The method of classifying risks;

(2) The making and filing of rates ~~which~~ that are not excessive, inadequate, or unfairly discriminatory and that are calculated on an actuarially sound basis and policy forms applicable to the various risks insured by the plan;

(3) The adjusting and processing of claims;

(4) The commission rates to be paid to agents or brokers for coverages written by the plan; and

(5) Any other insurance or investment functions that are necessary for the purpose of providing adequate and readily accessible coverage."

Section 3. G.S. 58-42-45, as reenacted by Section 1 of this act, reads as rewritten:

"**§ 58-42-45. Article ~~not~~ subject to Administrative Procedure ~~Act.~~ Act; legislative oversight of plans.**

(a) The provisions of Chapter 150B of the General Statutes shall ~~not~~ apply to this ~~Article, except that G.S. 150B-39 and G.S. 150B-41 apply to hearings conducted under G.S. 58-42-1.~~ Article.

(b) At the same time the Commissioner issues a notice of hearing under G.S. 150B-38, the Commissioner shall provide copies of the notice to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations. The Commissioner shall provide the Committee and Commission with copies of any plan promulgated by or approved by the Commissioner under G.S. 58-42-1(1) or (2)."

Section 4. G.S. 58-42-55, as reenacted in Section 1 of this act, reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article shall expire on July 1, ~~1997.~~ 2001."

Section 5. G.S. 58-45-60 reads as rewritten:

"**§ 58-45-60. Association and Commissioner immune from liability.**

There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner or any of his staff, the Association or its agents or employees, or against any participating insurer, for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the Association, or at any administrative hearings conducted in connection therewith under the provisions of this Article.~~ any member

insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 6. G.S. 58-46-35 reads as rewritten:

"**§ 58-46-35. Reports of inspection made available; immunity from liability.**

All reports of inspection performed by or on behalf of the association shall be made available to the members of the association, applicants and the Commissioner. There shall be no liability on the part of and no cause of action of any nature shall arise against ~~the Commissioner, any of his staff, the association or any of its agents or employees, or against any participating insurer for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the association, or at any administrative hearing conducted in connection therewith under the provisions of this Article.~~ any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article."

Section 7. G.S. 58-45-15 reads as rewritten:

"**§ 58-45-15. Powers and duties of Association.**

The Association shall, pursuant to the provisions of this Article and the plan of operation, and with respect to ~~essential property insurance on insurable property,~~ the insurance coverages authorized in this Article, have the power on behalf of its members:

(1) To cause to be issued policies of insurance to applicants;

(2) To assume reinsurance from its members;

(3) To cede reinsurance to its members and to purchase reinsurance in behalf of its members."

Section 7.1. The prefatory language of Section 8 of Chapter 498 of the 1997 Session Laws reads as rewritten:

"Section 8. Effective January 1, ~~2000,~~ 2002, G.S. 58-45-45(b), as amended by Section 7 of this act, reads as rewritten:".

Section 8. 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 9. This act is effective when it becomes law.

HB 165:
Joint Underwriting Association

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Redwine
Date:	May 12, 1999	**Summary by:**	Linwood Jones
Version:	3rd		Committee Counsel

SUMMARY: This bill reauthorizes the authority of the Commissioner of Insurance to order the creation of joint underwriting associations to provide insurance coverage not readily available in the marketplace, rewrites the immunity clauses for directors of the Beach and FAIR Plans, makes an additional technical amendment concerning the Beach Plan, and extends the rate "cap" on certain Beach Plan policies for an additional two years.

BILL ANALYSIS:

Sections 1 through 4 of the bill restore the authority of the Commissioner of Insurance to create risk-sharing plans or require insurance companies to prepare such plans to jointly provide insurance when coverage in the market is not readily available and the Commissioner finds that it is in the public interest to make it available. The insurance mechanism established under these plans is also known as a "joint underwriting association."

The authority to require joint underwriting associations was first given to the Commissioner of Insurance in 1986 as a means to address problems businesses were having in finding liability insurance. However, the JUA authority can also be used for many other types of insurance when those coverages are no longer readily available in the market, including, for example, property insurance, credit insurance, auto insurance, and workers' compensation insurance. It cannot be used for life insurance or health insurance. Since its inception in 1986, this authority has been set to expire approximately every two years so that the General Assembly can review it before deciding to renew it. The authority expired in 1997 when the insurance bill in which the renewal provision was included failed, primarily because of other provisions in that bill.

The Legislative Research Commission's Study Committee on Insurance Issues has recommended the renewal of the JUA authority because of concerns about homeowners' insurance availability on the beaches and in the coastal counties. The JUA authority has not been exercised in the past for any type of insurance coverage.

Under the JUA authority, if the Commissioner finds, after a public hearing, that a particular insurance coverage is not readily available in the voluntary market and that the public interest requires that it be made available, he can order insurers to form a joint underwriting association to underwrite all eligible risks. The hearing must be conducted pursuant to the APA, and two legislative committees (Gov. Ops. and the APA Oversight Committee) must be notified of the hearing. If the Commissioner adopts a JUA plan after a hearing, a copy of the plan must also be provided to these committees.

The rates charged by a JUA for policies it issues must be calculated on an actuarially-sound basis. In addition, because a JUA is intended to be only a temporary measure to alleviate an insurance availability problem, the Commissioner is required to evaluate, at least annually, the continuing need for any JUA that is created.

The Commissioner's JUA authority under this bill expires July 1, 2001 (subject, of course, to the legislature reauthorizing it again prior to the date of expiration).

Sections 5 and 6 of the bill rewrite the immunity clauses under the Beach and FAIR Plans. The immunity clauses protect the Beach and FAIR Plan employees, their agents, the Department of Insurance, and insurance companies from liability for good faith actions taken in carrying out their duties under the FAIR and Beach Plans. These plans are a type of statutorily-mandated joint underwriting association that provide property insurance coverage to persons who have difficulty obtaining that coverage in the voluntary market.

Section 7 deletes a reference in the Beach Plan laws to the Beach Plan Association's duties with respect to "essential property insurance." The Beach Plan now offers more than just essential property insurance; thus, this conforming change is needed.

Section 7.1 extends for an additional two years the rate "cap" on wind-only policies issued by the Beach Plan in the coastal area. In 1997, the legislature authorized the Beach Plan to begin writing "wind-only" policies in the 18-county coastal area. This was designed to encourage insurers to write more homeowners policies in the coastal area by allowing them to drop the wind coverage, with the wind coverage to be written by the Beach Plan. A provision was included in the legislation to provide that the Beach Plan would charge 90% of the approved wind rate on these particular policies. This was done to try to keep the average homeowner's premium close to what he or she would have paid on a regular homeowners policy that included wind coverage. This provision only applies to a small percentage of policies in the coastal area – i.e., only those where the Beach Plan is writing wind-only coverage. The provision does not protect these homeowners from general rate increases, increases in the approved wind rate charged by the Beach Plan, nor loss of discounts, nor does it apply to the wind-only policies written by the Beach Plan in the beach areas. The 90% "cap" is set to expire at the end of this year. Section 7.1 extends it for an additional 2 years. (This extension was recommended by the Department of Insurance, after consultation with a task force, in an April 1st report to the legislature. The report is in response to an LRC Study Committee's request for a recommendation on this provision).

Section 8 is a severability clause.

Section 9 makes this act effective when it becomes law.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☒ House Committee Substitute #1 for
S.B. 90 A BILL TO BE ENTITLED AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES.

☐ 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 (# 2), unfavorable as to House committee substitute bill (#1).

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 4

SENATE BILL 90
Health Care Committee Substitute Adopted 3/3/99
House Committee Substitute Favorable 4/7/99
House Committee Substitute #2 Favorable 6/10/99

Short Title: Insurance/Cover Contraceptives. (Public)

Sponsors:

Referred to:

February 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services; exemption for religious employers.**

(a) Except as provided in subsection (e) of this section, every insurer providing a health benefit plan that provides coverage for prescription drugs or devices shall provide coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. Except as otherwise provided in this subsection, the same deductibles, coinsurance, and other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices. A health benefit plan may require that the total coinsurance, based on the useful life of the drug or device, be paid in advance for those drugs or devices that are inserted or prescribed and do not have to be refilled on a periodic basis.

(b) Every insurer providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall provide coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

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

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Insurer' includes 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.

(3) 'Outpatient contraceptive services' means consultations, examinations, procedures, and medical services provided on an

outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

(4) 'Prescribed contraceptive drugs or devices' means drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State. Prescription drugs or devices required to be covered under this section shall not include the prescription drug known as 'RU-486', and the prescription drug marketed under the name 'Preven'.

(d) A health benefit plan subject to this section shall not do any of the following:

(1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section.

(2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section.

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section.

(4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services.

(e) A religious employer may request an insurer providing a health benefit plan to provide to the religious employer a health benefit plan that excludes coverage for prescription contraceptive drugs or devices that are contrary to the employer's religious tenets. Upon request, the insurer shall provide the requested health benefit plan. An insurer providing a health benefit plan requested by a religious employer pursuant to this section shall provide written notice to each person covered under the health benefit plan that prescription contraceptive drugs or devices are excluded from coverage pursuant to this section at the request of the employer. The notice shall appear, in not less than 10-point type, in the health benefit plan, application, and sales brochure for the health benefit plan. Nothing in this subsection authorizes a health benefit plan to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, or for prescription contraception that is necessary to preserve the life or health of a person covered under the plan. As used in this subsection, the term 'religious employer' means an entity for which all of the following are true:

(1) The entity is organized and operated exclusively for religious purposes and is tax exempt under section 501(c)(3) of the U.S. Internal Revenue Code.

(2) The inculcation of religious values is the primary purpose of the entity.

(3) The entity employs primarily persons who share the religious tenets of the entity."

Section 2. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-174, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-174 apply to standard plans developed and approved under G.S. 58-50-125.

(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 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 90
Health Care Committee Substitute Adopted 3/3/99
House Committee Substitute Favorable 4/7/99
Proposed House Committee Substitute S90-PCS4701-RN

Short Title: Insurance/Cover Contraceptives. (Public)

Sponsors:

Referred to:

February 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services; exemption for religious employers.**

(a) Except as provided in subsection (e) of this section, every insurer providing a health benefit plan that provides coverage for prescription drugs or devices shall provide coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. Except as otherwise provided in this subsection, the same deductibles, coinsurance, and other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices. A health benefit plan may require that the total coinsurance, based on the useful life of the drug or device, be paid in advance for those drugs or devices that are inserted or prescribed and do not have to be refilled on a periodic basis.

(b) Every insurer providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall provide coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

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

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Insurer' includes 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.

(3) 'Outpatient contraceptive services' means consultations, examinations, procedures, and medical services provided on an

outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

(4) 'Prescribed contraceptive drugs or devices' means drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State. Prescription drugs or devices required to be covered under this section shall not include the prescription drug known as 'RU-486', and the prescription drug marketed under the name 'Preven'.

(d) A health benefit plan subject to this section shall not do any of the following:

(1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section.

(2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section.

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section.

(4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services.

(e) A religious employer may request an insurer providing a health benefit plan to provide to the religious employer a health benefit plan that excludes coverage for prescription contraceptive drugs or devices that are contrary to the employer's religious tenets. Upon request, the insurer shall provide the requested health benefit plan. An insurer providing a health benefit plan requested by a religious employer pursuant to this section shall provide written notice to each person covered under the health benefit plan that prescription contraceptive drugs or devices are excluded from coverage pursuant to this section at the request of the employer. The notice shall appear, in not less than 10-point type, in the health benefit plan, application, and sales brochure for the health benefit plan. Nothing in this subsection authorizes a health benefit plan to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, or for prescription contraception that is necessary to preserve the life or health of a person covered under the plan. As used in this subsection, the term 'religious employer' means an entity for which all of the following are true:

(1) The entity is organized and operated exclusively for religious purposes and is tax exempt under section 501(c)(3) of the U.S. Internal Revenue Code.

(2) The inculcation of religious values is the primary purpose of the entity.

(3) The entity employs primarily persons who share the religious tenets of the entity."

Section 2. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-174, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-174 apply to standard plans developed and approved under G.S. 58-50-125.

(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 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 3

SENATE BILL 90
Health Care Committee Substitute Adopted 3/3/99
House Committee Substitute Favorable 4/7/99

Short Title: Insurance/Cover Contraceptives. (Public)

Sponsors:

Referred to:

February 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services; exemption for religious employers.**

(a) Except as provided in subsection (e) of this section, every entity providing a health benefit plan that provides coverage for prescription drugs or devices shall provide coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. Except as otherwise provided in this subsection, the same deductibles, coinsurance, and other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices. A health benefit plan may require that the total coinsurance, based on the useful life of the drug or device, be paid in advance for those drugs or devices that are inserted or prescribed and do not have to be refilled on a periodic basis.

(b) Every entity providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall provide coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

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

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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.

(2) 'Insurer' includes 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.

(3) 'Outpatient contraceptive services' means consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

(4) 'Prescribed contraceptive drugs or devices' means drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State. Prescription drugs or devices required to be covered under this section shall not include the prescription drug known as 'RU-486', and the prescription drug marketed under the name 'Preven'.

(d) A health benefit plan subject to this section shall not do any of the following:

(1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section.

(2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section.

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section.

(4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services.

(e) A religious employer may request an entity providing a health benefit plan to provide to the religious employer a health benefit plan that excludes coverage for prescription contraceptive drugs or devices that are contrary to the employer's religious tenets. Upon request, the entity shall provide the requested health benefit plan. An entity providing a health benefit plan requested by a religious employer pursuant to this section shall provide written notice to each person covered under the health benefit plan that prescription contraceptive drugs or devices are excluded from coverage pursuant to this section at the request of the employer. The notice shall appear, in not less than 10-point type, in the health benefit plan, application, and sales brochure for the health benefit plan. Nothing in this subsection authorizes a health benefit plan to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, or for prescription contraception that is necessary to preserve the life or health of a person covered under the plan. As used in this subsection, the term 'religious employer' means an entity for which all of the following are true:

(1) The entity is organized and operated exclusively for religious purposes and is tax exempt under section 501(c)(3) of the U.S. Internal Revenue Code.

(2) The inculcation of religious values is the primary purpose of the entity.

(3) The entity employs primarily persons who share the religious tenets of the entity."

Section 2. Effective January 1, 2000, 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. 58-50-123(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. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) 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.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-174, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-174 apply to standard plans developed and approved under G.S. 58-50-125.

(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 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

ROLL CALL VOTE

10 YES 8 NO = 18 (TOTAL)

HB# ____
SB# 90

HOUSE STANDING COMMITTEE ON INSURANCE

House Subcommittee on ____

YES	NO	MEMBER (last name)	YES	NO	MEMBER (last name)
___	___	HURLEY, CHAIR	___	✓	WILSON, C.
___	✓	BARBEE	✓	___	WRIGHT
✓	___	BOYD-MCINTYRE	___	___	
___	___	BRUBAKER	___	___	
✓	___	COLE	___	___	
✓	___	DEDMON	___	___	
___	✓	DOCKHAM	___	___	
✓	___	EARLE	___	___	
___	✓	ESPOSITO	___	___	
___	✓	GRADY	___	___	
✓	___	HARDAWAY	___	___	
___	✓	HOLMES	___	___	
___	✓	HOWARD	___	___	
✓	___	MILLER	___	___	
___	___	REDWINE	___	___	
✓	___	SAUNDERS, VICE-CHAIR	___	___	
✓	___	SMITH	___	___	
✓	___	WAINWRIGHT, VICE-CHAIR	___	___	
___	✓	WARNER	___	___	
___	___		___	___	
___	___		Ex officio Members		
___	___	HACKNEY	___	___	Speaker Pro Tempore
___	___	BADDOUR	___	___	Majority Leader
___	___	CUNNINGHAM	___	___	

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 90

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

S90-ARN-001

Page 1 of __

Date _____ ,1999

Comm. Sub. [YES]
Amends Title []
3rd Edition

Rep. _____

moves to amend the bill on page 1, line 11, page 2, line 1, and page 3, lines 24, 27, and 28 by deleting the word "entity" each time it appears and inserting the word "insurer";

and on page 2, between lines 34 and 35 by inserting the following:

" m. ~~Individual health and individual accident and health policies.~~ short-term limited duration ~~insurance~~ health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

S90:
Insurance /Cover Contraceptives

BILL ANALYSIS

Committee: House Insurance
Date: April 12, 1999
Version: 3rd Ed.

Introduced by: Sen. Forrester
Summary by: Ed Rossi
Committee Co-Counsel

SUMMARY: Senate bill 90 requires health benefit plans that provide prescription drug coverage to also provide coverage for FDA approved contraceptive drugs or devices[1]. In addition, it also requires health benefit plans that provide coverage for outpatient services to also provide coverage for outpatient contraceptive services. The bill provides a religious exemption for religious employers that meet all of the following criteria:

1. *The religious employer is tax exempt.*
2. *Its primary purpose is the inculcation of religious values.*
3. *The employer primarily employs persons who share its religious tenets*

This religious exemption only applies to coverage for prescription contraceptives; it does not apply to outpatient contraceptive services.

BACKGROUND: According to the National Council of State Legislatures ("NCSL"), 10 states currently require insurers to provide contraceptive coverage.[2] The coverage provided in these states varies, with some states providing coverage only for oral contraceptives and others providing coverage for all FDA approved contraceptive drugs or devices. (A chart showing the types of coverage provided in these states is attached to this memo.) NCSL also reports that:

- 15% of traditional indemnity plans covered all 5 FDA approved contraceptive methods.
- 49% of traditional indemnity plans covered none of the FDA approved methods.
- 39% of HMO plans covered all 5 FDA approved methods.
- 7% of HMO plans did not provide contraceptive coverage at all.[3]

BILL ANALYSIS: Section 1. Of the bill adds a new section to Article 3 of Chapter 58 of the General Statutes:

Subsection (a) of this new section requires health benefit plans that provide prescription drug coverage to provide coverage for FDA approved contraceptive drugs or devices. This coverage must cover the insertion and removal of contraceptive devises and must also cover any "medically necessary" examinations associated with the drugs or devices. In general, the same coinsurance and deductibles that apply to other covered prescription drugs or devises must apply to contraceptive drugs or devices. However, under certain circumstances a health benefit plan can require that the total coinsurance, based

[1] Currently, there are 5 FDA approved contraceptive methods: Norplant, Depo- Provera , the IUD, the diaphragm, contraceptive pills. Women's Health: A Legislative Overview, NCSL Issue Brief, 4/29/99
[2] Id.
[3] Id.

on the life of the drug or devise, be paid in advance. ***This subsection creates a religious exemption for religious employers as provided for in subsection (e).***

Subsection (b) of the new section requires insurers who provide coverage for out patient services to also provide coverage for outpatient contraceptive services. The term "outpatient contraceptive services" is defined in the bill to include "...consultations, examinations, procedures, and medical services provided on an outpatient basis...related to the use of contraceptive methods to prevent pregnancy."[4] ***This subsection does not provide a religious exemption.***

Subsection (c) is the definitional subsection. It provides that the prescription drugs or devises requiring coverage by this bill do not include, "the prescription drug known as 'RU-486'...[or] the prescription drug marketed under the name 'Preven.'"[5]

Subsection (d) prohibits health benefit plans from engaging in certain practices, including:

- Denying eligibility solely to avoid the purpose of the section.
- Offering monetary incentives to enrollees to encourage their acceptance of lesser coverage.
- Penalizing or otherwise limiting reimbursement to providers because they prescribed contraceptives or provided outpatient contraceptive services.

Subsection (e) provides a religious exemption. This exemption only applies to religious employers who meet the following criteria:

4. The religious employer is tax exempt.
5. Its primary purpose is the inculcation of religious values.
6. The employer primarily employs persons who share its religious tenets

This religious exemption only applies to coverage for prescription contraceptives; it does not apply to outpatient contraceptive services.

If a religious employer requests an exemption, as provided for in this bill, the health benefit plan is required to provide written notice to its enrollees that coverage for prescription contraceptives is being excluded from the plan at the employer's request. This notice is required to be in at least 10-point type.

The religious exemption does not apply to contraceptives that are prescribed for reasons other than contraception, including contraceptive prescriptions that are necessary to preserve the life or health of an enrollee.[6]

Section 2. of the bill addresses health plans that cover small employers with less than 50 employees. Under North Carolina law, insurance companies that provide coverage to these employers must offer two types of guaranteed health plans -- a "standard plan" and a "basic plan." The standard plan is the plan that provides more benefits. This section requires the "standard plan" to provide the same contraceptive coverage requirements that are found in Section 1. of the bill. This small employer coverage is to begin as of January 1, 2000.

Section 3. contains a severability clause.

Section 4. provides that bill is effective when it becomes law and applies to health benefit plan policies that are issued or renewed on or after January 1, 2000.

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[4] Page 2 lines 40 through 43.
[5] Page 3 lines 7 & 8.
[6] Page 3 lines 33 through 37.

State	Statute, Code or Regulation
GEORGIA	Requires every health benefit policy that provides coverage for prescription drugs to provide coverage for any prescribed contraceptive drug or device approved by the FDA. Defines "health benefit policy" to include specified insurers including state employee plans. H 374 (1999)
HAWAII (offering)	Mandated offering of coverage for contraceptive services and FDA-approved contraceptive prescription drugs and devices if pregnancy-related coverage is provided. 432:1-604.5, 431:10A-116.6 (Michie, 1994)
IDAHO	Requires individual and small employer plans to cover prescriptions including oral contraceptives. Also includes coverage for surgical, implantable and injectable contraceptives, but these are subject to a 12-month waiting period with the exception of tubal ligations performed in conjunction with a Caesarean delivery. According to Group Standard Plan Design and Individual Basic Plan Design.
IOWA (offering-oral only)	Individual and small employer market insurers must offer a basic and standard plan that includes coverage for oral contraceptives. Coverage for alternative forms of contraception is to be reviewed based on medical necessity. Admin. Code. 191-71.14 (513B) and 191-75.10 (513C). (Nov. 5, 1997)
KENTUCKY (offering)	Standard plan requirements: The Department of Insurance has verified that under the required benefits in the standard plan requirements for individual and small group health plans, these health plans in the state must offer at least one package with coverage for prescription drugs and contraceptives. Coinsurance applies at two levels, depending on whether you have plan A or plan B coverage (20 percent coinsurance or 40 percent coinsurance). 1994.
MARYLAND	Effective Oct. 1, 1998, insurers, nonprofit health service plans and HMOs that cover prescription drugs will be required to cover FDA-approved prescription drugs or devices, insertion and removal of the devices and medically necessary exams. Religious organizations may be granted an exemption. 1998 Law - H 457
MINNESOTA	A regulation that requires HMOs to provide coverage for prescription drugs has been interpreted to require HMOs to provide coverage for contraceptive drugs. Reg. 62D.02 subdivision 8 and 62D.04 subdivision 1 (MN rules 4685.0100 subpart 5 and 4685.0700 subpart 3)
TEXAS (oral only)	Effective Jan 1, 1978, Administrative Code states that "no insurer may exclude from prescription drug benefits oral contraceptives when all other prescription drugs are covered." 28 Texas Admin. Code, Chap. 21.404(3)
VIRGINIA (offering)	Mandated offering of coverage by individual and group accident and sickness insurance policies and HMOs that include coverage for prescription drugs for any FDA-approved prescription contraceptive drug or device. 38.2-3407.5:1 (Michie) Ch. 748, 1997 Va. Adv. Serv.7 (1997 Law - H 1233)
WEST VIRGINIA (offering)	HMOs must provide or make available, at a minimum, basic health care services that are defined as encompassing cost-effective, preventive services, including voluntary family planning services. 33-25A-2(1),(11) (1996 & Supp.1997) Note: The Insurance Commissioner's office clarified that "voluntary family planning services" is interpreted as including coverage for contraceptives.

* **California, New Mexico** and **Ohio** all include some type of provision in their statute that requires coverage for medically necessary voluntary family planning services which include contraceptives. Since it is only for "medically necessary" services, this is not interpreted as requiring private insurers to cover contraceptives.

Source: Health Policy Tracking Service, National Conference of State Legislatures, April 1999.

Figure 5 shows the same information as the above table.

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 20, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 20, 1999, at 12:00 noon. Representative Hurley called the meeting to order and introduced the page, Matt Randolph (Person County). The following Committee members were present: Representatives Barbee, Brubaker, Cole, Dedmon, Esposito, Grady, Saunders, Smith, Warner, and C. Wilson. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

SB 839, entitled, AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO REQUIRE INTERIM CLAIMS PAYMENTS TO PROVIDERS IN THE EVENT CLAIMS CANNOT BE TIMELY PROCESSED DUE TO YEAR 2000 COMPUTER PROBLEMS. The Chair presented a proposed House committee substitute and moved for adoption. Representative Saunders seconded the motion. The motion passed. Senator Wellons was recognized to explain the committee substitute. Representative C. Wilson made a motion to give a favorable report to the House committee substitute, unfavorable to the Senate committee substitute bill. Motion passed.

SB 643, entitled, AN ACT TO AMEND THE LAW GOVERNING INSURANCE PREMIUM FINANCING. As the sponsor for this bill, Senator Reeves, was not available the Chair presented a proposed House committee substitute. Representative Barbee moved to approve the committee substitute. Motion passed. The Chair explained the House committee substitute for SB 643. Representative Saunders made a motion to give a favorable report to the House committee substitute, unfavorable to the Senate committee substitute bill. Motion passed.

SB 344, entitled, AN ACT TO PROVIDE EXPANDED ACCESS TO SPECIALTY CARE IN MANAGED CARE PLANS. Senator Forrester was recognized to explain the bill. Representative Barbee made a motion to give a favorable report to the Senate committee substitute bill. Motion passed.

SB 347, entitled, AN ACT TO REQUIRE HEALTH BENEFIT PLANS TO COVER NONFORUMULARY DRUGS AND DEVICES WHEN MEDICALLY NECESSARY. Senator Forrester was recognized to explain the bill. The Chair presented an amendment signed by Representative Saunders, which would amend the bill on page 1, line 9, by deleting the words "or restrictive". Representative Saunders made a motion to accept the amendment. Motion passed. Representative Esposito made a motion to roll the amendment into a House committee substitute, with a favorable report to the House committee substitute, unfavorable to the Senate committee substitute bill. Motion passed.

There being no further business, the Chair adjourned the meeting at 12:25 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS:

Visitor Registration Form
SB 344, SB 347, SB 643, and SB 839
Proposed House Committee Substitutes
Amendment
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — 5-20-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Moore & Van Allen
[illegible]	UNC-CH
[illegible]	NCHAC
Alan Miles	Bailey & Dixon LLP
[illegible]	Glaxo Wellcome
Karen Gillespie	Bristol-Myers Squibb
[illegible]	MAMSI
[illegible]	NC AHP
[illegible]	BCBS
[illegible]	NCMS
[illegible]	NCMS
[illegible]	Poyner & Spruill
[illegible]	Carolina Healthcare Sys, L
[illegible]	
[illegible]	NC DOI
Harold H. Webb	Premium Finance INS,
Tommy Harrelson	" " "
Glenn Jernigan	N.C. Property and Casualty Insurance
Anne L. Edwards	Christie Business Comm on Public NC
Crissy Porter	Bone & Associates
[illegible]	NCIOSA
[illegible]	HFW
[illegible]	MFJS
[illegible]	Hospice / APPL NC
[illegible]	

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 839 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO REQUIRE INTERIM CLAIMS PAYMENTS TO PROVIDERS IN THE EVENT CLAIMS CANNOT BE TIMELY PROCESSED DUE TO YEAR 2000 COMPUTER PROBLEMS.

☐ 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 3

SENATE BILL 839
Insurance Committee Substitute Adopted 4/28/99
House Committee Substitute Favorable 5/24/99

Short Title: Insurance Claims Payments/Y2K. (Public)

Sponsors:

Referred to:

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO REQUIRE INTERIM CLAIMS PAYMENTS TO PROVIDERS IN THE EVENT CLAIMS CANNOT BE TIMELY PROCESSED DUE TO YEAR 2000 COMPUTER PROBLEMS.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 2 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-2-235. Interim claims payments authorized.**

(a) Every insurer shall report to the Commissioner if it cannot process claims submitted by health care providers in a timely manner due to problems associated with the change in years from 1999 to 2000. The report shall be made within five business days of determining that the problem exists.

(b) The Commissioner shall require an insurer to make interim payments to health care providers if the Commissioner determines, after investigation, that (i) the insurer cannot make claims payments in a timely manner in accordance with the insurer's contractual agreement with the health care provider, or if no contractual agreement exists, within 30 days of receipt of a clean claim and (ii) the insurer's inability to process claims is the result of Year 2000-related problems in the insurer's electronic systems. In determining the amount of the interim payment, the Commissioner shall use the same methodology, if any, that is applicable and required under federal law for determining the amount of interim payments to health care providers in the event

of a Year 2000-related disruption in an insurer's claims processing systems. If there is no applicable federal law governing interim payments in the event of such Year 2000-related problems, the interim payment made by the insurer shall be:

(1) Not less than eighty percent (80%) of the amount paid to the health care provider during the same calendar month of 1999; or

(2) If the health care provider did not submit claims for services to, or was not under contract with, the insurer during the same calendar month in 1999, an amount equal to the average of the most recent three months of claims payable to the health care provider by that insurer.

(c) An interim payment is not considered payment in full unless it equals or exceeds the actual amount due and payable to the health care provider. If an insurer makes an interim payment that exceeds the amount owed to the provider during any payment period, the insurer may recover the excess payment through a remittance adjustment by offsetting current or future payments payable to the provider. If the offset cannot be applied to those payments because they are less than the excess interim payments, the insurer may bill the health care provider for the excess payment, and the provider shall remit payment to the insurer within 30 days thereafter.

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

(1) 'Health care provider' means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes; a health care facility as defined in G.S. 131E-176(9)(b); or a pharmacy.

(2) 'Insurer' means an entity that writes a health benefit plan as defined under G.S. 58-3-191 and that is 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. The term 'insurer' includes a third-party administrator.

(3) 'Third-party administrator' has the same meaning as defined under G.S. 58-56-2."

Section 2. The Commissioner may adopt temporary rules to implement this act.

Section 3. This act is effective when it becomes law and expires December 31, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S H

SENATE BILL 839
Insurance Committee Substitute Adopted 4/28/99
Proposed House Committee Substitute S839-PCS2769-RN

Short Title: Insurance Claims Payments/Y2K. (Public)

Sponsors:

Referred to:

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO REQUIRE INTERIM CLAIMS PAYMENTS TO PROVIDERS IN THE EVENT CLAIMS CANNOT BE TIMELY PROCESSED DUE TO YEAR 2000 COMPUTER PROBLEMS.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 2 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-2-235. Interim claims payments authorized.**

(a) Every insurer shall report to the Commissioner if it cannot process claims submitted by health care providers in a timely manner due to problems associated with the change in years from 1999 to 2000. The report shall be made within five business days of determining that the problem exists.

(b) The Commissioner shall require an insurer to make interim payments to health care providers if the Commissioner determines, after investigation, that (i) the insurer cannot make claims payments in a timely manner in accordance with the insurer's contractual agreement with the health care provider, or if no contractual agreement exists, within 30 days of receipt of a clean claim and (ii) the insurer's inability to process claims is the result of Year 2000-related problems in the insurer's electronic systems. In determining the amount of the interim payment, the Commissioner shall use the same methodology, if any, that is applicable and required under federal law for determining the amount of interim payments to health care providers in the event

of a Year 2000-related disruption in an insurer's claims processing systems. If there is no applicable federal law governing interim payments in the event of such Year 2000-related problems, the interim payment made by the insurer shall be:

(1) Not less than eighty percent (80%) of the amount paid to the health care provider during the same calendar month of 1999; or

(2) If the health care provider did not submit claims for services to, or was not under contract with, the insurer during the same calendar month in 1999, an amount equal to the average of the most recent three months of claims payable to the health care provider by that insurer.

