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

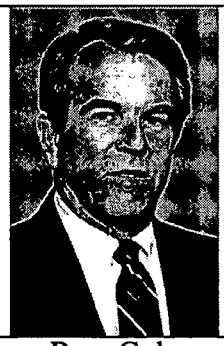
Rep. Saunders
Vice-Chair

Rep. Wainwright
Vice-Chair

Rep. Barbee

Rep. Boyd-
McIntyre

Rep. Brubaker



Rep. Cole

Rep. Dedmon

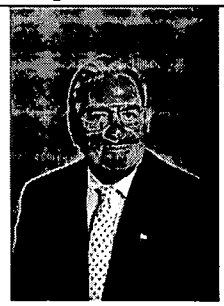
Rep. Dockham

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 Ford	NCDOI
Matt Gleason	The Capitol Group
Kathy Kaplan	
Susan Valauri	Nationwide
Wake Harris	NC DOI
Barbara Morales Burke	NCDOI
Alan Miles	Bowling & Bryson LLP
Ken Wright	BCBSNC
Andy Ellen	NC Retail Merchants
William Riddick	DOR
Art Case	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.
Daschell Cooper	NC DOI
Adam Searcy	NCHAC
Joyce Peters	MMMST
Mike Tyson	County Jail, MD
John Borowski	Zeb Alley PA.

Attachment II

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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.

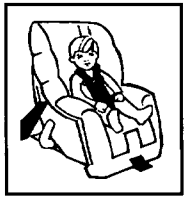
Which Seats to Use

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.

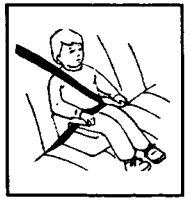
Infant Safety Seats

- 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

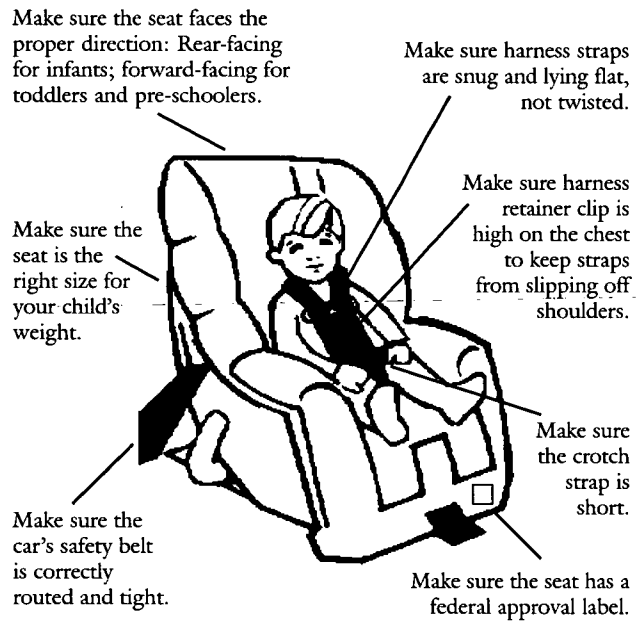
Attachment IV

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.

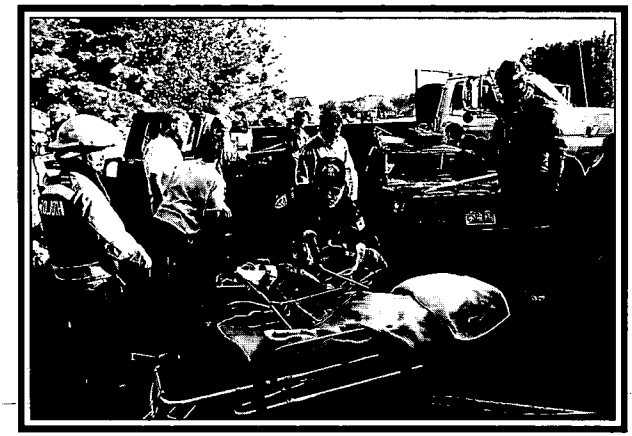
Do it right.
Your child's life is in your hands!



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*

g:\pubinfo\safdriv.pm5

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.

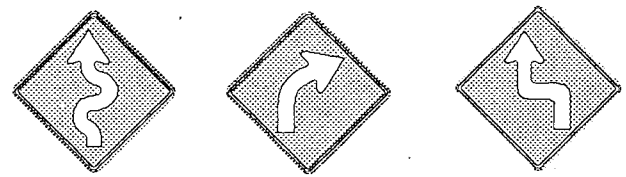
We know that traffic enforcement programs save lives and prevent injuries. Each year in North Carolina, more than 11,000 alcohol-related traffic crashes take their toll in death and injury. Fewer deaths and injuries also mean that taxpayers and insurance consumers will pay less to absorb the health and 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

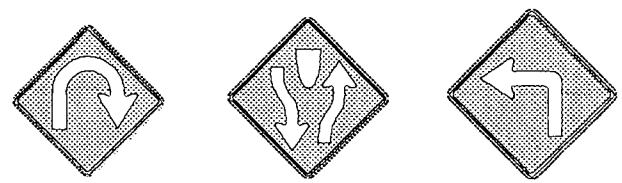
10,000 copies of this public document were printed at a cost of $578.00 or $.0.0578 per copy. 98-14414



IT PAYS TO BE A SAFE DRIVER

Jim Long, Insurance Commissioner

North Carolina Department of Insurance



If You Hav[redacted] Automobile Accident

If you are inv[redacted] 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

Dobbs Building • 430 N. Salisbury Street
P.O. Box 26387 • Raleigh, NC 27611
(919) 733-7349 • Fax (919) 733-6495

Consumer Services	733-2032
Consumer Toll-Free Number	(800) JIM LONG
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
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Special Services	733-2200
State Property Fire Fund	733-3901
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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 & Spruill
	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]	NCAHIP
	Janice Peters	NAIFA-NC
	Barrett Brewer	Capital Strategies
	H.D. Reaves Jr	Home Federal S&L, Fayetteville
	[illegible]	Progress Energy & Carolina Pwr. & Light N.C.
	[illegible]	Bode Call & Stroupe
	Chris Valaurie	N.C. Bankers Assn
	Lisa Lewis	[illegible]
	Jim Blackburn	County Commissioners Assoc.
	[illegible]	Insurance Dept
	Dashiell Propes	"
	Jean Preston	Asst 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.

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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 Pevia	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]	NCAHP
Paul Mahoney	NCANP
Ken Kinion	American General Financial Corp
James Andrews	NC State AFL-CIO
Barrett Brewer	Capital Strategies
[illegible]	Moore & Van Allen
[illegible]	NCMBA
Kim Hibbard	NCLM
John McMillan	MFAs
Mary Miles	Bailey & Dixon LLP
Alina Gregory	Poyner & Spruill
Hugh Wilson	NCHA
G. Peyton Maynard	GPM
George Troutman	Womble Carlyle Sandridge & Rice
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:

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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."

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"**§ 58-45-15. Powers and duties of Association.**

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(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.)

1 moves to amend the bill on page 2, line 5

2 ( ) WHICH CHANGES THE TITLE

3 by _____

4 adding at the end of the line

5 "at least annually"

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)

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
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Administrative Division
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Terrence D. Sullivan, Director
Research Division
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Raleigh, NC 27603-5925
(919) 733-2578

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

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	Nationwide
4. Joe Piercy	NCALU
5. Beth Price	Jordan Price
6. Joyce Pedersen	MAMSI
7. Cathleen M Smith	Claxo
8. Betsy Cooke	Smart Law Firm for NCSIGA
9. Ann Case	NCRMA
10. Andy Eller	NCRMA
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 Nielsinski	BCBSNC
18. WH 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.	Arnold 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.

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.

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 Campaign 369 Montford Ave 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 Mulvihill	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	Cardinal 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 Rutgmo	CYPC
Adam Searing	NCHAC
Tommy Watts	Carolinas HealthCare System
Mac Barkley	Licensed Professional Counselors
B Michael Herman	Health Insurance Association of America
Robert Pasahal	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

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.

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

Section 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.

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) 765-9136

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:

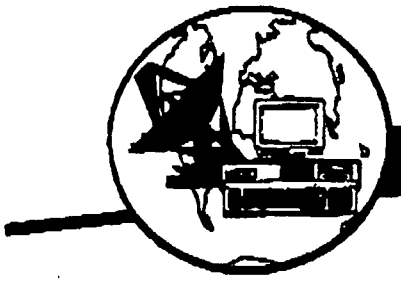
I am a Family Physician and I am writing in support of your bill #678 to provide insurance coverage for Acupuncture performed by licensed Acupuncturists. I see no reason why coverage should be limited to physicians, given that there are relatively few physicians who are trained in this technique, and 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

In association with the University of North Carolina Area Health Education Centers Program
An Equal Opportunity (M/F) Program



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 Eight 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	NHAIC
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	" " Ral
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 Hyman	CCEMC Morehead City, NC
Ken Wright	RBSNA
W. Allard	WSA

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.

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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 Hamm	Smith Anderson
Tommy Hendrix	Enterprise Rent a Car
Richard O'Brien	PFFPNC
David Anders	PFFPNC
Bobby Riddle	PFFPNC
Alan Layton	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.

<u>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.</u>

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
Name of Committee

4/22/99
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.

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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

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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	Arcyp — M/J
2.	Wendy Jennings	N.C. Insurance Commission
3.	[illegible]	Smith Helms
4.	Ben 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.	Will Jones	NCSA
18.	B Simmons	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 _____.

____ 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 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	Nationwide
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 Leamon	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 McMurray	NC DOT
Bill Hale	NC DOI
Pam Carpenter	PCS
Doug Dale	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 1

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

H 1

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
Date: April 23, 1999
Version: 1st Ed.

Introduced by: Rep. Insko
Summary by: Ed Rossi
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 Janell	Northstar Plating / Caro Bumper
Mike D	Carolina Automotive Group
Michael Harrold	NAII
Charles Cromer	NCATL
David Feffell	H, Mc CCTC P.A.
[illegible]	NCSSA
[illegible]	Auto. Parts Assn.
Amy Jo Bain	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
[illegible] Hammack	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 Scott	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

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 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

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(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.

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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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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

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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	**Introduced by:**	Rep. Boyd-McIntyre
Date:	April 20, 1999	**Summary by:**	Linwood Jones
Version:	1st		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 <u>cannot</u> 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 <u>may</u> 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 <u>**source**</u> 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 <u>**source**</u> 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	Atty Gen Office
Faith Lawrence	DHHS
[illegible]	DHHS
[illegible]	BCBSNC
[illegible]	DHHS / Public Health
[illegible]	PEJ
[illegible]	NCMS
SARA NETZER	Student
[illegible]	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
[illegible]	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	Assessor / Mayor's
Charles Cramer	NCATL
John Bowdich	Zeb Alley P.A.
Adam Searing	NCNAC
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]	Progress Energy

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:

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e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners.
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:

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(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

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.

---

[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.
[illegible]	
[illegible]	NC DOI
Harold H. Webb	Premium Finance INS,
Tommy Harrelson	" " "
Glenn Jernigan	N.C. Property and Casualty Assn
[illegible]	Christian Science Comm on Publ for NC
Crissy Porter	Bone & Associates
[illegible]	NCIOSA
[illegible]	HFW
[illegible]	MFS
[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

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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
Date: May 20, 1999
Version: 3rd Edition

Introduced by: Sen. Forrester
Summary by: Linwood Jones
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

S D

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)

S756-ARN-001 Page 3 of __

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	**Introduced by:**	Sen. Horton
Date:	April 21, 1999	**Summary by:**	Ed Rossi
Version:	2nd Ed.		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
Ian 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 AHIP
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~~ 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	Progressive Insurance
Glenn Jernigan	Property and Casualty Assn of N.C.
Alan Dodd	NCMIP
Mary Lou	BCBSNC
[illegible]	NCSAS
Susan Valaurie	Nationwide
Bob Prow	Jordan Price Wall
Alan Bibby	Bailey & Dixon
Lori G Harris	BCBS
Jenni Cohen	NCMS
Joyce Bolen	MANSP
Adam Searing	NCHAC
Andy Ellen	NCRMA
Amy Lee	NCPHA
NM Potter Jr	NCDS & NCPDA
NT Burnett	GPCPD

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 Lou 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	NCCUBA
David Simmons	ZDA, PA
Bob Pryor	Jordan Price
Will Fox	AHHC
Mark Hale	NCDOI
Mark 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 Mayhew	[illegible]
Y Hugh Tilson	NCNA
Robt Paschal	Young, Moore & Henderson, P.A.
[signature]	BCBSNC
Criss Porter	Bone and Associates
[signature]	NCDOT
[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]	NCAA
[illegible]	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.

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"**§ 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."

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(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.