(c) An interim payment is not considered payment in full unless it equals or exceeds the actual amount due and payable to the health care provider. If an insurer makes an interim payment that exceeds the amount owed to the provider during any payment period, the insurer may recover the excess payment through a remittance adjustment by offsetting current or future payments payable to the provider. If the offset cannot be applied to those payments because they are less than the excess interim payments, the insurer may bill the health care provider for the excess payment, and the provider shall remit payment to the insurer within 30 days thereafter.

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

(1) 'Health care provider' means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes; a health care facility as defined in G.S. 131E-176(9)(b); or a pharmacy.

(2) 'Insurer' means an entity that writes a health benefit plan as defined under G.S. 58-3-191 and that is 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. The term 'insurer' includes a third-party administrator.

(3) 'Third-party administrator' has the same meaning as defined under G.S. 58-56-2."

Section 2. The Commissioner may adopt temporary rules to implement this act.

Section 3. This act is effective when it becomes law and expires December 31, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 839
Insurance Committee Substitute Adopted 4/28/99

Short Title: Insurance Claims Payments/Y2K. (Public)

Sponsors:

Referred to:

April 13, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO REQUIRE INTERIM CLAIMS PAYMENTS TO PROVIDERS IN THE EVENT CLAIMS CANNOT BE TIMELY PROCESSED DUE TO YEAR 2000 COMPUTER PROBLEMS.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 2 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"§ 58-2-235. Interim claims payments authorized.

(a) Every insurer, third-party administrator, and health care provider shall report to the Commissioner if it cannot process or submit claims for services in a timely manner due to problems associated with the change in years from 1999 to 2000. The report shall be made within five business days of determining that the problem exists.

(b) The Commissioner shall require an insurer or third-party administrator to make interim payments to health care providers if the Commissioner determines, after investigation, that delayed or incorrect processing of claims for services are the result of Year 2000-related problems in the health care provider's, insurer's, or third-party administrator's electronic systems, and that interim payments are necessary to prevent the disruption of the delivery of health care services. The Commissioner shall determine the amount of the interim payments. In determining the amount, the Commissioner shall use the same methodology, if any, that is applicable under federal law for determining the amount of interim payments required by federal law.

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

(1) 'Health care provider' means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes; a health care facility as defined in G.S. 131E-176(9)(b); or a pharmacy.

(2) 'Insurer' means an entity that writes a health benefit plan as defined under G.S. 58-3-191 and that is 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.

(3) 'Third-party administrator' has the same definition as applies under G.S. 58-56-2."

Section 2. The Commissioner may adopt temporary rules to implement this act.

Section 3. This act is effective when it becomes law and expires December 31, 2000.

SB 839:
Insurance Claims Payments/Y2K

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Wellons
Date:	May 20, 1999	**Summary by:**	Linwood Jones Committee Counsel
Version:	House PCS for Second Edition		

Senate Bill 839 addresses potential problems that may arise with payments to health care providers as a result of insurers' or third party administrators' Year 2000 computer problems by giving the Commissioner of Insurance authority (for one year) to order interim payments to health care providers in certain cases.

The bill requires an insurer (including HMOs, service corporations, MEWAs, and third party administrators, which are included in the definition of "insurer" for purposes of this act) to report to the Commissioner of Insurance within 5 business days if it is unable to process health insurance claims because of Y2K problems.

The Commissioner must order the insurer to make interim payments to providers if both of the following apply:

> (1) The insurer is unable to pay the providers in a timely manner under the terms of its contract with the provider, or if no contract exists, within 30 days of receiving a valid claim; and
> (2) The insurer's inability to make timely payments is caused by a Y2K problem with its computers.

The amount of the interim payment will be determined as follows:

- If the federal government has in place by that time a methodology for determining interim payments for federal programs in the event of insurers' Y2K problems, that methodology will be used to determine the amount of the payment.
- If there is no federal methodology, the amount of the interim payment to a provider will be:
  - 80% or more of the amount that the insurer paid that provider during the same month the previous year (1999); or
  - If the insurer did not make payments to the provider during that month in 1999, an amount equal to the average of the most recent three months of payments to that provider.

If an insurer overpays a provider through interim payments, it can recover the overpayment by offsetting the overpaid amount against pending and future payments to be made to the provider or by billing the provider for the overpaid amount if offset is not possible. An interim payment to a health care provider is not deemed payment in full unless it equals or exceeds the actual amount due the provider.

A health care provider, for purposes of this act, includes the approximately 25 or so different types of providers licensed, registered, or certified in Chapter 90 of the General Statutes, health care facilities, and pharmacies. An insurer, for purposes of this act, also includes a third party administrator that processes health insurance claims.

The Commissioner may adopt temporary rules to implement the act.

The act is effective when it becomes law, although the substantive provisions do not actually take effect until January 1, 2000. (The ability to adopt temporary rules would take effect upon the act becoming law). The act expires December 31, 2000.

SB 839:
Insurance Claims Payments/Y2K

BILL ANALYSIS

Committee: House Insurance
Date: May 20, 1999
Version: 2nd Edition

Introduced by: Sen. Wellons
Summary by: Linwood Jones
Committee Counsel

The Proposed Committee Substitute for Senate Bill 839 addresses potential problems that may arise with health claims payments as a result of Year 2000 computer problems by giving the Commissioner of Insurance authority (for one year) to order interim payments to health care providers in certain cases.

The bill requires "insurers" (including HMOs, service corporations, and MEWAs), third party administrators, and health care providers to report to the Commissioner of Insurance within 5 business days if they are unable to process health insurance claims because of Y2K problems. The act directs the Commissioner to require insurers and third party administrators to make interim payments to providers if the Commissioner (1) has investigated and determined that delayed or incorrect claims processing is the result of Y2K computer problems that the insurer, TPA, or health care provider is experiencing and (2) finds that these interim payments are necessary to prevent the disruption of the delivery of health care services. The Commissioner is authorized to determine the amount of the interim payments. If a methodology for similar payments is developed by the federal government, the Commissioner must use that methodology in determining the amount of the payments.

A health care provider, for purposes of this act, includes the approximately 25 or so types of providers licensed, registered, or certified in Chapter 90 of the General Statutes, health care facilities, and pharmacies.

The Commissioner may adopt temporary rules to implement the act.

The act is effective when it becomes law, although the substantive provisions do not actually take effect until January 1, 2000. (The ability to adopt temporary rules would take effect upon the act becoming law). The act expires December 31, 2000.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 643 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAW GOVERNING INSURANCE PREMIUM FINANCING.

☐ 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 3

SENATE BILL 643
Insurance Committee Substitute Adopted 4/28/99
House Committee Substitute Favorable 5/24/99

Short Title: Insurance Premium Financing. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING INSURANCE PREMIUM FINANCING.

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.~~ type that is legible, as determined by rule. 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:~~ and the following:

~~(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':~~

'INSURANCE PREMIUM FINANCE AGREEMENT

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 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,~~ balance payable by the insured, meaning the sum of the amounts stated under items c. and d. of this subdivision.

f. ~~the~~ 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 pertaining to the time from which the service charge is calculated 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~~ any insurance ~~contracts, or from due date of such premiums; however, not more than~~ contract financed on the premium finance agreement.

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), 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 and shall ~~mail~~ send ~~a copy of the request for~~ notice of the requested 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.

(3) Upon receipt of a copy of the request for cancellation notice by the insurer, the insurance contract shall be cancelled 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.

(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 otherwise unpaid, there is no 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,~~ insured, as provided in subdivision (8) of this section, 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 amount to be refunded to the premium finance company shall be calculated upon the deposit premium and the insurer shall return that amount to the premium finance company no later than 30 days after the effective date of cancellation. This provision shall not limit any other remedies the insurer may have against the insured for additional premiums.

(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 one dollar ($1.00). 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.

(10) If a mortgagee or other loss payee is shown on the insurance contract, the insurer shall notify the mortgagee or loss payee of the

cancellation. The written notice shall be sent by mail, personal delivery, electronic mail, or facsimile transmission to the designated mortgagee's or loss payee's last known address. Proof of mailing is sufficient proof of notice. Failure to send this notice to any designated mortgagee or loss payee shall not give rise to any claim on the part of the insured."

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 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, any rebate whatsoever, either from the service charge for financing specified in the insurance premium finance agreement or otherwise, or~~ 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; the term 'insurance agent' includes employees of the insurance agent; and the word 'company' means an insurance premium finance company."

Section 8. This act becomes effective October 1, 1999, and applies to premium finance agreements or contracts entered into on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 643
Insurance Committee Substitute Adopted 4/28/99
Proposed House Committee Substitute S643-PCS3820-RN

Short Title: Insurance Premium Financing. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING INSURANCE PREMIUM FINANCING.

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.~~ type that is legible, as determined by rule. 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:~~ and the following:

~~(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':~~

'INSURANCE PREMIUM FINANCE AGREEMENT

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 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,~~ balance payable by the insured, meaning the sum of the amounts stated under items c. and d. of this subdivision.

f. ~~the~~ 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 pertaining to the time from which the service charge is calculated 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~~ any insurance ~~contracts, or from due date of such premiums; however, not more than~~ contract financed on the premium finance agreement.

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), 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 and shall ~~mail~~ send ~~a copy of the request for~~ notice of the requested 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.

(3) Upon receipt of a copy of the request for cancellation notice by the insurer, the insurance contract shall be cancelled 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.

(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 otherwise unpaid, there is no 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,~~ insured, as provided in subdivision (8) of this section, 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 amount to be refunded to the premium finance company shall be calculated upon the deposit premium and the insurer shall return that amount to the premium finance company no later than 30 days after the effective date of cancellation. This provision shall not limit any other remedies the insurer may have against the insured for additional premiums.

(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 one dollar ($1.00). 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.

(10) If a mortgagee or other loss payee is shown on the insurance contract, the insurer shall notify the mortgagee or loss payee of the

cancellation. The written notice shall be sent by mail, personal delivery, electronic mail, or facsimile transmission to the designated mortgagee's or loss payee's last known address. Proof of mailing is sufficient proof of notice. Failure to send this notice to any designated mortgagee or loss payee shall not give rise to any claim on the part of the insured."

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 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, any rebate whatsoever, either from the service charge for financing specified in the insurance premium finance agreement or otherwise, or~~ 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; the term 'insurance agent' includes employees of the insurance agent; and the word 'company' means an insurance premium finance company."

Section 8. This act becomes effective October 1, 1999, and applies to premium finance agreements or contracts entered into on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 643
Insurance Committee Substitute Adopted 4/28/99

Short Title: Insurance Premium Financing. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING INSURANCE PREMIUM FINANCING.

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.~~ type that is legible, as determined by rule. 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:~~ and the following:

~~(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':~~

'INSURANCE PREMIUM FINANCE AGREEMENT

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 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;~~ balance payable by the insured, meaning the sum of the amounts stated under items c. and d. of this subdivision.

f. ~~the~~ 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 pertaining to the time from which the service charge is calculated 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~~ any insurance ~~contracts, or from due date of such premiums; however, not more than~~ contract financed on the premium finance agreement.

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), 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 and shall ~~mail~~ send ~~a copy of the request for~~ notice of the requested 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.

(3) Upon receipt of a copy of the request for cancellation notice by the insurer, the insurance contract shall be cancelled 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.

(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 otherwise unpaid, there is no 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,~~ insured, as provided in subdivision (8) of this section, 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 amount to be refunded to the premium finance company shall be calculated upon the deposit premium and the insurer shall return that amount to the premium finance company no later than 30 days after the effective date of cancellation. This provision shall not limit any other remedies the insurer may have against the insured for additional premiums.

(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 one dollar ($1.00). 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 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, any rebate whatsoever, either from the service charge for financing specified in the insurance premium finance agreement or otherwise, or~~ 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; the term 'insurance agent' includes employees of the insurance agent; and the word 'company' means an insurance premium finance company."

Section 8. This act becomes effective October 1, 1999, and applies to premium finance agreements or contracts entered into on or after that date.

SB 643:
Insurance Premium Financing

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Reeves
Date:	May 20, 1999	**Summary by:**	Linwood Jones
Version:	House PCS for 2nd Edition		Committee Counsel

Senate Bill 643 makes several changes to the laws regulating insurance premium financing companies and insurance premium financing agreements.

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 changes the law governing the required contents of a premium financing agreement. The type size requirement is changed from 8-point type to a legible size determined by rule of the Commissioner. This section also 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 makes clear that unrefunded money (of less than $1.00) 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 by mail, personal delivery, e-mail, or fax. Currently, the delivery must be by mail. An insurance policy is considered 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 amount to be refunded will be calculated on the deposit premium and must be returned to the premium finance company within 30 days. 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 $1.00 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. This section also requires an insurer to notify a mortgagee or loss payee shown on the insurance contract when it cancels the policy.

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.

Section 8 provides that this act is effective October 1, 1999, and applies to premium financing agreements entered into on or after that date.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 344 A BILL TO BE ENTITLED AN ACT TO PROVIDE EXPANDED ACCESS TO SPECIALTY CARE IN MANAGED CARE 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 344
Health Care Committee Substitute Adopted 4/7/99

Short Title: Mgd. Care/Specialist Referral. (Public)

Sponsors:

Referred to:

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE EXPANDED ACCESS TO SPECIALTY CARE IN MANAGED CARE PLANS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-223. Managed care access to specialist care.**

(a) Each insurer offering a health benefit plan that does not allow direct access to all in-plan specialists shall develop and maintain written policies and procedures by which an insured may receive an extended or standing referral to an in-plan specialist. The procedure shall provide for an extended or standing referral to a specialist if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician, in consultation with the specialist, requires ongoing specialty care. The extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with the insurer in consultation with the primary care physician, the specialist, and the insured or the insured's designee.

(b) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement,

to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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 are 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, or a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(3) 'Serious or chronic degenerative, disabling, or life-threatening disease or condition' means a disease or condition, which in the opinion of the patient's treating primary care physician and specialist, requires frequent and periodic monitoring and consultation with the specialist on an ongoing basis."

Section 2. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 347 A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH BENEFIT PLANS TO COVER NONFORMULARY DRUGS AND DEVICES WHEN MEDICALLY NECESSARY.

☐ 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 4

SENATE BILL 347
Insurance Committee Substitute Adopted 4/14/99
Third Edition Engrossed 4/15/99
House Committee Substitute Favorable 5/24/99

Short Title: Pres. Drug Formularies. (Public)

Sponsors:

Referred to:

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS TO COVER NONFORMULARY DRUGS AND DEVICES WHEN MEDICALLY NECESSARY.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-221. Access to nonformulary prescription drugs.**

(a) If an insurer maintains one or more closed formularies for prescription drugs or devices, then the insurer shall do all of the following:

(1) Develop the formulary or formularies in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating providers who are licensed to prescribe prescription drugs or devices.

(2) Make available to participating providers and pharmacists the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the participating physician without prior approval from the insurer, after the participating physician notifies the insurer that:

a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and

b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary drug or device as provided in this section.

(c) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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 are 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 organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter."

Section 2. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 347
Insurance Committee Substitute Adopted 4/14/99
Third Edition Engrossed 4/15/99
Proposed House Committee Substitute S347-PCS1745-RN

Short Title: Pres. Drug Formularies. (Public)

Sponsors:

Referred to:

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS TO COVER NONFORMULARY DRUGS AND DEVICES WHEN MEDICALLY NECESSARY.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-221. Access to nonformulary prescription drugs.**

(a) If an insurer maintains one or more closed formularies for prescription drugs or devices, then the insurer shall do all of the following:

(1) Develop the formulary or formularies in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating providers who are licensed to prescribe prescription drugs or devices.

(2) Make available to participating providers and pharmacists the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the participating physician without prior approval from the insurer, after the participating physician notifies the insurer that:

a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and

b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary drug or device as provided in this section.

(c) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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 are 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 organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter."

Section 2. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 3

SENATE BILL 347
Insurance Committee Substitute Adopted 4/14/99
Third Edition Engrossed 4/15/99

Short Title: Pres. Drug Formularies. (Public)

Sponsors:

Referred to:

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS TO COVER NONFORMULARY DRUGS AND DEVICES WHEN MEDICALLY NECESSARY.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-221. Access to nonformulary prescription drugs.**

(a) If an insurer maintains one or more closed or restrictive formularies for prescription drugs or devices, then the insurer shall do all of the following:

(1) Develop the formulary or formularies in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating providers who are licensed to prescribe prescription drugs or devices.

(2) Make available to participating providers and pharmacists the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty or additional cost-

sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the participating physician without prior approval from the insurer, after the participating physician notifies the insurer that:

a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and

b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary drug or device as provided in this section.

(c) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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 withc regard to fault and that are statutorily required to contained in any liability policy or equivalent self-insuranc

(2) 'Insurer' means an entity that writes a health benefit plan and th is an insurance company subject to this Chapter, a servi corporation organized under Article 65 of this Chapter, a heal maintenance organization organized under Article 67 of th Chapter, or a multiple employer welfare arrangement und Article 49 of this Chapter."

Section 2. This act is effective when it becomes law and applies to heal benefit plans that are delivered, issued for delivery, or renewed on and after Janua 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, plan is presumed to occur on each anniversary of the date on which coverage w first effective on the person or persons covered by the health benefit plan.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. 347 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

1 moves to amend the bill on page 1, line 9

2 ( ) WHICH CHANGES THE TITLE

3 by deleting the words "or restrictive"

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

10 _____

11 _____

12 _____

13 _____

14 _____

15 _____

16 _____

17 _____

18 _____

19 _____

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

SB 347 (PCS): Prescription Drug Formularies

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Forrester
Date:	May 20, 1999	**Summary by:**	Linwood Jones
Version:	3rd Edition		Committee Counsel

SUMMARY:

Senate Bill 347 provides that if an insurer maintains a closed formulary for prescription drugs and devices, the insurer must do the following:

- Develop the formulary in conjunction with and with the approval of a pharmacy and therapeutics committee that includes participating providers who are licensed to prescribe drugs and medical devices
- Make the formulary list available to participating providers and pharmacists, including a list by major therapeutic category that specifies whether a drug or device is preferred over another
- Allow an enrollee to obtain, without additional penalty or cost-sharing beyond that provided for in the health plan, coverage for a drug or device not on the formulary if the drug is determined to be medically necessary by the primary care physician. The physician is not required to obtain prior approval from the insurer but must first notify the insurer that (1) the formulary drugs or devices have been ineffective or are expected to cause adverse reactions in or harm to the patient and (2) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug or has been approved as an exception to the clinical protocol under the insurer's protocol procedure.

An insurer cannot terminate or nonrenew a participating provider's contract because the provider prescribed a medically necessary and appropriate nonformulary device or drug.

This bill applies to health benefit plans offered by insurers, service corporations, HMOs, and multiple employer welfare arrangements. It does not apply to specialized health and health-related policies such as disability income insurance, accident insurance, specified disease policies, and hospital indemnity policies.

The bill takes effect January 1, 2000, and applies to plans issued or renewed on or after that date. Renewal is presumed to occur on each anniversary of the date on which coverage was first effective for the covered person.

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 27, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 27, 1999, at 12:35 P.M. Representative Hurley called the meeting to order. The following Committee members were present: Representatives Barbee, Brubaker, Cole, Dockham, Howard, Smith, Wainwright, and C. Wilson. Linwood Jones, Staff Counsel, was in attendance. A list of visitors attending is attached. The following bills were considered:

SB 293, entitled, AN ACT TO REMOVE THE SUNSET FROM AN ACT PROVIDING FOR REIMBURSEMENT BY HEALTH INSURERS FOR SERVICES PROVIDED BY FEE-BASED PRACTICING PASTORAL COUNSELORS. Representative Wainwright was recognized to present and explain the bill for Senator Cooper. Upon a motion made by Representative Barbee, the Committee voted to give the Senate committee substitute a favorable report.

SB 389, entitled, AN ACT TO CLARIFY THE 1998 CHANGE IN THE LAW GOVERNING THE FILING OF FINANCIAL REPORTS BY SMALL TOWN OR COUNTY MUTUALS. The Chair presented SB 389 and recognized Linwood Jones, Staff Counsel, to explain the bill. Upon a motion made by Representative Dockham, the Committee voted to give the Senate committee substitute a favorable report.

SB 756, entitled, AN ACT TO INCREASE MANDATORY LIABILITY INSURANCE REQUIREMENTS FOR CERTAIN MOTOR VEHICLES AND TO MAKE CONFORMING CHANGES IN CHAPTER 58 OF THE GENERAL STATUTES. The Chair presented a technical amendment to this bill. Upon a motion made by Representative C. Wilson, the Committee voted to adopt the amendment. Senator Horton was recognized to explain SB 756. Upon a motion made by Representative Brubaker, the Committee voted to roll the amendment into a House committee substitute and give a favorable report to the House committee substitute, unfavorable report to the original bill (Second Edition Engrossed).

SB 685, entitled, AN ACT TO CLARIFY THAT TREATMENT OR SERVICES RENDERED BY PHYSICIAN ASSISTANTS SHALL BE REIMBURSABLE UNDER THE STATE HEALTH PLAN AND OTHER HEALTH INSURANCE POLICIES UNDER CERTAIN CIRCUMSTANCES. The Chair presented an amendment to this bill. Linwood Jones, Staff Counsel, explained the amendment. Upon a motion made by Representative Barbee, the Committee voted to adopt the amendment. Senator Lucas was recognized to explain SB 685. Upon a motion made by Representative Smith, the Committee voted to roll the amendment into a House committee substitute with a favorable report to the House Committee substitute, unfavorable to the original Senate bill.

There being no further business, the Chair adjourned the meeting at 1:05 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS:

Visitor Registration Form
SB 293, SB 389, SB 756, and SB 685
Amendments
Bill Summaries

VISITOR REGISTRATION SHEET

Insurance — Name of Committee

May 27, 1999 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Katherine Miller	Harry Kaplan
Susan Valauri	Nationwide
Debbie Taylor	NCATA
John McKee	NFOS
Christa Cramer	NCATL
Scott Hammack	NCAIC
Joyce Peters	MAMSI
LISA REYES	THE INSIDER
Starla McKenney	DOI
Bob Price	Jordan Price Wall

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 293 A BILL TO BE ENTITLED AN ACT TO REMOVE THE SUNSET FROM AN ACT PROVIDING FOR REIMBURSEMENT BY HEALTH INSURERS FOR SERVICES PROVIDED BY FEE-BASED PRACTICING PASTORAL COUNSELORS.

☒ 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 293
Insurance Committee Substitute Adopted 4/1/99

Short Title: Pastoral Counseling Reimb./Sunset Off. (Public)

Sponsors:

Referred to:

March 8, 1999

A BILL TO BE ENTITLED

AN ACT TO REMOVE THE SUNSET FROM AN ACT PROVIDING FOR REIMBURSEMENT BY HEALTH INSURERS FOR SERVICES PROVIDED BY FEE-BASED PRACTICING PASTORAL COUNSELORS.

The General Assembly of North Carolina enacts:

Section 1. Section 6 of Chapter 406 of the 1995 Session Laws reads as rewritten:

"Sec. 6. This act becomes effective July 15, 1995, and applies to treatment or services rendered on or after that date. ~~This act expires July 1, 1999.~~"

Section 1.1. G.S. 90-396 is repealed.

Section 2. This act is effective when it becomes law.

SB 293:
Pastoral Counseling Reimb. Sunset Off

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Cooper
Date:	May 27, 1999	**Summary by:**	Linwood Jones
Version:	2nd		Committee Counsel

Senate Bill 293 removes the July 1, 1999 sunset on direct insurance reimbursement for fee-based pastoral counselors.

Fee-based pastoral counselors are ministers who provide pastoral counseling for compensation (other than the ordinary duties performed by a minister as authorized by the minister's church, denomination, or faith group). They have been certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors since 1991.

In 1995, legislation was enacted to provide for insurance reimbursement of these pastoral counselors under commercial health insurance policies and under the State Health Plan.

Under the State Health Plan, the certified pastoral counselors were added to the list of practitioners who are authorized to be reimbursed for their services in providing medically necessary treatment for chemical dependency and mental illness *(see sections 1 and 2 of the 1995 law)*. To make them eligible for insurance reimbursement by commercial insurers, the fee-based pastoral counselors were added to the list of practitioners under the provider anti-discrimination laws for health insurance companies *(section 3 of the 1995 law)* and hospital and medical service corporations *(section 4 of the 1995 law)*. The 1995 law also added the fee-based pastoral counselors to the list of "qualified professionals" under the Mental Health, Developmental Disabilities, and Substance Abuse Act of *1985 (see section 5 of the 1995 law)*.

The 1995 law contained a sunset so that the entire act would expire on July 1, 1999. Senate Bill 293 would remove the sunset so that all of the provisions in the 1995 legislation will continue in effect on and after July 1, 1999.

The bill also repeals G.S. 90-396, which is no longer necessary in light of the authorization for third party reimbursement.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 389 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE 1998 CHANGE IN THE LAW GOVERNING THE FILING OF FINANCIAL REPORTS BY SMALL TOWN OR COUNTY MUTUALS.

☒ 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.

☐ 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)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 389
Insurance Committee Substitute Adopted 4/7/99

Short Title: Town/County Financial Reports. (Public)

Sponsors:

Referred to:

March 16, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE 1998 CHANGE IN THE LAW GOVERNING THE FILING OF FINANCIAL REPORTS BY SMALL TOWN OR COUNTY MUTUALS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-2-165 reads as rewritten:

"**§ 58-2-165. Annual, semiannual, monthly, or quarterly statements to be filed with Commissioner.**

(a) ~~Every~~ Except as provided in subsection (a1) of this section, every insurance company shall file in the Commissioner's office, on or before March 1 of each year, a statement showing the business standing and financial condition of the company, association, or order on the preceding December 31, signed and sworn to by the chief managing agent or officer thereof, before the Commissioner or some officer authorized by law to administer oaths. Provided, the Commissioner may, for good and sufficient cause shown by an applicant company, extend the filing date of the company's annual statement, for a reasonable period of time, not to exceed 30 days. In addition, except as provided in subsection (a1) of this section, the Commissioner may require any insurance company, association, or order to file its statement semiannually, quarterly, or ~~monthly, except that a town or county mutual, organized under G.S. 58-7-75(5)d., is required to file only an annual statement or an audited financial statement that was prepared by a certified public accountant if for the preceding year it had a direct written premium of less than one hundred fifty thousand dollars ($150,000) and fewer than 400 policyholders.~~ monthly.

(a1) A town or county mutual, organized under G.S. 58-7-75(5)d., is required to file only an annual statement or an audited financial statement that was prepared by a certified public accountant if for the preceding year it had a direct written premium of less than one hundred fifty thousand dollars ($150,000) and fewer than 400 policyholders. The Commissioner shall not require those mutuals to file statements semiannually, quarterly, or monthly.

(b) The Commissioner may require statements under this section, G.S. 58-2-170, and G.S. 58-2-190 to be filed in a format that can be read by electronic data processing ~~equipment.~~ equipment, provided that this subsection does not apply to an audited financial statement prepared by a certified public accountant that is submitted by a town or county mutual pursuant to subsection (a1) of this section.

(c) ~~All~~ Except as provided herein, all statements filed under this section must be prepared in accordance with the appropriate NAIC Annual Statement Instructions Handbook and pursuant to the NAIC Accounting Practices and Procedures Manual and on the NAIC Model Financial Statement Blank, unless further modified by the Commissioner as the Commissioner considers to be appropriate. This subsection does not apply to statements filed by a town or county mutual organized under G.S. 58-7-75(5)d. if for the preceding year it had a direct written premium of less than one hundred fifty thousand dollars ($150,000) and fewer than 400 policyholders."

Section 2. This act is effective retroactively to October 30, 1998.

SB 389:
Town/County Financial Reports

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. R.L. Martin
Date:	May 27, 1999	**Summary by:**	Linwood Jones
Version:	2nd Edition		Committee Counsel

SUMMARY: Last year, the General Assembly enacted a law to relieve the smallest farm mutuals from certain reporting requirements applicable to insurance companies generally. The change in the law, which was included in House Bill 926 and which became effective on October 30, 1998, provided that these small farm mutuals (those with fewer than 400 policyholders and $150,000 in annual written premium) could file with the Commissioner of Insurance an annual statement *or an audited financial statement prepared by a CPA* instead of the statements required to be filed by other insurance companies. This provision was designed to relieve the small farm mutuals from two requirements: (1) the filing of monthly, quarterly, and semi-annual financial reports and (2) the filing of the report on the reporting form required by the NAIC (National Association of Insurance Commissioners).

The Department of Insurance has asked for additional clarification on the second issue -- relieving the farm mutual from the reqirement of using the NAIC form. Although the language in last year's bill says that the farm mutual can file *an audited financial statement prepared by a CPA* instead of an annual statement, the Department has asked for additional clarification that this audited statement is sufficient and that the NAIC form need not accompany it.

The bill makes clear that these small farm mutuals are not required to use the NAIC form. The bill also provides that a farm mutual's report, when filed in the form of a certified audit, is not subject to the provision that allows the Commissioner to require certain reports to be in an electronically readable format.

This bill has been made retroactive to October 30, 1998, because it is considered a technical clarification of the law that passed last year in House Bill 926 and which took effect on that date.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
S.B. 756 A BILL TO BE ENTITLED AN ACT TO INCREASE MANDATORY LIABILITY INSURANCE REQUIREMENTS FOR CERTAIN MOTOR VEHICLES AND TO MAKE CONFORMING CHANGES IN CHAPTER 58 OF THE GENERAL STATUTES.

☐ 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, unfavorable as to original bill.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 3

SENATE BILL 756
Second Edition Engrossed 4/28/99
House Committee Substitute Favorable 6/1/99

Short Title: Increase Auto Insurance Coverage. (Public)

Sponsors:

Referred to:

April 5, 1999

A BILL TO BE ENTITLED

AN ACT TO INCREASE MANDATORY LIABILITY INSURANCE REQUIREMENTS FOR CERTAIN MOTOR VEHICLES AND TO MAKE CONFORMING CHANGES IN CHAPTER 58 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-279.1(11) reads as rewritten:

"(11) 'Proof of financial responsibility': Proof of ability to respond in damages for liability, on account of accidents occurring subsequent to the effective date of said proof, arising out of the ownership, maintenance or use of a motor vehicle, in the amount of ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident, and, subject to said limit for one person, in the amount of ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and in the amount of ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident. Nothing contained herein shall prevent an insurer and an insured from entering into a contract, not affecting third parties, providing for a deductible as to property damage at a rate approved by the Commissioner of Insurance."

Section 2. G.S. 20-279.5(c) reads as rewritten:

"(c) This section shall not apply under the conditions stated in G.S. 20-279.6 nor:

(1) To such operator or owner if such owner had in effect at the time of such accident an automobile liability policy with respect to the motor vehicle involved in such accident;

(2) To such operator, if not the owner of such motor vehicle, if there was in effect at the time of such accident a motor vehicle liability policy or bond with respect to his operation of motor vehicles not owned by him;

(3) To such operator or owner if the liability of such operator or owner for damages resulting from such accident is, in the judgment of the Commissioner, covered by any other form of liability insurance policy or bond or sinking fund or group assumption of liability;

(4) To any person qualifying as a self-insurer, nor to any operator for a self-insurer if, in the opinion of the Commissioner from the information furnished him, the operator at the time of the accident was probably operating the vehicle in the course of the operator's employment as an employee or officer of the self-insurer; nor

(5) To any employee of the United States government while operating a vehicle in its service and while acting within the scope of his employment, such operations being fully protected by the Federal Tort Claims Act of 1946, which affords ample security to all persons sustaining personal injuries or property damage through the negligence of such federal employee.

No such policy or bond shall be effective under this section unless issued by an insurance company or surety company authorized to do business in this State, except that if such motor vehicle was not registered in this State, or was a motor vehicle which was registered elsewhere than in this State at the effective date of the policy or bond, or the most recent renewal thereof, or if such operator not an owner was a nonresident of this State, such policy or bond shall not be effective under this section unless the insurance company or surety company if not authorized to do business in this State shall execute a power of attorney authorizing the Commissioner to accept service on its behalf of notice or process in any action upon such policy, or bond arising out of such accident, and unless said insurance company or surety company, if not authorized to do business in this State, is authorized to do business in the state or other jurisdiction where the motor vehicle is registered or, if such policy or bond is filed on behalf of an operator not an owner who was a nonresident of this State, unless said insurance company or surety company, if not authorized to do business in this State, is authorized to do business in the state or other jurisdiction of residence of such operator; provided, however, every such policy or bond is subject, if the accident has resulted in bodily injury or death, to a limit, exclusive of interest and cost, of not less than ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and,

subject to said limit for one person, to a limit of not less than ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and, if the accident has resulted in injury to or destruction of property, to a limit of not less than ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident."

Section 3. G.S. 20-279.15 reads as rewritten:

"**§ 20-279.15. Payment sufficient to satisfy requirements.**

In addition to other methods of satisfaction provided by law, judgments herein referred to shall, for the purpose of this Article, be deemed satisfied:

(1) When ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) has been credited upon any judgment or judgments rendered in excess of that amount because of bodily injury to or death of one person as the result of any one accident; or

(2) When, subject to such limit of ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person, the sum of ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) has been credited upon any judgment or judgments rendered in excess of that amount because of bodily injury to or death of two or more persons as the result of any one accident; or

(3) When ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) has been credited upon any judgment or judgments rendered in excess of that amount because of injury to or destruction of property of others as a result of any one accident;

Provided, however, payments made in settlement of any claims because of bodily injury, death or property damage arising from a motor vehicle accident shall be credited in reduction of the amounts provided for in this section."

Section 4. G.S. 20-279.21(b)(2) reads as rewritten:

"(b) Such owner's policy of liability insurance:

(1) Shall designate by explicit description or by appropriate reference all motor vehicles with respect to which coverage is thereby to be granted;

(2) Shall insure the person named therein and any other person, as insured, using any such motor vehicle or motor vehicles with the express or implied permission of such named insured, or any other persons in lawful possession, against loss from the liability imposed by law for damages arising out of the ownership, maintenance or use of such motor vehicle or motor vehicles within the United States of America or the Dominion of Canada subject to limits exclusive of interest and costs, with respect to each such motor vehicle, as follows: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of

one person in any one accident and, subject to said limit for one person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident; and".

Section 5. G.S. 20-279.25(a) reads as rewritten:

"(a) Proof of financial responsibility may be evidenced by the certificate of the State Treasurer that the person named therein has deposited with him ~~sixty-five thousand dollars ($65,000)~~ eighty-five thousand dollars ($85,000) in cash, or securities such as may legally be purchased by savings banks or for trust funds of a market value of ~~sixty-five thousand dollars ($65,000).~~ eighty-five thousand dollars ($85,000). The State Treasurer shall not accept any such deposit and issue a certificate therefor and the Commissioner shall not accept such certificate unless accompanied by evidence that there are no unsatisfied judgments of any character against the depositor in the county where the depositor resides."

Section 6. G.S. 20-280 reads as rewritten:

"**§ 20-280. Filing proof of financial responsibility with governing board of municipality or county.**

(a) Within 30 days after March 27, 1951, every person, firm or corporation engaging in the business of operating a taxicab or taxicabs within a municipality shall file with the governing board of the municipality in which such business is operated proof of financial responsibility as hereinafter defined.

No governing board of a municipality shall hereafter issue any certificate of convenience and necessity, franchise, license, permit or other privilege or authority to any person, firm or corporation authorizing such person, firm or corporation to engage in the business of operating a taxicab or taxicabs within the municipality unless such person, firm or corporation first files with said governing board proof of financial responsibility as hereinafter defined.

Within 30 days after the ratification of this section, every person, firm or corporation engaging in the business of operating a taxicab or taxicabs without the corporate limits of a municipality or municipalities, shall file with the board of county commissioners of the county in which such business is operated proof of financial responsibility as hereinafter defined.

No person, firm or corporation shall hereafter engage in the business of operating a taxicab or taxicabs without the corporate limits of a municipality or municipalities in any county unless such person, firm or corporation first files with the board of county commissioners of the county in which such business is operated proof of financial responsibility as hereinafter defined.

(b) As used in this section 'proof of financial responsibility' shall mean a certificate of any insurance carrier duly authorized to do business in the State of North Carolina certifying that there is in effect a policy of liability insurance insuring the owner and operator of the taxicab business, his agents and employees while in the performance of their duties against loss from any liability imposed by law for

damages including damages for care and loss of services because of bodily injury to or death of any person and injury to or destruction of property caused by accident and arising out of the ownership, use or operation of such taxicab or taxicabs, subject to limits (exclusive of interests and costs) with respect to each such motor vehicle as follows: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident.

(c) Every person, firm or corporation who engages in the taxicab business and who is a member of or participates in any trust fund or sinking fund, which said trust fund or sinking fund is for the sole purpose of paying claims, damages or judgments against persons, firms or corporations engaging in the taxicab business and which trust fund or sinking fund is approved by the governing body of any city or municipality with a population of over 50,000, shall be deemed a compliance with the financial responsibility provisions of this section.

Provided, however, that in the case of operators of 15 or more taxicabs, the limits (exclusive of interests and costs), with respect to each such motor vehicle shall be as follows: twenty thousand dollars ($20,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, forty thousand dollars ($40,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident."

Section 7. G.S. 20-281 reads as rewritten:

"**§ 20-281. Liability insurance prerequisite to engaging in business; coverage of policy.**

From and after July 1, 1953, it shall be unlawful for any person, firm or corporation to engage in the business of renting or leasing motor vehicles to the public for operation by the rentee or lessee unless such person, firm or corporation has secured insurance for his own liability and that of his rentee or lessee, in such an amount as is hereinafter provided, from an insurance company duly licensed to sell motor vehicle liability insurance in this State. Each such motor vehicle leased or rented must be covered by a policy of liability insurance insuring the owner and rentee or lessee and their agents and employees while in the performance of their duties against loss from any liability imposed by law for damages including damages for care and loss of services because of bodily injury to or death of any person and injury to or destruction of property caused by accident arising out of the operation of such motor vehicle, subject to the following minimum limits: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident, and ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five

thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident. Provided, however, that nothing in this Article shall prevent such operators from qualifying as self-insurers under terms and conditions to be prepared and prescribed by the Commissioner of Motor Vehicles or by giving bond with personal or corporate surety, as now provided by G.S. 20-279.24, in lieu of securing the insurance policy hereinbefore provided for."

Section 8. G.S. 58-37-35(b) reads as rewritten:

"(b) The Facility shall reinsure for each coverage available therein to the standard percentage of one hundred percent (100%) or lesser equitable percentage established in the plan of operation as follows:

(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

a. Bodily injury liability: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident;

b. Property damage liability: ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each person;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall not be available for motorcycles;

d. Uninsured motorist: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person; ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident for bodily injury; ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission.

(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 dollars ($100,000)~~ one million dollars ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;

Uninsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible).

(3) Whenever the additional ceding privileges are provided as in G.S. 58-37-35(b)(2) for any component of motor vehicle insurance, the same additional ceding privileges shall be available to 'all other' types of risks subject to the rating jurisdiction of the North Carolina Rate Bureau."

Section 8.1. If House Bill 296 (1999 Session) becomes law, Section 8 of this act is repealed and G.S. 58-37-35(b), as amended by House Bill 296, reads as rewritten:

"(b) The Facility shall reinsure for each coverage available therein to the standard percentage of one hundred percent (100%) or lesser equitable percentage established in the plan of operation as follows:

(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

a. Bodily injury liability: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident;

b. Property damage liability: ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each person;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall not be available for motorcycles;

d. Uninsured motorist: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person; ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident for bodily injury; ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission.

(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 million dollars ($1,000,000) each person and each accident for bodily injury liability;

Uninsured motorist: one million dollars ($1,000,000) each person and each accident for bodily injury and fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible).

(3) Whenever the additional ceding privileges are provided as in G.S. 58-37-35(b)(2) for any component of motor vehicle insurance, the same additional ceding privileges shall be available to 'all other' types of risks subject to the rating jurisdiction of the North Carolina Rate Bureau."

Section 9. This act becomes effective July 1, 2000, and applies to new or renewal policies written to become effective on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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SENATE BILL 756
Second Edition Engrossed 4/28/99
Proposed House Committee Substitute S756-PCS6680-RN

Short Title: Increase Auto Insurance Coverage. (Public)

Sponsors:

Referred to:

April 5, 1999

A BILL TO BE ENTITLED

AN ACT TO INCREASE MANDATORY LIABILITY INSURANCE REQUIREMENTS FOR CERTAIN MOTOR VEHICLES AND TO MAKE CONFORMING CHANGES IN CHAPTER 58 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-279.1(11) reads as rewritten:

"(11) 'Proof of financial responsibility': Proof of ability to respond in damages for liability, on account of accidents occurring subsequent to the effective date of said proof, arising out of the ownership, maintenance or use of a motor vehicle, in the amount of ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident, and, subject to said limit for one person, in the amount of ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and in the amount of ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident. Nothing contained herein shall prevent an insurer and an insured from entering into a contract, not affecting third parties, providing for a deductible as to property damage at a rate approved by the Commissioner of Insurance."

Section 2. G.S. 20-279.5(c) reads as rewritten:

"(c) This section shall not apply under the conditions stated in G.S. 20-279.6 nor:

(1) To such operator or owner if such owner had in effect at the time of such accident an automobile liability policy with respect to the motor vehicle involved in such accident;

(2) To such operator, if not the owner of such motor vehicle, if there was in effect at the time of such accident a motor vehicle liability policy or bond with respect to his operation of motor vehicles not owned by him;

(3) To such operator or owner if the liability of such operator or owner for damages resulting from such accident is, in the judgment of the Commissioner, covered by any other form of liability insurance policy or bond or sinking fund or group assumption of liability;

(4) To any person qualifying as a self-insurer, nor to any operator for a self-insurer if, in the opinion of the Commissioner from the information furnished him, the operator at the time of the accident was probably operating the vehicle in the course of the operator's employment as an employee or officer of the self-insurer; nor

(5) To any employee of the United States government while operating a vehicle in its service and while acting within the scope of his employment, such operations being fully protected by the Federal Tort Claims Act of 1946, which affords ample security to all persons sustaining personal injuries or property damage through the negligence of such federal employee.

No such policy or bond shall be effective under this section unless issued by an insurance company or surety company authorized to do business in this State, except that if such motor vehicle was not registered in this State, or was a motor vehicle which was registered elsewhere than in this State at the effective date of the policy or bond, or the most recent renewal thereof, or if such operator not an owner was a nonresident of this State, such policy or bond shall not be effective under this section unless the insurance company or surety company if not authorized to do business in this State shall execute a power of attorney authorizing the Commissioner to accept service on its behalf of notice or process in any action upon such policy, or bond arising out of such accident, and unless said insurance company or surety company, if not authorized to do business in this State, is authorized to do business in the state or other jurisdiction where the motor vehicle is registered or, if such policy or bond is filed on behalf of an operator not an owner who was a nonresident of this State, unless said insurance company or surety company, if not authorized to do business in this State, is authorized to do business in the state or other jurisdiction of residence of such operator; provided, however, every such policy or bond is subject, if the accident has resulted in bodily injury or death, to a limit, exclusive of interest and cost, of not less than ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and,

subject to said limit for one person, to a limit of not less than ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and, if the accident has resulted in injury to or destruction of property, to a limit of not less than ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident."

Section 3. G.S. 20-279.15 reads as rewritten:

"**§ 20-279.15. Payment sufficient to satisfy requirements.**

In addition to other methods of satisfaction provided by law, judgments herein referred to shall, for the purpose of this Article, be deemed satisfied:

(1) When ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) has been credited upon any judgment or judgments rendered in excess of that amount because of bodily injury to or death of one person as the result of any one accident; or

(2) When, subject to such limit of ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person, the sum of ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) has been credited upon any judgment or judgments rendered in excess of that amount because of bodily injury to or death of two or more persons as the result of any one accident; or

(3) When ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) has been credited upon any judgment or judgments rendered in excess of that amount because of injury to or destruction of property of others as a result of any one accident;

Provided, however, payments made in settlement of any claims because of bodily injury, death or property damage arising from a motor vehicle accident shall be credited in reduction of the amounts provided for in this section."

Section 4. G.S. 20-279.21(b)(2) reads as rewritten:

"(b) Such owner's policy of liability insurance:

(1) Shall designate by explicit description or by appropriate reference all motor vehicles with respect to which coverage is thereby to be granted;

(2) Shall insure the person named therein and any other person, as insured, using any such motor vehicle or motor vehicles with the express or implied permission of such named insured, or any other persons in lawful possession, against loss from the liability imposed by law for damages arising out of the ownership, maintenance or use of such motor vehicle or motor vehicles within the United States of America or the Dominion of Canada subject to limits exclusive of interest and costs, with respect to each such motor vehicle, as follows: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of

one person in any one accident and, subject to said limit for one person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident; and".

Section 5. G.S. 20-279.25(a) reads as rewritten:

"(a) Proof of financial responsibility may be evidenced by the certificate of the State Treasurer that the person named therein has deposited with him ~~sixty-five thousand dollars ($65,000)~~ eighty-five thousand dollars ($85,000) in cash, or securities such as may legally be purchased by savings banks or for trust funds of a market value of ~~sixty-five thousand dollars ($65,000).~~ eighty-five thousand dollars ($85,000). The State Treasurer shall not accept any such deposit and issue a certificate therefor and the Commissioner shall not accept such certificate unless accompanied by evidence that there are no unsatisfied judgments of any character against the depositor in the county where the depositor resides."

Section 6. G.S. 20-280 reads as rewritten:

"§ 20-280. Filing proof of financial responsibility with governing board of municipality or county.

(a) Within 30 days after March 27, 1951, every person, firm or corporation engaging in the business of operating a taxicab or taxicabs within a municipality shall file with the governing board of the municipality in which such business is operated proof of financial responsibility as hereinafter defined.

No governing board of a municipality shall hereafter issue any certificate of convenience and necessity, franchise, license, permit or other privilege or authority to any person, firm or corporation authorizing such person, firm or corporation to engage in the business of operating a taxicab or taxicabs within the municipality unless such person, firm or corporation first files with said governing board proof of financial responsibility as hereinafter defined.

Within 30 days after the ratification of this section, every person, firm or corporation engaging in the business of operating a taxicab or taxicabs without the corporate limits of a municipality or municipalities, shall file with the board of county commissioners of the county in which such business is operated proof of financial responsibility as hereinafter defined.

No person, firm or corporation shall hereafter engage in the business of operating a taxicab or taxicabs without the corporate limits of a municipality or municipalities in any county unless such person, firm or corporation first files with the board of county commissioners of the county in which such business is operated proof of financial responsibility as hereinafter defined.

(b) As used in this section 'proof of financial responsibility' shall mean a certificate of any insurance carrier duly authorized to do business in the State of North Carolina certifying that there is in effect a policy of liability insurance insuring the owner and operator of the taxicab business, his agents and employees while in the performance of their duties against loss from any liability imposed by law for

damages including damages for care and loss of services because of bodily injury to or death of any person and injury to or destruction of property caused by accident and arising out of the ownership, use or operation of such taxicab or taxicabs, subject to limits (exclusive of interests and costs) with respect to each such motor vehicle as follows: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident.

(c) Every person, firm or corporation who engages in the taxicab business and who is a member of or participates in any trust fund or sinking fund, which said trust fund or sinking fund is for the sole purpose of paying claims, damages or judgments against persons, firms or corporations engaging in the taxicab business and which trust fund or sinking fund is approved by the governing body of any city or municipality with a population of over 50,000, shall be deemed a compliance with the financial responsibility provisions of this section.

Provided, however, that in the case of operators of 15 or more taxicabs, the limits (exclusive of interests and costs), with respect to each such motor vehicle shall be as follows: twenty thousand dollars ($20,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, forty thousand dollars ($40,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident."

Section 7. G.S. 20-281 reads as rewritten:

"**§ 20-281. Liability insurance prerequisite to engaging in business; coverage of policy.**

From and after July 1, 1953, it shall be unlawful for any person, firm or corporation to engage in the business of renting or leasing motor vehicles to the public for operation by the rentee or lessee unless such person, firm or corporation has secured insurance for his own liability and that of his rentee or lessee, in such an amount as is hereinafter provided, from an insurance company duly licensed to sell motor vehicle liability insurance in this State. Each such motor vehicle leased or rented must be covered by a policy of liability insurance insuring the owner and rentee or lessee and their agents and employees while in the performance of their duties against loss from any liability imposed by law for damages including damages for care and loss of services because of bodily injury to or death of any person and injury to or destruction of property caused by accident arising out of the operation of such motor vehicle, subject to the following minimum limits: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident, and ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five

thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident. Provided, however, that nothing in this Article shall prevent such operators from qualifying as self-insurers under terms and conditions to be prepared and prescribed by the Commissioner of Motor Vehicles or by giving bond with personal or corporate surety, as now provided by G.S. 20-279.24, in lieu of securing the insurance policy hereinbefore provided for."

Section 8. G.S. 58-37-35(b) reads as rewritten:

"(b) The Facility shall reinsure for each coverage available therein to the standard percentage of one hundred percent (100%) or lesser equitable percentage established in the plan of operation as follows:

(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

a. Bodily injury liability: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident;

b. Property damage liability: ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each person;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall not be available for motorcycles;

d. Uninsured motorist: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person; ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident for bodily injury; ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission.

(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 dollars ($100,000)~~ one million dollars ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability;

Uninsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible).

(3) Whenever the additional ceding privileges are provided as in G.S. 58-37-35(b)(2) for any component of motor vehicle insurance, the same additional ceding privileges shall be available to 'all other' types of risks subject to the rating jurisdiction of the North Carolina Rate Bureau."

Section 8.1. If House Bill 296 (1999 Session) becomes law, Section 8 of this act is repealed and G.S. 58-37-35(b), as amended by House Bill 296, reads as rewritten:

"(b) The Facility shall reinsure for each coverage available therein to the standard percentage of one hundred percent (100%) or lesser equitable percentage established in the plan of operation as follows:

(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

a. Bodily injury liability: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident;

b. Property damage liability: ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each person;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall not be available for motorcycles;

d. Uninsured motorist: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person; ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident for bodily injury; ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission.

(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 million dollars ($1,000,000) each person and each accident for bodily injury liability;

Uninsured motorist: one million dollars ($1,000,000) each person and each accident for bodily injury and fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible).

(3) Whenever the additional ceding privileges are provided as in G.S. 58-37-35(b)(2) for any component of motor vehicle insurance, the same additional ceding privileges shall be available to 'all other' types of risks subject to the rating jurisdiction of the North Carolina Rate Bureau."

Section 9. This act becomes effective July 1, 2000, and applies to new or renewal policies written to become effective on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 756
Second Edition Engrossed 4/28/99

Short Title: Increase Auto Insurance Coverage. (Public)

Sponsors: Senators Horton; Allran, Ballance, Ballantine, Carpenter, Cochrane, Dalton, East, Forrester, Foxx, Gulley, Hartsell, Kerr, Martin of Guilford, Miller, Odom, Perdue, Phillips, Rand, Rucho, Soles, and Wellons.

Referred to: Judiciary II.

April 5, 1999

A BILL TO BE ENTITLED

AN ACT TO INCREASE MANDATORY LIABILITY INSURANCE REQUIREMENTS FOR CERTAIN MOTOR VEHICLES AND TO MAKE CONFORMING CHANGES IN CHAPTER 58 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-279.1(11) reads as rewritten:

"(11) 'Proof of financial responsibility': Proof of ability to respond in damages for liability, on account of accidents occurring subsequent to the effective date of said proof, arising out of the ownership, maintenance or use of a motor vehicle, in the amount of ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident, and, subject to said limit for one person, in the amount of ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and in the amount of ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident. Nothing contained herein shall prevent an insurer and an insured from entering into a contract, not affecting third parties, providing

for a deductible as to property damage at a rate approved by the Commissioner of Insurance."

Section 2. G.S. 20-279.5(c) reads as rewritten:

"(c) This section shall not apply under the conditions stated in G.S. 20-279.6 nor:

(1) To such operator or owner if such owner had in effect at the time of such accident an automobile liability policy with respect to the motor vehicle involved in such accident;

(2) To such operator, if not the owner of such motor vehicle, if there was in effect at the time of such accident a motor vehicle liability policy or bond with respect to his operation of motor vehicles not owned by him;

(3) To such operator or owner if the liability of such operator or owner for damages resulting from such accident is, in the judgment of the Commissioner, covered by any other form of liability insurance policy or bond or sinking fund or group assumption of liability;

(4) To any person qualifying as a self-insurer, nor to any operator for a self-insurer if, in the opinion of the Commissioner from the information furnished him, the operator at the time of the accident was probably operating the vehicle in the course of the operator's employment as an employee or officer of the self-insurer; nor

(5) To any employee of the United States government while operating a vehicle in its service and while acting within the scope of his employment, such operations being fully protected by the Federal Tort Claims Act of 1946, which affords ample security to all persons sustaining personal injuries or property damage through the negligence of such federal employee.

No such policy or bond shall be effective under this section unless issued by an insurance company or surety company authorized to do business in this State, except that if such motor vehicle was not registered in this State, or was a motor vehicle which was registered elsewhere than in this State at the effective date of the policy or bond, or the most recent renewal thereof, or if such operator not an owner was a nonresident of this State, such policy or bond shall not be effective under this section unless the insurance company or surety company if not authorized to do business in this State shall execute a power of attorney authorizing the Commissioner to accept service on its behalf of notice or process in any action upon such policy, or bond arising out of such accident, and unless said insurance company or surety company, if not authorized to do business in this State, is authorized to do business in the state or other jurisdiction where the motor vehicle is registered or, if such policy or bond is filed on behalf of an operator not an owner who was a nonresident of this State, unless said insurance company or surety company, if not authorized to do business in this State, is authorized to do business in the state or other jurisdiction of residence of such operator; provided, however, every such policy or bond is subject, if the accident has resulted in bodily injury or death, to a limit, exclusive of interest and

cost, of not less than ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, to a limit of not less than ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and, if the accident has resulted in injury to or destruction of property, to a limit of not less than ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident."

Section 3. G.S. 20-279.15 reads as rewritten:

"**§ 20-279.15. Payment sufficient to satisfy requirements.**

In addition to other methods of satisfaction provided by law, judgments herein referred to shall, for the purpose of this Article, be deemed satisfied:

(1) When ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) has been credited upon any judgment or judgments rendered in excess of that amount because of bodily injury to or death of one person as the result of any one accident; or

(2) When, subject to such limit of ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person, the sum of ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) has been credited upon any judgment or judgments rendered in excess of that amount because of bodily injury to or death of two or more persons as the result of any one accident; or

(3) When ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) has been credited upon any judgment or judgments rendered in excess of that amount because of injury to or destruction of property of others as a result of any one accident;

Provided, however, payments made in settlement of any claims because of bodily injury, death or property damage arising from a motor vehicle accident shall be credited in reduction of the amounts provided for in this section."

Section 4. G.S. 20-279.21(b)(2) reads as rewritten:

"(b) Such owner's policy of liability insurance:

(1) Shall designate by explicit description or by appropriate reference all motor vehicles with respect to which coverage is thereby to be granted;

(2) Shall insure the person named therein and any other person, as insured, using any such motor vehicle or motor vehicles with the express or implied permission of such named insured, or any other persons in lawful possession, against loss from the liability imposed by law for damages arising out of the ownership, maintenance or use of such motor vehicle or motor vehicles within the United States of America or the Dominion of Canada subject to limits exclusive of interest and costs, with respect to each such motor

vehicle, as follows: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident; and".

Section 5. G.S. 20-279.25(a) reads as rewritten:

"(a) Proof of financial responsibility may be evidenced by the certificate of the State Treasurer that the person named therein has deposited with him ~~sixty-five thousand dollars ($65,000)~~ eighty-five thousand dollars ($85,000) in cash, or securities such as may legally be purchased by savings banks or for trust funds of a market value of ~~sixty-five thousand dollars ($65,000).~~ eighty-five thousand dollars ($85,000). The State Treasurer shall not accept any such deposit and issue a certificate therefor and the Commissioner shall not accept such certificate unless accompanied by evidence that there are no unsatisfied judgments of any character against the depositor in the county where the depositor resides."

Section 6. G.S. 20-280 reads as rewritten:

"**§ 20-280. Filing proof of financial responsibility with governing board of municipality or county.**

(a) Within 30 days after March 27, 1951, every person, firm or corporation engaging in the business of operating a taxicab or taxicabs within a municipality shall file with the governing board of the municipality in which such business is operated proof of financial responsibility as hereinafter defined.

No governing board of a municipality shall hereafter issue any certificate of convenience and necessity, franchise, license, permit or other privilege or authority to any person, firm or corporation authorizing such person, firm or corporation to engage in the business of operating a taxicab or taxicabs within the municipality unless such person, firm or corporation first files with said governing board proof of financial responsibility as hereinafter defined.

Within 30 days after the ratification of this section, every person, firm or corporation engaging in the business of operating a taxicab or taxicabs without the corporate limits of a municipality or municipalities, shall file with the board of county commissioners of the county in which such business is operated proof of financial responsibility as hereinafter defined.

No person, firm or corporation shall hereafter engage in the business of operating a taxicab or taxicabs without the corporate limits of a municipality or municipalities in any county unless such person, firm or corporation first files with the board of county commissioners of the county in which such business is operated proof of financial responsibility as hereinafter defined.

(b) As used in this section 'proof of financial responsibility' shall mean a certificate of any insurance carrier duly authorized to do business in the State of North Carolina certifying that there is in effect a policy of liability insurance insuring

the owner and operator of the taxicab business, his agents and employees while in the performance of their duties against loss from any liability imposed by law for damages including damages for care and loss of services because of bodily injury to or death of any person and injury to or destruction of property caused by accident and arising out of the ownership, use or operation of such taxicab or taxicabs, subject to limits (exclusive of interests and costs) with respect to each such motor vehicle as follows: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident.

(c) Every person, firm or corporation who engages in the taxicab business and who is a member of or participates in any trust fund or sinking fund, which said trust fund or sinking fund is for the sole purpose of paying claims, damages or judgments against persons, firms or corporations engaging in the taxicab business and which trust fund or sinking fund is approved by the governing body of any city or municipality with a population of over 50,000, shall be deemed a compliance with the financial responsibility provisions of this section.

Provided, however, that in the case of operators of 15 or more taxicabs, the limits (exclusive of interests and costs), with respect to each such motor vehicle shall be as follows: twenty thousand dollars ($20,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, forty thousand dollars ($40,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident."

Section 7. G.S. 20-281 reads as rewritten:

"**§ 20-281. Liability insurance prerequisite to engaging in business; coverage of policy.**

From and after July 1, 1953, it shall be unlawful for any person, firm or corporation to engage in the business of renting or leasing motor vehicles to the public for operation by the rentee or lessee unless such person, firm or corporation has secured insurance for his own liability and that of his rentee or lessee, in such an amount as is hereinafter provided, from an insurance company duly licensed to sell motor vehicle liability insurance in this State. Each such motor vehicle leased or rented must be covered by a policy of liability insurance insuring the owner and rentee or lessee and their agents and employees while in the performance of their duties against loss from any liability imposed by law for damages including damages for care and loss of services because of bodily injury to or death of any person and injury to or destruction of property caused by accident arising out of the operation of such motor vehicle, subject to the following minimum limits: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident, and ~~fifty thousand dollars ($50,000)~~ sixty

thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident. Provided, however, that nothing in this Article shall prevent such operators from qualifying as self-insurers under terms and conditions to be prepared and prescribed by the Commissioner of Motor Vehicles or by giving bond with personal or corporate surety, as now provided by G.S. 20-279.24, in lieu of securing the insurance policy hereinbefore provided for."

Section 8. G.S. 58-37-35(b) reads as rewritten:

"(b) The Facility shall reinsure for each coverage available therein to the standard percentage of one hundred percent (100%) or lesser equitable percentage established in the plan of operation as follows:

(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

a. Bodily injury liability: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident;

b. Property damage liability: ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each person;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall not be available for motorcycles;

d. Uninsured motorist: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person; ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident for bodily injury; ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission.

(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 dollars ($100,000) each person and three hundred thousand dollars ($300,000) each accident for bodily injury liability;
Uninsured motorist: one hundred thousand dollars ($100,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible).

(3) Whenever the additional ceding privileges are provided as in G.S. 58-37-35(b)(2) for any component of motor vehicle insurance, the same additional ceding privileges shall be available to 'all other' types of risks subject to the rating jurisdiction of the North Carolina Rate Bureau."

Section 9. This act becomes effective July 1, 2000, and applies to new or renewal policies written to become effective on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 756

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

S756-ARN-001 Page 1 of __

Date_____,1999

Comm. Sub. []
Amends Title []
____ Edition

Rep._____

moves to amend the bill on page 7, lines 2 through 8, by rewriting those lines to read:

" Underinsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and ~~three hundred thousand dollars ($300,000)~~ each accident for bodily injury liability; Uninsured motorist: ~~one hundred thousand dollars ($100,000)~~ one million dollars ($1,000,000) each person and each accident for bodily injury and ~~fifteen thousand dollars ($15,000)~~ fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible)."

and on page 7, between lines 13 and 14, by inserting the following:

"Section 8.1. If House Bill 296 (1999 Session) becomes law, Section 8 of this act is repealed and G.S. 58-37-35(b), as amended by House Bill 296, reads as rewritten:

"(b) The Facility shall reinsure for each coverage available therein to the standard percentage of one hundred percent (100%) or lesser equitable percentage established in the plan of operation as follows:

(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 756

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

S756-ARN-001

a. Bodily injury liability: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person, ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident;

b. Property damage liability: ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each person;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall no be available for motorcycles;

d. Uninsured motorist: ~~twenty-five thousand dollars ($25,000)~~ thirty thousand dollars ($30,000) each person; ~~fifty thousand dollars ($50,000)~~ sixty thousand dollars ($60,000) each accident for bodily injury; ~~fifteen thousand dollars ($15,000)~~ twenty-five thousand dollars ($25,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission.

(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;

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 756

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

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Underinsured motorist: one million dollars ($1,000,000) each person and each accident for bodily injury liability;
Uninsured motorist: one million dollars ($100,000,000) each person and each accident for bodily injury and fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible).

(3) Whenever the additional ceding privileges are provided as in G.S. 58-37-35(b)(2) for any component of motor vehicle insurance, the same additional ceding privileges shall be available to 'all other' types of risks subject to the rating jurisdiction of the North Carolina Rate Bureau."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

S756:
Increase Auto Insurance Coverage

BILL ANALYSIS

Committee: House Insurance
Date: April 21, 1999
Version: 2nd Ed.

Introduced by: Sen. Horton
Summary by: Ed Rossi
Committee Co-Counsel

SUMMARY: Senate bill 756 raises the mandatory minimum automobile insurance liability limits from:

- ***$25,000 to $30,000 for the death or injury of one person.***
- ***$50,000 to $60,000 for the death or injury of two or more persons.***
- ***$15,000 to $25, 000 for property damage.***

This bill applies to motor vehicles in general.

CURRENT LAW: North Carolina law requires drivers to carry a minimum amount of insurance. Without proof of such insurance, no driver's license can be issued. See G.S. § 20-7(c1). In addition, drivers must also provide proof of insurance in order to get their license restored after it has been suspended or revoked, and the law also requires drivers to show proof of insurance to get limited driving privileges. See G.S. § § 20-13.2(e), 20-16.1 (g), 20-19(k), and 20-179.3(1).

BACKGROUND: Senate bill 756 is the companion bill House bill 990, which was introduced by Representative Nesbitt. As originally introduced, both bills provided coverage as follows: $50,000 for the death/injury of one person; and $100,000 for the death/injury of two or more persons.