2000

HOUSE INSURANCE COMMITTEE

MINUTES

HOUSE COMMITTEE ON INSURANCE
2000 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	Mia Bailey	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	Susanne Streb	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
HALL, John D.	Joan Peacock	733-5898	614	60
HOLMES, George	Glenda Jacobs	733-5771	2119	29
HOWARD, Julia	Cindy Hobbs	733-5904	1023	51
MILLER, George	Cynthia Sexton	733-5995	532	43
REDWINE, David	Nancy Brantley	733-5829	635	19
SAUNDERS, Drew, Vice-Chair	Ruth Fish	733-5776	1219	82
SMITH, Ronald	Ann Jordan	733-5773	2223	2
WAINWRIGHT, William, Vice-Chair	Blinda Edwards	715-3001	420	8
WARNER, Alex	Ann Stancil	733-5853	1206	11

WILSON, Connie	Chris Floyd	733-5903	501	73
WRIGHT, Tom	Clarestene Stewart	733-5754	528	5

Cindy Avrette
Frank Folger
Trina Griffin,
Committee Counsel

Rep. Hurley
Chair

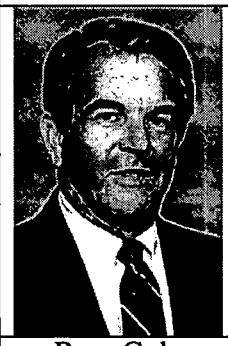
Rep. Saunders
Vice-Chair

Rep. Wainwright
Vice-Chair

Rep. Barbee

Rep. Boyd-
McIntyre

Rep. Brubaker


Rep. Cole

Rep. Dedmon

Rep. Dockham

Rep. Earle

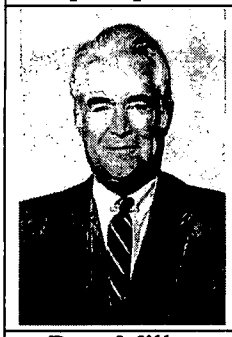
Rep. Esposito

Rep. Grady

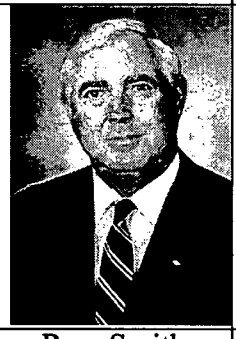
Rep. Hall

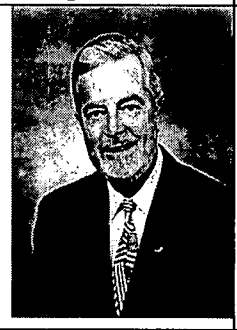
Rep. Holmes

Rep. Howard


Rep. Miller

Rep. Redwine


Rep. Smith


Rep. Warner

Rep. C. Wilson

Rep. Wright

HOUSE INSURANCE COMMITTEE
2000 SESSION

ATTENDANCE

HOUSE COMMITTEE ON INSURANCE

2000 Session

DATES	6-1	6-20	6-22	6-30							
HURLEY, Bill **CHAIR**	X	X	X	X							
BARBEE, Bobby		X	X	X							
BOYD-MCINTYRE, Flossie											
BRUBAKER, Harold	X	X	X								
COLE, Nelson	X	X	X	X							
DEDMON, Andrew	X	X	X	X							
DOCKHAM, Jerry	X		X	X							
EARLE, Beverly											
ESPOSITO, Theresa	X	X	X	X							
GRADY, Robert	X	X	X								
HALL, John D.	X	X	X	X							
HOLMES, George		X									
HOWARD, Julia	X	X		X							
MILLER, George											
REDWINE, David			X								
SAUNDERS, Drew **VICE-CHAIR**	X	X	X	X							
SMITH, Ronald (Ronnie)	X	X	X								
WAINWRIGHT, William **VICE-CHAIR**		X	X	X							
WARNER, Alex		X	X	X							
WILSON, Connie	X	X									
WRIGHT, Tom	X			X							
Ex-Officio Members											
HACKNEY, Joe											
BADDOUR, Phil											
CUNNINGHAM, W. Pete											

NOTE: * IN OUT DATE COLUMN INDICATES HOUSE RULE 36 (a)
LETTER RETURNED FROM BILL SPONSOR

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: INSURANCE Valid Through 18-JUL-2000

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	HF-POSTPONED INDEFINITELY	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	*HF-POSTPONED INDEFINITELY	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	HF-POSTPONED INDEFINITELY	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 -RE-REF COM ON HEALTH	04-15-99	00-07-05
H1126	HACKNEY	PHYS. CONTRACTS/NONCOMPETE PROHIBITE	*S -REF TO COM ON JUDICI	04-15-99	04-27-99
H1133	HACKNEY	HEALTH INS./LIABILITY	*S -REF TO COM ON JUDICI	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	*R -CH. SL 99-0383	04-15-99	04-23-99
H1206	INSKO	HEALTH INS./MENTAL HLTH PRECERT.	*HF-POSTPONED INDEFINITELY	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 18-JUL-2000

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**	*
H1529=	NYE	HMO INSOLVENCY	*S -RE-REF COM ON FINANCE	00-05-15	00-06-22
H1530	NYE	INTERNAL REVIEW PANELISTS	HF-POSTPONED INDEFINITELY	00-05-15	
H1538=	NYE	EXTERNAL REVIEW/MANAGED CARE	HF-POSTPONED INDEFINITELY	00-05-16	00-06-19
H1567=	ALEXANDER	MENTAL HEALTH/CHEM. DEP. PARITY	HF-POSTPONED INDEFINITELY	00-05-17	
H1589=	HACKNEY	HMO PATIENT PROTECTION ACT	HF-POSTPONED INDEFINITELY	00-05-18	
H1696	**WAINWRIGHT**	**FIRE INS PUBLIC PROTECTION**	**H -PRES. TO GOV. 07-11**	**00-05-25**	**00-06-22**
H1699=	HURLEY	INSURANCE LICENSE FEES/RECIPROCITY	*R -CH. SL 00-0122	00-05-30	00-06-07
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	*R -CH. SL 99-0365	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.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 1, 2000

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 1, 2000, at 12:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Chris Beatty (Moore County), and Richard Kimbrell (Columbus County). The following Committee members were present: Representatives Brubaker, Cole, Dedmon, Dockham, Esposito, Grady, Hall, Howard, Saunders, Smith, C. Wilson, and Wright. Cindy Avrette, Trina Griffin, and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 1530, entitled, AN ACT TO REQUIRE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES PURSUANT TO G.S. 58-50-61 AND G.S. 58-50-62 TO INCLUDE ON THE REVIEW OR GRIEVANCE PANEL PROVIDERS LICENSED, CERTIFIED, OR REGISTERED IN NORTH CAROLINA IN THE SAME MEDICAL OR ALLIED OCCUPATION AS THE PROVIDERS WHO ARE PARTIES TO THE REVIEW OR GRIEVANCE.

HB 1538, entitled, AN ACT TO PROVIDE STANDARDS FOR THE ESTABLISHMENT AND MAINTENANCE OF EXTERNAL REVIEW PROCEDURES IN HEALTH INSURANCE AND MANAGED CARE TO ASSURE THAT COVERED PERSONS HAVE THE OPPORTUNITY FOR AN INDEPENDENT REVIEW OF A HEALTH BENEFIT PLAN COVERAGE DECISION MADE BY THE INSURER OR MANAGED CARE PLAN; AND TO MAKE CONFORMING AMENDMENTS TO EXISTING LAWS ON UTIIZATION REVIEW AND GRIEVANCES.

Representative Hurley indicated the Chair was forming a sub-committee to consider these two bills consisting of the following members: Representative Saunders, Chair, and Representatives Dedmon, Dockham, Smith, and C. Wilson.

Representative Nye was recognized to present HB 1530 and HB 1538, and indicated these two bills came from a LRC Study Committee. Mr. Bill Hale, Department of Insurance, was recognized to explain these bills.

HB 1699, entitled, AN ACT TO INCREASE FEES PAID BY INSURANCE LICENSE APPLICANTS; TO EQUALIZE RESIDENT AND NONRESIDENT INSURANCE BROKER LICENSE FEES; AND TO MAKE NORTH CAROLINA INSURANCE PRODUCER LICENSING LAWS COMPLY WITH THE RECIPROCITY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102. Mr. Bill Hale, Department of Insurance, was recognized to explain the bill. Representative C. Wilson presented an amendment which would amend the bill on page 2, line 22, rewriting the line to read: "administrative rule to secure a license shall, upon application for licensing, pay to", and made a motion to

accept the amendment. The motion passed. Representative Dedmon made a motion to roll the amendment into a committee substitute, with a favorable report to the House committee substitute, unfavorable to the original bill, with a recommendation that the House committee substitute be re-referred to the Committee on Finance. The motion passed.

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
House Bills 1530, 1538, 1699
Amendment HB 1699
Bill Summaries
Handouts

VISITOR REGISTRATION SHEET

INSURANCE — June 1, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charles Tanner	NCATL
Christy Earnhardt	NCATL
Joanne Schoen	NC Nurses Association
Susan Valaer	Nationwide
Robert Pasha	Young, Moore
Lon McKillian	Manchester Alliance
Dick Taylor	Smith Helms
Sara Perry	Ins. & Fin. Advisors
Julianne Bechtel	NCAHP
PAUL MAHONEY	NC ASSN OF HEALTH PLANS
Dick Taylor	NCATL
William Potter	NCPHA - NCDS

VISITOR REGISTRATION SHEET

INSURANCE — June 1, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeanne Doucette	NCAHP
Lisa Duncan	NCAHP
Peg O'Connell	MRNC
Elizabeth Ouzts	NCPIRG
Adam Searing	NCYAC
Della Adams	Consumer
Dawn Cambridge	Governor's Office of Substance Abuse Policy
Ken Wright	BCBSNC
Allen Feaster	NC Council of Comm Prog
Sally Cameron	NC Psychological
Myrna Miller	NASW-NC

VISITOR REGISTRATION SHEET

INSURANCE — June 1, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Johnny Rainey	Poyner & Spruill
Mike Mauney	SBI
Porter	Bare & Associates
Amy Jo Bain	NC Medical Society
Sue Keene	NC Medical Society
Michelle McPherson	A Hy General
Steve McMurray	NC DOT
Alan Miles	Bailey & Dixon LLP
Lori A. Harris	L. A. Harris & Assoc
Eddie Caldwell	H/E CC & C, P.A.
PERRI MORGAN	NFIB

VISITOR REGISTRATION SHEET

INSURANCE — June 1, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
C Ramsey	NCSOS

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1530*

Short Title: Internal Review Panelists. (Public)

Sponsors: Representatives Nye, Insko, Nesbitt, Cunningham, and Justus.

Referred to: Insurance.

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO REQUIRE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES PURSUANT TO G.S. 58-50-61 AND G.S. 58-50-62 TO INCLUDE ON THE REVIEW OR GRIEVANCE PANEL PROVIDERS LICENSED, CERTIFIED, OR REGISTERED IN NORTH CAROLINA IN THE SAME MEDICAL OR ALLIED OCCUPATION AS THE PROVIDERS WHO ARE PARTIES TO THE REVIEW OR GRIEVANCE.

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 either (i) 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 (ii) criteria 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 licensed to practice medicine in this State 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; ensure that at least one provider holding a valid North Carolina license, registration, or certification in the same medical or allied health occupation as the providers who are parties to the review, or if the provider is a medical doctor, at least one clinical peer of the party provider; and issue the decision in a timely manner pursuant to this section."

Section 2. G.S. 58-50-62 reads as rewritten:

"**§ 58-50-62. Insurer grievance procedures.**

(a) Purpose and Intent. -- The purpose of this section is to provide standards for the establishment and maintenance of procedures by insurers to assure that covered persons have the opportunity for appropriate resolutions of their grievances.

(b) Availability of Grievance Process. -- Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. The grievance process may provide for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first- and second-level reviews of grievances; except that an appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section.

(c) Grievance Procedures. -- Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office.

(d) Maintenance of Records. -- Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(e) First-Level Grievance Review. -- A grievance may be submitted by a covered person or his or her provider acting on the covered person's behalf.

(1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written

material. Within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.

(2) An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a ~~medical doctor~~ provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the providers who are parties to the grievance, or if the provider is a medical doctor, at least one clinical peer of the party provider with appropriate expertise to evaluate the matter. The written decision issued in a first-level grievance review shall contain:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.

b. A statement of the reviewers' understanding of the grievance.

c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.

(f) Second-Level Grievance Review. -- An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision.

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:

a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.

b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask

questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.

(2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one ~~clinical peer.~~ provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the providers who are parties to the grievance, or if the provider is a medical doctor, at least one clinical peer of the party provider. ~~Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section~~ An insurer may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

(g) Second-Level Grievance Review Procedures. -- An insurer's procedures for conducting a second-level grievance review shall include:

(1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.

(2) The covered person shall be notified in writing at least 15 days before the review meeting date.

(3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.

(h) Second-Level Grievance Review Decisions. -- An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:

(1) The professional qualifications and licensure of the members of the review panel.

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

(3) The review panel's recommendation to the insurer and the rationale behind that recommendation.

(4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.

(5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.

(6) The rationale for the insurer's decision if it differs from the review panel's recommendation.

(7) A statement that the decision is the insurer's final determination in the matter.

(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

(i) Expedited Second-Level Procedures. -- An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the insurer shall conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

(j) No insurer shall discriminate against any provider based on any action taken by the provider under this section or G.S. 58-50-61 on behalf of a covered person..

(k) Violation. -- A violation of this section subjects an insurer to G.S. 58-2-70."

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

HOUSE BILL 1530: INTERNAL REVIEW PANELISTS

BILL ANALYSIS

Committee: House Insurance
Date: June 1, 2000
Version: First Edition

Introduced by: Representative Nye
Summary by: Linda Attarian
Committee Counsel for LRC
Managed Care Issues
Committee

SUMMARY: ***The bill would amend G.S. 58-50-61 and 58-50-62, managed care grievance and appeals procedures, to require insurers to include on utilization review and grievance panels, providers who are licensed, certified or registered to practice in this State and who practices in the same medical or allied occupation as the providers who are parties to the review or grievance.***

CURRENT LAW

Definition of clinical peer: The term "clinical peer" means a health care professional who holds a license in a state of the United States in the same or similar specialty and routinely provides the health care services subject to the review.

Utilization review panels: North Carolina law provides that all insurers establish a utilization review program to evaluate that health care services offered by the insurer are medically necessary and appropriate. Only "qualified health care professionals" may administer the utilization review program, and they must do so under the direction of a medical doctor. The law does not define "qualified health professionals." Thus the law does not prohibit insurers from including clinical peers or providers with the same license as the party to the review in the utilization review process, but it does not require their participation.

Grievance procedures concerning utilization review: North Carolina law establishes a two-step process for appeal and grievance when a health plan denies authorization for a particular type of health service pursuant to its utilization review program. Only a medical doctor licensed in North Carolina may make this denial. A denial of authorization may be appealed under G.S. 58-50-61, and the appeal panel must include a medical doctor licensed in North Carolina, but the law does not require the inclusion of a clinical peer at this stage of the appeal. If the panel upholds the denial, the insured may proceed to a second level appeal, which is conducted according to the provisions of G.S. 58-50-62. When the subject of the second level grievance is a clinical matter, the panel must be made up of health care professionals qualified to evaluate the matter, including at least one clinical peer. If an insurer uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel, then it may use one of its employees on the second-level grievance review panel in the same matter provided the panel contains three or more persons.