According to Department of Insurance ("Department") estimates, approximately one-third of all automobile liability policyholders buy policies that are written at the statutory minimum liability limits addressed by this bill. The Department estimated that if the bill were enacted as originally introduced, these policyholders would get a 22% in their premiums and the remaining two-thirds of policyholders would get an offsetting 6.7% decrease in premiums because they no longer need to purchase as much underinsured coverage.[1]

POSSIBLE TECHNICAL CORRECTIONS: House bill 296 was presented to the Governor on May 25th. Section 8.3 of that bill and section 8 of this bill, in part, address the same subjects – coverage for uninsured and underinsured motorists. House bill 296 and Senate bill 756 provide coverage for uninsured and underinsured motorists as follows:

[1] Department letter

Bill Number	Uninsured Motorist	Underinsured Motorist
House Bill 296	$1,000,000 for each person & each accident for bodily injury. $50,000 for property damage.	$1,000,000 for each person & each accident for bodily injury.
Senate Bill 756	$100,000 for each person & each accident for bodily injury. $50,000 for property damage.	$100,000 for each person and $300,000 for each accident for bodily injury.

Should the committee wish that the provisions of both bills be consistent, a technical amendment will be needed to amend Senate bill 756, so that its uninsured and underinsured provisions match the provisions found in House bill 296.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☐ Committee Substitute for
S.B. 685 A BILL TO BE ENTITLED AN ACT TO CLARIFY THAT TREATMENT OR SERVICES RENDERED BY PHYSICIAN ASSISTANTS SHALL BE REIMBURSABLE UNDER THE STATE HEALTH PLAN AND OTHER HEALTH INSURANCE POLICIES UNDER CERTAIN CIRCUMSTANCES.

☐ 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, unfavorable as to original bill.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 685
House Committee Substitute Favorable 6/1/99

Short Title: Health Insurance/Phys. Assistants. (Public)

Sponsors:

Referred to:

April 1, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT TREATMENT OR SERVICES RENDERED BY PHYSICIAN ASSISTANTS SHALL BE REIMBURSABLE UNDER THE STATE HEALTH PLAN AND OTHER HEALTH INSURANCE POLICIES UNDER CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

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

"**§ 58-50-26. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied the payment or reimbursement on account of the fact that the services were rendered through a physician assistant acting under the authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

Section 2. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, ~~or advanced practice registered nurse.~~ advanced practice nurse, or physician assistant.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through

55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint which is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a 'duly licensed psychologist' shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and

certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a 'duly certified clinical social worker' is a 'certified clinical social worker' as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a 'duly certified fee-based practicing pastoral counselor' shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an 'advanced practice registered nurse' means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 3. G.S. 58-50-56(j) reads as rewritten:

"(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties. The list shall include participating physician assistants and their supervising physician."

Section 4. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-36. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a contract governed by this Article or Article 66 of this Chapter shall be denied the payment or reimbursement on account of the fact that the service was rendered through a physician assistant acting under authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

Section 5. G.S. 58-65-1(a) reads as rewritten:

"(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term 'hospital service plan' as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term 'medical service plan' as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or

permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term 'medical services plan' also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes."

Section 6. G.S. 58-65-1 is amended by adding the following new subsection to read:

"(b2) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board, pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 7. G.S. 135-40.6 is amended by adding the following new subdivision to read:

"(11) Coverage for Physician Services Provided by Physician Assistants. -- Notwithstanding any other provision of this section or the Plan, benefits shall be payable for physician services performed by a duly licensed physician assistant subject to the following limitations:

a. The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board, pursuant to G.S. 90-18.1, or is within the scope of practice of a physician assistant licensed or certified in and acting pursuant to laws

and rules applicable in the area where the service is provided;

b. The plan currently provides reimbursement for identical services performed by other licensed health care providers;

c. The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant; and

d. Nothing in this subdivision authorizes payment to more than one provider for the same service.

As used in this subdivision, a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 8. G.S. 135-40.7B(c) reads as rewritten:

"(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) 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) 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) Repealed by Session Laws 1997-512, s. 14.

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

(7), (8) Repealed by Session Laws 1997-512, s. 14.

(9) Certified fee-based practicing pastoral ~~counselors.~~ counselors; and

(10) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or certified."

Section 9. This act becomes effective January 1, 2000, and applies to treatment or services rendered on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 685
Proposed House Committee Substitute S685-PCS3827-RN

Short Title: Health Insurance/Phys. Assistants. (Public)

Sponsors:

Referred to:

April 1, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT TREATMENT OR SERVICES RENDERED BY PHYSICIAN ASSISTANTS SHALL BE REIMBURSABLE UNDER THE STATE HEALTH PLAN AND OTHER HEALTH INSURANCE POLICIES UNDER CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

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

"**§ 58-50-26. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied the payment or reimbursement on account of the fact that the services were rendered through a physician assistant acting under the authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

Section 2. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, ~~or advanced practice registered nurse.~~ advanced practice nurse, or physician assistant.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through

55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint which is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a 'duly licensed psychologist' shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and

certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a 'duly certified clinical social worker' is a 'certified clinical social worker' as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a 'duly certified fee-based practicing pastoral counselor' shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an 'advanced practice registered nurse' means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 3. G.S. 58-50-56(j) reads as rewritten:

"(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties. The list shall include participating physician assistants and their supervising physician."

Section 4. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-36. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a contract governed by this Article or Article 66 of this Chapter shall be denied the payment or reimbursement on account of the fact that the service was rendered through a physician assistant acting under authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

Section 5. G.S. 58-65-1(a) reads as rewritten:

"(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term 'hospital service plan' as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term 'medical service plan' as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or

permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term 'medical services plan' also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes."

Section 6. G.S. 58-65-1 is amended by adding the following new subsection to read:

"(b2) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board, pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 7. G.S. 135-40.6 is amended by adding the following new subdivision to read:

"(11) Coverage for Physician Services Provided by Physician Assistants. -- Notwithstanding any other provision of this section or the Plan, benefits shall be payable for physician services performed by a duly licensed physician assistant subject to the following limitations:

a. The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board, pursuant to G.S. 90-18.1, or is within the scope of practice of a physician assistant licensed or certified in and acting pursuant to laws

and rules applicable in the area where the service is provided;

b. The plan currently provides reimbursement for identical services performed by other licensed health care providers;

c. The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant; and

d. Nothing in this subdivision authorizes payment to more than one provider for the same service.

As used in this subdivision, a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 8. G.S. 135-40.7B(c) reads as rewritten:

"(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) 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) 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) Repealed by Session Laws 1997-512, s. 14.

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

(7), (8) Repealed by Session Laws 1997-512, s. 14.

(9) Certified fee-based practicing pastoral ~~counselors.~~ counselors; and

(10) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or certified."

Section 9. This act becomes effective January 1, 2000, and applies to treatment or services rendered on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 685

Short Title: Health Insurance/Phys. Assistants. (Public)

Sponsors: Senators Lucas; Dannelly, Kinnaird, Phillips, Rand, and Shaw of Cumberland.

Referred to: Health Care.

April 1, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT TREATMENT OR SERVICES RENDERED BY PHYSICIAN ASSISTANTS SHALL BE REIMBURSABLE UNDER THE STATE HEALTH PLAN AND OTHER HEALTH INSURANCE POLICIES UNDER CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

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

"**§ 58-50-26. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied the payment or reimbursement on account of the fact that the services were rendered through a physician assistant acting under the authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

Section 2. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, ~~or advanced practice registered nurse.~~ advanced practice nurse, or physician assistant.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through

55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint which is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a 'duly licensed psychologist' shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and

certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a 'duly certified clinical social worker' is a 'certified clinical social worker' as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a 'duly certified fee-based practicing pastoral counselor' shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an 'advanced practice registered nurse' means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;
(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 3. G.S. 58-50-56(j) reads as rewritten:

"(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties. The list shall include participating physician assistants and their supervising physician."

Section 4. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-36. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a contract governed by this Article or Article 66 of this Chapter shall be denied the payment or reimbursement on account of the fact that the service was rendered through a physician assistant acting under authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

Section 5. G.S. 58-65-1(a) reads as rewritten:

"(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term 'hospital service plan' as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term 'medical service plan' as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or

permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term 'medical services plan' also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes."

Section 6. G.S. 58-65-1 is amended by adding the following new subdivision to read:

"(b2) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board, pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 7. G.S. 135-40.6 is amended by adding the following new subdivision to read:

"(11) Coverage for Physician Services Provided by Physician Assistants. -- Notwithstanding any other provision of this section or the Plan, benefits shall be payable for physician services performed by a duly licensed physician assistant subject to the following limitations:

a. The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board, pursuant to G.S. 90-18.1;

b. The plan currently provides reimbursement for identical services performed by other licensed health care providers;

c. The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant; and

d. Nothing in this subdivision authorizes payment to more than one provider for the same service.

As used in this subdivision, a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 8. G.S. 135-40.7B(c) reads as rewritten:

"(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) 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) 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) Repealed by Session Laws 1997-512, s. 14.

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

(7), (8) Repealed by Session Laws 1997-512, s. 14.

(9) Certified fee-based practicing pastoral ~~counselors.~~ counselors; and

(10) Licensed physician assistants, pursuant to G.S. 90-18.1, under the supervision of a licensed psychiatrist."

Section 9. This act becomes effective January 1, 2000, and applies to treatment or services rendered on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 685

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

S685-ARN-001 Page 1 of __

Date_____,1999

Comm. Sub. []
Amends Title []
1st Edition

Rep._____

moves to amend the bill on page 5, line 42 by inserting between "18.1" and the semicolon the following:

", or is within the scope of practice of a physician assistant licensed or certified in and acting pursuant to laws and rules applicable in the area where the service is provided;"

and on page 6, lines 29-30 by rewriting those lines to read:

"(10) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or certified."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SB 685:
Health Insurance/Physician Assistants

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Lucas
Date:	May 27, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

Senate Bill 685 amends the insurance laws and insurance anti-discrimination laws to provide for insurance reimbursement for services performed by physician assistants. The reimbursement is required only when the service was within the scope of practice of the physician assistant and was performed in accordance with the Medical Board's rules governing physician assistants and the insurance policy covers the same service when another health care provider provides it. The reimbursement is required to be made only to the physician, clinic, or agency that employs the physician assistant. The bill makes clear that it is not authorizing payment to both the physician assistant and his or her employer for the same service. These changes will apply to commercial health insurance plans and service corporation plans. Sections 1 and 2 apply to commercial health insurance plans. Sections 4, 5, and 6 apply to hospital/ medical service corporation plans (Blue Cross).

Section 3 requires commercial insurers and service corporations to include a list of physician assistants and their supervising physicians in the list that they are already required to provide to enrollees that identifies providers in their area who participate in the health plan.

Sections 7 and 8 amend the State Health Plan laws to provide reimbursement for services performed by a physician assistant when the plan covers that service when performed by another provider and the PA was acting within the scope of practice and in accordance with applicable rules. The payment is made to the physician, clinic, or agency that employs the PA. This bill makes clear that it does not authorize payment for the same service twice under the Sate Health Plan. Section 8 also provides that mental health and chemical dependency services performed by a PA are reimbursable under the State Health Plan if performed under the supervision of a licensed psychiatrist.

This bill would take effect January 1, 2000, and would be applicable to services or treatment rendered on or after that date.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 10, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 10, 1999, at 12:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Paul Mobley (Wake County) and Phil Montague (Wake County). The following Committee members were present: Representatives Barbee, Cole, Dedmon, Dockham, Esposito, Grady, Hardaway, Howard, Redwine, Saunders, and Wright. Linwood Jones, Staff Counsel, was in attendance. A list of visitors attending is attached. The following bills were considered:

HB 306, entitled, AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES, AND TO CLARIFY THAT MECHANICAL BREAKDOWN AND RELATED INSURANCE ARE NOT UNDER THE JURISDICTION OF THE RATE BUREAU. Linwood Jones, Staff Counsel, was recognized to explain the changes made by the Senate Committee Substitute. Upon a motion made by Representative Hardaway, the Committee voted to concur with the Senate Committee Substitute to HB 306.

SB 766, entitled, AN ACT TO MAKE CERTAIN PROVISIONS IN THE INSURANCE LAW APPLICABLE TO HOSPITAL, MEDICAL, AND DENTAL SERVICE CORPORATIONS AND TO HEALTH MAINTENANCE ORGANIZATIONS. Senator Miller was recognized to explain the bill. Representative Wright made a motion to give a favorable report to SB 766. Motion passed.

There being no further business, the Chair adjourned the meeting at 12:10 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS

Visitor Registration Form
HB 306, SB 766
Bill Summaries
Handouts

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

JUNE 10, 1999 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nicole Burchett	Raysdale Liggett
Lou Schuca	Raysdale Liggett
Jennifer Weaver	Raysdale Liggett
John Phelps	NCLM
Melody Ray	
Steve Woodson	NC Farm Bureau Federation
Betsy Cooke	N.C. Self-Insur. Guaranty Assoc.
Joyce Peters	IP Assoc / MAMSI
[illegible]	NC AHP
John McMillan	MFTS
Bob Prim	Jordan Price Wall
Ken Wright	BCBSNC
[illegible]	Morris Van Allen
John Borkowski	Zeb Alley P.A.
Alan Miles	Bunday Davison LLP

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 4

HOUSE BILL 306
Committee Substitute Favorable 4/12/99
Third Edition Engrossed 4/13/99
Senate Insurance Committee Substitute Adopted 5/19/99

Short Title: Insurance Amendments/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES, AND TO CLARIFY THAT MECHANICAL BREAKDOWN AND RELATED

INSURANCE ARE NOT UNDER THE JURISDICTION OF THE RATE BUREAU.

The General Assembly of North Carolina enacts:

PART I. HEARINGS AND FAIR AND BEACH PLANS APPEALS.

Section 1.1. G.S. 58-2-50 reads as rewritten:

"**§ 58-2-50. ~~Examinations~~ Examinations, hearings, and investigations.**

All ~~examinations~~ examinations, hearings, and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. All hearings shall, unless otherwise specially provided, be held in accordance with this Article and Article 3A of Chapter 150B of the General Statutes and at a time and place designated in a written notice given by the Commissioner to the person cited to appear. The notice shall state the subject of inquiry and the specific charges, if any."

Section 1.2. 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 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~~ 10 days before each hearing, the appellant shall file with the Commissioner or ~~his~~ the Commissioner's 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 may be transcribed. ~~The~~ If the matter is between an insurer and the Association, the cost of ~~such~~ the 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. If the matter is between an insured and the Association, the

cost of transcribing shall be borne equally by the appellant and appellee; provided that the Commissioner may order the Association to pay recording or transcribing costs for which the insured is financially unable to pay. 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 1.3. 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~~ after the date of ~~such~~ the ruling or decision. The Commissioner, after a 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~~ 10 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 may be transcribed. ~~The~~ If the matter is between an insurer and the Association, the cost of ~~such~~ the 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. If the matter is between an insured and the Association, the cost of transcribing shall be borne equally by the appellant and appellee; provided that the Commissioner may order the Association to pay recording or transcribing costs for which the insured is financially unable to pay. 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 II. CONTINUING CARE RETIREMENT RECEIVERSHIPS.

Section 2. 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, the Department of Health and Human Services may, notwithstanding any other provision of law, accept and approve the addition of adult care home beds for that facility if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the facility or (ii) 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."

PART III. HANDICAPPED PERSONS.

Section 3.1. 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 and other coverage provisions 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.~~ No insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes shall be prohibited from excluding by waiver or otherwise, any preexisting conditions from coverage as prescribed in G.S. 58-51-15(a)(2)b."

Section 3.2. G.S. 168-22(b) reads as rewritten:

"(b) A family care home shall be 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 IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1. G.S. 58-50-65(a) reads as rewritten:

"(a) Nothing in Articles 50 through 55 of this Chapter ~~shall apply~~ applies to or ~~affect~~ affects any policy of liability or workers' compensation insurance, except that the provisions of ~~G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55~~ G.S. 58-50-56(g) and (h) ~~shall~~ apply to policies of workers' compensation ~~insurance.~~ insurance and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care provisions of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation insurance, the provisions of Chapter 97 govern."

Section 4.2. G.S. 97-2(21) reads as rewritten:

"(21) Managed care organization. -- The term 'managed care organization' means a preferred provider organization or a health maintenance organization regulated under Chapter 58 of the General Statutes. 'Managed care organization' also means a preferred provider benefit plan of an insurance company, hospital, or medical service corporation in which utilization review or quality management programs are used to manage the provision of health care services and benefits under this Chapter."

PART V. COMMERCIAL AIRCRAFT INSURANCE.

Section 5.1. G.S. 58-7-15(19) reads as rewritten:

"(19) 'Motor vehicle ~~and~~ or aircraft insurance,' meaning insurance against loss of or damage resulting from any cause to motor vehicles or aircraft and their equipment, and against legal liability of the insured for loss or damage to another's property resulting from the ownership, maintenance or use of motor vehicles or aircraft and against loss, damage or expense incident to a claim of such liability. This subdivision does not apply to commercial aircraft as defined in G.S. 58-1-5."

Section 5.2. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to ~~aviation~~ commercial aircraft insurance; to policies issued in this State covering risks with multistate locations,

except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 5.3. G.S. 58-21-10(8) reads as rewritten:

"(8) 'Surplus lines insurance' means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, ~~aviation~~ commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities."

Section 5.4. G.S. 58-28-5(a) reads as rewritten:

"(a) Except as ~~hereinafter provided,~~ otherwise provided in this section, it ~~shall be~~ is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in G.S. 58-28-10, without a ~~certificate of authority~~ license issued by the Commissioner. This section ~~shall~~ does not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this ~~Chapter;~~ Chapter.

(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the ~~Commissioner;~~ Commissioner.

(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such ~~policy;~~ policy.

(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or franchise accident and health insurance where the master policy ~~of such~~ for the insurance was lawfully issued and delivered in a state ~~where~~ in which the company was authorized to transact ~~business;~~ business.

(5) Transactions in this State involving all policies of insurance issued ~~prior to~~ before July 1, ~~1967;~~ 1967.

(6) The procuring of contracts of insurance issued to a nuclear ~~insured;~~ insured. As used in this subdivision, 'nuclear insured' means a public utility procuring insurance against radioactive

contamination and other risks of direct physical loss at a nuclear electric generating plant.

(7) Insurance independently procured, as specified in subsection (b) of this ~~section;~~ section.

(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.

(9) Transactions in this State involving commercial aircraft insurance, meaning insurance against (i) loss of or damage resulting from any cause to commercial aircraft and its equipment, (ii) legal liability of the insured for loss or damage to another person's property resulting from the ownership, maintenance, or use of commercial aircraft, and (iii) loss, damage, or expense incident to a liability claim."

Section 5.5. G.S. 58-1-5 reads as rewritten:

"**§ 58-1-5. Definitions.**

In this Chapter, unless the context clearly requires otherwise:

(1) 'Alien company' means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(1a) 'Commercial aircraft' means aircraft used in domestic, flag, supplemental, commuter, or on-demand operations, as defined in Federal Aviation Administration Regulations, 14 C.F.R. § 119.3, as amended.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina or an authorized designee of the Commissioner.

(3) 'Company' or 'insurance company' or 'insurer' includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations. 'Company' or 'insurance company' or 'insurer' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(4) 'Department' means the Department of Insurance of North Carolina.

(5) 'Domestic company' means a company incorporated or organized under the laws of this State.

(6) 'Foreign company' means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State.

(7) 'NAIC' means the National Association of Insurance Commissioners.

~~(8) "Nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.~~

(9) 'Person' means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert. 'Person' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(10) The singular form ~~shall include~~ includes the plural, and the masculine form ~~shall include~~ includes the feminine wherever appropriate."

PART VI. SURPLUS LINES FILINGS.

Section 6.1. G.S. 58-21-35 reads as rewritten:

"**§ 58-21-35. Duty to file ~~evidence of insurance and affidavits.~~ reports and retain affidavits.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall ~~execute and~~ file with the ~~Commissioner.~~ Commissioner a

~~(1)~~ ~~A written~~ report in a format prescribed by the Commissioner regarding the insurance and including the following information:

~~a.~~(1) The name ~~and address~~ of the ~~insured;~~ insured.

~~b.~~(2) The identity of the insurer or ~~insurers;~~ insurers.

~~c.~~(3) A description of the subject and location of the ~~risk;~~ risk.

~~d.~~(4) The amount of premium charged for the ~~insurance; and~~ insurance.

~~e. Such other pertinent information as the Commissioner may reasonably require; and~~

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

~~(2) An~~

(b) The licensee shall complete and retain an affidavit as to the efforts to place the coverage with admitted insurers and the results ~~thereof~~ of the efforts, in accordance with G.S. 58-21-15. The report and affidavit required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

Section 6.2. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-2. Relationship to other insurance laws.**

Unless surplus lines insurance, surplus lines licensees, or nonadmitted insurers are specifically referenced in a particular section of this Chapter, no sections contained in Articles of this Chapter other than this Article apply to surplus lines insurance, surplus lines licensees, or nonadmitted insurers."

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7.1. G.S. 105-259(b) is amended by adding a new subdivision to read:

"(16a) To provide the North Carolina Self-Insurance Guaranty Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of collecting the assessments authorized in G.S. 97-133(a)."

Section 7.2. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

~~(1) Obtain from each member self-insurer and file with the Commissioner individual reports specifying the aggregate benefits each member paid during the previous calendar year, and the annual standard premium that would have been paid by the individual member self-insurer during the previous calendar year, pursuant to manual rates established by the North Carolina Rate Bureau and using the experience rating procedure approved by the Commissioner for that member self-insurer or the annual premium collected by each group member self-insurer during the prior calendar year. These reports shall be due on or before July 15 following the close of that calendar year, except that this deadline may be extended by the Commissioner for up to three additional months for good cause shown.~~

(2) Assess each member of the Association as follows:

a. Each individual member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual ~~standard premium~~ gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual ~~standard premium.~~ gross premiums. Each group member self-insurer shall be annually assessed an amount equal to one-quarter of

one percent (0.25%) of the annual ~~premium collected by~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this one-quarter of one percent (0.25%) assessment. Assessments paid by members pursuant to this subdivision shall be credited toward the tax paid by self-insurers under Article 8B of Chapter 105 of the General Statutes. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll information as determined under G.S. 105-228.5(b), (b1), and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.

b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

c. If a self-insurer is a member of the Association for less than a full calendar year, the annual ~~standard premium~~ gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.

d. If application of the contribution rates referenced in ~~sub-subdivisions a. and b.~~ sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.

(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund

should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.

The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Be obligated to the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter. The Association shall pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this Article.

(5) After paying any claim resulting from a self-insurer's insolvency, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Assess the Fund in an amount necessary to pay only:

a. The obligations for the Association under this Article subsequent to an insolvency;

b. The expenses of handling covered claims subsequent to an insolvency;

c. The cost of examinations under G.S. 97-137; and

d. Other expenses authorized by this Article;

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Notify such persons as the Commissioner directs under G.S. 97-136;

(9) Handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association;

(11) Pay the other expenses of the Association authorized by this section; and

(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions ~~(1), (2),~~ (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association;

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post-insolvency assessment which shall be imposed as follows:

(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the individual member self-insurer for the premium calendar year bears to the annual ~~standard premium~~ gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual ~~collected premium~~ gross premiums of the group member self-insurer for the premium calendar year bears to the annual ~~collected premium~~ gross premiums of all group member self-insurers for the preceding calendar year.

(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.

(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an

amount greater than two and one-half percent (2.5%) of the annual ~~premium collected by~~ gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8. 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 or changes ~~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."

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9. G.S. 58-41-35 is repealed.

Section 9.1. 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 X. MORTALITY TABLE AND RESERVES UPDATE.

Section 10. G.S. 58-58-50(k) reads as rewritten:

"(k) The Commissioner shall adopt rules containing the minimum standards applicable to the valuation of health plans. The Commissioner may also adopt rules for the purpose of recognizing new annuity mortality tables for use in determining reserve liabilities for annuities and may adopt rules that govern minimum valuation standards for reserves of life insurance companies. In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC."

PART XI. MECHANICAL BREAKDOWN INSURANCE.

Section 11. G.S. 58-36-1(3) reads as rewritten:

"(3) The Bureau shall ~~have the duty and responsibility of promulgating and proposing~~ promulgate and propose rates for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; for insurance against theft of or physical damage to nonfleet private passenger ~~(nonfleet)~~ motor vehicles; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured and underinsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and, as provided in G.S. 58-36-100, for loss costs and residual market rate filings for workers' compensation and employers' liability insurance written in connection therewith. ~~The provisions of this~~ This subdivision ~~shall~~ does not apply to motor vehicles operated under certificates of authority from the Utilities Commission, the Interstate Commerce Commission, or their successor agencies, where insurance or other proof of financial responsibility is required by law or by regulations specifically applicable to such certificated vehicles. The Bureau shall have no jurisdiction over excess workers' compensation insurance for employers qualifying as self-insurers as provided in ~~G.S. 97-93;~~ Article 47 of this Chapter or Article 5 of Chapter 97 of the General Statutes; nor shall the Bureau's jurisdiction include farm buildings, farm dwellings and their appurtenant structures, farm personal property or other coverages written in connection with farm real or personal property; travel or camper trailers designed to be pulled by private passenger motor vehicles, unless insured under policies covering nonfleet private passenger motor vehicles; mechanical breakdown insurance covering nonfleet private passenger motor vehicles and other incidental coverages written in connection with this insurance, including emergency road service assistance, trip interruption reimbursement, rental car reimbursement, and tire

coverage; residential real and personal property insured in multiple line insurance policies covering business activities as the primary insurable interest; and marine, general liability, burglary and theft, glass, and animal collision insurance, except when such coverages are written as an integral part of a multiple line insurance policy for which there is an indivisible premium."

PART XII. EFFECT OF HEADINGS.

Section 12. 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 XIII. EFFECTIVE DATE.

Section 13. Sections 5.1 through 5.5 of this act become effective October 1, 1999. Section 6.1 of this act becomes effective January 1, 2000. The remainder of this act is effective when it becomes law, but Sections 1.1, 1.2, and 1.3 of this act shall not apply to appeals pending on the date this act becomes law.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☒ Senate Committee Substitute for
H.B. 306 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES, AND TO CLARIFY THAT MECHANICAL BREAKDOWN AND RELATED INSURANCE ARE NOT UNDER THE JURISDICTION OF THE RATE BUREAU.

☐ 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.

☐ 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.

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

HB 306:
Insurance Amendments

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Hardaway
Date:	June 3, 1999	**Summary by:**	Linwood Jones
Version:	4th		Committee Counsel

***FOR CONCURRENCE:* House Bill 306 has been returned to the House for concurrence. The Senate made the following changes to the bill:**

- *Amended Sections 1.2 and 1.3 concerning appeals to the Commissioner of Insurance from decisions of the associations administering the FAIR and Beach Plans. These plans provide property coverage for homeowners and businessowners who are unable to obtain the coverage in the voluntary insurance market. A person aggrieved by a decision of one of these associations may appeal to the Commissioner of Insurance for a hearing and a decision. Current law requires the hearing to be recorded and transcribed, with the costs of the recording and transcription shared by both parties initially and the losing party paying the prevailing party's share in the end. The House version of HB 306 would have authorized the Commissioner of Insurance to determine, by rule, the procedures for recordings and transcripts, if necessary, and how the costs would be shared. The Senate version provides that the hearing must be recorded and may be transcribed. If the dispute being appealed is between the association and an insurance company, the recording and transcription costs are shared as under current law, with the losing party reimbursing the winning party for these costs in the end. However, if the dispute is between the insured and the association, the costs are shared equally unless the Commissioner determines that the insured is financially unable to pay.*
- *Added a sentence to Section 3.1 to make clear that the general law on the use of pre-existing conditions in individual insurance policies applies to the underwriting of individual insurance policies for handicapped persons.*
- *Added Part XI of the bill to make clear that mechanical breakdown insurance for private passenger vehicles and similar coverages, such as emergency road service assistance, trip interruption reimbursement, rental car reimbursement, and tire coverage, are not under the jurisdiction of the Rate Bureau.*
- *Changed the effective dates so that most of the act is effective when it becomes law, except that the changes relating to commercial aircraft coverage (Part V) take effect October 1, 1999, and the change concerning surplus lines insurance information (Section 6.1) takes effect January 1, 2000.*

The following is a section by section summary of the bill:

PART I. HEARINGS AND FAIR AND BEACH PLAN APPEALS

Section 1.1 provides that all hearings before the Department of Insurance will be held in accordance with both Article 2 of Chapter 58 of the General Statutes and Article 3A of Chapter 150B of the General Statutes (APA), unless a particular insurance statute provides otherwise. The time and place of the hearing will be designated by the Department in a written notice sent to the person that is required to appear at the hearing, and the notice must state the subject of the hearing and any charges against the person.

Sections 1.2 and 1.3 provide that appeals under the Beach and FAIR Plans will be heard by the Department pursuant to rules adopted by the Department. The current law provides that these appeals are to be heard under the general hearing statute of the Department – G.S. 58-2-50.

The law currently requires the appeal hearing to be recorded and transcribed, with each side sharing the costs, although the prevailing side recovers those costs back once the appeal reaches "final adjudication." The bill amends this law to provide that if the appeal involves a matter between an insured and the Beach or FAIR Plans, the costs are borne equally by the insured and the Plan unless the Commissioner orders the Plan to pay when the insured is financially unable to do so.

The Beach and FAIR Plans are statutorily-created joint underwriting associations that provide property insurance coverage to homeowners and business owners unable to obtain that coverage in the voluntary insurance market.

PART II. CONTINUNG CARE RETIREMENT RECEIVERSHIPS

Section 2 allows DHHS to authorize additional beds for a continuing care retirement facility that is in receivership under the Commissioner of Insurance if the court finds that this is in the best interests of the facility or it will best serve the welfare of persons already under contract or who may contract with the facility.

PART III. HANDICAPPED PERSONS

Section 3.1. Currently, the State Handicapped Protection Act prohibits commercial insurance companies and service corporations from denying individual insurance coverage to a handicapped person solely because of his or her handicap, although they can refuse to cover preexisting conditions. Section 3.1 rewrites the language allowing pre-existing conditions to be excluded so that it conforms to the general law on pre-existing conditions for individual policies.

Section 3.2. Currently, a family care home is deemed a "residential" use of property for a number of purposes, including for insurance classification purposes. However, group homes are reportedly having difficulty in finding insurers willing to cover those risks under "residential" coverages. This change is designed to encourage insurers to write property and liability coverages for family care homes.

PART IV. WORKERS' COMPENSATION INSURANCE

Section 4.1 specifies that only certain PPO laws in Chapter 58 apply to workers' compensation insurance, including self-funded insurance plans, and that if there is any conflict between the PPO laws in Chapter 58 (which regulate commercial PPO plans) and PPO laws in Chapter 97 (which regulate workers' compensation care provided through PPOs), the provisions of Chapter 97 govern.

Section 4.2 redefines the definition of "managed care organization," as that term is used in the workers' compensation laws, to make clear that it picks up all preferred provider benefit plans.

PART V. COMMERCIAL AIRCRAFT INSURANCE

Sections 5.1 through 5.5 make several changes concerning aircraft insurance. Commercial aircraft means aircraft used commercially (for hire) for passengers or cargo. Commercial aircraft insurance is insurance covering the aircraft and liability coverage for passengers and cargo. These sections essentially provide that commercial aircraft insurance is not regulated as are other forms of insurance. These sections also specify that the term "company," when used in the insurance laws, does not include the State or a local unit of government and provide a definition of "nuclear insured," a term already used in the insurance laws.

PART VI. SURPLUS LINE FILINGS

Section 6.1 provides for additional information to be provided by surplus lines licensees to the Department of Insurance beyond what they already are required by law to provide. The new information required includes the policy number and policy period for each policy, the premium tax amount, and the address of the licensee. In addition, the information is no longer required to be filed in writing, but will instead be filed in a format "prescribed by the Commissioner," which may allow for electronic filings in addition to written filings.

Section 6.2 provides that the insurance laws applicable to insurance companies admitted to do business in North Carolina do not apply to surplus lines insurance companies except for Article 21 of Chapter 58 of the General Statutes (the Surplus Lines Act) and any other statute that specifically references surplus lines insurance or nonadmitted insurers.

PART VII. WORKERS COMPENSATION SELF-INSURANCE

Section 7.1 amends the State tax confidentiality statute to enable the Department of Revenue to provide the Self Insurance Guaranty Association with information on self-insurers' "premiums" so that the Association can collect assessments authorized by G.S. 97-133(a).

Section 7.2 directs the Secretary of Revenue to provide this information to the Association on individually self-insured employers and directs the Commissioner to provide the same information for group self-insured employers. This section also replaces the term "standard premium" with the term "gross premium."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT

Section 8 repeals the requirement that the Commissioner of Insurance file a biennial report with the legislature (through the Governor) of his official acts and rulings and a biennial report of his recommendations. The Commissioner would still be required to report recommended changes to the insurance laws to the Governor and the General Assembly from time to time.

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW

Section 9 repeals the agency business cessation law. This law was enacted in the 1986-87 liability insurance shortage to require insurers to report detailed information to the Commissioner about commercial property and liability insurance coverages that were cancelled or nonrenewed as a result of the company ceasing to do business through an insurance agency. The purpose of the law was to allow the Commissioner to track commercial property and liability insurance availability problems throughout the State. The Department no longer considers these reports necessary.

Section 9.1 makes a conforming change to reflect the change in Section 9.1.

PART X. MORTALITY TABLE AND RESERVE UPDATE

Section 10 amends the Standard Valuation Law (G.S. 58-58-50) to provide that the Commissioner of Insurance can, through rules, recognize new mortality tables to determine reserve liabilities for annuities and minimum valuation standards for reserves of life insurance companies. The Commissioner may consider model rules recommended by the National Association of Insurance Commissioners (NAIC).

PART XI. MECHANICAL BREAKDOWN INSURANCE

Section 11 amends the law concerning the North Carolina Rate Bureau's jurisdiction to make clear that mechanical breakdown insurance on nonfleet private passenger vehicles and similar insurance coverages, such as emergency road service assistance, trip interruption reimbursement, rental car reimbursement, and tire coverage, do not fall under the jurisdiction of the Bureau. Additional stylistic changes are also made.

PART XII. HEADINGS

Section 12 provides that the headings in the bill are for reference only.

PART XIII. EFFECTIVE DATE

Section 13 provides that most of this act takes effect when it becomes law. Part V, relating to commercial aircraft insurance, becomes effective October 1, 1999, and Section 6.1, relating to changes in the information provided by surplus lines insurers, takes effect January 1, 2000.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

June 2, 1999

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: H.B. 306 -- Senate Changes

Sections 1.2 and 1.3: The law on FAIR and Beach Plan appeals procedures currently requires the appeal hearing to be recorded and transcribed, with each side sharing the costs, although the prevailing side recovers those costs back once the appeal reaches "final adjudication." Member insurance companies and individual insureds may appeal decisions of the Plans to the Commissioner, who acts as an appeals judge. **The Senate changes provide that if an individual appealing the Plan's decision is financially unable to pay his or her share, the Plan would bear the cost.**

Section 3.1: Currently, the State Handicapped Protection Act prohibits commercial insurance companies and service corporations from denying individual health insurance coverage to a handicapped person solely because of his or her handicap, although they can refuse to cover preexisting conditions. Section 3.1 amends the language on pre-existing conditions to conform with current State law. **The Senate made it clear that the general insurance laws on the use of preexisting conditions would still apply, which would mean that an "eligible" individual (essentially an individual who previously had 18 months or more of creditable coverage under a group health plan) would not be subject to preexisting conditions and any other individual would be subject to preexisting conditions for up to 12 months.**

Section 11: The Senate amended the law concerning the North Carolina Rate Bureau's jurisdiction to make clear that mechanical breakdown insurance on personal automobiles and similar coverages, such as emergency road service assistance, trip interruption reimbursement, rental car reimbursement, and tire coverage, do not fall under the jurisdiction of the Bureau. These coverages would be filed with the Commissioner of Insurance by the individual companies for approval.

Section 13: The Senate provided that most of this act takes effect when it becomes law. Part V, relating to commercial aircraft insurance, becomes effective October 1, 1999, and Section 6.1, relating to changes in the information provided by surplus lines brokers, takes effect January 1, 2000.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☐ Committee Substitute for
S.B. 766 A BILL TO BE ENTITLED AN ACT TO MAKE CERTAIN PROVISIONS IN THE INSURANCE LAW APPLICABLE TO HOSPITAL, MEDICAL, AND DENTAL SERVICE CORPORATIONS AND TO HEALTH MAINTENANCE ORGANIZATIONS.

☒ 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 766

Short Title: Service Corp. and HMO Laws. (Public)

Sponsors: Senator Miller.

Referred to: Insurance.

April 6, 1999

A BILL TO BE ENTITLED

AN ACT TO MAKE CERTAIN PROVISIONS IN THE INSURANCE LAW APPLICABLE TO HOSPITAL, MEDICAL, AND DENTAL SERVICE CORPORATIONS AND TO HEALTH MAINTENANCE ORGANIZATIONS.

The General Assembly of North Carolina enacts:

Section 1. Article 65 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-65-2. Other laws applicable to service corporations.**

The following provisions of this Chapter are applicable to service corporations that are subject to this Article:

G.S. 58-2-125. Authority over all insurance companies; no exemptions from license.

G.S. 58-2-155. Investigation of charges.

G.S. 58-2-160. Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.

G.S. 58-2-162. Embezzlement by insurance agents, brokers, or administrators.

G.S. 58-2-185. Record of business kept by companies and agents; Commissioner may inspect.

G.S. 58-2-190. Commissioner may require special reports.

G.S. 58-2-195. Commissioner may require records, reports, etc., for agencies, agents, and others.

G.S. 58-2-200. Books and papers required to be exhibited.

G.S. 58-3-50. Companies must do business in own name; emblems, insignias, etc.

G.S. 58-3-115. Twisting with respect to insurance policies; penalties.

G.S. 58-50-35. Notice of nonpayment of premium required before forfeiture.
G.S. 58-51-25. Policy coverage to continue as to mentally retarded or physically handicapped children."

Section 2. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-171. Other laws applicable to HMOs.**

The following provisions of this Chapter are applicable to HMOs that are subject to this Article:

G.S. 58-2-125. Authority over all insurance companies; no exemptions from license.
G.S. 58-2-155. Investigation of charges.
G.S. 58-2-160. Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
G.S. 58-2-162. Embezzlement by insurance agents, brokers, or administrators.
G.S. 58-2-185. Record of business kept by companies and agents; Commissioner may inspect.
G.S. 58-2-190. Commissioner may require special reports.
G.S. 58-2-195. Commissioner may require records, reports, etc., for agencies, agents, and others.
G.S. 58-2-200. Books and papers required to be exhibited.
G.S. 58-3-50. Companies must do business in own name; emblems, insignias, etc.
G.S. 58-3-115. Twisting with respect to insurance policies; penalties.
G.S. 58-50-35. Notice of nonpayment of premium required before forfeiture.
G.S. 58-51-25. Policy coverage to continue as to mentally retarded or physically handicapped children.
G.S. 58-51-35. Insurers and others to afford coverage to mentally retarded and physically handicapped children.
G.S. 58-51-45. Policies to be issued to any person possessing the sickle-cell trait or hemoglobin C trait."

Section 3. G.S. 58-65-125 reads as rewritten:

"§ **58-65-125. ~~Revocation of certificate of authority; dissolution.~~** Revocation, suspension, and refusal to renew license; unfair trade practices.

~~Whenever the Commissioner of Insurance shall find as a fact that any corporation subject to the provisions of this Article and Article 66 of this Chapter is being operated for profit or fraudulently conducted, or is not complying with the provisions of this Article and Article 66 of this Chapter, he shall be authorized to revoke the certificate of authority or license theretofore granted after notice and hearing, and may at any time thereafter institute or cause to be instituted the necessary proceedings under the laws of this State looking to the dissolution of such corporation, and any dissolution, liquidation, merger, or reorganization of a corporation or corporations subject to the provisions of this Article and Article 66 of this Chapter shall be under the supervision of the Commissioner of Insurance who shall have all powers with respect thereto granted to him under the insurance laws of this State. If, at any time, a corporation organized under the provisions of this Article~~

~~and Article 66 of this Chapter is financially unable to comply with the provisions of this Article and Article 66 of this Chapter or to comply with any of the provisions of any of the hospital contracts or subscribers' contracts issued by said corporation in pursuance of this Article and Article 66 of this Chapter, the Commissioner of Insurance shall have the right without court action, to transfer all its assets, liabilities, and obligations, to any other corporation, whether organized under the provisions of this Article and Article 66 of this Chapter, or not, under such contract of reinsurance with such transferee corporation, that he deems to the best interests of the corporation, its members and creditors whose assets, obligations and liabilities, are transferred. This action on the part of the Commissioner of Insurance is without prejudice to the rights of the corporations whose assets, liabilities and obligations are so transferred, to institute other and proper legal remedies, and to question the action so taken by the Commissioner of Insurance as herein provided, provided, however, that the action taken by the Commissioner of Insurance herein shall not be affected pending a final determination by the court with reference thereto.~~

(a) The Commissioner may revoke, suspend, or refuse to renew the license of any service corporation if:

(1) The service corporation fails or refuses to comply with any law, order, or rule applicable to the service corporation.

(2) The service corporation's financial condition is unsound.

(3) The service corporation has published or made to the Department or to the public any false statement or report.

(4) The service corporation refuses to submit to any examination authorized by law.

(5) The service corporation is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.

(b) Any suspension, revocation, or refusal to renew a service corporation's license under this section may also be made applicable to the license or registration of any natural person regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.

(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if a service corporation fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the service corporation to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or the claimant's legal representative and shall do one of the following, as applicable:

(1) Advise that the claim is being investigated.

(2) Be a payment of the claim.

(3) Be a bona fide written offer of settlement.

(4) Be a written denial of the claim.

(d) Article 63 of this Chapter applies to service corporations and their agents and representatives."

Section 4. G.S. 58-13-10 reads as rewritten:

"**§ 58-13-10. Scope.**

This Article applies to all domestic insurers and to all kinds of insurance written by those insurers under Articles 1 through ~~66~~ 68 of this Chapter. Foreign insurers ~~are to~~ shall comply in substance with the requirements and limitations of this ~~section.~~ Article. 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."

Section 5. G.S. 58-65-105 reads as rewritten:

"**§ 58-65-105. Visitations and examinations.**

~~The Commissioner of Insurance or any deputy or examiner or other person whom he may appoint shall have the power of visitations and examination into the affairs of any such corporation and free access to all the books, papers and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents, or employees or other persons in relation to the affairs, transactions and conditions of the corporation.~~ Service corporations subject to this Article shall be examined under G.S. 58-2-131, 58-2-132, 58-2-133, and 58-2-134."

Section 6. 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.~~ life and health insurance companies.

(b) Every such corporation ~~after the first full year of doing business after the passage of this Article and Article 66 of this Chapter~~ 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 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.

~~In the event~~ (d) 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 the Commissioner gives notice of ~~such~~ the increase."

Section 7. G.S. 58-65-115 reads as rewritten:

"**§ 58-65-115. Licensing and regulation of agents.**

Every agent of any ~~hospital~~ service corporation authorized to do business in this State under ~~the provisions of~~ this Article ~~and Article 66 of this Chapter shall be~~ is subject to the licensing provisions of Article 33 of this ~~Chapter.~~ Chapter and all other provisions in this Chapter applicable to life and health insurance agents."

Section 8. G.S. 58-67-90 reads as rewritten:

"**§ 58-67-90. ~~Regulation~~ Licensing and regulation of agents.**

~~The licensing provisions of Article 33 of this Chapter shall apply to the licensing of Article 67 agents.~~ Every agent of any HMO authorized to do business in this State under this Article is subject to the licensing provisions of Article 33 of this Chapter and all other provisions in this Chapter applicable to life and health insurance agents."

Section 9. G.S. 58-28-35 reads as rewritten:

"**§ 58-28-35. Provisions of Article additional to existing ~~law.~~ law; application.**

The powers vested in the Commissioner by this Article are additional to any other powers to enforce any penalties, fines, or forfeitures authorized by law with respect to transacting the business of insurance without authority. This Article applies to all kinds of insurance, including service corporations that would be subject to Article 65 of this Chapter, HMOs that would be subject to Article 67 of this Chapter, MEWAs that would be subject to Article 49 of this Chapter, and self-insured workers' compensation operations that would be subject to Article 47 of this Chapter or Article 4 of Chapter 97 of the General Statutes."

Section 10. G.S. 58-50-1 reads as rewritten:

"**§ 58-50-1. Waiver by insurer.**

The acknowledgment by any insurer of the receipt of notice given under any policy covered by Articles 49, 50 through ~~55~~ 55, 65, or 67 of this Chapter, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim ~~thereunder,~~ the policy, shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under ~~such~~ the policy."

Section 11. G.S. 58-65-100 reads as rewritten:

"**§ 58-65-100. ~~Reports~~ Statements filed with ~~Commissioner of Insurance.~~ Commissioner.**

~~Every such corporation shall annually on or before the first day of March of each year, file in the office of the Commissioner of Insurance a sworn statement verified by at least two of the principal officers of the said corporation showing its condition on the thirty-first day of December, then next preceding, which shall be in such form and shall contain such matter as the Commissioner of Insurance shall prescribe. In~~

~~case any such corporation shall fail to file any such annual statement as herein required, the said Commissioner of Insurance shall be authorized and empowered to suspend the certificate of authority issued to such corporation until such statement shall be properly filed.~~ Every service corporation subject to this Article is subject to G.S. 58-2-165."

Section 12. G.S. 58-67-55 reads as rewritten:

"**§ 58-67-55. ~~Annual report.~~ Statements filed with Commissioner.**

~~Every such health maintenance organization shall annually on or before the first day of March of each year, file in the office of the Commissioner of Insurance a sworn statement verified by at least two of the principal officers of the health maintenance organization showing its condition on the thirty-first day of December, then next preceding, which shall be in such form as the Commissioner of Insurance shall prescribe. In case any such health maintenance organization shall fail to file any such annual statement as herein required, the said Commissioner of Insurance shall be authorized and empowered to suspend the certificate of authority issued to such health maintenance organization until such statement shall be properly filed.~~ Every HMO subject to this Article is subject to G.S. 58-2-165."

Section 13. G.S. 58-63-5 reads as rewritten:

"**§ 58-63-5. Definitions.**

When used in this Article:

(2) 'Person' ~~shall mean~~ means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of ~~insurance, including agents,~~ insurance under this Chapter; and includes agents, brokers, limited representatives, and adjusters."

Section 14. G.S. 58-67-65(b) reads as rewritten:

"(b) ~~The provisions of Article 63 of this Chapter shall be construed to apply to health maintenance organizations, health care plans and evidences of coverage except to the extent that the Commissioner determines that the nature of health maintenance organizations, health care plans and evidences of coverage render such sections clearly inappropriate.~~ Article 63 of this Chapter applies to health maintenance organizations and their agents and representatives."

Section 15. This act becomes effective January 1, 2000.

SB 766:
Service Corporation and HMO Laws

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Miller
Date:	June 2, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

Senate Bill 766 provides that several different insurance laws that apply to commercial insurers also apply to hospital, medical, and dental service corporations (Blue Cross and Delta Dental) and HMOs. Sections 1 and 2 of the bill list the applicable laws. Sections 3 through 14 make similar changes to other insurance laws.

Section 3 amends the law governing the Commissioner's authority over service corporations so that it conforms to similar authority the Commissioner has over insurers and HMOs. This section also provides that unfair trade practice laws to which insurance companies and HMOs are subject also apply to service corporations.

Section 4 provides that the Asset Protection Act applies to HMOs. This law already applies to insurance companies and service corporations.

Section 5 rewrites the examination laws for service corporations by bringing those corporations under the examination laws that apply to insurers and HMOs.

Section 6 rewrites the investment and reserve laws of the service corporations to include a reference to the specific law regulating insurance investments and to delete language that is no longer necessary.

Sections 7 and 8 provide that agents of service corporations and HMOs are subject to all laws governing life and health insurance agents generally.

Section 9 provides that the unauthorized insurer laws, which empower the Commissioner to obtain cease and desist orders against unauthorized insurance companies, also apply to unauthorized service corporations, HMOs, mutliple employer welfare arrangements, and self-insured workers' compensation arrangements.

Scetion 10 adds service corporations and HMOs to the law that protects insurers from forfeiting their defense of a health insurance claim simply by acknowledging receipt of the claim or providing claims forms to the policyholder.

Sections 11 and 12 provide that the service corporations' and HMO's annual statements are to be filed in accordance with the law that applies to the filing of statements by insurance companies.

Section 13 makes a technical, conforming change in a definitional section.

Section 14 rewrites the law that makes HMOs subject to the unfair trade practice laws. The current law says that the HMO is subject to those laws to the extent that the Commissioner determines that they are appropriately applied to the HMO. Section 14 provides that the HMO and its agents are subject to the law.

Section 15 makes this act effective January 1, 2000.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

June 2, 1999

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: S.B. 766 – Service Corporation and HMO Laws

The laws governing hospital, medical, and dental service corporations (Article 65 of Chapter 58 of the General Statutes) and health maintenance organizations (Article 67 of Chapter 58 of the General Statutes) each contain provisions that, in effect, state that nothing in Chapter 58 outside of those articles applies to service corporations or HMOs unless they specifically mention service corporations or HMOs. Those provisions are G.S. 58-65-1(a) and G.S. 58-67-170(a).

The purpose of S.B. 766 is to make certain provisions apply to service corporations and HMOs that, in the Commissioner's opinion, should apply to them.

Section 1 adds a new section to Article 65, which lists a number of Chapter 58 provisions that would be applicable to service corporations.

Section 2 adds a new section to Article 67, which lists a number of Chapter 58 provisions that would be applicable to HMOs.

Section 3 rewrites the service corporation license sanction statute to make it conform with the license sanction statutes for insurance companies (G.S. 58-3-100) and HMOs (G.S. 58-67-140). It also makes the insurance unfair trade practice law (Article 63 of Chapter 58 of the General Statutes) applicable to service corporations. Article 63 already applies to HMOs.

Section 4 makes the Asset Protection Act (Article 13 of Chapter 58 of the General Statutes) applicable to HMOs. Article 13 already applies to service corporations.

Section 5 makes the insurance company examination laws (G.S. 58-2-131 through G.S. 58-2-134) applicable to service corporations. Those laws were made

applicable to HMOs in 1997. The examination law in Article 65 being amended is antiquated. The examination laws that will apply to service corporations are comprehensive.

Section 6 rewrites the law providing for service corporation investments and reserves by making only the investment laws for life and health insurance companies apply to service corporations. The references being deleted (investments by banks, trust companies, executors, administrators, and guardians) were in the original service corporation laws in 1941 and are no longer relevant or appropriate.

Sections 7 and 8 make parallel amendments to the laws on agents of service corporations and HMOs by making it clear that all provisions in Chapter 58 that apply to life and health insurance agents apply to service corporation and HMO agents.

Section 9 amends the unauthorized insurer law (Article 28 of Chapter 58 of the General Statutes) by making it clear that it applies to service corporations, HMOs, and multiple employer welfare arrangements that attempt to do business with being licensed.

Section 10 amends the insurer waiver law by making it clear that it applies to service corporations, HMOs, and multiple employer welfare arrangements. This law provides that an insurer does not waive any rights in defense of a claim by handling a claim.

Sections 11 and 12 rewrite the service corporation and HMO financial statement laws to make the insurance company financial statement law applicable to them.

Section 13 makes a conforming change to the definition of "person" in the insurance unfair trade practices law.

Section 14 rewrites the HMO law that provides that HMOs are subject to the insurance unfair trade practices law.

Section 15 provides for a January 1, 2000, effective date.

General Statutes that would apply to service corporations and HMOS:

§ 58-2-125. Authority over all insurance companies; no exemptions from license.

Every insurance company must be licensed and supervised by the Commissioner, and must pay all licenses, taxes, and fees as prescribed in the insurance laws of the State for the class of company, association, or order to which it belongs. No provision in any statute, public or private, may relieve any company, association, or order from the supervision prescribed for the class of companies, associations, or orders of like character, or release it from the payment of the licenses, taxes, and fees prescribed for companies, associations, and orders of the same class; and all such special provisions or exemptions are hereby repealed. It is unlawful for the Commissioner to grant or issue a license to any company, association, or order, or agent for them, claiming such exemption from supervision by his Department and release for the payment of license, fees, and taxes.

§ 58-2-155. Investigation of charges.

Upon his own motion or upon complaint being filed by a citizen of this State that a company authorized to do business in the State has violated any of the provisions of Articles 1 through 64 of this Chapter, the Commissioner shall investigate the matter, and, if necessary, examine, under oath, by himself or his accredited representatives the president and such other officer or agents of such companies as may be deemed proper; also all books, records, and papers of the same. In case the Commissioner shall find upon substantial evidence that any complaint against a company is justified, said company, in addition to such penalties as are imposed for violation of any of the provisions of Articles 1 through 64 of this Chapter shall be liable for the expenses of the investigation, and the Commissioner shall promptly present said company with a statement of such expenses. If the company refuses or neglects to pay, the Commissioner is authorized to bring a civil action for the collection of these expenses.

§ 58-2-160. Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.

(a) As used in this section, "Commissioner" includes an employee, agent, or designee of the Commissioner. A person, or an employee or agent of that person, acting without actual malice, is not subject to civil liability for libel, slander, or any other cause of action by virtue of furnishing to the Commissioner under the requirements of law or at the direction of the Commissioner reports or other information relating to (i) any known or suspected fraudulent insurance or reinsurance claim, transaction, or act or (ii) the financial condition of any licensee. In the absence of actual malice, members of the NAIC, their duly authorized committees, subcommittees, task forces, delegates, and employees, and all other persons charged with the responsibility of collecting, reviewing, analyzing, or disseminating the information developed from filings of financial statements or examinations of licensees are not subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, analysis, or dissemination of the data and information collected from such filings or examinations.

(b) The Commissioner, acting without actual malice, is not subject to civil liability for libel or slander by virtue of an investigation of (i) any known or suspected fraudulent insurance or reinsurance claim, transaction, or act or (ii) the financial condition of any licensee; or by virtue of the publication or dissemination of any official report related to any such investigation, which report is published or disseminated in the absence of fraud, bad faith, or actual malice on the part of the Commissioner. The Commissioner is not subject to civil liability in relation to the collecting, reviewing, analyzing, or dissemination of information that is developed by the NAIC from the filing of financial statements with the NAIC or from the examination of insurers by the NAIC and that is communicated to the Commissioner, including any investigation or publication or dissemination of any report or other information in relation thereto, which report is published or disseminated in the absence of fraud, bad faith, negligence, or actual malice on the part of the Commissioner.

(c) During the course of an investigation of (i) a known or suspected fraudulent insurance or reinsurance claim, transaction, or act or (ii) the financial condition of any licensee, the Commissioner may request any person to furnish copies of any information relative to the (i) known or suspected claim, transaction, or act

or (ii) financial condition of the licensee. The person shall release the information requested and cooperate with the Commissioner pursuant to this section.

§ 58-2-162. Embezzlement by insurance agents, brokers, or administrators.

If any insurance agent, broker, or administrator embezzles or fraudulently converts to his own use, or, with intent to use or embezzle, takes, secretes, or otherwise disposes of, or fraudulently withholds, appropriates, lends, invests, or otherwise uses or applies any money, negotiable instrument, or other consideration received by him in his performance as an agent, broker, or administrator, he shall be guilty of a felony. If the value of the money, negotiable instrument, or other consideration is one hundred thousand dollars ($100,000) or more, violation of this section is a Class C felony. If the value of the money, negotiable instrument, or other consideration is less than one hundred thousand dollars ($100,000), violation of this section is a Class H felony.

§ 58-2-185. Record of business kept by companies and agents; Commissioner may inspect.

All companies, agents, or brokers doing any kind of insurance business in this State must make and keep a full and correct record of the business done by them, showing the number, date, term, amount insured, premiums, and the persons to whom issued, of every policy or certificate or renewal. Information from these records must be furnished to the Commissioner on demand, and the original books of records shall be open to the inspection of the Commissioner when demanded.

§ 58-2-190. Commissioner may require special reports.

The Commissioner may also address to any authorized insurer, rating organization, advisory organization, joint underwriting or joint reinsurance organization, or the North Carolina Rate Bureau or Motor Vehicle Reinsurance Facility, or its officers any inquiry in relation to its transactions or condition or any matter connected therewith. Every corporation or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be verified, if required by the Commissioner, by such individual, or by such officer or officers of a corporation, as he shall designate.

§ 58-2-195. Commissioner may require records, reports, etc., for agencies, agents and others.

(a) The Commissioner is empowered to make and promulgate reasonable rules and regulations governing the recording and reporting of insurance business transactions by insurance agencies, agents, brokers and producers of record, any of which agencies, agents, brokers or producers of record are licensed in this State or are transacting insurance business in this State to the end that such records and reports will accurately and separately reflect the insurance business transactions of such agency, agent, broker or producer of record in this State. Information from records required to be kept pursuant to the provisions of this section must be furnished the Commissioner on demand and the original records required to be kept pursuant to the provisions of this section shall be open to the inspection for the Commissioner or any other authorized employee described in G.S. 58-2-25 when demanded.

(b) Every insurance agency transacting insurance business in this State shall at all times have appointed some person employed or associated with such agency who shall have the responsibility of seeing that such records and reports as are required pursuant to the provisions of this section are kept and maintained.

(c) Any person subject to the provisions of subsection (a) of this section who violates the provisions of this section or the rules and regulations prescribed by the Commissioner pursuant to the provisions of this section may after notice and hearing: for the first offense have his license or licenses (in case license be issued for more than one company in such person's case) suspended or revoked for not less than one month nor more than six months and for the second offense shall have his license or licenses (in case license be issued from more than one company in his case) suspended or revoked for the period of one year and such person shall not thereafter be licensed for one year from the date said revocation or suspension first became effective.

(d) For the purpose of enforcing the provisions of this section the Commissioner or any other authorized employee described in G.S. 58-2-25 is authorized and empowered to examine persons, administer oaths and require production of papers and records relative to this section.

(e) Whenever the Commissioner deems it to be prudent for the protection of policyholders in this State, he or any other authorized employee described in G.S. 58-2-25 shall visit and examine any insurance agency, agent, broker, adjuster, motor vehicle damage appraiser, or producer of record. The refusal of any agency,

agent, broker, adjuster, motor vehicle damage appraiser, or producer of record to submit to examination is grounds for the revocation or refusal of a license.

§ 58-2-200. Books and papers required to be exhibited.

It is the duty of any person having in his possession or control any books, accounts, or papers of any company licensed under Articles 1 through 64 of this Chapter, to exhibit the same to the Commissioner or to any deputy, actuary, accountant, or persons acting with or for the Commissioner. Any person who shall refuse, on demand, to exhibit the books, accounts, or papers, as above provided, or who shall knowingly or willfully make any false statement in regard to the same, shall be subject to suspension or revocation of his license under Articles 1 through 64 of this Chapter; and shall be deemed guilty of a Class 1 misdemeanor. 58-3-50. Companies must do business in own name; emblems,

§ 58-3-50. Companies must do business in own name; emblems, insignias, etc.

Every insurance company or group of companies must conduct its business in the State in, and the policies and contracts of insurance issued by it shall be headed or entitled only by, its proper or corporate name or names. There shall not appear on the policy anything that would indicate that it is the obligation of any other than the company or companies responsible for the payment of losses under the policy, though it will be permissible to stamp or print on the policy, the name or names of the department or general agency issuing the same, and the group of companies with which the company is financially affiliated. The use of any emblem, insignia, or anything other than the true and proper corporate name of the company or group of companies shall be permitted only with the approval of the Commissioner.

§ 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.

§ 58-50-35. Notice of nonpayment of premium required before forfeiture.

No insurance company doing business in this State and issuing health and/or accident insurance policies, other than contracts of group insurance or disability and/or accidental death benefits in connection with policies of life insurance, the premium for which is to be collected in weekly, monthly, or other periodical installments by authority of a payroll deduction order executed by the assured and delivered to such insurance company or the assured's employer authorizing the deduction of such premium installments from the assured's salary or wages, shall, during the period for which such policy is issued, declare forfeited or lapsed any such policy hereafter issued or renewed until and unless a written or printed notice of the failure of the employer to remit said premium or installment thereof stating the amount or portion thereof due on such policy and to whom it must be paid, has been duly addressed and mailed to the person who is insured under such policy at least 15 days before said policy is canceled or lapsed.

§ 58-51-25. Policy coverage to continue as to mentally retarded or physically handicapped children.

An individual or group accident and health insurance policy, hospital service policy, or medical service plan policy, delivered or issued for delivery in this State after July 1, 1969, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract, shall also provide in substance that attainment of such limiting age shall not operate or terminate the coverage of such child while the child is and continues to be (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (ii) chiefly dependent upon the policyholder or subscriber for support and maintenance: Provided, proof of such incapacity and dependency is furnished to the insurer, hospital service plan corporation, or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation, but not more frequently than annually after the child's attainment of the limiting age.

General Statutes (already apply to service corporations) that would apply to HMOs:

§ 58-51-35. Insurers and others to afford coverage to mentally retarded and physically handicapped children.

(a) No insurance company licensed in this State pursuant to the provisions of Articles 1 through 64 of this Chapter and no corporation governed by the provisions of Articles 65 and 66 of this Chapter shall refuse to issue or deliver any individual or group accident and health insurance policy of hospital or medical service plan policy in this State which it is currently issuing for delivery in this State and which affords benefits or coverage for minor children of the applicant, by reason of the physical handicap or mental retardation of any minor children of the applicant; nor shall any such policy issued and delivered in this State carry a higher premium rate or charge or restrict or exclude coverage or benefits by reason of said mental retardation or physical handicap. Provided, however, such policy may exclude benefits, otherwise payable for disability, hospitalization, or medical or other therapeutic expense directly and solely attributable to such mental retardation or such physical handicap.

(b) The Commissioner shall revoke the license of any insurer or any corporation governed by the provisions of Articles 65 and 66 of this Chapter if it fails to comply with the provisions of this section.

(c) The provisions of this section shall apply to corporations governed by the provisions of Articles 65 and 66 of this Chapter.

§ 58-51-45. Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.

No insurance company licensed in this State pursuant to the provisions of Articles 1 through 64 of this Chapter shall refuse to issue or deliver any policy (regardless of whether any of such policies shall be defined as individual, family, group, blanket, franchise, industrial or otherwise) which is currently being issued for delivery in this State, and which affords benefits or coverage for any medical treatment or service authorized or permitted to be furnished by a hospital, clinic, family health plan, neighborhood health plan, health maintenance organization, physician, physician's assistant, nurse practitioner or any medical service facility or personnel by reason of the fact that the person to be insured possesses sickle cell trait or hemoglobin C trait, nor shall any such policy issued and delivered in this State carry a higher premium rate or charge by reason of the fact that the person to be insured possesses said trait.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 17, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 17, 1999, at 12:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Meg Tatum (Cumberland County), Greg Stryker (Cumberland County), Chandler Vatavuk (Durham County), and Ashley Moore (Wake County). The following Committee members were present: Representatives Boyd-McIntrye, Brubaker, Cole, Dedmon, Grady, Howard, Saunders, Wainwright, C. Wilson, and Wright, Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bill was considered:

SB 594, entitled, AN ACT TO CLARIFY THE LAWS ON TITLE INSURANCE RATE MAKING, COMMERCIAL GENERAL LIABILITY POLICY EXTENDED REPORTING, AND INSURANCE FRAUD; TO MAKE A TECHNICAL CORRECTION IN THE LITTERING LAW; TO PROVIDE FOR UNIFORM APPLICATION OF NEW LAWS TO HEALTH BENEFIT PLANS; TO AMEND THE LAW GOVERNING CEASE AND DESIST ORDERS FOR UNAUTHORIZED INSURERS, TO ALLOW LICENSING OF A FOREIGN OR ALIEN INSURER TO BE DELAYED UNDER CERTAIN CIRCUMSTANCES, TO AMEND THE LAW GOVERNING AN INSURER'S ACKNOWLEDGEMENT OF A CLAIM, AND TO PROVIDE THAT POLICIES WRITTEN BY SURETY BONDSMEN ARE SUBJECT TO THE LAW GOVERNING THE USE OF DEPOSITS FOR UNPAID LIABILITIES. Representative Saunders made a motion to consider a proposed House committee substitute for SB 594. Motion passed. Bill Hale with the Department of Insurance was recognized to explain the proposed committee substitute section by section. Representative C. Wilson presented an amendment (attached) which amends the bill on page 6, lines 29-38, and moved that it be adoped. The motion passed. Representative Wright made a motion to roll the amendment into the proposed committee substitute and give a favorable report to the House committee substitute, unfavorable report to the Senate committee substitute. The motion passed.