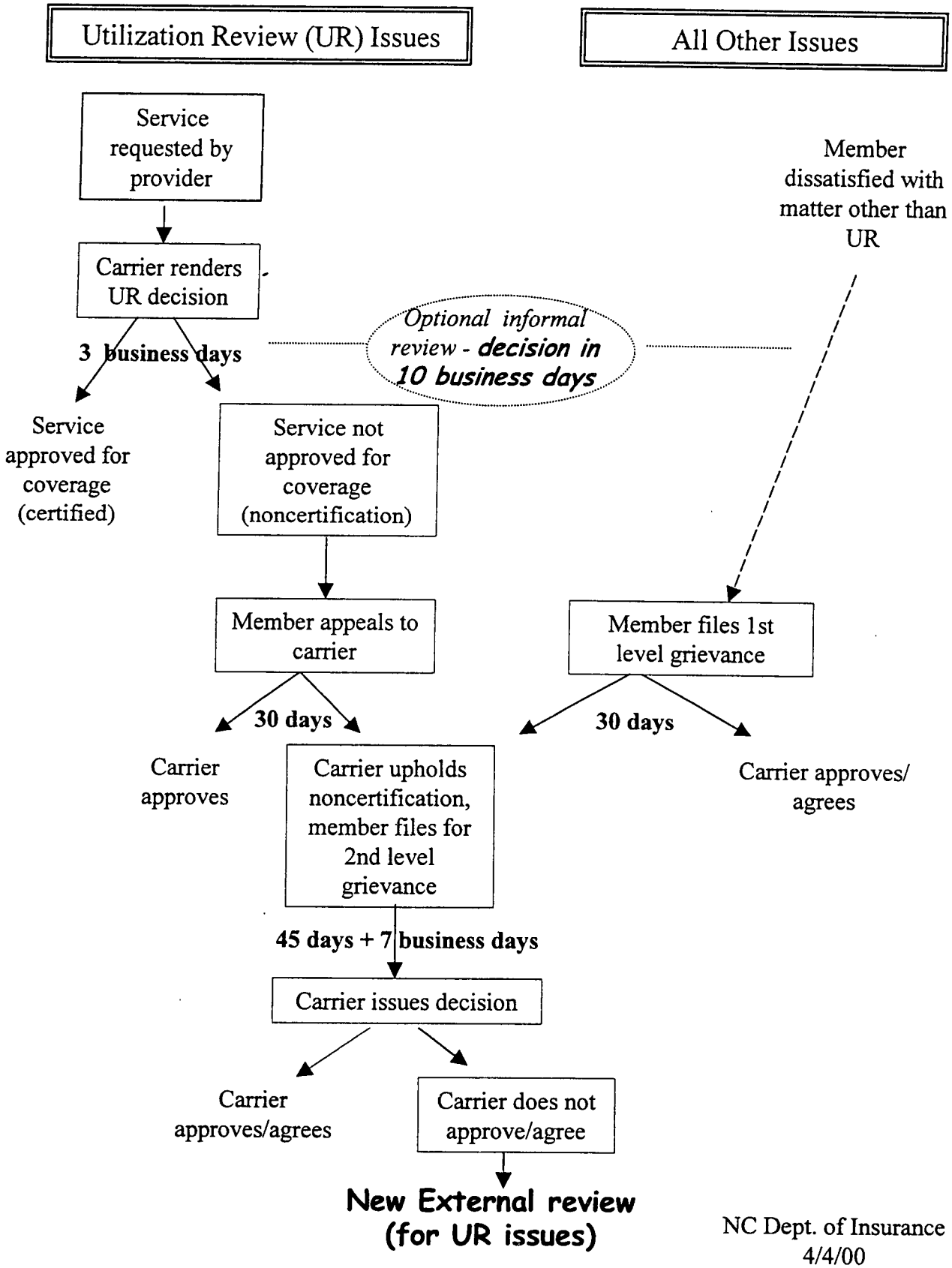
BILL ANALYSIS: **Section 1** amends G.S 58-50-61(d) to require that, in issuing a utilization review decision, at least one provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the provider who is a party to the review is included in the utilization review decision making process. If one of the providers party to the review is a medical doctor, then the insurer must involve a clinical peer of that provider.

Section 2 amends G.S. 58-50-62 to require that an insurers' grievance panel includes in the first and second-level grievance review panels at least one provider holding a valid North Carolina license,

registration, or certification in the same medical or allied occupation as the provider who are parties to the review. If one of the providers party to the grievance review is a medical doctor, then the insurer must include a clinical peer of that provider on the panels. Also, since the amended section requires the inclusion of a clinical peer on the appeal of a noncertification under G.S. 58-50-61 and on a first-level grievance review panel, the bill clarifies that an insurer may include one of the insurer's employees on the second-level review panel if it has three or more persons.

The act becomes effective when it becomes law.

INTERNAL APPEAL & GRIEVANCE (EXISTING LAW)
WITH PROPOSED MODIFICATIONS



NC Dept. of Insurance
4/4/00

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1538*

Short Title: External Review/Managed Care. (Public)

Sponsors: Representatives Nye, Insko, Nesbitt, Cunningham, Justus; Gardner, Wainwright, C. Wilson, and Hackney.

Referred to: Insurance.

May 16, 2000

A BILL TO BE ENTITLED

AN ACT TO PROVIDE STANDARDS FOR THE ESTABLISHMENT AND MAINTENANCE OF EXTERNAL REVIEW PROCEDURES IN HEALTH INSURANCE AND MANAGED CARE TO ASSURE THAT COVERED PERSONS HAVE THE OPPORTUNITY FOR AN INDEPENDENT REVIEW OF A HEALTH BENEFIT PLAN COVERAGE DECISION MADE BY THE INSURER OR MANAGED CARE PLAN; AND TO MAKE CONFORMING AMENDMENTS TO EXISTING LAWS ON UTILIZATION REVIEW AND GRIEVANCES.

The General Assembly of North Carolina enacts:

Section 1. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"ARTICLE 50.

General Accident and Health Insurance Regulations."

Section 2. Article 50 of Chapter 58 of the General Statutes is amended as follows:

(1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

Section 3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

Section 4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. -- As used in this ~~section and~~ section, in G.S. 58-50-62, and in Part 4 of this Article, the term:".

Section 5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Health Benefit Plan External Review.

"§ 58-50-75. Purpose, scope, and definitions.

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

(1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.

(2) 'Disclose' means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(3) 'Health information' means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to: the past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family; the provision of health care services to an individual; or payment for the provision of health care services to an individual.

(4) 'Independent review organization' or 'organization' means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions.

(5) 'Protected health information' means health information that identifies an individual who is the subject of the information; or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

"§ 58-50-76: Reserved for future codification.

"§ 58-50-77. Notice of right to external review.

(a) An insurer shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in this section at the time the insurer sends written notice of a decision on a second-level grievance review in which the insurer upheld its original noncertification as set forth in G.S. 58-50-62.

(b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 and G.S. 58-50-62, but that the organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.

(2) The covered person may file a grievance under the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62, but if the insurer has not issued a written decision to the covered person within 45 days after the date the covered person files the grievance with the insurer and the covered person has not requested or agreed to a delay, the covered person may file a request for external review under G.S. 58-50-80 of this section and shall be considered to have exhausted the insurer's internal grievance process for purposes of G.S. 58-50-79.

(c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a final second-level grievance review decision under G.S. 58-50-62, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or

(2) If the second-level grievance review decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services,

but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.

(d) In addition to the information to be provided under subsections (b) and (c) of this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information.

(e) An insurer that has collected protected health information under a valid authorization under this Part may use and disclose the protected health information to a person acting on behalf of or at the direction of the insurer for the performance of the insurer's insurance functions: claims administration, claims adjustment and management, fraud investigation, underwriting, loss control, rate-making functions, reinsurance, risk management, case management, disease management, quality assessment, quality improvement, provider credentialing verification, utilization review, peer review activities, grievance procedures, policyholder service functions, and internal administration of compliance, managerial, and information systems. Additional insurance functions may be allowed for the purpose of this subsection with the prior approval of the Commissioner. The protected health information shall not be used or disclosed for any purpose other than in the performance of the insurer's insurance functions.

(f) Except for a request for an expedited external review under G.S. 58-50-82, all requests for external review shall be made in writing to the Commissioner.

"**§ 58-50-78:** Reserved for future codification.

"**§ 58-50-79. Exhaustion of internal grievance process.**

(a) Except as provided in subsections (d) through (g) of this section, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a noncertification appeal decision under G.S. 58-50-61 and G.S. 58-50-62.

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 45 days since the date the covered person filed the grievance with the insurer.

(c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal grievance process.

(d) At the same time a covered person files a request for an expedited review of an appeal involving a noncertification as set forth in G.S. 58-50-61(l), the covered person may file a request for an expedited external review of the noncertification under G.S. 58-50-82 if the covered person has a medical condition where the time

frame for completion of an expedited review of the appeal involving a noncertification set forth in G.S. 58-50-61(j) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An insurer may waive its right to conduct an expedited review of an appeal and allow the covered person to proceed with an expedited external review of the noncertification.

(e) Upon receipt of a request for an expedited external review under subsection (d) of this section, the organization conducting the external review in accordance with the provisions of G.S. 58-50-82 shall immediately determine whether the covered person shall be required to complete the expedited review process set forth in G.S. 58-50-61(j) before it conducts the expedited external review, unless the insurer has waived its right to conduct an expedited review of the appeal decision.

(f) Upon a determination made under subsection (e) of this section that the covered person must first complete the expedited appeal process under G.S. 58-50-61(j), the organization immediately shall notify the covered person and the insurer of this determination and that it will not proceed with the expedited external review under G.S. 58-50-82 until completion of the expedited appeal process and the covered person's grievance at the completion of the expedited appeal process remains unresolved.

(g) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement.

(h) If the requirement to exhaust the insurer's internal grievance procedures is waived under subsection (g) of this section, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80.

"**§ 58-50-80. Standard external review.**

(a) Within 60 days after the date of receipt of a notice of a noncertification appeal decision or a second-level grievance review decision under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner immediately shall notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The insurer shall immediately submit to the Commissioner the information required for the preliminary review under subsection (c) of this section.

(c) Within five business days after the date of receipt of a request for an external review, the Commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(2) The health care service that is the subject of the noncertification appeal decision or the second-level grievance review decision

upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.

(3) The covered person has exhausted the insurer's internal grievance process under G.S. 58-50-62(i) unless the covered person is not required to exhaust the insurer's internal grievance process under G.S. 58-50-79.

(4) The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review, including the authorization form provided under G.S. 58-50-77(e).

(d) Upon completion of the preliminary review under subsection (c) of this section, the Commissioner immediately shall notify the covered person in writing whether the request is complete and whether the request has been accepted for external review.

(e) If the request is accepted for external review, the Commissioner shall:

(1) Include in the notice provided under subsection (d) of this section a statement that the covered person may submit to the Commissioner in writing within seven days after the date of the notice additional information and supporting documentation that the organization shall consider when conducting the external review.

(2) Immediately notify the insurer in writing of the acceptance of the request for external review.

(3) Provide the covered person and the covered person's provider with a list of organizations approved under G.S. 58-50-85.

(4) Inform the covered person that the covered person has the right to select the organization of his or her choice and notify the Commissioner within five days after receipt of the notice, and that if the covered person does not select an organization and inform the Commissioner of the selection within five days after receipt of the notice, the Commissioner will assign an organization to conduct the external review.

(f) If the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 90 days after the date of the insurer's decision for which external review is requested. If the request is not accepted for external review, the Commissioner shall inform the covered person and the insurer in writing of the reasons for its nonacceptance.

(g) If the insured does not select an organization of his or her choice and notify the Commissioner of the selection within five days after receipt of the Commissioner's notice under subsection (e) of this section, the Commissioner shall systematically assign an appropriate independent review organization that has been approved under G.S. 58-50-85 to conduct the external review. In reaching a decision,

the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(h) Within seven days after the date of receipt of the notice provided under subsection (e) of this section, the insurer or its designee utilization review organization shall provide to the assigned organization, the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision. Except as provided in subsection (i) of this section, failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review.

(i) If the insurer or its utilization review organization fails to provide the documents and information within the time specified in subsection (h) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision or the second-level grievance review decision. Immediately upon making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(j) The assigned organization shall review all of the information and documents received under subsections (h) and (i) of this section and any other information submitted in writing by the covered person under subsection (e) of this section that has been forwarded to the organization by the Commissioner. Upon receipt of any information submitted by the covered person under subsection (e) of this section, at the same time the Commissioner forwards the information to the organization, the Commissioner shall forward the information to the insurer.

(k) Upon receipt of the information required to be forwarded under subsection (j) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision.

(l) Immediately upon making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (k) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(m) In addition to the documents and information provided under subsections (h) and (i) of this section, the assigned organization, to the extent the documents or information are available and the organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records.

(2) The attending health care provider's recommendation.
(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
(4) The terms of coverage under the covered person's health benefit plan with the insurer to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.
(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations. Local practice guidelines may be used when appropriate.
(6) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.
(7) Medical necessity, as defined in G.S. 58-3-200(b).

(n) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, and the Commissioner.

(o) The organization shall include in the notice sent under subsection (n) of this section:

(1) A general description of the reason for the request for external review.
(2) The date the organization received the assignment from the Commissioner to conduct the external review.
(3) The date the organization received information and documents submitted by the covered person and by the insurer.
(4) The date the external review was conducted.
(5) The date of its decision.
(6) The principal reason or reasons for its decision.
(7) The clinical rationale for its decision.
(8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.
(9) The professional qualifications and licensure of the clinical peer reviewers.
(10) Notice to the covered person that he or she is not liable for the cost of the external review.

(p) Upon receipt of a notice of a decision under subsection (n) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer immediately shall approve the coverage that was the subject of the noncertification appeal decision or second-level grievance review decision.