There being no further business, the Chair adjourned the meeting at 12:35 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

Attachments: Visitor Registration Form, SB 594, Proposed Committee Substitute, Amendment and Bill Analysis

VISITOR REGISTRATION SHEET

Insurance — 6/17/99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ben Murray	NCNA
Joe Glusa	Pfizer Inc
Glenn Jernigan	Property and Casualty Assn of N.C.
[illegible]	NCMHP
[illegible]	BCBSNC
[illegible]	NCSOS
Susan Valauri	Nationwide
[illegible]	Jordan Price Wall
[illegible]	Bailey & Dixon
Lori G Harris	BCBS
Jenni Cohen	NCMS
Joyce Rakes	MANC
Adam Searing	NCHAC
Andy Ellen	NCRMA
[illegible]	NCPHA
NM Potter Jr	NCDOS & NCPDA
MT Burnett	GACPD

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 594 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE LAWS ON TITLE INSURANCE RATE MAKING, COMMERCIAL GENERAL LIABILITY POLICY EXTENDED REPORTING, AND INSURANCE FRAUD; TO MAKE A TECHNICAL CORRECTION IN THE LITTERING LAW; TO PROVIDE FOR UNIFORM APPLICATION OF NEW LAWS TO HEALTH BENEFIT PLANS; TO AMEND THE LAW GOVERNING CEASE AND DESIST ORDERS FOR UNAUTHORIZED INSURERS, TO ALLOW LICENSING OF A FOREIGN OR ALIEN INSURER TO BE DELAYED UNDER CERTAIN CIRCUMSTANCES, TO AMEND THE LAW GOVERNING AN INSURER'S ACKNOWLEDGEMENT OF A CLAIM, AND TO PROVIDE THAT POLICIES WRITTEN BY SURETY BONDSMEN ARE SUBJECT TO THE LAW GOVERNING THE USE OF DEPOSITS FOR UNPAID LIABILITIES.

☐ 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.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 3

SENATE BILL 594
Insurance Committee Substitute Adopted 4/22/99
House Committee Substitute Favorable 6/22/99

Short Title: Miscellaneous Ins. Changes. (Public)

Sponsors:

Referred to:

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAWS ON TITLE INSURANCE RATE MAKING, COMMERCIAL GENERAL LIABILITY POLICY EXTENDED REPORTING, AND INSURANCE FRAUD; TO MAKE A TECHNICAL CORRECTION IN THE LITTERING LAW; TO PROVIDE FOR UNIFORM APPLICATION OF NEW LAWS TO HEALTH BENEFIT PLANS; TO AMEND THE LAW GOVERNING CEASE AND DESIST ORDERS FOR UNAUTHORIZED INSURERS; TO ALLOW LICENSING OF A FOREIGN OR ALIEN INSURER TO BE DELAYED UNDER CERTAIN CIRCUMSTANCES; TO AMEND THE LAW GOVERNING AN INSURER'S ACKNOWLEDGMENT OF A CLAIM; TO PROVIDE THAT POLICIES WRITTEN BY SURETY BONDSMEN ARE SUBJECT TO THE LAW GOVERNING THE USE OF DEPOSITS FOR UNPAID LIABILITIES; TO DELAY THE EFFECTIVE DATE FOR THE REGULATION OF THIRD-PARTY ADMINISTRATORS FOR SELF-INSURED WORKERS' COMPENSATION; TO AMEND THE LAW ON COVERAGE FOR NONFORMULARY DRUGS; AND TO MAKE VARIOUS TECHNICAL CHANGES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of

insurance. This Article does not apply to insurance written under Articles 21, 26, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to aviation insurance; to policies issued in this State covering risks with multistate locations, except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 2. G.S. 58-40-140(a) reads as rewritten:

"(a) Any policy for commercial general liability coverage or professional liability insurance wherein the insurer offers, and the insured elects to purchase, an extended reporting period for claims arising during the expiring policy period must provide:

(1) That in the event of a cancellation permitted by G.S. 58-41-15 or nonrenewal effective under G.S. 58-41-20, there shall be a 30-day period after the effective date of the cancellation or nonrenewal during which the insured may elect to purchase coverage for the extended reporting period.

(2) That the limit of liability in the policy aggregate for the extended reporting period shall be one hundred percent (100%) of the expiring policy ~~aggregate.~~ aggregate that was in effect at the inception of the policy.

(3) Within 45 days after the mailing or delivery of the written request of the insured, the insurer shall mail or deliver the following loss information covering a three-year period:

a. Aggregate information on total closed claims, including date and description of occurrence, and any paid losses;

b. Aggregate information on total open claims, including date and description of occurrence, and amounts of any payments;

c. Information on notice of any occurrence, including date and description of occurrence."

Section 3. G.S. 58-2-161(a) reads as rewritten:

"(a) For the purposes of this section:

(1) ~~'Insurer' includes an entity under Articles 49 and 65 through 67 of this Chapter, the Teachers' and State Employees' Comprehensive Major Medical Plan under Chapter 135 of the General Statutes, and an employer or group of employers that insure its workers' compensation liability under Chapter 97 of the General Statutes.~~ 'Insurer' has the same meaning as in G.S. 58-1-5(3) and also includes:

a. Any hull insurance and protection and indemnity club operating under Article 20 of this Chapter.

b. Any surplus lines insurer operating under Article 21 of this Chapter.
c. Any risk retention group or purchasing group operating under Article 22 of this Chapter.
d. Any local government risk pool operating under Article 23 of this Chapter.
e. Any risk-sharing plan operating under Article 42 of this Chapter.
f. The North Carolina Insurance Underwriting Association operating under Article 45 of this Chapter.
g. The North Carolina Joint Insurance Underwriting Association operating under Article 46 of this Chapter.
h. The North Carolina Insurance Guaranty Association operating under Article 48 of this Chapter.
i. Any multiple employer welfare arrangement operating under Article 49 of this Chapter.
j. The North Carolina Life and Health Insurance Guaranty Association operating under Article 62 of this Chapter.
k. Any service corporation operating under Article 65 of this Chapter.
l. Any health maintenance organization operating under Article 67 of this Chapter.
m. The Teachers' and State Employees' Comprehensive Major Medical Plan operating under Chapter 135 of the General Statutes.
n. A group of employers self-insuring their workers' compensation liabilities under Article 47 of this Chapter.
o. An employer self-insuring its workers' compensation liabilities under Article 5 of Chapter 97 of the General Statutes.
p. The North Carolina Self-Insurance Guaranty Association under Article 4 of Chapter 97 of the General Statutes.
q. Any reinsurer licensed or accredited under this Chapter.

(2) 'Statement' includes any application, notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X rays, test result, or other evidence of loss, injury, or expense."

Section 4. G.S. 14-399(f1) reads as rewritten:

"(f1) If a violation of this section involves the operation of a motor vehicle, upon a finding of guilt, the court shall forward a record of the finding to the Department of Transportation, Division of Motor Vehicles, which shall record a penalty of one point on the violator's drivers license pursuant to the point system established by G.S. 20-16. There shall be no insurance premium surcharge or assessment of points under the

classification plan adopted ~~pursuant to G.S. 58-30.4~~ under G.S. 58-36-65 for a finding of guilt under this section."

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

"**§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.**

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' does not mean any 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. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Insurer' includes 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) Whenever a law is enacted by the General Assembly that applies to a health benefit plan, the term 'health benefit plan' shall be defined for purposes of that law as provided in subsection (a) of this section unless that law provides a different

definition or otherwise expressly provides that the definition in this section is not applicable.

(c) Whenever a law is enacted by the General Assembly that applies to health benefit plans that are delivered, issued for delivery, or renewed on and after a certain date, the renewal of a health benefit plan 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."

Section 6. G.S. 58-28-20 reads as rewritten:

"**§ 58-28-20. Cease and desist orders.**

(a) Whenever the Commissioner, from evidence satisfactory to him, has reasonable grounds to believe that any person is violating or is about to violate G.S. 58-28-5, he may, after notice and opportunity for hearing, reduce his findings to writing and issue and cause to be served upon such person an order to cease and desist from violating G.S. 58-28-5.

(b) Until the expiration of the time allowed under G.S. 58-28-25(a) for filing a petition for review, if no such petition has been duly filed within such time; or if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the Court, the Commissioner may at any time, upon such notice and in such manner as he considers proper, modify or set aside in whole or in part any order issued by him under this section.

(c) After the expiration of the time allowed for filing a petition for review, if no such petition has been duly filed within such time, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued by him under this section, whenever in his opinion conditions of fact or of law have so changed as to require such action or if the public interest requires.

(d) Whenever the Commissioner has evidence that any person has or is violating G.S. 58-28-5, or has or is violating any order or requirement of the Commissioner issued or promulgated by the Commissioner under this Article, and that the interests of policyholders, creditors, or the public may be irreparably harmed by delay, the Commissioner may issue a cease and desist order. Notice of the cease and desist order and notice of hearing shall be delivered by first-class mail."

Section 7. G.S. 58-16-5 is amended by adding a new subdivision to read:

"(8) Satisfies the Commissioner that the operation of the company in this State would not be hazardous to prospective policyholders, creditors, or the general public."

Section 8. G.S. 58-5-63 reads as rewritten:

"**§ 58-5-63. Interest; liquidation of deposits for liabilities.**

(a) All insurance companies making deposits under this Article are entitled to interest on those deposits, which shall remain in the deposit accounts. 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.

(b) If any company fails to pay its insurance policy liabilities after those liabilities have been established by settlement or final adjudication, the Commissioner may liquidate the amount of the company's deposit and accrued interest specified in subsection (a) of this section that will satisfy the company's policy liabilities and make payment to the person to whom the liability is owed. After payment has been made, the Commissioner may require the company to deposit the amount paid out under this subsection. As used in this section, 'insurance policy' includes a policy written by a surety bondsman under Article 71 of this Chapter."

Section 9. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes an insured, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer."

Section 10. Section 58(b) of S.L. 1998-217 reads as rewritten:

"(b) This section becomes effective January 1, ~~2000.~~ 2002."

Section 11.(a) Section 2.1 of S.L. 1999-132 is repealed.

Section 11.(b) G.S. 58-30-10(14), as amended by Section 7.3 of S.L. 1999-132, reads as rewritten:

"(14) 'Insurer' means any entity that is or should be licensed under Articles 7, 16, 26, 47, 49, 65, or 67 of this Chapter or under Article 5 of Chapter 97 of the General Statutes. For the purposes of this Article, 'insurer' also includes continuing care retirement ~~centers~~ communities that are or should be licensed under Article 64 of this Chapter."

Section 12.(a) G.S. 58-36-75(b) and G.S. 58-36-75(e) are repealed.

Section 12.(b) G.S. 58-36-75(d) reads as rewritten:

"(d) There shall be no ~~Facility recoupment surcharge under G.S. 58-37-40(f) or~~ Safe Driver Incentive Plan surcharges under G.S. 58-36-65 for accidents occurring when only operating a firefighting, rescue squad, or law enforcement vehicle in accordance with G.S. 20-125(b) and in response to an emergency if the operator of the vehicle at the time of the accident was a paid or volunteer member of any fire department, rescue squad, or any law enforcement agency. This exception does not include an accident occurring after the vehicle ceases to be used in response to the emergency and the emergency ceases to exist."

Section 13. The Codifier of Rules may amend the text of the administrative rules in Title 11 of the North Carolina Administrative Code to reflect the recodification of Chapter 58 of the General Statutes. An amendment pursuant to this section is exempt from Chapter 150B of the General Statutes and review by the

Rules Review Commission to the extent that it does not change the substance of the rule.

Section 14.(a) G.S. 58-3-221(c), as enacted by S.L. 1999-178, reads as rewritten:

"(c) As used in this section:

(1) 'Closed formulary' means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

~~(1)~~ (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 by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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 are statutorily required to be contained in any liability policy or equivalent self-insurance.

~~(2)~~ (3) 'Insurer' means an entity that writes a health benefit plan and that is 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 under Article 49 of this Chapter."

Section 14.(b) G.S. 58-3-221, as enacted by S.L. 1999-178, is amended by adding a new subsection to read:

"(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer."

Section 15. Sections 1 through 3 and Sections 5 through 9 of this act become effective October 1, 1999. The remaining sections of this act are effective when they become law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 594
Insurance Committee Substitute Adopted 4/22/99
Proposed House Committee Substitute S594-PCS1758-RN

Short Title: Miscellaneous Ins. Changes. (Public)

Sponsors:

Referred to:

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAWS ON TITLE INSURANCE RATE MAKING, COMMERCIAL GENERAL LIABILITY POLICY EXTENDED REPORTING, AND INSURANCE FRAUD; TO MAKE A TECHNICAL CORRECTION IN THE LITTERING LAW; TO PROVIDE FOR UNIFORM APPLICATION OF NEW LAWS TO HEALTH BENEFIT PLANS; TO AMEND THE LAW GOVERNING CEASE AND DESIST ORDERS FOR UNAUTHORIZED INSURERS; TO ALLOW LICENSING OF A FOREIGN OR ALIEN INSURER TO BE DELAYED UNDER CERTAIN CIRCUMSTANCES; TO AMEND THE LAW GOVERNING AN INSURER'S ACKNOWLEDGMENT OF A CLAIM; TO PROVIDE THAT POLICIES WRITTEN BY SURETY BONDSMEN ARE SUBJECT TO THE LAW GOVERNING THE USE OF DEPOSITS FOR UNPAID LIABILITIES; TO DELAY THE EFFECTIVE DATE FOR THE REGULATION OF THIRD-PARTY ADMINISTRATORS FOR SELF-INSURED WORKERS' COMPENSATION; TO AMEND THE LAW ON COVERAGE FOR NONFORMULARY DRUGS; AND TO MAKE VARIOUS TECHNICAL CHANGES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of

insurance. This Article does not apply to insurance written under Articles 21, 26, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to aviation insurance; to policies issued in this State covering risks with multistate locations, except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 2. G.S. 58-40-140(a) reads as rewritten:

"(a) Any policy for commercial general liability coverage or professional liability insurance wherein the insurer offers, and the insured elects to purchase, an extended reporting period for claims arising during the expiring policy period must provide:

(1) That in the event of a cancellation permitted by G.S. 58-41-15 or nonrenewal effective under G.S. 58-41-20, there shall be a 30-day period after the effective date of the cancellation or nonrenewal during which the insured may elect to purchase coverage for the extended reporting period.

(2) That the limit of liability in the policy aggregate for the extended reporting period shall be one hundred percent (100%) of the expiring policy ~~aggregate.~~ aggregate that was in effect at the inception of the policy.

(3) Within 45 days after the mailing or delivery of the written request of the insured, the insurer shall mail or deliver the following loss information covering a three-year period:

a. Aggregate information on total closed claims, including date and description of occurrence, and any paid losses;

b. Aggregate information on total open claims, including date and description of occurrence, and amounts of any payments;

c. Information on notice of any occurrence, including date and description of occurrence."

Section 3. G.S. 58-2-161(a) reads as rewritten:

"(a) For the purposes of this section:

(1) ~~'Insurer' includes an entity under Articles 49 and 65 through 67 of this Chapter, the Teachers' and State Employees' Comprehensive Major Medical Plan under Chapter 135 of the General Statutes, and an employer or group of employers that insure its workers' compensation liability under Chapter 97 of the General Statutes.~~ 'Insurer' has the same meaning as in G.S. 58-1-5(3) and also includes:

a. Any hull insurance and protection and indemnity club operating under Article 20 of this Chapter.

b. Any surplus lines insurer operating under Article 21 of this Chapter.
c. Any risk retention group or purchasing group operating under Article 22 of this Chapter.
d. Any local government risk pool operating under Article 23 of this Chapter.
e. Any risk-sharing plan operating under Article 42 of this Chapter.
f. The North Carolina Insurance Underwriting Association operating under Article 45 of this Chapter.
g. The North Carolina Joint Insurance Underwriting Association operating under Article 46 of this Chapter.
h. The North Carolina Insurance Guaranty Association operating under Article 48 of this Chapter.
i. Any multiple employer welfare arrangement operating under Article 49 of this Chapter.
j. The North Carolina Life and Health Insurance Guaranty Association operating under Article 62 of this Chapter.
k. Any service corporation operating under Article 65 of this Chapter.
l. Any health maintenance organization operating under Article 67 of this Chapter.
m. The Teachers' and State Employees' Comprehensive Major Medical Plan operating under Chapter 135 of the General Statutes.
n. A group of employers self-insuring their workers' compensation liabilities under Article 47 of this Chapter.
o. An employer self-insuring its workers' compensation liabilities under Article 5 of Chapter 97 of the General Statutes.
p. The North Carolina Self-Insurance Guaranty Association under Article 4 of Chapter 97 of the General Statutes.
q. Any reinsurer licensed or accredited under this Chapter.

(2) 'Statement' includes any application, notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X rays, test result, or other evidence of loss, injury, or expense."

Section 4. G.S. 14-399(f1) reads as rewritten:

"(f1) If a violation of this section involves the operation of a motor vehicle, upon a finding of guilt, the court shall forward a record of the finding to the Department of Transportation, Division of Motor Vehicles, which shall record a penalty of one point on the violator's drivers license pursuant to the point system established by G.S. 20-16. There shall be no insurance premium surcharge or assessment of points under the

classification plan adopted ~~pursuant to G.S. 58-30.4~~ under G.S. 58-36-65 for a finding of guilt under this section."

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

"**§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.**

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' does not mean any 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. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Insurer' includes 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) Whenever a law is enacted by the General Assembly that applies to a health benefit plan, the term 'health benefit plan' shall be defined for purposes of that law as provided in subsection (a) of this section unless that law provides a different

definition or otherwise expressly provides that the definition in this section is not applicable.

(c) Whenever a law is enacted by the General Assembly that applies to health benefit plans that are delivered, issued for delivery, or renewed on and after a certain date, the renewal of a health benefit plan 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."

Section 6. G.S. 58-28-20 reads as rewritten:

"**§ 58-28-20. Cease and desist orders.**

(a) Whenever the Commissioner, from evidence satisfactory to him, has reasonable grounds to believe that any person is violating or is about to violate G.S. 58-28-5, he may, after notice and opportunity for hearing, reduce his findings to writing and issue and cause to be served upon such person an order to cease and desist from violating G.S. 58-28-5.

(b) Until the expiration of the time allowed under G.S. 58-28-25(a) for filing a petition for review, if no such petition has been duly filed within such time; or if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the Court, the Commissioner may at any time, upon such notice and in such manner as he considers proper, modify or set aside in whole or in part any order issued by him under this section.

(c) After the expiration of the time allowed for filing a petition for review, if no such petition has been duly filed within such time, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued by him under this section, whenever in his opinion conditions of fact or of law have so changed as to require such action or if the public interest requires.

(d) Whenever the Commissioner has evidence that any person has or is violating G.S. 58-28-5, or has or is violating any order or requirement of the Commissioner issued or promulgated by the Commissioner under this Article, and that the interests of policyholders, creditors, or the public may be irreparably harmed by delay, the Commissioner may issue a cease and desist order. Notice of the cease and desist order and notice of hearing shall be delivered by first-class mail."

Section 7. G.S. 58-16-5 is amended by adding a new subdivision to read:

"(8) Satisfies the Commissioner that the operation of the company in this State would not be hazardous to prospective policyholders, creditors, or the general public."

Section 8. G.S. 58-5-63 reads as rewritten:

"**§ 58-5-63. Interest; liquidation of deposits for liabilities.**

(a) All insurance companies making deposits under this Article are entitled to interest on those deposits, which shall remain in the deposit accounts. 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.

(b) If any company fails to pay its insurance policy liabilities after those liabilities have been established by settlement or final adjudication, the Commissioner may liquidate the amount of the company's deposit and accrued interest specified in subsection (a) of this section that will satisfy the company's policy liabilities and make payment to the person to whom the liability is owed. After payment has been made, the Commissioner may require the company to deposit the amount paid out under this subsection. As used in this section, 'insurance policy' includes a policy written by a surety bondsman under Article 71 of this Chapter."

Section 9. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes an insured, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer."

Section 10. Section 58(b) of S.L. 1998-217 reads as rewritten:

"(b) This section becomes effective January 1, ~~2000.~~ 2002."

Section 11.(a) Section 2.1 of S.L. 1999-132 is repealed.

Section 11.(b) G.S. 58-30-10(14), as amended by Section 7.3 of S.L. 1999-132, reads as rewritten:

"(14) 'Insurer' means any entity that is or should be licensed under Articles 7, 16, 26, 47, 49, 65, or 67 of this Chapter or under Article 5 of Chapter 97 of the General Statutes. For the purposes of this Article, 'insurer' also includes continuing care retirement ~~centers~~ communities that are or should be licensed under Article 64 of this Chapter."

Section 12.(a) G.S. 58-36-75(b) and G.S. 58-36-75(e) are repealed.

Section 12.(b) G.S. 58-36-75(d) reads as rewritten:

"(d) There shall be no ~~Facility recoupment surcharge under G.S. 58-37-40(f) or~~ Safe Driver Incentive Plan surcharges under G.S. 58-36-65 for accidents occurring when only operating a firefighting, rescue squad, or law enforcement vehicle in accordance with G.S. 20-125(b) and in response to an emergency if the operator of the vehicle at the time of the accident was a paid or volunteer member of any fire department, rescue squad, or any law enforcement agency. This exception does not include an accident occurring after the vehicle ceases to be used in response to the emergency and the emergency ceases to exist."

Section 13. The Codifier of Rules may amend the text of the administrative rules in Title 11 of the North Carolina Administrative Code to reflect the recodification of Chapter 58 of the General Statutes. An amendment pursuant to this section is exempt from Chapter 150B of the General Statutes and review by the

Rules Review Commission to the extent that it does not change the substance of the rule.

Section 14.(a) G.S. 58-3-221(c), as enacted by S.L. 1999-178, reads as rewritten:

"(c) As used in this section:

(1) 'Closed formulary' means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

~~(1)~~ (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 by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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 are statutorily required to be contained in any liability policy or equivalent self-insurance.

~~(2)~~ (3) 'Insurer' means an entity that writes a health benefit plan and that is 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 under Article 49 of this Chapter."

Section 14.(b) G.S. 58-3-221, as enacted by S.L. 1999-178, is amended by adding a new subsection to read:

"(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer."

Section 15. Sections 1 through 3 and Sections 5 through 9 of this act become effective October 1, 1999. The remaining sections of this act are effective when they become law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 594
Insurance Committee Substitute Adopted 4/22/99

Proposed House Committe Substitute
S594-CSRN-003

Short Title: Miscellaneous Ins. Changes. (Public)

Sponsors:

Referred to:

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAWS ON TITLE INSURANCE RATE MAKING, COMMERCIAL GENERAL LIABILITY POLICY EXTENDED REPORTING, AND INSURANCE FRAUD; TO MAKE A TECHNICAL CORRECTION IN THE LITTERING LAW; TO PROVIDE FOR UNIFORM APPLICATION OF NEW LAWS TO HEALTH BENEFIT PLANS; TO AMEND THE LAW GOVERNING CEASE AND DESIST ORDERS FOR UNAUTHORIZED INSURERS, TO ALLOW LICENSING OF A FOREIGN OR ALIEN INSURER TO BE DELAYED UNDER CERTAIN CIRCUMSTANCES, TO AMEND THE LAW GOVERNING AN INSURER'S ACKNOWLEDGEMENT OF A CLAIM, TO PROVIDE THAT POLICIES WRITTEN BY SURETY BONDSMEN ARE SUBJECT TO THE LAW GOVERNING THE USE OF DEPOSITS FOR UNPAID LIABILITIES, TO DELAY THE EFFECTIVE DATE FOR THE REGULATION OF THIRD PARTY ADMINISTRATORS FOR SELF-INSURED WORKERS' COMPENSATION, TO AMEND THE LAW ON COVERAGE FOR NONFORMULARY DRUGS, AND TO MAKE VARIOUS TECHNICAL CHANGES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies

licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 26, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to aviation insurance; to policies issued in this State covering risks with multistate locations, except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 2. G.S. 58-40-140(a) reads as rewritten:

"(a) Any policy for commercial general liability coverage or professional liability insurance wherein the insurer offers, and the insured elects to purchase, an extended reporting period for claims arising during the expiring policy period must provide:

(1) That in the event of a cancellation permitted by G.S. 58-41-15 or nonrenewal effective under G.S. 58-41-20, there shall be a 30-day period after the effective date of the cancellation or nonrenewal during which the insured may elect to purchase coverage for the extended reporting period.

(2) That the limit of liability in the policy aggregate for the extended reporting period shall be one hundred percent (100%) of the expiring policy ~~aggregate.~~ aggregate that was in effect at the inception of the policy.

(3) Within 45 days after the mailing or delivery of the written request of the insured, the insurer shall mail or deliver the following loss information covering a three-year period:

a. Aggregate information on total closed claims, including date and description of occurrence, and any paid losses;

b. Aggregate information on total open claims, including date and description of occurrence, and amounts of any payments;

c. Information on notice of any occurrence, including date and description of occurrence."

Section 3. G.S. 58-2-161(a) reads as rewritten:

"(a) For the purposes of this section:

(1) ~~'Insurer' includes an entity under Articles 49 and 65 through 67 of this Chapter, the Teachers' and State Employees' Comprehensive Major Medical Plan under Chapter 135 of the General Statutes, and an employer or group of employers that insure its workers' compensation liability under Chapter 97 of the General Statutes.~~ 'Insurer' has the same meaning as in G.S. 58-1-5(3) and also includes:

a. Any hull insurance and protection and indemnity club operating under Article 20 of this Chapter.

b. Any surplus lines insurer operating under Article 21 of this Chapter.

c. Any risk retention group or purchasing group operating under Article 22 of this Chapter.

d. Any local government risk pool operating under Article 23 of this Chapter.

e. Any risk-sharing plan operating under Article 42 of this Chapter.

f. The North Carolina Insurance Underwriting Association operating under Article 45 of this Chapter.

g. The North Carolina Joint Insurance Underwriting Association operating under Article 46 of this Chapter.

h. The North Carolina Insurance Guaranty Association operating under Article 48 of this Chapter.

i. Any multiple employer welfare arrangement operating under Article 49 of this Chapter.

j. The North Carolina Life and Health Insurance Guaranty Association operating under Article 62 of this Chapter.

k. Any service corporation operating under Article 65 of this Chapter.

l. Any health maintenance organization operating under Article 67 of this Chapter.

m. The Teachers' and State Employees' Comprehensive Major Medical Plan operating under Chapter 135 of the General Statutes.

n. A group of employers self-insuring their workers' compensation liabilities under Article 47 of this Chapter.

o. An employer self-insuring its workers' compensation liabilities under Article 5 of Chapter 97 of the General Statutes.
p. The North Carolina Self-Insurance Guaranty Association under Article 4 of Chapter 97 of the General Statutes.
q. Any reinsurer licensed or accredited under this Chapter.

(2) 'Statement' includes any application, notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X rays, test result, or other evidence of loss, injury, or expense."

Section 4. G.S. 14-399(f1) reads as rewritten:

"(f1) If a violation of this section involves the operation of a motor vehicle, upon a finding of guilt, the court shall forward a record of the finding to the Department of Transportation, Division of Motor Vehicles, which shall record a penalty of one point on the violator's drivers license pursuant to the point system established by G.S. 20-16. There shall be no insurance premium surcharge or assessment of points under the classification plan adopted ~~pursuant to G.S. 58-30.4~~ under G.S. 58-36-65 for a finding of guilt under this section."

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

"**§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.**

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its

representatives. 'Health benefit plan' does not mean any 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. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Insurer' includes 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) Whenever a law is enacted by the General Assembly that applies to a health benefit plan, the term 'health benefit plan' shall be defined for purposes of that law as provided in subsection (a) of this section unless that law provides a different definition or otherwise expressly provides that the definition in this section is not applicable.

(c) Whenever a law is enacted by the General Assembly that applies to health benefit plans that are delivered, issued for delivery, or renewed on and after a certain date, the renewal of a health benefit plan 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."

Section 6. G.S. 58-28-20 reads as rewritten:

"**§ 58-28-20. Cease and desist orders.**

(a) Whenever the Commissioner, from evidence satisfactory to him, has reasonable grounds to believe that any person is

violating or is about to violate G.S. 58-28-5, he may, after notice and opportunity for hearing, reduce his findings to writing and issue and cause to be served upon such person an order to cease and desist from violating G.S. 58-28-5.

(b) Until the expiration of the time allowed under G.S. 58-28-25(a) for filing a petition for review, if no such petition has been duly filed within such time; or if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the Court, the Commissioner may at any time, upon such notice and in such manner as he considers proper, modify or set aside in whole or in part any order issued by him under this section.

(c) After the expiration of the time allowed for filing a petition for review, if no such petition has been duly filed within such time, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued by him under this section, whenever in his opinion conditions of fact or of law have so changed as to require such action or if the public interest requires.

(d) Whenever the Commissioner has evidence that any person has or is violating G.S. 58-28-5, or has or is violating any order or requirement of the Commissioner issued or promulgated by the Commissioner under this Article, and that the interests of policyholders, creditors, or the public may be irreparably harmed by delay, the Commissioner may issue a cease and desist order. Notice of the cease and desist order and notice of hearing shall be delivered by first-class mail."

Section 7. Article 16 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-16-6. Interests of prospective policyholders.**

Notwithstanding G.S. 58-16-5, the Commissioner may delay the licensing of a foreign or alien insurance company if, in the Commissioner's opinion, the operation of the company in this State would be hazardous to prospective policyholders, creditors, or the general public. The Commissioner may license the company after the grounds for delaying the license have been corrected, eliminated, or remedied."

Section 8. G.S. 58-5-63 reads as rewritten:

"**§ 58-5-63. Interest; liquidation of deposits for liabilities.**

(a) All insurance companies making deposits under this Article are entitled to interest on those deposits, which shall remain in the deposit accounts. 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.

(b) If any company fails to pay its insurance policy liabilities after those liabilities have been established by settlement or final adjudication, the Commissioner may liquidate the amount of the company's deposit and accrued interest specified in subsection (a) of this section that will satisfy the company's policy liabilities and make payment to the person to whom the liability is owed. After payment has been made, the Commissioner may require the company to deposit the amount paid out under this subsection. As used in this section, 'insurance policy' includes a policy written by a surety bondsman under Article 71 of this Chapter."

Section 9. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes an insured, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer."

Section 10. Section 58(b) of S.L. 1998-217 reads as rewritten:

"(b) This section becomes effective January 1, ~~2000.~~ 2002."

Section 11(a). Section 2.1 of S.L. 1999-132 is repealed.

Section 11(b). G.S. 58-30-10(14), as amended by Section 7.3 of S.L. 1999-132, reads as rewritten:

"(14) 'Insurer' means any entity that is or should be licensed under Articles 7, 16, 26, 47, 49, 65, or 67 of this Chapter or under Article 5 of Chapter 97 of the General Statutes. For the purposes of this Article, 'insurer' also includes continuing care retirement ~~centers~~ communities that are or should be licensed under Article 64 of this Chapter."

Section 12(a). G.S. 58-36-75(b) and G.S. 58-36-75(e) are repealed.

Section 12(b). G.S. 58-36-75(d) reads as rewritten:

"(d) There shall be no ~~Facility recoupment surcharge under G.S. 58-37-40(f) or~~ Safe Driver Incentive Plan surcharges under G.S. 58-36-65 for accidents occurring when only operating a firefighting, rescue squad, or law enforcement vehicle in accordance with G.S. 20-125(b) and in response to an emergency if the operator of the vehicle at the time of the accident was a paid or volunteer member of any fire department, rescue squad, or any law enforcement agency. This exception does not include an accident occurring after the vehicle ceases to be used in response to the emergency and the emergency ceases to exist."

Section 13. The Codifier of Rules may amend the text of the administrative rules in Title 11 of the North Carolina Administrative Code to reflect the recodification of Chapter 58 of the General Statutes. An amendment pursuant to this section is exempt from Chapter 150B of the General Statutes and review by the Rules Review Commission to the extent that it does not change the substance of the rule.

Section 14(a). G.S. 58-3-221(c), as enacted by S.L. 1999-178, reads as rewritten:

"(c) As used in this section:

(1) 'Closed formulary' means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

~~(1)~~ (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 by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, 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 care 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 are statutorily required to be contained in any liability policy or equivalent self-insurance.

~~(2)~~ (3) 'Insurer' means an entity that writes a health benefit plan and that is 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 under Article 49 of this Chapter."

Section 14(b). G.S. 58-3-221, as enacted by S.L. 1999-178, is amended by adding a new subsection to read:

"(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer."

Section 15. Sections 1 through 3 and sections 5 through 9 of this act become effective October 1, 1999. The remaining sections of this act are effective when they become law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 594
Insurance Committee Substitute Adopted 4/22/99

Short Title: Miscellaneous Ins. Changes. (Public)

Sponsors:

Referred to:

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAWS ON TITLE INSURANCE RATE MAKING, COMMERCIAL GENERAL LIABILITY POLICY EXTENDED REPORTING, AND INSURANCE FRAUD; TO MAKE A TECHNICAL CORRECTION IN THE LITTERING LAW; TO PROVIDE FOR UNIFORM APPLICATION OF NEW LAWS TO HEALTH BENEFIT PLANS; TO AMEND THE LAW GOVERNING CEASE AND DESIST ORDERS FOR UNAUTHORIZED INSURERS, TO ALLOW LICENSING OF A FOREIGN OR ALIEN INSURER TO BE DELAYED UNDER CERTAIN CIRCUMSTANCES, TO AMEND THE LAW GOVERNING AN INSURER'S ACKNOWLEDGEMENT OF A CLAIM, AND TO PROVIDE THAT POLICIES WRITTEN BY SURETY BONDSMEN ARE SUBJECT TO THE LAW GOVERNING THE USE OF DEPOSITS FOR UNPAID LIABILITIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 26, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to aviation insurance; to policies issued in this State covering risks with multistate locations,

except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 2. G.S. 58-40-140(a) reads as rewritten:

"(a) Any policy for commercial general liability coverage or professional liability insurance wherein the insurer offers, and the insured elects to purchase, an extended reporting period for claims arising during the expiring policy period must provide:

(1) That in the event of a cancellation permitted by G.S. 58-41-15 or nonrenewal effective under G.S. 58-41-20, there shall be a 30-day period after the effective date of the cancellation or nonrenewal during which the insured may elect to purchase coverage for the extended reporting period.

(2) That the limit of liability in the policy aggregate for the extended reporting period shall be one hundred percent (100%) of the expiring policy ~~aggregate.~~ aggregate that was in effect at the inception of the policy.

(3) Within 45 days after the mailing or delivery of the written request of the insured, the insurer shall mail or deliver the following loss information covering a three-year period:

a. Aggregate information on total closed claims, including date and description of occurrence, and any paid losses;

b. Aggregate information on total open claims, including date and description of occurrence, and amounts of any payments;

c. Information on notice of any occurrence, including date and description of occurrence."

Section 3. G.S. 58-2-161(a) reads as rewritten:

"(a) For the purposes of this section:

(1) ~~'Insurer' includes an entity under Articles 49 and 65 through 67 of this Chapter, the Teachers' and State Employees' Comprehensive Major Medical Plan under Chapter 135 of the General Statutes, and an employer or group of employers that insure its workers' compensation liability under Chapter 97 of the General Statutes.~~ 'Insurer' has the same meaning as in G.S. 58-1-5(3) and also includes:

a. Any hull insurance and protection and indemnity club operating under Article 20 of this Chapter.

b. Any surplus lines insurer operating under Article 21 of this Chapter.

c. Any risk retention group or purchasing group operating under Article 22 of this Chapter.

d. Any local government risk pool operating under Article 23 of this Chapter.
e. Any risk-sharing plan operating under Article 42 of this Chapter.
f. The North Carolina Insurance Underwriting Association operating under Article 45 of this Chapter.
g. The North Carolina Joint Insurance Underwriting Association operating under Article 46 of this Chapter.
h. The North Carolina Insurance Guaranty Association operating under Article 48 of this Chapter.
i. Any multiple employer welfare arrangement operating under Article 49 of this Chapter.
j. The North Carolina Life and Health Insurance Guaranty Association operating under Article 62 of this Chapter.
k. Any service corporation operating under Article 65 of this Chapter.
l. Any health maintenance organization operating under Article 67 of this Chapter.
m. The Teachers' and State Employees' Comprehensive Major Medical Plan operating under Chapter 135 of the General Statutes.
n. A group of employers self-insuring their workers' compensation liabilities under Article 47 of this Chapter.
o. An employer self-insuring its workers' compensation liabilities under Article 5 of Chapter 97 of the General Statutes.
p. The North Carolina Self-Insurance Guaranty Association under Article 4 of Chapter 97 of the General Statutes.
q. Any reinsurer licensed or accredited under this Chapter.

(2) 'Statement' includes any application, notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X rays, test result, or other evidence of loss, injury, or expense."

Section 4. G.S. 14-399(f1) reads as rewritten:

"(f1) If a violation of this section involves the operation of a motor vehicle, upon a finding of guilt, the court shall forward a record of the finding to the Department of Transportation, Division of Motor Vehicles, which shall record a penalty of one point on the violator's drivers license pursuant to the point system established by G.S. 20-16. There shall be no insurance premium surcharge or assessment of points under the classification plan adopted ~~pursuant to G.S. 58-30.4~~ under G.S. 58-36-65 for a finding of guilt under this section."

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

"§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' does not mean any 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.

(2) 'Insurer' includes 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) Whenever a law is enacted by the General Assembly that applies to health benefit plans that are delivered, issued for delivery, or renewed on and after a certain date, the renewal of a health benefit plan 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."

Section 6. G.S. 58-28-20 reads as rewritten:

"**§ 58-28-20. Cease and desist orders.**

(a) Whenever the Commissioner, from evidence satisfactory to him, has reasonable grounds to believe that any person is violating or is about to violate G.S. 58-28-5, he may, after notice and opportunity for hearing, reduce his findings to

writing and issue and cause to be served upon such person an order to cease and desist from violating G.S. 58-28-5.

(b) Until the expiration of the time allowed under G.S. 58-28-25(a) for filing a petition for review, if no such petition has been duly filed within such time; or if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the Court, the Commissioner may at any time, upon such notice and in such manner as he considers proper, modify or set aside in whole or in part any order issued by him under this section.

(c) After the expiration of the time allowed for filing a petition for review, if no such petition has been duly filed within such time, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued by him under this section, whenever in his opinion conditions of fact or of law have so changed as to require such action or if the public interest requires.

(d) Whenever the Commissioner has articulate evidence that any person has or is violating G.S. 58-28-5, or has or is violating any order or requirement of the Commissioner issued or promulgated by the Commissioner under this Article, and that the interests of policyholders, creditors, or the public may be irreparably harmed by delay, the Commissioner may issue a cease and desist order. Notice of the cease and desist order and notice of hearing shall be delivered by first-class mail."

Section 7. Article 16 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-16-6. Interests of prospective policyholders.**

Notwithstanding G.S. 58-16-5, the Commissioner may delay the licensing of a foreign or alien insurance company if, in the Commissioner's opinion, the operation of the company in this State would be hazardous to prospective policyholders, creditors, or the general public. The Commissioner may license the company after the grounds for delaying the license have been corrected, eliminated, or remedied."

Section 8. G.S. 58-5-63 reads as rewritten:

"**§ 58-5-63. Interest; liquidation of deposits for liabilities.**

(a) All insurance companies making deposits under this Article are entitled to interest on those deposits, which shall remain in the deposit accounts. 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.

(b) If any company fails to pay its insurance policy liabilities after those liabilities have been established by settlement or final adjudication, the Commissioner may liquidate the amount of the company's deposit and accrued interest specified in subsection (a) of this section that will satisfy the company's policy liabilities and make payment to the person to whom the liability is owed. After payment has been made, the Commissioner may require the company to deposit the amount paid out under this subsection. As used in this section, 'insurance policy' includes a policy written by a surety bondsman under Article 71 of this Chapter."

Section 8.1. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes an insured, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer."

Section 9. This act becomes effective October 1, 1999.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

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 s 29-38

( ) WHICH CHANGES THE TITLE

by rewriting those lines to read:

Section 7. G.S. 58-16-5 is amended by adding a new subdivision:

"(8) Satisfies the Commissioner that the operation of the company in this State would not be hazardous to prospective policyholders, creditors, or the general public."

SIGNED Connie Wilson

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

SB 594:
Miscellaneous Insurance Changes

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Miller
Date:	June 10, 1999	**Summary by:**	Linwood Jones
Version:	House PCS		Committee Counsel

Section 1 of the bill deletes title insurance from the Insurance Regulatory Reform Act of 1986. That Act, which was passed in 1986 during the liability insurance crisis, provides certain protection to insureds with respect to cancellations and nonrenewals of policies. The Act covers only certain types of policies, including title insurance. The Department of Insurance has recommended removing title insurance from this Act because title insurance does not readily fit under the Act's provisions and because title insurance regulation is already provided for elsewhere in the insurance laws.

Section 2 amends the law that currently governs professional liability insurance and commercial general liability insurance policies that provide for extended reporting periods for claims arising during the expiring policy period. The law currently provides that the liability limits for the extended reporting period must be the same as the expiring policy aggregate. Section 2 provides that the liability limits for the extended reporting period must be the same as the expiring policy's limits at its inception.

Section 3 expands the definition of who is an insurer for purposes of the insurance fraud laws. The revised definition adds various other insurer-type groups: hull insurance and protection and indemnity clubs (relating to commercial fishermen), surplus lines carriers, risk retention groups, local government risk pools, several different types of JUAs, and the guaranty associations.

Section 4 corrects an outdated reference in the littering laws. The reference is to the statute that relates to the assessment of insurance points.

Section 5 provides that when the legislature enacts a law that applies to health benefit plans delivered, issued for delivery, or renewed on or after a certain date, the *renewal* is presumed to occur on the anniversary date on which coverage was first effective on the person or person covered by the health benefit plan. This type of provision – applying a health law change to policies issued or renewed on or after the effective date of the change – is common in health insurance legislation enacted by the General Assembly. The definition of "health benefit plan" and "insurer" in this section are also compatible with how those terms have typically been defined in health insurance legislation.

This section also provides that when the legislature enacts a law relating to a "health benefit plan," the term health benefit plan will be defined as provided in this section unless the legislature provides otherwise. This definition is the typical definition of a "health benefit plan," except that it also adds "short-term limited duration policies" to the list of health insurance plans that are not included under the term "health benefit plan." Short-term limited duration policies were also excluded recently under the definition of health benefit plans for contraceptive coverage (SB 90).

Section 6 amends the law governing the Commissioner's authority to issue cease and desist orders against unauthorized insurance companies. If the Commissioner has articulate evidence of a past or current violation of this law, and he determines that the policyholders, creditors, or the public may be harmed by delay in issuing a case and desist order, he may issue the order immediately. Notice of the order and of the hearing must be sent by first class mail to the person.

Section 7 amends the law that governs the admission of foreign or alien insurance companies to do business in North Carolina. Section 7 provides that even if the company meets the standards for admission set out in G.S. 58-16-5, the Commissioner can delay granting the company a license if the operation of the company in this State would be hazardous to prospective policyholders, creditors, or the general public. The Commissioner may license the company after the grounds for delay have been remedied.

Section 8 provides that policies written by surety bondsmen fall under the statute that regulates the statutory deposits that surety bond companies are required to make with the Commissioner as a condition of doing business in North Carolina. Deposits (and part of the interest thereon) may be used by the Commissioner to satisfy the company's unpaid policy liabilities that have been established by settlement or final judgment.

Section 9 makes clear that the law requiring insurance companies to promptly acknowledge a filed claim also applies to HMOs, service corporations, and multiple employer welfare arrangements and that a claimant, for purposes of this law, includes both the insured and the insured's health care provider or health care facility who is responsible for directly filing the claim on behalf of the insured.

Section 10 delays the effective date of the licensing law for third party administrators who administer self-insured workers' compensation plans. The law is currently scheduled to take effect January 1, 2000, but this section will delay the effective date for 2 years – until January 1, 2002. The Department of Insurance has asked for additional funding to administer the law and has requested the delay until the funding is available.

Section 11 is a minor technical change to merge two different sections of Session Law 1999-132 (House Bill 296) that amended the same definition of "insurer." The merger of the two changes is carried out by repealing the first change (Section 2.1 of House Bill 296) and rewriting the second change (Section 7.3 of House Bill 296) to reflect both changes.

Section 12(a) repeals two subsections of the law relating to Facility recoupment insurance surcharges on motor vehicles. These two subsections are outdated because they refer to Facility surcharges as if they were still collected based on a person's record of moving violations and accidents. Since 1995, Facility surcharges have been allocated to *all* auto policies, without regard to the driver's record. A similar outdated provision (subsection (c) of the same law) was removed in House Bill 296 earlier this session.

Section 12(b) makes a similar conforming change to subsection (d) of the same law. The reference to Facility recoupment surcharges here is outdated since Facility recoupment surcharges are no longer based on accidents or moving violations. However, because this section also refers to SDIP surcharges – more commonly referred to as "insurance points" – the remainder of subsection (d) is kept intact so that the law as it applies to insurance points is not changed.

Section 13 authorizes the OAH Codifier of Rules to update obsolete statutory references in the Insurance rules without those changes being required to go through the usual rules review process. This is similar to a provision in the House budget (Section 11 of HB 168) allowing the Codifier of Rules to make changes within the rules to reflect the reorganization of DENR and DHHS (as long as the changes do not affect the substance of the rules).

Section 14 amends Senate Bill 347, which has been ratified and is awaiting the Governor's signature in order to become law. Senate Bill 347 requires insurers with closed drug formularies to pay for nonformulary drugs in certain instances. This section amends Senate Bill 347 to provide a definition for a "closed formulary."

Section 15 provides that Sections 1 through 3 and 5 through 9 of this bill become effective October 1, 1999. The remainder of the bill takes effect when it becomes law.

Statutes repealed in Sec. 12

company or company group for at least six continuous months, some or all of which were after the accident, the insurance company shall remove any premium surcharge or assessment of points against the insured if requirements (i), (ii), and (iii) of this subsection are met. Also notwithstanding (iv) of this subsection, an insurance company may choose not to assess a premium surcharge or points against an insured who has been covered by liability insurance with that company or with the company's group for less than six months immediately preceding the accident, if requirements (i), (ii), and (iii) are met.

(a2) The subclassification plan shall provide that there shall be no premium surcharge or assessment of points against an insured where (i) the insured's driver's license has been revoked under G.S. 20-16.5; and (ii) the insured is subsequently acquitted of the offense involving impaired driving, as defined in G.S. 20-4.01(24a), that is related to the revocation, or the charge for that offense is dismissed. In addition, no insurer shall use, for rating, underwriting, or classification purposes, including ceding any risk to the Facility or writing any kind of coverage subject to this Article, any license revocation under G.S. 20-16.5 if the insured is acquitted or the charge is dismissed as described in this subsection.

(b) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) shall provide that with respect to a conviction for any moving traffic violation that is not listed in subsection (c) of this section, there shall be no Motor Vehicle Reinsurance Facility recoupment surcharge pursuant to G.S. 58-37-40(f) unless (i) the vehicle owner, principal operator, or any licensed operator in the owner's household has a driving record consisting of one or more convictions for a moving traffic violation, other than the conviction for the exempt violation, or one or more at-fault accidents during the three-year period immediately preceding the date of the application for a policy or the date of the preparation of the renewal of a policy, or (ii) the moving traffic violation for which the operator has been convicted occurred at the time of an accident for which he was at fault. Nothing in this section affects any provisions in the subclassification plan for premium surcharges for moving traffic violations or at-fault accidents.

(c) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) shall provide for facility recoupment surcharges pursuant to G.S. 58-37-40(f) and G.S. 58-37-75, in addition to premium surcharges, for convictions for the following moving traffic violations:

General Statute	Description of Offense
20-12.1	Being impaired while accompanying a permittee who is learning to drive
20-28	Driving while license is suspended or revoked
20-138.1	Driving a vehicle while impaired
20-138.2	Driving a commercial vehicle while impaired
20-138.3	Driving by provisional licensee after consuming alcohol or drugs

General Statute	Description of Offense
20-140(a)	Driving carelessly and heedlessly in willful or wanton disregard of the rights of others
20-140(b)	Driving without due caution in a manner so as to endanger other people or property
20-141(a)	Only driving at least 11 miles per hour over the posted speed limit
20-141(j1)	Driving more than 15 mph over legal limit
20-141.1	Speeding in a school zone
20-141.3(a)	Engaging in prearranged speed competition with another motor vehicle
20-141.3(b)	Willfully engaging in speed competition with another motor vehicle (not prearranged)
20-141.3(c)	Allowing or authorizing others to use one's motor vehicle in prearranged speed competition or placing or receiving a bet or wager on a prearranged speed competition
20-141.4(a1)	Death by vehicle (unintentionally causing death of another while engaged in impaired driving)
20-141.4(a2)	Death by vehicle (unintentionally causing death of another as a result of a violation of motor vehicle law intended to regulate traffic or used to control operation of a vehicle)
20-141.5	Speeding while fleeing or attempting to elude arrest
20-166(a)	Failure to stop by driver who knew or should have known he was involved in accident and that accident caused death or injury to any person
20-166(c)	Failure of driver involved in accident causing property damage or personal injury or death (if driver did not know of injury or death) to stop at scene of accident
20-175.2	Failure to yield right-of-way to blind person at crossings, intersections, and traffic control signal points

General Statute	Description of Offense
20-217	Failure to stop and remain stopped when approaching a stopped school bus engaged in receiving or discharging passengers and while bus has mechanical stop signal displayed
14-18	Voluntary manslaughter
14-18	Involuntary manslaughter

(d) There shall be no Facility recoupment surcharge under G.S. 58-37-40(f) or Safe Driver Incentive Plan surcharges under G.S. 58-36-65 for accidents occurring when only operating a firefighting, rescue squad, or law enforcement vehicle in accordance with G.S. 20-125(b) and in response to an emergency if the operator of the vehicle at the time of the accident was a paid or volunteer member of any fire department, rescue squad, or any law enforcement agency. This exception does not include an accident occurring after the vehicle ceases to be used in response to the emergency and the emergency ceases to exist.

(e) There shall be no Facility recoupment surcharge under G.S. 58-37-40(f) for any accident involving only damage to the operator's vehicle or to the property of another for which full payment or compensation has been made by the operator at fault; and when the motor vehicle insurer of the operator has not made any payment under any kind of insurance policy for such property damage to or on behalf of such operator. Notwithstanding the provision of this subsection, an insured still has a duty to report such accident to his insurer and to law enforcement authorities if such duty is required by the insurance contract or by law.

(f) The subclassification plan shall provide that with respect to a conviction for a "violation of speeding 10 miles per hour or less over the speed limit" there shall be no premium surcharge nor any assessment of points unless there is a driving record consisting of a conviction or convictions for a moving traffic violation or violations, except for a prayer for judgment continued for any moving traffic violation, during the three years immediately preceding the date of application or the preparation of the renewal. The subclassification plan shall also provide that with respect to a prayer for judgment continued for any moving traffic violation, there shall be no premium surcharge nor any assessment of points unless the vehicle owner, principal operator, or any licensed operator in the owner's household has a driving record consisting of a prayer or prayers for judgment continued for any moving traffic violation or violations during the three years immediately preceding the date of application or the preparation of the renewal. For the purpose of this subsection, a "prayer for judgment continued" means a determination of guilt by a jury or a court though no sentence has been imposed. For the purpose of this subsection, a "violation of speeding 10 miles per hour or less over the speed limit" does not include the offense of speeding in a school zone in excess of the posted school zone speed limit.

(f1) The subclassification plan shall provide that in the event an insured is at fault in an accident and is convicted of a moving traffic violation in connection with the accident, only the higher plan premium surcharge between the accident and the conviction shall be assessed on the policy.

(g) As used in this section "conviction" means a conviction as defined in G.S. 20-279.1 and means an infraction as defined in G.S. 14-3.1. (1987, c. 869, s. 6; 1991, c. 101, s. 1; c. 713, s. 1; c. 720, s. 90; 1991 (Reg. Sess., 1992), c. 837, s. 11; c. 997, s. 1; 1993, c. 285, s. 11; 1995 (Reg. Sess., 1996), c. 730, s. 3; 1997-332, s. 1; 1997-443, s. 19.26(d).)

Editor's Note. —

Session Laws 1997-332, s. 2, provides that the North Carolina Rate Bureau shall amend the subclassification plan to implement the provisions of that act no later than October 1, 1997, that the amendments to the plan become effective January 1, 1998, and apply to at-fault accidents that occur on or after that date, and with respect to any at-fault accidents occurring prior to January 1, 1998, the surcharge and period for which the surcharge is applied and collected shall be determined by the subclassification plan in effect at the time the at-fault accident occurred.

Session Laws 1997-443, s. 1.1, provides: "This act shall be known as 'The Current Operations and Capital Improvements Appropriations Act of 1997'".

Session Laws 1997-443, s. 35.2, provides: "Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 1997-99 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 1997-99 fiscal biennium."

Session Laws 1997-443, s. 35.4, is a severability clause.

Effect of Amendments. — Session Laws 1997-332, s. 1, effective July 25, 1997, rewrote subsection (a).

Session Laws 1997-443, s. 19.26(d), effective December 1, 1997, and applicable to offenses committed on or after that date, in subsection (c) deleted "20-141(j)", deleted "Driving in excess of 55 mph and at least 15 mph over legal limit, while fleeing or attempting to elude arrest by a law enforcement officer", inserted "20-141.5", and inserted "Speeding while fleeing or attempting to elude arrest."

§ 58-36-85. Termination of a nonfleet private passenger motor vehicle insurance policy.

(a) Definitions. — The following definitions apply in this section:

(1) Policy. — A nonfleet private passenger motor vehicle liability insurance policy, including a policy 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.

(2) Terminate. — To cancel or refuse to renew a policy.

(b) Termination Restrictions. — An insurer shall not terminate a policy for a reason that is not specified in G.S. 58-37-50(1) through (5) or G.S. 58-36-65(g). A termination of a policy is not effective unless the insurer either has notified a named insured of the termination by sending a written termination notice by first class mail to the insured's last known address or is not required by this subsection to send a written termination notice. Proof of mailing of a written termination notice is proof that the notice was sent.

An insurer is not required to send a written termination notice if any of the following applies:

(1) The insurer has manifested its willingness to renew the policy by issuing or offering to issue a renewal policy, a certificate, or other evidence of renewal.

(2) The insurer has manifested its willingness to renew the policy by any means not described in subdivision (1) of this subsection, including mailing a premium notice or expiration notice by first class mail to the named insured and the

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 1, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on July 1, 1999, at 12:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Julie Robinson (Guilford County), Nathan Cooper (Wake County), and Taylor Miffleton (Mecklenburg County). The following Committee members were present: Representatives Barbee, Boyd-McIntyre, Brubaker, Cole, Dedmon, Dockham, Esposito, Hackney, Hardaway, Saunders, Smith, Wainwright, Warner, and C. Wilson. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

SB 513, entitled, AN ACT TO REQUIRE HEALTH BENEFIT PLANS THAT COVER PRESCRIPTION DRUGS TO ISSUE UNIFORM PRESCRIPTION DRUG IDENTIFICATION CARDS. A proposed House committee substitute was presented. Upon a motion made by Representative Saunders, the House committee substitute was adopted for discussion. Senator Wellons was recognized to explain the bill and House committee substitute. Representative Wainwright made a motion to give a favorable report to the House committee substitute, unfavorable report to the Senate committee substitute bill. Motion passed.

SB 394, entitled, AN ACT TO ALLOW PREMIUMS FOR AUTOMOBILE AND PROPERTY AND CASUALTY INSURANCE COVERAGE TO BE PAID BY CREDIT CARD. A proposed House committee substitute was presented. Upon a motion made by Representative Dedmon, the House committee substitute was adopted for discussion. Senator Hartsell was recognized to explain the bill and House committee substitute. Representative Barbee moved to give a favorable report to the House committee substitute, unfavorable report to the original Senate bill. Motion passed.

HB 1133, entitled, AN ACT TO PROVIDE THAT AN INSURER PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE INSURER'S FAILURE TO EXERCISE ORDINARY CARE. The Chair indicated this bill would be discussed today, but a vote would not be taken at this time. A proposed House committee substitute was presented. Upon a motion made by Representative Warner, the House committee substitute was adopted for discussion. Representative Hackney was recognized to explain the bill and committee substitute. Mr. Jim Kerr with the N.C. Medical Society explained some of the changes in this committee substitute. Mr. Paul Mahoney, Executive Director of the N.C. Association of Health Plans, and Mr. Robert Paschal, with the Health Insurance Association of America spoke against the bill. After discussion, this bill was tabled until the next INSURANCE Committee meeting.

There being no further business, the Chair adjourned the meeting at 12:35 p.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS:

Visitor Registration Form
SB 513, SB 394, HB 1133
Proposed Committee Substitute
Bill Analysis

VISITOR REGISTRATION SHEET

Insurance — 7/1/99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Peters	AARP Legislative Mgmt
Robin Hill Corbett	ECU-SON
Peyton Mahnan	"
HUGH TILSON	NCHA
Tommy Worth	Carolinas HealthCare System
Steve Keen	NC Med Soc.
Harry Kaplan	"
John Bode	Bode Call Stroupe
Paul Mahoney	NC ASSN HEALTH PLANS
Cindy Cramer	ncatl
[illegible]	CST
Cindy Ell	NCRMA
Barrett Brown	CSI
Lucius Pullen	ATTORNEY
Jeri Ann Harris	BCBS
Mike Maine	Merck
Lisa Piercy	NC Assn of Life Underwriters
Mari Smith	Glaxo - Wellcome
[illegible]	NCMS
Robert Pasichal	Young, Moore & Henderson, P.A.
Dave Horne	Smith Anderson
Susan Valaani	Nationwide
Amy Fullbright	Hunton & Williams
Adam Searing	~~Adam Searing~~ NCHAC
John Bowdish	Bob Alley P.A.
Lisa Reyes	The Insider
Jim Case	NCRMA
Alan Miles	Bailey & Dixon

VISITOR REGISTRATION SHEET

Insurance — 7/1/99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paul Williams	NCCBA
David Simmons	ZDA, PA
Bob Pryor	Jordan Price
Will Fox	AHHC
Mark Hale	NCDOI
Herb Carlton	Merck

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 513 A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH BENEFIT PLANS THAT COVER PRESCRIPTION DRUGS TO ISSUE UNIFORM PRESCRIPTION DRUG IDENTIFICATION CARDS.

☐ 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, unfavorable as to Senate committee substitute bill.

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 3

SENATE BILL 513
Insurance Committee Substitute Adopted 4/28/99
House Committee Substitute Favorable 7/6/99

Short Title: Presc. Drug ID Card. (Public)

Sponsors:

Referred to:

March 25, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS THAT COVER PRESCRIPTION DRUGS TO ISSUE UNIFORM PRESCRIPTION DRUG IDENTIFICATION CARDS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-174. Uniform prescription drug identification cards.**

(a) Every health benefit plan that provides coverage for prescription drugs or devices and that issues a prescription drug card, shall issue to its insureds a uniform prescription drug identification card. The uniform prescription drug identification card shall contain the information listed in subdivisions (1) through (7) of this subsection in the following order beginning at the top left margin of the card:

(1) The health benefit plan's name and/or logo.

(2) The American National Standards Institute assigned Issuer Identification Number.

(3) The processor control number.

(4) The insured's group number.

(5) The health benefit plan's card issuer identifier.

(6) The insured's identification number.

(7) The insured's name.

(a1) In addition to the information required under subsection (a), the uniform prescription drug card shall contain, in one of the lower-most elements on the back side of the card, the following information:

(1) The health benefit plan's claims submission name and address.

(2) The health benefit plan's help desk telephone number and name.

Nothing in this section shall require a health benefit plan to violate a contractual agreement, service mark agreement, or trademark agreement.

(b) A new uniform prescription drug identification card as required under subsection (a) of this section shall be issued annually by a health benefit plan if there has been any change in the insured's coverage in the previous 12 months. A change in the insured's coverage shall include, but is not limited to, the addition or deletion of a dependent of the insured covered by a health benefit plan.

(c) Not later than January 1, 2003, the uniform prescription drug identification card provided under subsection (a) of this section shall contain one of the following mediums capable of the processing or adjudicating of a claim through electronic verification:

(1) A magnetic strip.

(2) A bar code.

(3) Any new technology available that is capable of processing or adjudicating a claim by electronic verification.

(d) As used in this section, '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:

(1) Accident.

(2) Credit.

(3) Disability income.

(4) Long-term or nursing home care.

(5) Medicare supplement.

(6) Specified disease.

(7) Dental or vision.

(8) Coverage issued as a supplement to liability insurance.

(9) Workers' compensation.

(10) Medical payments under automobile or homeowners.

(11) 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.

(12) Hospital income or indemnity.

(e) This section shall not apply to an entity that has its own facility and employs or contracts with physicians, pharmacists, nurses, and other health care personnel, to the extent that the entity dispenses prescription drugs or devices from its own pharmacies to its employees and to enrollees of its health benefit plan. This section does not apply to a health benefit plan that issues a single identification card to its insureds for all services covered under the plan."

Section 2. This act is effective when it becomes law and, except as provided in G.S. 58-3-174(c) as enacted in Section 1 of this act, applies to health benefit plans that are delivered, issued for delivery, or renewed on and after July 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 513
Insurance Committee Substitute Adopted 4/28/99
Proposed House Committee Substitute S513-PCS7702-RN

Short Title: Presc. Drug ID Card. (Public)

Sponsors:

Referred to:

March 25, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS THAT COVER PRESCRIPTION DRUGS TO ISSUE UNIFORM PRESCRIPTION DRUG IDENTIFICATION CARDS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-174. Uniform prescription drug identification cards.**

(a) Every health benefit plan that provides coverage for prescription drugs or devices and that issues a prescription drug card, shall issue to its insureds a uniform prescription drug identification card. The uniform prescription drug identification card shall contain the information listed in subdivisions (1) through (7) of this subsection in the following order beginning at the top left margin of the card:

(1) The health benefit plan's name and/or logo.

(2) The American National Standards Institute assigned Issuer Identification Number.

(3) The processor control number.

(4) The insured's group number.

(5) The health benefit plan's card issuer identifier.

(6) The insured's identification number.

(7) The insured's name.

(a1) In addition to the information required under subsection (a), the uniform prescription drug card shall contain, in one of the lower-most elements on the back side of the card, the following information:

(1) The health benefit plan's claims submission name and address.

(2) The health benefit plan's help desk telephone number and name.