"**§ 58-50-81:** Reserved for future codification.

"**§ 58-50-82. Expedited external review.**

(a) Except as provided in subsection (g) of this section, a covered person may make a request for an expedited external review with the Commissioner at the time the covered person receives:

(1) An appeal decision upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(l) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited appeal of a noncertification as set forth in G.S. 58-50-61(l); or

(2) A second-level grievance review decision upholding a noncertification under G.S. 58-50-62(h) or (i):

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) At the time the Commissioner receives a request for an expedited external review, the Commissioner immediately shall:

(1) Notify and provide a copy of the request to the insurer that made the noncertification appeal decision or second-level grievance review decision which is the subject of the request.

(2) For a request that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(c), assign an organization that has been approved under G.S. 58-50-87. The organization shall immediately determine whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The organization shall then inform the covered person, insurer, and Commissioner of its determination and conduct a review and make a decision on the review within the appropriate time frame.

(c) In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(d) At the time the insurer receives the notice under subsection (b) of this section, the insurer or its designee utilization review organization shall immediately provide or transmit all necessary documents and information considered in making the final noncertification decision to the assigned organization electronically or by telephone or facsimile or any other available expeditious method.

(e) In addition to the documents and information provided or transmitted under subsection (d) of this section, the assigned organization, to the extent the information or documents are available and the organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) The attending health care provider's recommendation.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) The terms of coverage under the covered person's health benefit plan with the insurer to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations. Local practice guidelines may be used when appropriate.

(6) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.

(7) Medical necessity, as defined in G.S. 58-3-200(b).

(f) As expeditiously as the covered person's medical condition or circumstances require, but not more than four days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision and notify the covered person, the insurer, and the Commissioner of the decision.

(g) If the notice provided under subsection (f) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt of the notice, a decision under subsection (f) of this section reversing the noncertification appeal decision or second-level grievance review decision, the

insurer immediately shall approve the coverage that was the subject of the noncertification.

(h) An expedited external review may not be provided for retrospective noncertifications.

"§ 58-50-83: Reserved for future codification.

"§ 58-50-84. Binding nature of external review decision.

(a) An external review decision is binding on the insurer.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.

(c) A covered person may not file a subsequent request for external review involving the same noncertification appeal decision or second-level grievance review decision for which the covered person has already received an external review decision under this Part.

"§ 58-50-85. Approval of independent review organizations.

(a) The Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part to ensure that an organization satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner shall develop an application form for initially approving and for reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87.

(c) The Commissioner may, in his discretion, determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.

(d) The Commissioner may charge an application fee that independent review organizations shall submit to the Commissioner with an application for approval and reapproval.

(e) An approval is effective for two years, unless the Commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under G.S. 58-50-87.

(f) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review

organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Part that is maintained by the Commissioner under subsection (g) of this section.

(g) The Commissioner shall maintain and periodically update a list of approved independent review organizations.

"**§ 58-50-86:** Reserved for future codification.

"**§ 58-50-87. Minimum qualifications for independent review organizations.**

(a) As a condition of approval under G.S. 58-50-85 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

c. The confidentiality of medical and treatment records and clinical review criteria.

d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) Agree to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) Agree to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience

treating patients with the same or similar injury, illness, or medical condition of the covered person.

(3) If the covered person's treating provider is a medical doctor, hold a nonrestricted license from the North Carolina Medical Board and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) If the covered person's treating provider is not a medical doctor, hold a nonrestricted North Carolina license, registration, or certification in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial,

or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

"**§ 58-50-88:** Reserved for future codification.

"**§ 58-50-89. Hold harmless for independent review organizations.**

No independent review organization or clinical peer reviewer working on behalf of an organization shall be liable in damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

"**§ 58-50-90. External review reporting requirements.**

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, at least annually, a report in the format specified by the Commissioner.

(c) The report shall include in the aggregate and for each insurer:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.

(3) The average length of time for resolution.

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.

(5) The number of external reviews under G.S. 58-50-80(k) and (l) that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.

(6) Any other information the Commissioner may request or require.

(d) The organization shall retain the written records required under this section for at least three years.

(e) Each insurer shall maintain written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review of which the insurer receives notice from the Commissioner under this Part. The insurer shall retain the written records required under this section for at least three years.

"**§ 58-50-91:** Reserved for future codification.

"**§ 58-50-92. Funding of external review.**

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review.

"**§ 58-50-93. Disclosure requirements.**

(a) Each insurer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of a noncertification appeal decision or a second-level grievance review decision upholding a noncertification with the Commissioner. The statement shall include the telephone number and address of the Commissioner.

(c) In addition to subsection (b) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

"**§ 58-50-94. Competitive selection of independent review organizations.**

(a) The Commissioner shall prepare and publish requests for proposals from independent review organizations that want to be approved under G.S. 58-50-85. All proposals shall be sealed. The Commissioner shall open all proposals in public.

(b) After the public opening, the Commissioner shall review the proposals, examining the costs and quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations in order to allow insureds a choice of review organizations and shall ensure that at least one review organization is available to and capable of reviewing cases involving highly specialized services and treatments of any nature. The Commissioner may reject any or all proposals.

(c) An independent review organization may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. An independent review organization seeking to modify or withdraw a proposal shall submit to the Commissioner a written request, with facts and evidence in support of its position, before the determination made by the Commissioner under subsection (b) of this section, but not later than two days after the public opening of the proposals. The Commissioner shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) The provisions of Article 3C of Chapter 143 of the General Statutes do not apply to this Part.

"**§ 58-50-95. Report by Commissioner.**

The Commissioner shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report should include the number of reviews, character of the reviews, dollar amounts in question, and any other information relevant to the evaluation of the effectiveness of this Part."

Section 6. G.S. 58-50-61(a)(13) reads as rewritten:

"(13) 'Noncertification' means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A 'noncertification' is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A 'noncertification' includes any situation in which an insurer or its designated agent makes an evaluation or review of medical information about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic and the extent to which coverage under the health benefit plan is affected by that decision."

Section 7. G.S. 58-50-61(a)(17)g. reads as rewritten:

"g. Retrospective review. -- Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the

review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met."

Section 8. G.S. 58-50-61(i) reads as rewritten:

"(i) Requests for Informal Reconsideration. -- An insurer may establish procedures for informal reconsideration of noncertifications and if established, such procedures shall be in writing. The reconsideration shall be conducted between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the ~~insurer~~ insurer, after a written notice of noncertification has been issued in accordance with subsection (h) of this section. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration the insurer upholds the noncertification decision, the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision in fewer than 10 business days, it shall treat the request for informal reconsideration as a request for an appeal, except that the requirements of subsection (k) of this section shall apply on or before the 10th business day after receipt of the request for an informal reconsideration."

Section 9. G.S. 58-50-62 is amended by adding a new subsection to read:

"(b1) Informal Consideration of Grievances. -- If the insurer provides procedures for informal considerations of grievances, the procedures shall be in writing and the following requirements apply:

(1) If the grievance concerns a clinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section shall apply on the 10th business day after receipt of the grievance.

(2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall issue a written decision that includes the information set forth in G.S. 58-50-62(c).

(3) If the insurer is unable to render an informal consideration decision within 10 business days of receipt of the grievance, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section shall apply on the 10th business day after receipt of the grievance."

Section 10. G.S. 58-50-61(k)(5) reads as rewritten:

"(5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under ~~G.S~~

~~58-50-62.~~ G.S. 58-50-62 if the insurer's decision on the appeal is to uphold its noncertification."

Section 11. G.S. 58-50-62(e)(2)e. reads as rewritten:

"e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this ~~section.~~ section if the insurer's decision on the first-level grievance review is not in favor of the covered person."

Section 12. G.S. 58-50-62(h)(7) reads as rewritten:

"(7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance."

Section 13. The Commissioner of Insurance shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report shall include the number of reviews, character of the reviews, dollar amounts in question, and any other information relevant to the evaluation of the effectiveness of the external review procedures established pursuant to this act.

Section 14. 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 15. This act becomes effective July 1, 2001.

HB 1538:
INDEPENDENT EXTERNAL REVIEW

BILL ANALYSIS

Committee: House Insurance
Date: June 1, 2000
Version: 1st Edition

Introduced by: Rep. Nye
Summary by: Linda Attarian*
Counsel to Managed Care LRC

SUMMARY: ***This bill, which was recommended by the Managed Care LRC, would add a new Part to Article 50 Chapter 58 of the General Statutes to establish an external, independent review process for consumers to obtain an external review of disputes regarding complaints and issues relating to the consumer's health benefit plan. A request for an external review would be made to the Commissioner of Insurance after exhausting all internal appeals. External reviews would be conducted by independent review organizations that are approved by the Commissioner of Insurance. The decision of the review organization must be made within 45 days or four days if necessary to avoid jeopardizing the health or life of the covered person. The decision would be binding upon the insurer. The insurer would pay the cost of the review. The act would become effective July 1, 2001, and would not be applicable to self-funded employer health plans regulated under ERISA.***

CURRENT LAW: **Internal Appeal and Grievance Procedures.**

North Carolina law provides for two step internal appeal and grievance procedure that allows consumers to appeal denials of preauthorizations of covered services or other matters in dispute between the consumer and the health benefit plan. Consumers whose appeal of a preauthorization denial or whose first-level grievance review has been decided in favor of the insurer have a right to file a written grievance with the insurer and to have a panel investigate and make a determination regarding the grievance. Consumers also have a right to request the review, appeal and grievance through a person authorized to act on their behalf or through their health care provider.

Appeals of Utilization Review Decisions: Under current law, when a consumer requests authorization of a particular procedure or service or continued authorization of ongoing care, the insurer must make a determination within two business days of the request. If the insurer denies authorization (referred to as a noncertification), the consumer may informally appeal the denial. This informal appeal procedure allows the consumer to explain why the procedure should have been authorized. This appeal requires that the preauthorization denial be reviewed by at least one medical doctor, licensed in NC, who was not involved in the denial. The insurer must issue a written decision to the consumer and the health care provider within 30 days of the request for review. The insurer must provide an expedited review and issue a decision within four days when it is necessary to avoid jeopardizing the health of the patient.

First-Level Grievance Appeal: If the dispute concerns a matter of dissatisfaction other than a request for covered services, the consumer has a right to an informal review of the grievance. The current law requires that the insurer select someone with appropriate expertise, who was not involved in the matter, to evaluate the grievance. A written decision must be issued within 30 days of the request.

Second-Level Grievance Appeal: If the consumer is dissatisfied with the outcome of the informal, first level grievance appeal, or of the informal appeal of the denial of preauthorization, the consumer has a right to file a formal, second-level grievance appeal with the insurer. At this stage, the matter giving rise to the appeal must be evaluated by persons who were not previously involved in the matter, who are not

employed by the insurer and who do not have a financial interest in the outcome of the appeal. However, these persons are appointed to serve on the panel by the insurer.

When the grievance concerns a utilization review matter or clinical issue, all members of the review panel must be health care professionals with appropriate expertise, including at least one clinical peer. One member of the panel may be an employee of the insurer if the panel is made up of three or more persons and the insurer included a clinical peer in the review of an appeal or first level grievance. The review must be held within 45 days of receipt of request and a written decision must be provided to the consumer seven days after the review meeting. An expedited review (within four days) must be provided if it is necessary to avoid jeopardizing the life or health of the patient.

BILL ANALYSIS:

Sections 1 through 4 of the bill divide Article 50 of Chapter 58 of the General Statutes, concerning general regulation of insurance, into five Parts and make conforming changes to existing language in the Article. Section 5 adds a new Part 4 to Article 50 of Chapter 58 to create a mechanism for independent, external review of an appeal decision upholding an initial noncertification decision or a second level grievance review decision that upheld an initial noncertification decision. The Part will apply to all persons who provide or perform utilization review.

Sections 6 amends the definition of "noncertification" under G.S. 58-3-190 to include (1) determinations and claims concerning whether a health care service provided in an emergency setting meets the prudent layperson standard for coverage; and (2) any review concerning whether a requested treatment is experimental, investigational, or cosmetic and the extent to which coverage under the health benefit plan is affected by that decision.

Section 7 amends the definition of "retrospective review" under G.S. 58-50-61(a)(17)g to specifically include reviews of claims concerning whether a health care service provided in an emergency setting meets the prudent layperson standard for coverage.

Section 8 amends G.S. 58-60-61(j), (Appeals of Noncertifications) to require informal reconsiderations of noncertifications to be conducted only after a written notice of the noncertification, meeting the requirements of G.S. 58-60-61 (h), has been issued. G.S. 58-60-61 (h) requires the notice to include the reasons for the noncertification, instructions on how to appeal the noncertifications, and instructions on how to request a written statement of the review criteria the insurer used in to make the noncertification. If the insurer is unable to reach an informal reconsideration decision in fewer than 10 business days, the informal reconsideration is to be treated as a formal appeal.

Section 9 adds a new subsection to G.S. 58-50-62 (Insurer grievance procedures), to provide similar requirements for procedures related to informal considerations of grievances as those outlined in Section 8.

Sections 10-12 makes clarifying and conforming amendments to current law.

Section 13 requires the Commissioner of Insurance to make biannual reports to the Joint Legislative Health Care Oversight Committee concerning the number and appropriateness of external appeals requested and conducted.

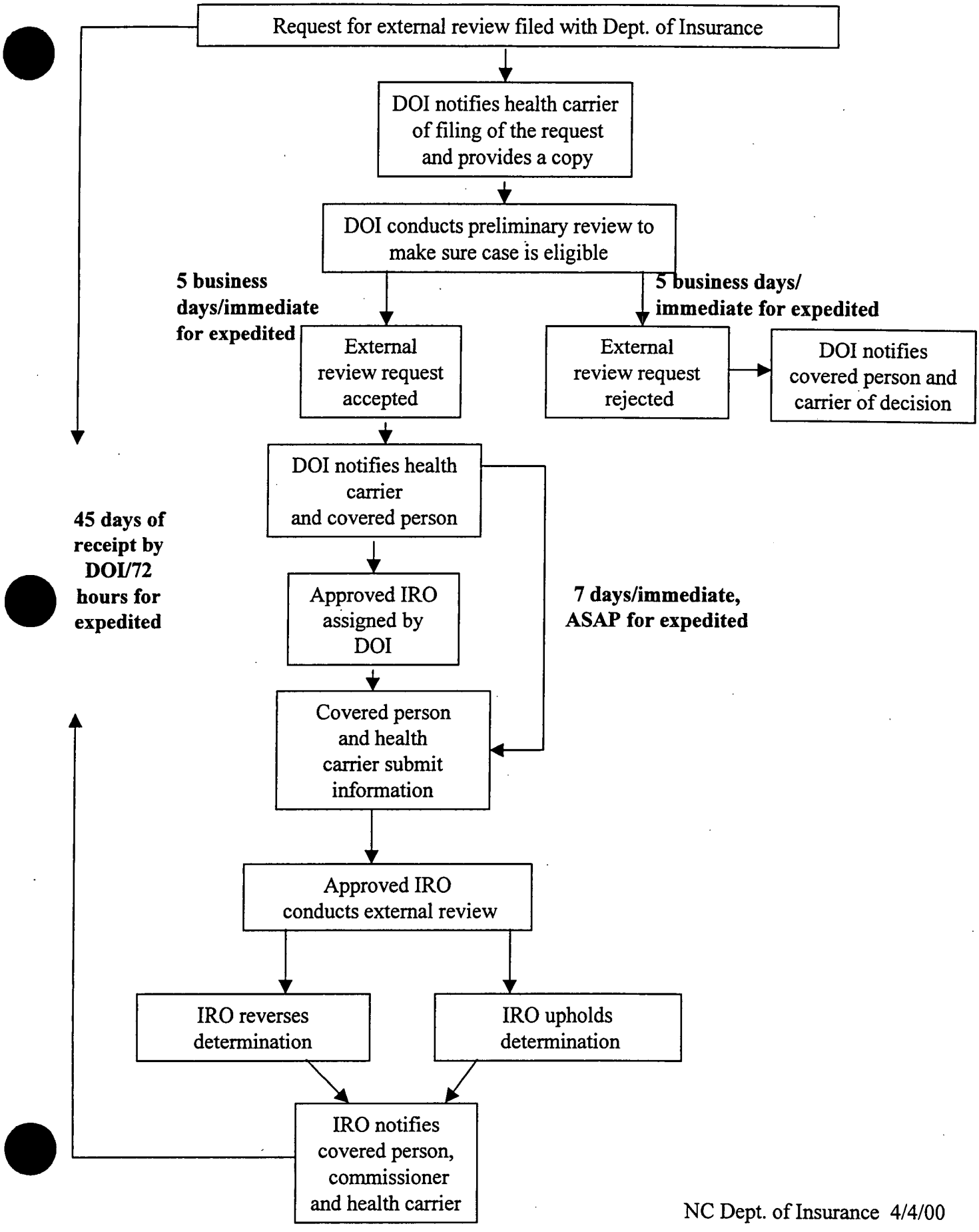
Section 14 is a severability clause.

Section 15 makes the bill effective July 1, 2001.

See attached chart for the key elements of Section 5, Independent External Review (prepared by Dee Atkinson, Research Assistant).

*This bill summary was modified for the House Insurance Committee by Trina Griffin, Committee Counsel.

Proposed External Review Process



NC Dept. of Insurance 4/4/00

North Carolina Law Addressing External Grievance Review Procedures

1	Predominant State Regulator Involved in the External Review	Department of Insurance (DOI).
2	Entities Whose Decisions are Eligible for External Review	Health Insurer.
3	Who May Request External Review	Covered Person.
4	Decisions that are Eligible for External Review	1) A noncertification appeal decision and 2) a second level grievance review decision.
5	Dollar Threshold for External Review	None.
6	Cost Sharing Requirements	None.
7	Exhausting Internal Grievance Procedures	With some exceptions, a request for an external review shall not be made until the covered person has exhausted the insurer's internal grievance process. If the covered person has filed a grievance involving a noncertification appeal decision, but the insurer has not issued a written decision to the covered person within 45 days after the date it was filed and the covered person has not requested or agreed to a delay, the covered person is considered to have exhausted the insurer's internal grievance process.
8	Expedited Review	A covered person may make a request for an expedited external review with the Commissioner and if the Commissioner determines that the request meets the reviewability standards, an Independent Review Organization (IRO) will be assigned to complete the review on an expedited basis. If the IRO determines that the timeframe for a standard review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the IRO must conduct the review and make the decision within four days.

9	General Description of Process	The request for external review is filed with the Department of Insurance. DOI notifies the health carrier of the filing of the request and provides a copy. DOI conducts a preliminary review to make sure the case is eligible. If the external review request is accepted, DOI notifies the insurer and covered person. The covered person has five days to select an approved Independent Review Organization (IRO). If the covered person hasn't selected an organization within five days, the Commissioner makes an assignment. The covered person and the insurer submit documents and information considered in making the internal review decision. The IRO conducts external review. IRO reverses or upholds determination, then notifies the covered person, Commissioner, and insurer. Except for a request for an expedited external review, all requests for external review must be made in writing.
10	Funding	The insurer against which a request for a standard review or an expedited external review is filed shall pay the cost of the IRO in conducting the external review.
11	Qualifications of Reviewer	The Commissioner approves IROs eligible to be assigned to conduct external reviews. The Commissioner develops an application form for initially approving and for re-approving organizations. Any IRO wishing to be approved submits the application form and includes with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87. To be approved under G.S. 58-50-87, an IRO maintains written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum: 1. A quality assurance mechanism in place that ensures: a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner. b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the IRO and suitable matching of reviewers to specific cases. c. The confidentiality of medical and treatment records and clinical review criteria. AND d. That any person employed by or under contract with the IRO adheres to the requirements of this Part. 2. A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

		3. Agree to maintain and provide to the Commissioner the information set out in G.S. 58-50-85. 4. Agree to contractual terms or written requirements established by the Commissioner. 5. A program for credentialing clinical peer reviewers. All clinical peer reviewers assigned by an IRO shall be physicians or other appropriate health care providers who meet the following minimum qualifications: 1. Be an expert in the treatment of the covered person's medical condition. 2. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person. 3. Hold a non-restricted license in a state of the US and, for physicians, a license from the North Carolina Medical Board, and if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area(s) appropriate. AND 4. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by a hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.
12	Conflicts of Interest	Neither the IRO nor any clinical peer reviewer assigned by the IRO may have a material professional, familial, or financial conflict of interest with any of the following: 1. The insurer. 2. The covered person or the covered person's authorized representative. 3. Any officer, director, or management employee of the insurer. 4. The healthcare provider, the health care provider's medical group or independent practice association recommending the health care service or treatment. 5. The facility at which the recommended healthcare service or treatment would be provided. 6. The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person. The IRO may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers

13	Standard of Review	The IRO reviews all of the information and documents received. In addition to documents received, the IRO considers: • the covered person's medical records, • the attending health care professional's recommendation, • consulting reports from appropriate health care professionals and other documents submitted, • the terms of coverage under the covered person's health benefit plan, • the most appropriate practice guidelines, including local practice guidelines, and any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization. • Medical necessity, as defined in G.S. 58-3-200(b). Within 45 days after the date of receipt of the request for external review, the IRO provides written notice of its decision to uphold or reverse the noncertification appeal decision or second level grievance review decision to the covered person, the insurer, and the Commissioner.
14	Time Frames	A covered person has 60 days after the date of receipt of a notice of a noncertification appeal decision or a second level grievance review decision to file a request with the Commissioner for an external review. Within 5 business days after the date of receipt of a request for an external review, the Commissioner has to complete a preliminary review of the request. If the request is not complete, the Commissioner will notify the covered person what information or materials are needed to review the request. The covered person has 90 days to furnish the materials. Once the request is accepted for review, the covered person has five days to select an IRO. The insurer or its designee utilization review organization has 7 days to forward documents and any information to the IRO. Within 45 days, the IRO has to provide written notice of its decision to uphold or reverse the decision to the covered person, the insurer, and the Commissioner. The decision of an expedited review must be made within four days.
15	Binding Nature of Decision	The decision is binding on the insurer. It is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law. A covered person may not file a subsequent request for external review involving the same noncertification appeal decision or second level grievance review decision for which the covered person has already received an external review decision.
16	Attorney's Fees	Does not address attorneys.
17	Confidentiality Requirements	For purposes of conducting an external review, the insurer provides an authorization form by which the covered person authorizes the insurer to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

18	Liability of Reviewer	No IRO or clinical peer reviewer working on behalf of an IRO shall be liable in damages to any person for any opinions rendered during or upon completion of an external review, unless the opinion was rendered in bad faith or involved gross negligence.
19	Data Reporting	Each IRO is required to maintain for at least three years written records in the aggregate and by insurer on all requests for which it conducted an external review during a calendar year and submit a report, at least annually, to the Commissioner. Each insurer shall maintain for at least three years written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review that are filed with the insurer or that the insurer received notice of from the Commissioner.
20	Disclosure Requirements	Each insurer must provide each covered person a description of the plan's external review procedures, including a statement that informs the covered person of their right to file a request for external review.

2000 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. 1699 A BILL TO BE ENTITLED AN ACT TO INCREASE FEES PAID BY INSURANCE LICENSE APPLICANTS; TO EQUALIZE RESIDENT AND NONRESIDENT INSURANCE BROKER LICENSE FEES; AND TO MAKE NORTH CAROLINA INSURANCE PRODUCER LICENSING LAWS COMPLY WITH THE RECIPROCITY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

☐ 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, and recommendation that the committee substitute bill be re-referred to the Committee on Finance.

☐ 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)

5/25/00

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 1699

Short Title: Insurance License Fees/Reciprocity/AB. (Public)

Sponsors: Representatives Hurley; Barefoot, Culp, Davis, Dedmon, Earle, Fox, Gibson, Hall, Melton, Michaux, Morris, Oldham, Redwine, Saunders, Sutton, Teague, Tolson, Warner, and Wright.

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

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO INCREASE FEES PAID BY INSURANCE LICENSE APPLICANTS; TO EQUALIZE RESIDENT AND NONRESIDENT INSURANCE BROKER LICENSE FEES; AND TO MAKE NORTH CAROLINA INSURANCE PRODUCER LICENSING LAWS COMPLY WITH THE RECIPROCITY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-33-125 reads as rewritten:

"**§ 58-33-125. Fees.**

(a) The following table indicates the annual fees that are required for the respective licenses issued, renewed, or cancelled under this Article and Article 21 of this Chapter:

Adjuster	$ 75.00
Adjuster, crop hail only	20.00
Agent appointment cancellation (paid by insurer)	10.00
Agent appointment, individual	20.00
Agent appointment, nonindividual	50.00
Agent appointment, Medicare supplement and long-term care, individual	10.00
Agent appointment, Medicare supplement and long-term care, nonindividual	20.00

Agent, overseas military	20.00
Broker, nonresident	~~100.00~~
	50.00
Broker, resident	50.00
Limited representative	20.00
Limited representative cancellation (paid by insurer)	10.00
Motor vehicle damage appraiser	75.00
Recertification, continuing education	5.00
Surplus lines licensee, corporate	50.00
Surplus lines licensee, individual	50.00

These fees are in lieu of any other license fees. Fees paid by an insurer on behalf of a person who is licensed or appointed to represent the insurer shall be paid to the Commissioner on a quarterly or monthly basis, in the discretion of the Commissioner. The recertification fee in this subsection shall be paid by persons subject to G.S. 58-33-130 at the time they renew their licenses or appointments under G.S. 58-33-130(c).

(b) Whenever a temporary license may be issued pursuant to this Article, the fee shall be at the same rate as provided in subsection (a) of this section; and any amounts so paid for a temporary license may be credited against the fee required for an appointment by the sponsoring company.

(c) Any person who is not ~~registered~~ licensed and who is required by law or administrative rule to secure a license shall, upon application for registration, pay to the Commissioner a fee of ~~thirty dollars ($30.00).~~ fifty dollars ($50.00). ~~In the event~~ If a person requests additional licensing for other kinds of ~~insurance is requested,~~ insurance, that person shall pay a fee of ~~thirty dollars ($30.00)~~ fifty dollars ($50.00) ~~shall be paid~~ to the Commissioner upon application for ~~registration~~ licensing for each additional kind of insurance.

In addition to the fees prescribed by this subsection, any person applying for a supplemental license to sell Medicare supplement and long-term care insurance policies shall pay an additional fee of thirty dollars ($30.00) upon application for registration for those kinds of insurance.

(d) The requirement for an examination, prelicensing education, continuing education, or a registration fee does not apply to agents for domestic farmers' mutual assessment fire insurance companies or associations who solicit and sell only those kinds of insurance specified in G.S. 58-7-75(5)d for such companies or associations.

(e) In the event a license issued under this Article is lost, stolen, or destroyed, the Commissioner may issue a duplicate license upon a written request from the licensee and payment of a fee of five dollars ($5.00).

(f) Whenever a printed record of an agent's file is requested, the fee shall be ten dollars ($10.00) for each copy whether or not the agent is currently licensed, previously licensed, or no record of that agent exists.

(g) All fees prescribed by this section are nonrefundable."

Section 2. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-33-32. Interstate reciprocity in producer licensing.

(a) The purpose of this section is to make North Carolina insurance producer licensing comply with the reciprocity requirements in the federal Gramm-Leach-Bliley Act, Public Law 106-102. This section does not apply to surplus lines licensees in Article 21 of this Chapter, except as provided in subsections (c) and (d) of this section.

(b) As used in this section:

(1) 'Home state' means the District of Columbia and any state or territory of the United States in which an insurance producer maintains a principal place of residence or principal place of business and is licensed to act as an insurance producer.

(2) 'Insurance producer' or 'producer' means a person required to be licensed under this Article to sell, solicit, or negotiate insurance.