Nothing in this section shall require a health benefit plan to violate a contractual agreement, service mark agreement, or trademark agreement.

(b) A new uniform prescription drug identification card as required under subsection (a) of this section shall be issued annually by a health benefit plan if there has been any change in the insured's coverage in the previous 12 months. A change in the insured's coverage shall include, but is not limited to, the addition or deletion of a dependent of the insured covered by a health benefit plan.

(c) Not later than January 1, 2003, the uniform prescription drug identification card provided under subsection (a) of this section shall contain one of the following mediums capable of the processing or adjudicating of a claim through electronic verification:

(1) A magnetic strip.

(2) A bar code.

(3) Any new technology available that is capable of processing or adjudicating a claim by electronic verification.

(d) As used in this section, '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:

(1) Accident.

(2) Credit.

(3) Disability income.

(4) Long-term or nursing home care.

(5) Medicare supplement.

(6) Specified disease.

(7) Dental or vision.

(8) Coverage issued as a supplement to liability insurance.

(9) Workers' compensation.

(10) Medical payments under automobile or homeowners.

(11) 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.

(12) Hospital income or indemnity.

(e) This section shall not apply to an entity that has its own facility and employs or contracts with physicians, pharmacists, nurses, and other health care personnel, to the extent that the entity dispenses prescription drugs or devices from its own pharmacies to its employees and to enrollees of its health benefit plan. This section does not apply to a health benefit plan that issues a single identification card to its insureds for all services covered under the plan."

Section 2. This act is effective when it becomes law and, except as provided in G.S. 58-3-174(c) as enacted in Section 1 of this act, applies to health benefit plans that are delivered, issued for delivery, or renewed on and after July 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 513
Insurance Committee Substitute Adopted 4/28/99

Short Title: Presc. Drug ID Card. (Public)

Sponsors:

Referred to:

March 25, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS THAT COVER PRESCRIPTION DRUGS TO ISSUE UNIFORM PRESCRIPTION DRUG IDENTIFICATION CARDS.

The General Assembly of North Carolina enacts:

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

"§ 58-3-174. Uniform prescription drug identification cards.

(a) Every health benefit plan that provides coverage for prescription drugs or devices and that issues a prescription drug card, shall issue to its insureds a uniform prescription drug identification card. The uniform prescription drug identification card shall contain the information listed in subdivisions (1) through (8) of this subsection in the following order beginning at the top left margin of the card:

(1) The health benefit plan's name and /or logo.

(2) The American National Standards Institute assigned International Identification Number.

(3) The processor control number.

(4) The insured's group number.

(5) The health benefit plan's card issuer identifier.

(6) The insured's identification number.

(7) The insured's name.

(8) The health benefit plan's policy expiration date.

(a1) In addition to the information required under subsection (a) the uniform prescription drug card shall contain the following information:

(1) The health benefit plan's claims submission name and address.

(2) The health benefit plan's help desk telephone number and name.

Nothing in this section shall require a health benefit plan to violate a contractual agreement, service mark agreement, or trademark agreement.

(b) A new uniform prescription drug identification card as required under subsection (a) of this section shall be issued annually by a health benefit plan if there has been any change in the insured's coverage in the previous twelve months. A change in the insured's coverage shall include, but is not limited to, the addition or deletion of a dependent of the insured covered by a health benefit plan.

(c) Not later than January 1, 2001, the uniform prescription drug identification card provided under subsection (a) of this section shall contain a magnetic strip or bar code, or both, for electronic verification.

(d) As used in this section '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:

(1) Accident,

(2) Credit,

(3) Disability income,

(4) Long-term or nursing home care,

(5) Medicare supplement,

(6) Specified disease,

(7) Dental or vision,

(8) Coverage issued as a supplement to liability insurance,

(9) Workers' compensation,

(10) Medical payments under automobile or homeowners,

(11) 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, and

(12) Hospital income or indemnity.

(e) This section shall not apply to an entity that has its own facility and employs or contracts with physicians, pharmacists, nurses, and other health care personnel, to the extent that the entity dispenses prescription drugs or devices from its own pharmacies to its employees and to enrollees of its health benefit plan. This section does not apply to a health benefit plan that issues a single identification card to its insureds for all services covered under the plan."

Section 2. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after July 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan 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.

SB 513:
Uniform Prescription ID Card

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Wellons
Date:	April 28, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 1st Edition		Committee Counsel

The Proposed Committee Substitute for Senate Bill 513 requires health plans that provide prescription drug coverage to provide uniform prescription drug I.D. cards to their insureds. The ID card must contain the health benefit plan's name and any logo, its ANSI International ID number, the processor control number, the insured's group number, the plan's card issuer identifier, the insured's ID number and name, the plan's policy expiration date, the plan's claims submission name and address, and the plan's help desk name and telephone number. The committee substitute's specification of the required data eliminates legal concerns in the original bill about the delegation of legislative authority to a private organization.

The plan must issue a new card if there has been any change in the insured's coverage within the past 12 months, including changes in dependents. By January 1, 2001, the ID card must contain a magnetic strip or bar code (or both) for electronic verification.

If a plan uses an ID card for all services it covers, it can comply with this act by incorporating the required data on that card. This act does not require a plan to violate any contractual agreement, service mark agreement, or trademark agreement.

This act applies to health benefit plans offered by insurers, service corporations (Blue Cross), and multiple employer welfare arrangements. The act also applies to HMOs except as noted below. The act does not apply to self-funded plans (which are exempt from State regulation by ERISA), specialized/limited health plans such as Medicare supplemental insurance, disability income policies, and specified disease policies, nor to HMOs to the extent they use their own pharmacy facilities to serve their enrollees and employees.

This act would take effect July 1, 2000, and would apply to health plans issued or renewed on or after that date.

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☐ Committee Substitute for
S.B. 394 A BILL TO BE ENTITLED AN ACT TO ALLOW PREMIUMS FOR AUTOMOBILE AND PROPERTY AND CASUALTY INSURANCE COVERAGE TO BE PAID BY CREDIT CARD.

☐ 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.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 394
House Committee Substitute Favorable 7/6/99

Short Title: Credit Card Payment of Insurance. (Public)

Sponsors:

Referred to:

March 17, 1999

A BILL TO BE ENTITLED

AN ACT TO ALLOW PREMIUMS FOR INSURANCE COVERAGE TO BE PAID BY CREDIT CARD.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-3-145 reads as rewritten:

"**§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance ~~policies through credit card facilities prohibited; exceptions.~~ policies.**

~~Except as otherwise provided herein, no authorized insurer and no representative of such insurer or insurance broker shall employ or avail itself of the facilities of any person, firm or corporation engaged in the credit card business to solicit or negotiate any contract of insurance upon any life or risk within the State of North Carolina, or accept the payment of premiums upon a policy of insurance, insuring any life or risk in the State of North Carolina, through the use of any credit card facility. Except as otherwise provided herein, no person, firm or corporation engaged in the business of extending credit through a credit card system shall, on behalf of any insurer, its representative or any insurance broker, utilize his or its credit card facilities to solicit for, negotiate contracts of insurance or accept the payment of premiums upon any contract of insurance from credit card holders or prospective credit card holders who reside in this State. The solicitation for and the negotiation of policies of insurance prohibited by this section shall include, but shall not be limited to, the transmittal of applications for insurance, premium rate schedules, circulars, letters or sales literature pertaining to insurance to credit card holders or prospective credit card holders who reside in this State. Credit card business as used in this section shall mean the~~

~~business of extending credit to persons who are holders of credit cards issued by the credit card facility or organization entitling the holder to pay charges for purchases or other transactions through the use of credit card facilities.~~

~~Nothing in this section shall prohibit an authorized insurer, the representative of such insurer, or an insurance broker from accepting payment of an insurance premium through a credit card facility provided and operated by a banking corporation principally domiciled in this State and doing business under the laws of the State of North Carolina or the United States. No such bank shall be prohibited from making such credit card facility available for this limited purpose, provided, that all records relating to the payment of insurance premiums through such credit card facility are maintained within the State of North Carolina.~~

~~Nothing in this section shall prohibit an authorized insurer, the representative of such insurer, or an insurance broker from notifying its or his customers or prospective customers through means other than credit card facilities of the availability of credit card facilities for the payment of insurance premiums.~~

~~Nothing in this section shall prohibit any authorized insurer qualified to do business in the State of North Carolina pursuant to the provisions of Articles 1 through 64 of this Chapter, and any representative of such insurer or insurance broker, from employing or availing itself of the facilities of any person, firm or corporation engaged in the business of extending credit through a credit card system for the limited purposes of soliciting for or negotiating any contract of travel accident insurance upon any life or risk within the State of North Carolina arising from travel, including but not limited to airline flight insurance, or accepting the payment of premiums thereon, through the use of any credit card facility. Nor shall anything in this section prohibit any person, firm or corporation engaged in the business of extending credit through a credit card system on behalf of any insurer, its representative or any insurance broker, from utilizing his or its credit card facilities for the limited purposes of soliciting for or negotiating contracts of travel accident insurance, including but not limited to airline flight insurance, or accepting the payment of premiums thereon, from credit card holders or prospective credit card holders who reside in this State.~~

An insurer, agent, or broker may accept payment of an insurance premium by credit card if the insurer accepting payment by credit card meets the following conditions:

(1) The insurer makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons.

(2) Unless otherwise agreed to in writing by the insurer and the agent or broker, the insurer pays the fees charged by the credit card company for the payment of premiums by credit card."

Section 2. G.S. 58-57-105(a) reads as rewritten:

"(a) ~~Notwithstanding G.S. 58-3-145, credit~~ Credit card facilities may be used for the solicitation, negotiation, or payment of premiums for credit insurance on the unpaid balance of any credit card ~~account.~~ account pursuant to G.S. 58-3-145.

Solicitation or negotiation for credit insurance on credit card account balances may not be made by unsolicited telephone calls or facsimile transmissions."

Section 3. This act becomes effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 394
Proposed House Committee Substitute S394-PCS7701-RU

Short Title: Credit Card Payment of Insurance. (Public)

Sponsors:

Referred to:

March 17, 1999

A BILL TO BE ENTITLED

AN ACT TO ALLOW PREMIUMS FOR INSURANCE COVERAGE TO BE PAID BY CREDIT CARD.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-3-145 reads as rewritten:

"**§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance ~~policies through credit card facilities prohibited; exceptions.~~ policies.**

~~Except as otherwise provided herein, no authorized insurer and no representative of such insurer or insurance broker shall employ or avail itself of the facilities of any person, firm or corporation engaged in the credit card business to solicit or negotiate any contract of insurance upon any life or risk within the State of North Carolina, or accept the payment of premiums upon a policy of insurance, insuring any life or risk in the State of North Carolina, through the use of any credit card facility. Except as otherwise provided herein, no person, firm or corporation engaged in the business of extending credit through a credit card system shall, on behalf of any insurer, its representative or any insurance broker, utilize his or its credit card facilities to solicit for, negotiate contracts of insurance or accept the payment of premiums upon any contract of insurance from credit card holders or prospective credit card holders who reside in this State. The solicitation for and the negotiation of policies of insurance prohibited by this section shall include, but shall not be limited to, the transmittal of applications for insurance, premium rate schedules, circulars, letters or sales literature pertaining to insurance to credit card holders or prospective credit card holders who reside in this State. Credit card business as used in this section shall mean the~~

~~business of extending credit to persons who are holders of credit cards issued by the credit card facility or organization entitling the holder to pay charges for purchases or other transactions through the use of credit card facilities.~~

~~Nothing in this section shall prohibit an authorized insurer, the representative of such insurer, or an insurance broker from accepting payment of an insurance premium through a credit card facility provided and operated by a banking corporation principally domiciled in this State and doing business under the laws of the State of North Carolina or the United States. No such bank shall be prohibited from making such credit card facility available for this limited purpose, provided, that all records relating to the payment of insurance premiums through such credit card facility are maintained within the State of North Carolina.~~

~~Nothing in this section shall prohibit an authorized insurer, the representative of such insurer, or an insurance broker from notifying its or his customers or prospective customers through means other than credit card facilities of the availability of credit card facilities for the payment of insurance premiums.~~

~~Nothing in this section shall prohibit any authorized insurer qualified to do business in the State of North Carolina pursuant to the provisions of Articles 1 through 64 of this Chapter, and any representative of such insurer or insurance broker, from employing or availing itself of the facilities of any person, firm or corporation engaged in the business of extending credit through a credit card system for the limited purposes of soliciting for or negotiating any contract of travel accident insurance upon any life or risk within the State of North Carolina arising from travel, including but not limited to airline flight insurance, or accepting the payment of premiums thereon, through the use of any credit card facility. Nor shall anything in this section prohibit any person, firm or corporation engaged in the business of extending credit through a credit card system on behalf of any insurer, its representative or any insurance broker, from utilizing his or its credit card facilities for the limited purposes of soliciting for or negotiating contracts of travel accident insurance, including but not limited to airline flight insurance, or accepting the payment of premiums thereon, from credit card holders or prospective credit card holders who reside in this State.~~

An insurer, agent, or broker may accept payment of an insurance premium by credit card if the insurer accepting payment by credit card meets the following conditions:

(1) The insurer makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons.

(2) Unless otherwise agreed to in writing by the insurer and the agent or broker, the insurer pays the fees charged by the credit card company for the payment of premiums by credit card."

Section 2. G.S. 58-57-105(a) reads as rewritten:

"(a) ~~Notwithstanding G.S. 58-3-145, credit~~ Credit card facilities may be used for the solicitation, negotiation, or payment of premiums for credit insurance on the unpaid balance of any credit card ~~account.~~ account pursuant to G.S. 58-3-145.

Solicitation or negotiation for credit insurance on credit card account balances may not be made by unsolicited telephone calls or facsimile transmissions."

Section 3. This act becomes effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 394

Short Title: Credit Card Payment of Insurance. (Public)

Sponsors: Senator Hartsell.

Referred to: Insurance.

March 17, 1999

A BILL TO BE ENTITLED

AN ACT TO ALLOW PREMIUMS FOR AUTOMOBILE AND PROPERTY AND CASUALTY INSURANCE COVERAGE TO BE PAID BY CREDIT CARD.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-3-145 reads as rewritten:

"**§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance policies through credit card facilities prohibited; exceptions.**

(a) Except as otherwise provided herein, no authorized insurer and no representative of such insurer or insurance broker shall employ or avail itself of the facilities of any person, firm or corporation engaged in the credit card business to solicit or negotiate any contract of insurance upon any life or risk within the State of North Carolina, or accept the payment of premiums upon a policy of insurance, insuring any life or risk in the State of North Carolina, through the use of any credit card facility. Except as otherwise provided herein, no person, firm or corporation engaged in the business of extending credit through a credit card system shall, on behalf of any insurer, its representative or any insurance broker, utilize his or its credit card facilities to solicit for, negotiate contracts of insurance or accept the payment of premiums upon any contract of insurance from credit card holders or prospective credit card holders who reside in this State. The solicitation for and the negotiation of policies of insurance prohibited by this section shall include, but shall not be limited to, the transmittal of applications for insurance, premium rate schedules, circulars, letters or sales literature pertaining to insurance to credit card holders or prospective credit card holders who reside in this State. Credit card business as used in this section shall mean the business of extending credit to persons

who are holders of credit cards issued by the credit card facility or organization entitling the holder to pay charges for purchases or other transactions through the use of credit card facilities.

(b) Nothing in this section shall prohibit an authorized insurer, the representative of such insurer, or an insurance broker from accepting payment of an insurance premium through a credit card facility provided and operated by a banking corporation principally domiciled in this State and doing business under the laws of the State of North Carolina or the United States. No such bank shall be prohibited from making such credit card facility available for this limited purpose, provided, that all records relating to the payment of insurance premiums through such credit card facility are maintained within the State of North Carolina.

(c) Nothing in this section shall prohibit an authorized insurer, the representative of such insurer, or an insurance broker from notifying its or his customers or prospective customers through means other than credit card facilities of the availability of credit card facilities for the payment of insurance premiums.

(d) Nothing in this section shall prohibit any authorized insurer qualified to do business in the State of North Carolina pursuant to the provisions of ~~Articles 1 through 64 of~~ this Chapter, and any representative of such insurer or insurance broker, from employing or availing itself of the facilities of any person, firm or corporation engaged in the business of extending credit through a credit card system for the limited purposes of soliciting for or negotiating any contract of travel accident insurance upon any life or risk within the State of North Carolina arising from travel, including but not limited to airline flight insurance, or accepting the payment of premiums thereon, through the use of any credit card facility. Nor shall anything in this section prohibit any person, firm or corporation engaged in the business of extending credit through a credit card system on behalf of any insurer, its representative or any insurance broker, from utilizing ~~his or~~ its credit card facilities for the limited purposes of soliciting for or negotiating contracts of travel accident insurance, including but not limited to airline flight insurance, or accepting the payment of premiums thereon, from credit card holders or prospective credit card holders who reside in this State.

(e) Nothing in this section shall prohibit any authorized insurer qualified to do business in the State of North Carolina pursuant to the provisions of this Chapter, and any representative of the insurer or insurance broker, from employing or availing itself of the facilities of any person, firm, or corporation engaged in the business of extending credit through a credit card system for the limited purpose of accepting the payment of premiums through a credit card facility on (i) any contract of insurance against loss to real property under Articles 36, 44, 45, or 46 of this Chapter or (ii) any motor vehicle liability policy, as defined in G.S. 20-279.21. Nor shall anything in this section prohibit any person, firm, or corporation engaged in the business of extending credit through a credit card system on behalf of any insurer, its representative, or any insurance broker, from utilizing its credit card facilities for the limited purpose of accepting the payment of premiums from credit card holders or prospective credit card holders who reside in this State on (i) any contract of insurance against loss to

real property under Articles 36, 44, 45, or 46 of this Chapter or (ii) any motor vehicle liability policy, as defined in G.S. 20-279.21."

Section 2. This act becomes effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1133
Committee Substitute Favorable 4/23/99
Proposed Committee Substitute H1133-PCS3452-RN

Short Title: Health Ins./Liability. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT A MANAGED CARE ENTITY PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE MANAGED CARE ENTITY'S FAILURE TO EXERCISE ORDINARY CARE.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 1G.

"Health Care Liability.

"**§ 90-21.50. Definitions.**

As used in this Article, unless the context clearly indicates otherwise, the term:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Health and Human Services 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;
k. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance; and
l. Hospital income or indemnity.

(2) 'Health care provider' means:
a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes:
1. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services;
2. The officers and directors of a health care facility; and
3. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:
a. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or
b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) 'Health care treatment decision' means a determination that:
a. Is made by a managed care entity;
b. Governs the extent to which health care services are provided for, arranged for, paid for, or reimbursed under a health benefit plan; and

c. Affects the quality of the diagnosis, care, or treatment provided under the health benefit plan to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, or a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means that degree of care that a managed care entity of ordinary prudence situated in the same or similar communities at the time of the alleged act giving rise to the cause of action would use under the same or similar circumstances.

(9) 'Physician' means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

"§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has the right to exercise influence or significant control with respect to the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

(1) Neither the managed care entity nor an agent or employee for whom the managed care entity is liable under subsection (b) of this section controlled, influenced, or participated in the health care treatment decision; and

(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrolled.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed

care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider.

"**§ 90-21.53. Separate trial required.**

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider."

Section 2. G.S. 1A-1, Rule 42, reads as rewritten:

"**Rule 42. Consolidation; separate trials.**

(a) Consolidation. -- ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. --

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim,~~ cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims,~~ cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

Section 3. This act becomes effective October 1, 1999, and applies to causes of action arising on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1133
Committee Substitute Favorable 4/23/99

Short Title: Health Ins./Liability. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT AN INSURER PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE INSURER'S FAILURE TO EXERCISE ORDINARY CARE.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 1G.

"Health Care Liability.

"§ 90-21.50. Definitions.

As used in this Article, unless the context clearly indicates otherwise, the term:

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

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

(2) 'Health care provider' means:

a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes:

1. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services;
2. The officers and directors of a health care facility; and
3. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:

a. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or
b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) 'Health care treatment decision' means a determination made when health care services are provided for, arranged for, paid for,

or reimbursed by an insurer or managed care entity under a health benefit plan that affects the quality of the diagnosis, care, or treatment provided to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, or a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes.

(7) 'Managed care entity' means an entity that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a pharmacy that is issued a permit by the North Carolina State Board of Pharmacy under this Chapter.

(8) 'Ordinary care' means:

a. For an insurer or managed care entity, that degree of care that an insurer or managed care entity of ordinary prudence would use under the same or similar circumstances; or

b. For a person that is an agent or employee of an insurer or managed care entity, that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as the person would use in the same or similar circumstances.

(9) 'Physician' means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

"**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each insurer or managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for

damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each insurer or managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has the right to exercise influence or significant control with respect to the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against an insurer or managed care entity for a health benefit plan that:

(1) Neither the insurer or managed care entity nor an agent or employee for whom the insurer or managed care entity is liable under subsection (b) of this section controlled, influenced, or participated in the health care treatment decision; and

(2) The insurer or other managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrolled.

(d) In an action brought under this Article against an insurer or managed care entity, a finding that a physician or health care provider is an agent or employee of the insurer or managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the insurer's or managed care entity's health benefit plan.

(e) In any action brought under this Article against an insurer or managed care entity, any law that prohibits the corporate practice of medicine may not be used as a defense by the insurer or managed care entity.

(f) An insurer or managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the insurer or managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of an insurer or managed care entity when the insurer or managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article imposes liability on a physician or health care provider in addition to that otherwise imposed under existing law. No insurer or managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider, except where there is joint and several liability.

(h) Nothing in this Article shall be construed to create an obligation on the part of an insurer or managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(i) A health insurer or managed care entity may not enter into a contract with a physician, hospital, or other health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the health insurer or managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a pharmacy.

This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees or a pharmacy issued a permit by the North Carolina Board of Pharmacy under this Chapter.

"§ 90-21.53. Separate trial required.

Upon motion of any party in an action brought pursuant to this Article involving an insurer or managed care entity, the court shall order a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider."

Section 2. G.S. 1A-1, Rule 42, reads as rewritten:

"Rule 42. Consolidation; separate trials.

(a) Consolidation. -- ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. --

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim,~~ cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims,~~ cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action instituted pursuant to Article 1G of Chapter 90 of the General Statutes involving an insurer, as defined in G.S. 90-21.50, the court shall order a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

Section 3. This act is effective when it becomes law and applies to causes of action arising on and after July 1, 1999.

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 8, 1999

The House Committee on Insurance met in Room 1228 of the Legislative Building on July 8, 1999, at 12:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Katie Bailey (Rowan County), Katie Jo Sutton (Haywood County), and Heather Lohmeyer (Forsyth County). The following Committee members were present: Representatives Barbee, Boyd-McIntyre, Brubaker, Cole, Cunningham, Dedmon, Dockham, Esposito, Grady, Hackney, Hardaway, Howard, Miller, Saunders, Smith, Wainwright, and C. Wilson. Linwood Jones and Ed Rossi, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bill was considered:

HB 1133, entitled, AN ACT TO PROVIDE THAT AN INSURER PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE INSURER'S FAILURE TO EXERCISE ORDINARY CARE. Representative Hackney was recognized to explain the bill and proposed committee substitute adopted at the July 1, 1999 meeting. Mr. Harry Kaplan with the Doctors Health Plan, Wellness Plan of North Carolina, and QualChoice of North Carolina and Mr. John McMillan with NCCBI were recognized to speak in opposition to the bill. Representative Barbee indicated he would like to have this bill referred to a study commission. Representative Dockham asked if this bill is eligible for consideration since it did not reach the crossover deadline. Representative Hackney indicated the Speaker had ruled that it is eligible for consideration because it does raise court fees and is a Finance matter. Representative Hackney made a motion to give a favorable report to the proposed committee substitute (#2) with an unfavorable report to committee substitute (#1). The motion passed.

The Chair indicated this would be the last INSURANCE Committee meeting for this session, and thanked all concerned for their participation.

There being no further business, the Chair adjourned the meeting at 12:40 p.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS: Visitor Registration Forms, HB 1133, Proposed Committee Substitute

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

7/8/99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
John McNamara	General Electric
[signature]	Moore & Van Allen
Anna Scanlon	NCMS Foundation
Mari Smith	NCSA
[signature]	Poyner & Spruill
Jim Kerr	Smith, Anderson
Steve [signature]	NCMS
[signature]	NCMS
Peyton Mangum	[illegible]
Y Hugh Tilson	NCNA
Robt Pasichal	Young, Moore & Henderson, P.A.
[signature]	BCBSNC
Criss Porter	Bone and Associates
[signature]	NCDOI
[signature]	LA Harris & Assoc

VISITOR REGISTRATION SHEET

Insurance — July 8, 1999
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Peters	JP Associates
[illegible]	NCAIF
Adam Searing	NCHAC
[illegible]	NCJCDC
[illegible]	NCSOS
Paul Mahoney	NC ASSN OF HEALTH PLANS
[illegible]	CSC
[illegible]	
[illegible]	MFDS
[illegible]	NCAJ
Charles Cromer	NCATA
Amy Fulbright	Hunton & Williams
Vandana Shah	NC Atty Gen Office
JOHN SANDERS	

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **John W. "Bill" Hurley** for the Committee on **INSURANCE.**

☒ Committee Substitute for
H.B. 1133 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT AN INSURER PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE INSURER'S FAILURE TO EXERCISE ORDINARY CARE.

☐ 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 (# 2), ☒ which changes the title, unfavorable as Committee Substitute Bill # 1.

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

☐ 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)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), 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 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(b), 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 3

HOUSE BILL 1133
Committee Substitute Favorable 4/23/99
Committee Substitute #2 Favorable 7/14/99

Short Title: Health Ins./Liability. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT A MANAGED CARE ENTITY PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE MANAGED CARE ENTITY'S FAILURE TO EXERCISE ORDINARY CARE.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 1G.

"Health Care Liability.

"**§ 90-21.50. Definitions.**

As used in this Article, unless the context clearly indicates otherwise, the term:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Health and Human Services 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;
k. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance; and
l. Hospital income or indemnity.

(2) 'Health care provider' means:
a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes:
1. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services;
2. The officers and directors of a health care facility; and
3. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:
a. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or
b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) 'Health care treatment decision' means a determination that:
a. Is made by a managed care entity;
b. Governs the extent to which health care services are provided for, arranged for, paid for, or reimbursed under a health benefit plan; and

c. Affects the quality of the diagnosis, care, or treatment provided under the health benefit plan to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, or a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means that degree of care that a managed care entity of ordinary prudence situated in the same or similar communities at the time of the alleged act giving rise to the cause of action would use under the same or similar circumstances.

(9) 'Physician' means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

"**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has the right to exercise influence or significant control with respect to the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

(1) Neither the managed care entity nor an agent or employee for whom the managed care entity is liable under subsection (b) of this section controlled, influenced, or participated in the health care treatment decision; and

(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrolled.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed

care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider.

"**§ 90-21.53. Separate trial required.**

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider."

Section 2. G.S. 1A-1, Rule 42, reads as rewritten:

"**Rule 42. Consolidation; separate trials.**

(a) Consolidation. -- ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. --

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim~~, cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims~~, cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

Section 3. This act becomes effective October 1, 1999, and applies to causes of action arising on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1133
Committee Substitute Favorable 4/23/99
Proposed Committee Substitute H1133-PCS3452-RN

Short Title: Health Ins./Liability. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT A MANAGED CARE ENTITY PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE MANAGED CARE ENTITY'S FAILURE TO EXERCISE ORDINARY CARE.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 1G.

"Health Care Liability.

"**§ 90-21.50. Definitions.**

As used in this Article, unless the context clearly indicates otherwise, the term:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Health and Human Services 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;
k. Insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability policy or equivalent self-insurance; and
l. Hospital income or indemnity.

(2) 'Health care provider' means:
a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes:
1. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services;
2. The officers and directors of a health care facility; and
3. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:
a. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or
b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) 'Health care treatment decision' means a determination that:
a. Is made by a managed care entity;
b. Governs the extent to which health care services are provided for, arranged for, paid for, or reimbursed under a health benefit plan; and

c. Affects the quality of the diagnosis, care, or treatment provided under the health benefit plan to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, or a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means that degree of care that a managed care entity of ordinary prudence situated in the same or similar communities at the time of the alleged act giving rise to the cause of action would use under the same or similar circumstances.

(9) 'Physician' means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

"**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has the right to exercise influence or significant control with respect to the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

(1) Neither the managed care entity nor an agent or employee for whom the managed care entity is liable under subsection (b) of this section controlled, influenced, or participated in the health care treatment decision; and

(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrolled.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed

care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider.

"**§ 90-21.53. Separate trial required.**

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider."

Section 2. G.S. 1A-1, Rule 42, reads as rewritten:

"**Rule 42. Consolidation; separate trials.**

(a) Consolidation. -- ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. --

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim,~~ cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims,~~ cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

Section 3. This act becomes effective October 1, 1999, and applies to causes of action arising on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1133
Committee Substitute Favorable 4/23/99

Short Title: Health Ins./Liability. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT AN INSURER PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE INSURER'S FAILURE TO EXERCISE ORDINARY CARE.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 1G.

"Health Care Liability.

"§ 90-21.50. Definitions.

As used in this Article, unless the context clearly indicates otherwise, the term:

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

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

(2) 'Health care provider' means:

a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes:

1. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services;
2. The officers and directors of a health care facility; and
3. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:

a. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or
b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) 'Health care treatment decision' means a determination made when health care services are provided for, arranged for, paid for,

or reimbursed by an insurer or managed care entity under a health benefit plan that affects the quality of the diagnosis, care, or treatment provided to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, or a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes.

(7) 'Managed care entity' means an entity that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a pharmacy that is issued a permit by the North Carolina State Board of Pharmacy under this Chapter.

(8) 'Ordinary care' means:

a. For an insurer or managed care entity, that degree of care that an insurer or managed care entity of ordinary prudence would use under the same or similar circumstances; or

b. For a person that is an agent or employee of an insurer or managed care entity, that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as the person would use in the same or similar circumstances.

(9) 'Physician' means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

"§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.

(a) Each insurer or managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for

damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each insurer or managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has the right to exercise influence or significant control with respect to the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against an insurer or managed care entity for a health benefit plan that:

(1) Neither the insurer or managed care entity nor an agent or employee for whom the insurer or managed care entity is liable under subsection (b) of this section controlled, influenced, or participated in the health care treatment decision; and

(2) The insurer or other managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrolled.

(d) In an action brought under this Article against an insurer or managed care entity, a finding that a physician or health care provider is an agent or employee of the insurer or managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the insurer's or managed care entity's health benefit plan.

(e) In any action brought under this Article against an insurer or managed care entity, any law that prohibits the corporate practice of medicine may not be used as a defense by the insurer or managed care entity.

(f) An insurer or managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the insurer or managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of an insurer or managed care entity when the insurer or managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article imposes liability on a physician or health care provider in addition to that otherwise imposed under existing law. No insurer or managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider, except where there is joint and several liability.

(h) Nothing in this Article shall be construed to create an obligation on the part of an insurer or managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(i) A health insurer or managed care entity may not enter into a contract with a physician, hospital, or other health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the health insurer or managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

"§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a pharmacy.

This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees or a pharmacy issued a permit by the North Carolina Board of Pharmacy under this Chapter.

"§ 90-21.53. Separate trial required.

Upon motion of any party in an action brought pursuant to this Article involving an insurer or managed care entity, the court shall order a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider."

Section 2. G.S. 1A-1, Rule 42, reads as rewritten:

"Rule 42. Consolidation; separate trials.

(a) Consolidation. -- ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. --

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim;~~ cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, ~~crossclaims;~~ cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action instituted pursuant to Article 1G of Chapter 90 of the General Statutes involving an insurer, as defined in G.S. 90-21.50, the court shall order a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

Section 3. This act is effective when it becomes law and applies to causes of action arising on and after July 1, 1999.