(3) 'License' means a document issued by the Commissioner authorizing a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit to an insurance carrier.

(4) 'Limited line credit insurance' includes any type of credit insurance written under Article 57 of this Chapter, mortgage life, mortgage guaranty, mortgage disability, automobile dealer gap insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that the Commissioner determines should be designated a form of limited line credit insurance.

(5) 'Limited line credit insurance producer' means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(6) 'Negotiate' means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(7) 'Sell' means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(8) 'Solicit' means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(9) 'Uniform Application' means the most recent version of the NAIC Uniform Application for resident and nonresident producer licensing.

(10) 'Uniform Business Entity Application' means the most recent version of the NAIC Uniform Business Entity Application for a resident and a nonresident corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(c) Unless denied licensure under G.S. 58-33-30 or G.S. 58-33-50, a nonresident person shall receive a nonresident producer license if:

(1) The person is currently licensed as a resident and in good standing in that person's home state;

(2) The person has submitted the proper request for licensure and has paid the fees required by G.S. 58-33-125;

(3) The person has submitted or transmitted to the Commissioner the application for licensure that the person submitted to that person's home state, or in lieu of the same, a completed Uniform Application or Uniform Business Entity Application; and

(4) The person's home state awards nonresident producer licenses to residents of this State on the same basis.

The Commissioner may verify the producer's licensing status through the producer database maintained by the NAIC or affiliates or subsidiaries of the NAIC.

(d) Notwithstanding any other provision of this section, a person licensed as a surplus lines producer in that person's home state shall receive a nonresident surplus lines license pursuant to the provisions of this section. Except for the licensure provisions of this section, nothing in this section otherwise amends or supersedes any provision of Article 21 of this Chapter.

(e) Notwithstanding any other provision of this section, a person licensed or registered as a viatical settlement broker, viatical settlement provider, or viatical settlement representative, as defined in G.S. 58-58-42(a), in that person's home state shall receive a nonresident viatical settlement broker, viatical settlement provider, or viatical settlement representative license pursuant to this section. Except for the licensure provisions of this section, nothing in this section otherwise amends or supersedes any provision of G.S. 58-58-42.

(f) Notwithstanding any other provision of this section, a person licensed as a limited line credit insurance producer or other type of insurance producer in that person's home state shall receive a nonresident limited lines producer license pursuant to the provisions of this section, granting the same scope of authority as granted under the license issued by the producer's home state.

(g) An individual who applies for an insurance producer license in this State who was previously licensed for the same kinds of insurance in that individual's home state shall not be required to complete any prelicensing education or examination. This exemption is available only if:

(1) The applicant is currently licensed in the applicant's home state; or

(2) The application is received within 90 days after the cancellation of the applicant's previous license and the applicant's home state

issues a certification that, at the time of cancellation, the applicant was in good standing in that state; or

(3) The home state's producer database records, maintained by the NAIC or affiliates or subsidiaries of the NAIC, indicate that the producer is or was licensed in good standing for the kind of insurance requested.

(h) The Commissioner shall not assess a greater fee for an insurance license or related service to a nonresident producer based solely on the fact that the producer does not reside in this State.

(i) The Commissioner shall waive any license application requirements for a nonresident license applicant with a valid license from the applicant's home state, except the requirements imposed by subsection (c) of this section, if the applicant's home state awards nonresident licenses to residents of this State on the same basis.

(j) A nonresident producer's satisfaction of the nonresident producer's home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this State's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this State on the same basis.

(k) A producer shall report to the Commissioner any administrative action taken against the producer in another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other relevant legal documents.

(l) Within 30 days after the initial pretrial hearing date, a producer shall report to the Commissioner any criminal prosecution of the producer taken in any state. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents."

Section 3. G.S. 58-33-30(h)(2)b. reads as rewritten:

"b. ~~A~~ Except as provided in G.S. 58-33-32, a nonresident of this State may be licensed without taking an otherwise required written examination if the ~~Commissioner~~ insurance regulator of the state of the applicant's residence certifies that the applicant has passed a similar written examination or has been a continuous holder, prior to the time such written examination was required, of a license like the license being applied for in this State."

Section 4. This act becomes effective July 1, 2000.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 1

H. B. No. 1699 DATE 6/1/00

S. B. No. _____ Amendment No. 1
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) CONNIE WILSON
)
Sen.)

moves to amend the bill on page 2, line 22

( ) WHICH CHANGES THE TITLE

by rewriting the line to read:

"administrative rule to secure a license shall, upon application for ~~registration~~, licensing, pay to

SIGNED Connie Wilson

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1699
Proposed Committee Substitute H1699-PCS8197

Short Title: Insurance License Fees/Reciprocity/AB. (Public)

Sponsors:

Referred to:

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO INCREASE FEES PAID BY INSURANCE LICENSE APPLICANTS; TO EQUALIZE RESIDENT AND NONRESIDENT INSURANCE BROKER LICENSE FEES; AND TO MAKE NORTH CAROLINA INSURANCE PRODUCER LICENSING LAWS COMPLY WITH THE RECIPROCITY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-33-125 reads as rewritten:

"**§ 58-33-125. Fees.**

(a) The following table indicates the annual fees that are required for the respective licenses issued, renewed, or cancelled under this Article and Article 21 of this Chapter:

Adjuster	$ 75.00
Adjuster, crop hail only	20.00
Agent appointment cancellation (paid by insurer)	10.00
Agent appointment, individual	20.00
Agent appointment, nonindividual	50.00
Agent appointment, Medicare supplement and long-term care, individual	10.00
Agent appointment, Medicare supplement and long-term care, nonindividual	20.00
Agent, overseas military	20.00

Broker, nonresident	~~100.00~~
	50.00
Broker, resident	50.00
Limited representative	20.00
Limited representative cancellation (paid by insurer)	10.00
Motor vehicle damage appraiser	75.00
Recertification, continuing education	5.00
Surplus lines licensee, corporate	50.00
Surplus lines licensee, individual	50.00

These fees are in lieu of any other license fees. Fees paid by an insurer on behalf of a person who is licensed or appointed to represent the insurer shall be paid to the Commissioner on a quarterly or monthly basis, in the discretion of the Commissioner. The recertification fee in this subsection shall be paid by persons subject to G.S. 58-33-130 at the time they renew their licenses or appointments under G.S. 58-33-130(c).

(b) Whenever a temporary license may be issued pursuant to this Article, the fee shall be at the same rate as provided in subsection (a) of this section; and any amounts so paid for a temporary license may be credited against the fee required for an appointment by the sponsoring company.

(c) Any person who is not ~~registered~~ licensed and who is required by law or administrative rule to secure a license shall, upon application for ~~registration,~~ licensing, pay to the Commissioner a fee of ~~thirty dollars ($30.00).~~ fifty dollars ($50.00). ~~In the event~~ If a person requests additional licensing for other kinds of ~~insurance is requested,~~ insurance, that person shall pay a fee of ~~thirty dollars ($30.00)~~ fifty dollars ($50.00) ~~shall be paid~~ to the Commissioner upon application for ~~registration~~ licensing for each additional kind of insurance.

In addition to the fees prescribed by this subsection, any person applying for a supplemental license to sell Medicare supplement and long-term care insurance policies shall pay an additional fee of thirty dollars ($30.00) upon application for registration for those kinds of insurance.

(d) The requirement for an examination, prelicensing education, continuing education, or a registration fee does not apply to agents for domestic farmers' mutual assessment fire insurance companies or associations who solicit and sell only those kinds of insurance specified in G.S. 58-7-75(5)d for such companies or associations.

(e) In the event a license issued under this Article is lost, stolen, or destroyed, the Commissioner may issue a duplicate license upon a written request from the licensee and payment of a fee of five dollars ($5.00).

(f) Whenever a printed record of an agent's file is requested, the fee shall be ten dollars ($10.00) for each copy whether or not the agent is currently licensed, previously licensed, or no record of that agent exists.

(g) All fees prescribed by this section are nonrefundable."

Section 2. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-32. Interstate reciprocity in producer licensing.**

(a) The purpose of this section is to make North Carolina insurance producer licensing comply with the reciprocity requirements in the federal Gramm-Leach-Bliley Act, Public Law 106-102. This section does not apply to surplus lines licensees in Article 21 of this Chapter, except as provided in subsections (c) and (d) of this section.

(b) As used in this section:

(1) 'Home state' means the District of Columbia and any state or territory of the United States in which an insurance producer maintains a principal place of residence or principal place of business and is licensed to act as an insurance producer.

(2) 'Insurance producer' or 'producer' means a person required to be licensed under this Article to sell, solicit, or negotiate insurance.

(3) 'License' means a document issued by the Commissioner authorizing a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit to an insurance carrier.

(4) 'Limited line credit insurance' includes any type of credit insurance written under Article 57 of this Chapter, mortgage life, mortgage guaranty, mortgage disability, automobile dealer gap insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that the Commissioner determines should be designated a form of limited line credit insurance.

(5) 'Limited line credit insurance producer' means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(6) 'Negotiate' means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(7) 'Sell' means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(8) 'Solicit' means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(9) 'Uniform Application' means the most recent version of the NAIC Uniform Application for resident and nonresident producer licensing.

(10) 'Uniform Business Entity Application' means the most recent version of the NAIC Uniform Business Entity Application for a resident and a nonresident corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(c) Unless denied licensure under G.S. 58-33-30 or G.S. 58-33-50, a nonresident person shall receive a nonresident producer license if:

(1) The person is currently licensed as a resident and in good standing in that person's home state;

(2) The person has submitted the proper request for licensure and has paid the fees required by G.S. 58-33-125;

(3) The person has submitted or transmitted to the Commissioner the application for licensure that the person submitted to that person's home state, or in lieu of the same, a completed Uniform Application or Uniform Business Entity Application; and

(4) The person's home state awards nonresident producer licenses to residents of this State on the same basis.

The Commissioner may verify the producer's licensing status through the producer database maintained by the NAIC or affiliates or subsidiaries of the NAIC.

(d) Notwithstanding any other provision of this section, a person licensed as a surplus lines producer in that person's home state shall receive a nonresident surplus lines license pursuant to the provisions of this section. Except for the licensure provisions of this section, nothing in this section otherwise amends or supersedes any provision of Article 21 of this Chapter.

(e) Notwithstanding any other provision of this section, a person licensed or registered as a viatical settlement broker, viatical settlement provider, or viatical settlement representative, as defined in G.S. 58-58-42(a), in that person's home state shall receive a nonresident viatical settlement broker, viatical settlement provider, or viatical settlement representative license pursuant to this section. Except for the licensure provisions of this section, nothing in this section otherwise amends or supersedes any provision of G.S. 58-58-42.

(f) Notwithstanding any other provision of this section, a person licensed as a limited line credit insurance producer or other type of insurance producer in that person's home state shall receive a nonresident limited lines producer license pursuant to the provisions of this section, granting the same scope of authority as granted under the license issued by the producer's home state.

(g) An individual who applies for an insurance producer license in this State who was previously licensed for the same kinds of insurance in that individual's home state shall not be required to complete any prelicensing education or examination. This exemption is available only if:

(1) The applicant is currently licensed in the applicant's home state; or

(2) The application is received within 90 days after the cancellation of the applicant's previous license and the applicant's home state

issues a certification that, at the time of cancellation, the applicant was in good standing in that state; or

(3) The home state's producer database records, maintained by the NAIC or affiliates or subsidiaries of the NAIC, indicate that the producer is or was licensed in good standing for the kind of insurance requested.

(h) The Commissioner shall not assess a greater fee for an insurance license or related service to a nonresident producer based solely on the fact that the producer does not reside in this State.

(i) The Commissioner shall waive any license application requirements for a nonresident license applicant with a valid license from the applicant's home state, except the requirements imposed by subsection (c) of this section, if the applicant's home state awards nonresident licenses to residents of this State on the same basis.

(j) A nonresident producer's satisfaction of the nonresident producer's home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this State's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this State on the same basis.

(k) A producer shall report to the Commissioner any administrative action taken against the producer in another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other relevant legal documents.

(l) Within 30 days after the initial pretrial hearing date, a producer shall report to the Commissioner any criminal prosecution of the producer taken in any state. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents."

Section 3. G.S. 58-33-30(h)(2)b. reads as rewritten:

"b. ~~A~~ Except as provided in G.S. 58-33-32, a nonresident of this State may be licensed without taking an otherwise required written examination if the ~~Commissioner~~ insurance regulator of the state of the applicant's residence certifies that the applicant has passed a similar written examination or has been a continuous holder, prior to the time such written examination was required, of a license like the license being applied for in this State."

Section 4. This act becomes effective July 1, 2000.

HOUSE BILL 1699 : INSURANCE LICENSE FEES/RECIPROCITY

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Hurley
Date:	June 1, 2000	**Summary by:**	Trina Griffin*
Version:	1st Edition		Committee Counsel

SUMMARY: ***This bill reduces the annual licensing fee for nonresident insurance brokers and increases the one-time application fee. This bill also establishes a system of reciprocity for the licensing of insurance agents and brokers ("producers"). It sets forth the procedures a nonresident person must follow to obtain a nonresident producer license. It is modeled after the Producer Licensing Model Act of the National Association of Insurance Commissioners.***

CURRENT LAW: Chapter 58-33-30 sets out the licensing requirements for all insurance agents and brokers including nonresidents. Specifically, it states that a nonresident is exempt from taking a written examination in North Carolina if the Commissioner of the nonresident's home state certifies that the nonresident passed a similar exam in his home state or has been a continuous holder of a license in his home state. There is also a reciprocity provision which provides that to the extent other states waive their restrictions with regard to licensing nonresidents, North Carolina will waive the same restrictions with regard to applicants from that state.

BACKGROUND: The federal Gramm-Leach-Bliley Act, which passed in November of 1999, mandates that a majority of states either (1) enact uniform laws and regulations governing the licensure of individuals and entities authorized to sell and solicit the purchase of insurance within the state OR (2) enact reciprocity laws and regulations governing the licensure of nonresident individuals and entities authorized to sell and solicit insurance within those states. If the states fail to comply with the mandate by November 12, 2002, the National Association of Registered Agents and Brokers (NARAB) will be established to provide a mechanism through which uniform licensing, appointment, continuing education, and other insurance producer sales qualification requirements and conditions can be adopted and applied on a multistate basis. Therefore, the purpose of this bill is to adopt provisions in compliance with the federal mandate.

BILL ANALYSIS:

Section 1 of the bill reduces the annual nonresident broker license fee from $100.00 to $50.00 and increases the one-time fee license application fee for all insurance licensees from $30.00 to $50.00.

Section 2 of the bill adds a new section to Article 33 of Chapter 58 to comply with the reciprocity requirements in the federal Gramm-Leach-Bliley Act and to establish a procedure for nonresident producers to obtain a license in North Carolina. The key provisions are as follows:

1. A nonresident can obtain a license in North Carolina if:
    - the nonresident is a licensed resident in good standing in his home state;
    - has submitted the proper fees and application;
    - has submitted a copy of his home state licensure application (or completed a Uniform Application); and
    - the home sate awards nonresident licenses on the same basis as North Carolina.

2. A nonresident applicant is exempt from the prelicensing education and examination requirements if:
    - the applicant is currently licensed in his home state; or
    - the application is received within 90 days after cancellation of the applicant's previous license and the home state certifies that at the time of the cancellation the applicant was in good standing;
    - or the home state's producer database indicates the applicant is or was licensed in good standing.
3. Satisfaction of the continuing education requirements in the applicant's home state will satisfy the continuing education requirements in this state as long as there is a reciprocal agreement for identical treatment for North Carolina applicants in that state.
4. This act would also require a producer to report to the Commissioner of Insurance any administrative action or criminal prosecution taken against the producer.

Section 3 of the bill makes conforming changes to 58-33-30, which deals with waiver of the written examination requirement for nonresidents, to include a reference to the new reciprocity section.

This act would become effective July 1, 2000.

*Information for this summary was contributed by Bill Hale, Legislative Counsel for the Department of Insurance.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

June 1, 2000

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: House Bill 1699 -- Insurance License Fees/Reciprocity

The following is a summary of the genesis of this bill and why North Carolina should enact it. In order to make it eligible for the 2000 budget session, some fee amounts have been changed. The nonresident broker fee would be reduced from $100/year to $50/year (same as resident brokers. The one-time license application fee would be increased from $30 to $50.

Short Summary:

This bill establishes a system of reciprocity for licensing of insurance agents and brokers (producers). It also sets forth the procedures a nonresident person should follow to obtain a nonresident producer license. It is taken from the Producer Licensing Model Act of the National Association of Insurance Commissioners (NAIC).

Relationship to Federal Legislation, If Any:

Public Law 106-102 (the Gramm-Leach-Bliley Act – Financial Services Modernization) mandates that a majority of the states (1) enact uniform laws and regulations governing the licensure of individuals and entities authorized to sell and solicit the purchase of insurance within the state or (2) enact reciprocity laws and regulations governing the licensure of nonresident individuals and entities authorized to sell and solicit insurance within those states. If states do not enact uniform laws and regulations or enact a system of reciprocal licensing by November 12, 2002, the National Association of Registered Agents and Brokers (NARAB) will be established to provide a mechanism through which uniform licensing, appointment, continuing education, and other insurance producer sales qualification requirements and conditions can be adopted and applied on a multistate basis.

Significance or Reason Why This Bill Should Be Enacted (Purpose):

This bill should be enacted to preserve the authority of North Carolina and other states to license insurance producers.

Memorandum
House Insurance Committee
Insurance License Fees/Reciprocity
June 1, 2000

Industry, Consumer, Federal Participants in the NAIC Process and Their Positions on the Issue, If Known:

State insurance regulators, insurance companies and agent associations were all involved in the development of this model act. The following states served on the NAIC working group that developed the model act: Delaware, Co-chair; South Dakota, Co-chair; Alabama, Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Idaho, Illinois, Iowa, Kentucky, Louisiana, Maryland, Minnesota, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas and Wisconsin. With the exception of California, all of the states on the working group supported the adoption of the model act.

The following associations were involved in the drafting of the model act: Council of Insurance Agents and Brokers, National Association of Insurance Financial Advisors, Independent Insurance Agents of America, Professional Insurance Agents, National Association of Professional Surplus Lines Offices, Consumer Credit Insurance Association, National Association of Life Companies, American Council of Life Insurers, GEICO, Alliance of American Insurers, American Bankers Association Insurance Group, USAA, Association of Banks in Insurance, National Association of Independent Insurers, National Association of Mutual Insurers, American Insurance Association and Progressive Insurance. While the Independent Insurance Agents of America and the American Insurance Association could not guarantee full support of the model, all of the other associations supported the adoption of the model act.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 20, 2000

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 20, 2000, at 4:00 P.M. Representative Hurley called the meeting to order and introduced the pages, Katie Mills and Manning Pruden (Chowan County). The following Committee members were present: Representatives Barbee, Brubaker, Cole, Dedmon, Esposito, Grady, Hall, Holmes, Howard, Saunders, Smith, Wainwright, Warner, and C. Wilson. Cindy Avrette, Trina Griffin, and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached. Representative Hurley indicated the following bills were to be considered and discussed, but a vote would not be taken on same:

HB 1696, entitled, AN ACT TO CLARIFY THE AUTHORITY OF THE COMMISSIONER OF INSURANCE AND STATE FIRE MARSHAL TO ESTABLISH PUBLIC PROTECTION CLASSIFICATIONS FOR FIRE INSURANCE RATING PURPOSES AND TO APPROPRIATE FUNDS FOR THAT PURPOSE. Representative Wainwright was recognized to present the bill, and offered a committee substitute and an amendment for consideration. Representative Dedmon moved to adopt the proposed committee substitute for discussion. The motion passed. Bill Hale with the Department of Insurance was recognized to further explain the amendment. Representative Wainwright moved for adoption of the amendment for discussion. The motion passed. Dashchiel Propes, Chief Deputy Commissioner, Department of Insurance, was recognized to explain HB 1696. Representative Barbee moved the bill be sent to a study committee for further consideration. Representative Wainwright opposed the motion. Mr. Dave Horne with the Smith Anderson Law Firm in Raleigh representing the National Association of Independent Insurers (NAII) was recognized to encourage the committee to study this issue. Commissioner Jim Long with the Department of Insurance was recognized to provide information pertaining to the bill and a meeting between the Department of Insurance and the Insurance Services Office (ISO) on June 16, 2000. Paul Miller, Executive Secretary with the NC State Firemen's Association, was recognized to speak on behalf of the bill. Representative Saunders requested that Representative Barbee hold his motion until the next Insurance Committee meeting on Thursday, June 22nd. Representative Barbee withdrew his motion.

HB 1529, entitled, AN ACT TO PROTECT PERSONS ENROLLED IN AN HMO FROM THE CONSEQUENCES OF THE INSOLVENCY OF THAT HMO BY AUTHORIZING ASSESSMENTS OF REMAINING HMOs IN THE STATE TO PAY FOR UNCOVERED EXPENDITURES OF AND CONTINUATION OF COVERAGE FOR THE ENROLLEES. Mr. Bill Hale, Department of Insurance, was recognized to explain the bill.

There being no further business, the Chair adjourned the meeting at 4:50 P.M.

Respectfully submitted,

Representative John W. "Bill" Hurley
Chairman

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS

Visitor Registration Form
House Bills 1696, 1529
Amendment and Proposed Committee Substitute HB 1696
Bill Summaries
Handout

VISITOR REGISTRATION SHEET

INSURANCE — June 20, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robbie S. Minnich	Bone and Associates
[signature]	" " "
[signature]	N.C. State Firemen's Assoc.
Tim Bradley	N.C. Dept of Insurance
[signature]	~~JP Assoc~~
[signature]	Young, Moore & Henderson
[signature]	Bone & Associates.
[signature]	NC Medical Society
Frank Lewis	OSBM
John Bowdish	Alley Associates
[signature]	NCAHF

VISITOR REGISTRATION SHEET

INSURANCE — June 20, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lon M Kilbride	Moore & Van Allen
John McMillan	Manning, Fulton & Skinner PA.
Susan Valcin	Nationwide
Joanne Schoen	NC Nurses Association
Al Pinto	Self
Sherri McClees	McClees Consulting Inc
Ken Wright	BCBSNC
[illegible]	Moore & Van Allen

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1696

Short Title: Fire Ins. Public Protection/AB. (Public)

Sponsors: Representative Wainwright.

Referred to: Insurance, if favorable, Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE AUTHORITY OF THE COMMISSIONER OF INSURANCE AND STATE FIRE MARSHAL TO ESTABLISH PUBLIC PROTECTION CLASSIFICATIONS FOR FIRE INSURANCE RATING PURPOSES AND TO APPROPRIATE FUNDS FOR THAT PURPOSE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-36-10(3) reads as rewritten:

"(3) In the case of ~~fire~~ property insurance ~~rates, as are subject to the ratemaking authority of the Bureau,~~ rates under this Article, consideration may be given to the experience of ~~such fire~~ property insurance business during the most recent five-year period for which that experience is available. In the case of ~~fire~~ property insurance rates ~~that are subject to the ratemaking authority of the Bureau,~~ under this Article, consideration shall be given to the insurance public protection classifications of ~~rural fire districts based upon standards~~ fire districts, which classifications shall be established and modified from time to time 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.~~ "

Section 2. G.S. 58-40-25(4) reads as rewritten:

"(4) ~~With respect to fire insurance, to the extent credits are provided for proximity to fire hydrants, insurers 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.~~ In the case of property insurance rates under this Article, consideration shall be given to the insurance public protection classifications of fire districts, which classifications shall be established and modified from time to time by the Commissioner."

Section 3. There is appropriated from the Department of Insurance Fund established in G.S. 58-6-25 to the Department of Insurance the sum of one hundred fifty thousand dollars ($150,000) for the 2000-2001 fiscal year for the expenses of establishing and modifying the insurance public protection classifications of fire districts as provided in G.S. 58-36-10(3) and G.S. 58-40-25(4).

Section 4. This act becomes effective July 1, 2000.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 1696 DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓

Rep.) WAINWRIGHT
)
Sen.)

moves to amend the bill on page 2, line 5 11 and 30

( ) WHICH CHANGES THE TITLE

by adding the following sentence to both lines immediately after "Officer.":

"In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization."

SIGNED Teresa Wainwright

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1696
H1696-CSSV-001
Proposed Committee Substitute H1696-CSSV-001
WARNING: LINE NUMBERS MAY CHANGE AFTER ADOPTION

Short Title: Fire Ins. Public Protection/AB. (Public)

Sponsors:

Referred to: Insurance, if favorable, Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE AUTHORITY OF THE COMMISSIONER OF INSURANCE AND STATE FIRE MARSHAL TO ESTABLISH PUBLIC PROTECTION CLASSIFICATIONS FOR FIRE INSURANCE RATING PURPOSES AND TO APPROPRIATE FUNDS FOR THAT PURPOSE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-36-10(3) reads as rewritten:

"(3) In the case of ~~fire~~ property insurance ~~rates, as are subject to the ratemaking authority of the Bureau,~~ rates under this Article, consideration may be given to the experience of ~~such fire~~ property insurance business during the most recent five-year period for which that experience is available. In the case of ~~fire~~ property insurance rates ~~that are subject to the ratemaking authority of the Bureau,~~ under this Article, consideration shall be given to the insurance public protection classifications of ~~rural fire districts based upon standards~~ fire districts 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.~~ The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Planning Officer."

Section 2. G.S. 58-40-25(4) reads as rewritten:

"(4) ~~With respect to fire insurance, to the extent credits are provided for proximity to fire hydrants, insurers 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.~~ In the case of property insurance rates under this Article, consideration shall be given to the insurance public protection classifications of fire districts established by the Commissioner. The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Planning Officer."

Section 3. There is appropriated from the Department of Insurance Fund established in G.S. 58-6-25 to the Department of Insurance the sum of one hundred fifty thousand dollars ($150,000) for the 2000-2001 fiscal year for the expenses of establishing and modifying the insurance public protection classifications of fire districts as provided in G.S. 58-36-10(3) and G.S. 58-40-25(4).

Section 4. This act becomes effective July 1, 2000.

HOUSE BILL 1696:
FIRE INS. PUBLIC PROTECTION

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Wainwright
Date:	June 20, 2000	**Summary by:**	Trina Griffin
Version:	Proposed Committee Substitute H1696-CSSV-001		Committee Counsel

SUMMARY: ***This bill clarifies the authority of the Commissioner of Insurance, who is also the State Fire Marshal, to establish public protection classifications for commercial and residential property insurance rating purposes and to appropriate $150,000 for that purpose. This bill also authorizes the Commissioner to establish and modify public protection districts for cities with populations of 100,000 or fewer in addition to rural areas.***

CURRENT LAW: Under the current law, the Commissioner of Insurance establishes public protection classifications in rural fire districts for residential property insurance. The Insurance Services Office, a private corporation, has traditionally provided this service for cities. With regard to G.S. 58-40-25(4), which deals with commercial property insurance, the language does not specifically state that the Commissioner of Insurance has the authority to establish and modify public protection classifications of fire districts. It states only that the Commissioner may approve classifications made and credits provided by insurers due to proximity to water sources. This bill would, in part, clarify the Commissioner's authority with regard to commercial property insurance.

BILL ANALYSIS:

Section 1. This section authorizes the Commissioner to establish and modify public protection districts for cities with populations of 100,000 or fewer and for all rural areas with regard to residential property insurance. In addition, the specific reference to "fire" insurance, which is too narrow and somewhat outdated, is replaced by the broader term "property" insurance.

Section 2. This section clarifies that the Commissioner of Insurance has the authority to establish and modify public protection classifications for fire districts with regard to commercial property insurance for property located in cities with populations of 100,000 or fewer and in all rural areas.

Section 3. This section appropriates $150,000 to the Department of Insurance for the expenses associated with establishing and modifying the insurance public protection classification of fire districts.

This act would become effective on July 1, 2000.

CONCERNS WITH THE INSURANCE SERVICES OFFICE, INC. (ISO)

1. Chief Dickinson of Ulah Volunteer Fire Department in Randolph County is very concerned because his department had worked extremely hard on preparing for the ISO survey to find out that all the paperwork had been "misplaced". The chief advised that he sent the material to the following address certified mail:

   Ron Brown, ISO/CRS
   1500 Foster Avenue, No. 120
   Richmond, Virginia

   This was mailed on August 9, 1996. The chief stated that a Pattie Breeder signed for this material at ISO. Main Concern: maps were the originals.

2. ISO was sent information from DOI on March 16, 1994, to change the listing of the Ahoskie Rural Insurance in the ISO publications. As of February 1997, listing has not been changed.

3. ISO was notified on November 8, 1995 that Pasquotank-Soundneck was no longer an insurance district in North Carolina. As of February 1997, the listing still appears.

4. ISO was notified on December 6, 1995, that the Pleasant Hill Fire Insurance District should not extend into Surry County. The Pleasant Hill Volunteer Fire Department does not respond into Surry County on first alarm. As of February 1997, the listing still appears in the publication manual.

5. ISO was notified on March 31, 1994, that the Orange-New Hope Fire Insurance District should be listed in Orange and Durham Counties. Still not listed in Publication Manual as being in Durham County.

6. ISO was notified on July 15, 1996, that Yanceyville Rural was a newly certified district. As of February 1997, the listing has not appeared in the publication manual.

7. ISO was notified on September 24, 1996, that Spindale Rural was a newly certified district. As of February 1997, the listing has not appeared in the manual.

8. ISO was notified on October 1, 1996, that Edenton Rural was a newly certified district. As of February 1997, the listing has not appeared in the manual.

9. ISO was notified on November 12, 1996, that Bostic Rural was a newly certified district. As of February 1997, the listing has not appeared in the manual.

10. Don Herman, Fire Marshal of Onslow County, is concerned because he nor the chief of Southwest Onslow Fire Department have not had an official reply from ISO since the inspection took place on July 10, 1995. Ron Brown acknowledged that he had sent the

paperwork to Atlanta and had not heard from them (ISO). Onslow County also submitted a request for six additional department surveys around July 1996 and had not received or heard anything from ISO as of February 1997.

11. ISO was notified on November 20, 1996, that Shallotte was a newly certified district. This was very important to the citizens because the town and rural district surrounding the town had regressed to a class 10. As of February 1997, the listing has not appeared in the manual.

12. ISO was notified on July 26, 1995, that the Moyton Fire Department did not respond to fire alarms in Greene County except on mutual aid. The Greene county listing needed to be removed from the manual. As of February 1997, the listing still appears in the manual.

13. ISO was notified on September 18, 1996, that the Pilot Fire Department does not respond to fires on first alarm in Nash County. The Nash County listing in the classification manual needed to be removed. As of February 1997, the listing still appears in the manual.

14. ISO was notified on September 24, 1996, the Town of Landis Fire Department, no longer responds outside the corporate limits of the town. As of February 1997, the listing in the ISO manual still indicates the department is responding outside the town limits of Landis.

15. ISO was notified on September 24, 1996, that the East Gaston OPA no longer exists. Documentation from the County Fire Marshal was sent to ISO. As of February 1997, the listing still appears in the ISO manual.

16. Fire and Rescue Inspector, A.C. Daniels, spoke with Chief William Outland of the Lasker Volunteer Fire Department. Chief Outland advised that the Lasker Fire Department had "Closed its doors" for the past two years and had not been operating. This department's rating is a Class 7 and the NC Department of Insurance had not had any reason to inspect for rating requirements. This information was revealed during A.C.'s visit with the chief to discuss the Lasker OPA, which had a rating of 7/9.

17. The city of Goldsboro had annexed areas of Wayne County that is being served by three non-profit corporations: Elroy VFD, Inc., Pinewood VFD, Inc. and New Hope VFD, Inc. When this annexation occurred, the city of Goldsboro's ISO rating of Class 3 extended with the annexation into the areas formerly served by the non-profit organizations. This action is accurate according to ISO guidelines. Goldsboro contracts with the non-profits to continue to respond into the annexed which is okay as long as the city is dispatched at the same time to structural fire alarms. This is not being done per the Fire Marshal of Wayne County. Only the Elroy VFD with ISO Class 7, Pinewood VFD with ISO Class 7 and New Hope VFD with an ISO Class 7 are getting dispatched to these areas on first alarm. Also these three departments received their rating by the water hauling method and not by utilization of the hydrant system. According to ISO, the city doing the

27. Wake County - Holly Springs - new fire department under Town Government has not been surveyed, but ISO gave Class 6 to district.

28. Wake County - Merger of Fairgrounds Fire Department with mobile water supply class 6 rating with YRAC VFD and Split Class 6/9S based on hydrants. ISO gave entire District "Western Wake" a straight Class 6. No survey at all.

29. Robeson County - Roland VFD - last inspection 22 years ago.

30. Nash County - Battleboro annexed with City of Rocky Mount. Became city of Rocky Mount. Was 5 ½ miles from "Nearest" responding station of Rocky Mount. Initially given a Class 3 rating, then changed to 3/9S after we brought this to ISO's attention. They still exceed the 5-mile limit. "Why argue 6 mile issue".

31. Brunswick County - OSFM inspected St. James Fire Department in December 1999. Reported to ISO in January 2000 - will not be published and effective until July 1, 2000. (6 months)

32. Just received information that even though the Town of Saint James was inspected and reported to ISO in January 2000, the Town will not be listed in the ISO Publication until ISO surveys the Town. There is no date that has been set for this survey. This will result in the citizens living inside the city limits of Saint James, will not be eligible for lower insurance premiums. This listing should have occurred the same time as the Saint James Rural District (see #31 above).

33. One major concern is that A.C. Daniels and I attend classes delivered by ISO and hear what is credited and how departments are graded. Out in the field we hear of discrepancies between ISO Inspectors method of grading when evaluating the same method of operation.

34. Spoke with the Chief of Liberty Fire Department last week, and he indicated that they had not been surveyed in the last 18 years.

35. Murphy Fire Department talked with Ron Brown and he advised them that if a merger of Murphy Fire Department and Peachtree Fire Department occurred, then all the commercial property within the new boundaries would qualify for Murphy's rating even though a survey had not been completed.

36. The last couple of weeks we had been getting notifications from ISO of updates for the manual, that have been incorrectly listed and the wrong fire district classification assigned to the respective department. Example: Parkwood-Western Fire District in Durham County and East Orange Fire District in Orange and Durham County.

Tim Bradley -- Senior Deputy Commissioner of Insurance --Office of State Fire Marshal

annexation must be dispatched on first alarm to all structure fires within the city and have a station within five miles of all property within the city, in order for the class 3 to apply.

18. During our inspection in February 1998, we discovered that Maysville Fire Department with a Class 7 rating was not responding to calls. After our inspection and further meetings with the Chief, the Department is back up and operating.

19. We inspected the substation in Odgen Fire District in New Hanover County and notified ISO of this inspection in October 1998. The Class 9S rating was not listed by ISO until August 1999.

20. Received a phone call from the President of Board of Directors of Stumpy Point Fire Department in Dare County. She advised that an ISO Representative was calling and asking for a map of the response district so as to apply the Class 9S in the entire response area which is much greater than 5 miles. The Representative at this time had in his possession a current five-mile map that had just been approved by A.C. Daniels for rating purposes.

21. Columbus County - An inspection by ISO of the ADR Fire District resulted in the District qualifying for a Class 6 rating. ISO gave the district a Class 5 because Rieglewood which ADR Fire & Rescue serves received enough points to qualify for a Class 5. ISO indicated that they would not let the Class 6 District effect the Class 5 so "Give Both Districts the Lower Rating" Class 5.

NOTE: Total points the ADR District received was 40.58. Needed at least 50 points to qualify for the Class 5.

22. Currituck County - ISO gave credit of Class 9 to Gibbs Wood which is an OPA in 1999 after agreeing to not rate any more OPA's in North Carolina.

23. Northampton County - Severn Fire Department - only has ONE fire truck, which will not pass service test a 7 members. Current ISO Class 7.

24. Cumberland County - Chief Hall of Cumberland Road Fire Department advised he had sent in 2 pre-fire survey packages and ISO advised him to send another - they could not locate the first two.

25. Northampton County - Following fire departments have not been surveyed since 1977 - Seaboard VFD, Class 8; Gaston VFD, Class 7; Lasker VFD, Class 7; and Woodlawn VFD, Class 6.

26. Pender County - Surf City - totally new fire department operating in the city limits and ISO recognizes a Class 7 with no inspection at all.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1529*

Short Title: HMO Insolvency. (Public)

Sponsors: Representatives Nye, Insko, Nesbitt, and Cunningham.

Referred to: Insurance.

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO PROTECT PERSONS ENROLLED IN AN HMO FROM THE CONSEQUENCES OF THE INSOLVENCY OF THAT HMO BY AUTHORIZING ASSESSMENTS OF REMAINING HMOs IN THE STATE TO PAY FOR UNCOVERED EXPENDITURES OF AND CONTINUATION OF COVERAGE FOR THE ENROLLEES.

The General Assembly of North Carolina enacts:

Section 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-126. Insolvency protection; assessment.**

(a) When an HMO in this State is declared insolvent by a court of competent jurisdiction, the Commissioner may levy an assessment on solvent HMOs doing business in this State to pay claims for uncovered expenditures for enrollees who are residents of this State and to provide continuation of coverage for enrollees not covered under G.S. 58-67-120, 58-67-125, or 58-67-130. Assessments against an HMO may not exceed two percent (2%) of that HMO's average annual premiums received in North Carolina on policies and contracts during the three calendar years immediately preceding the year in which the insolvent HMO was declared insolvent.

(b) To provide the funds necessary to carry out the powers and duties of the Commissioner under this section, the Commissioner shall assess the HMOs at such time and for such amounts, as the Commissioner finds necessary. Assessments not paid within 30 days of the written notice shall accrue interest at the rate of one percent (1%) per month, or any part thereof. Assessments shall not be made until necessary to implement the purposes of this section. Computation of assessments

under this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(c) The Commissioner may use funds obtained under subsection (a) of this section to pay claims for uncovered expenditures for enrollees of an insolvent HMO who are residents of this State, provide for continuation of coverage for enrollees who are residents of this State and are not covered under G.S. 58-67-120, 58-67-125, or 58-67-130, and administrative costs. The Commissioner may by rule prescribe the time, manner, and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver. A receiver or liquidator of an insolvent HMO shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(d) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the Commissioner to the extent of the benefits received. The Commissioner may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon that person. The Commissioner is subrogated to these rights against the assets of an insolvent HMO held by a receiver or liquidator of another jurisdiction.

(e) The assignment of subrogation rights of the Commissioner and allowed claim under this section have the same priority against the assets of the insolvent HMO as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

(f) When assessed funds are unused following the completion of the liquidation of an HMO, the Commissioner will distribute on a pro rata basis any unused amounts received under subsection (a) of this section to the HMOs that have been assessed under this section.

(g) The aggregate coverage of uncovered expenditures under this section shall not exceed three hundred thousand dollars ($300,000) with respect to one individual. Continuation of coverage for an enrollee shall continue for the duration of the contract period for which premiums have been paid and continuation of coverage for an enrollee who is confined in an inpatient facility shall continue until his or her discharge or expiration of benefits. The Commissioner may provide continuation of coverage on any reasonable basis; including continuation of the HMO contract or substitution of indemnity coverage in a form determined by the Commissioner.

(h) The Commissioner may abate or defer, in whole or in part, the assessment of an HMO if, in the Commissioner's opinion, payment of the assessment would endanger the HMO's ability to fulfill its contractual obligations. If an assessment against an HMO is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other HMOs in a manner consistent with the basis for assessments set forth in this section. An HMO that fails to pay an assessment within 30 days after notice is subject to a civil penalty of not more than one thousand dollars ($1,000) per day, or suspension or revocation of its license, or both.

(i) It is proper for any HMO, in determining its premium rates and policy owner dividends, to consider the amount reasonably necessary to meet its assessment obligations under this section."

Section 2. G.S. 58-30-220(2) reads as rewritten:

"(2) Claims or portions of claims for benefits under policies and for losses incurred, including claims of third parties under liability policies; claims of HMO enrollees and HMO enrollees' beneficiaries; beneficiaries, including situations where an enrollee or beneficiary is liable to a health care provider for services provided under the HMO plan; claims for unearned premiums; claims for funds or consideration held under funding agreements, as defined in G.S. 58-7-16; claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values; and claims of domestic and foreign guaranty associations, including claims for the reasonable administrative expenses of domestic and foreign guaranty associations; but excluding claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements, claims of other insurers for subrogation, and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages."

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 the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act becomes effective January 1, 2001.

HB 1529:
HMO INSOLVENCY

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Nye
Date:	June 13, 2000	**Summary by:**	Linda Attarian Committee Counsel for Managed Care LRC
Version:	1st edition		

SUMMARY: ***The act would amend Article 67 of Chapter 58 pertaining to the regulation of health maintenance organizations (HMOs) to provide a mechanism with which the Commissioner of Insurance may ensure that uncovered claims against an insolvent HMO are covered and health care coverage for enrollees is continued.***

CURRENT LAW:

Warning of financial instability: § 58-67-105 authorizes the Commissioner of Insurance to order an HMO that is experiencing financial instability to take reasonable actions to rectify the situation. The Commissioner is authorized to adopt rules to set uniform standards and criteria for the early warning that the continued operation of any HMO might be hazardous to its enrollees, creditors, or the general public.

Net worth: § 58-67-110 requires each full service HMO to maintain a minimum net worth of not less than one million dollars ($1,000,000). This amount is increased annually, depending on the amount of the HMO's contingency reserves. The statute further requires every full service HMO to have and maintain at all times an adequate plan, acceptable to the Commissioner, for protection against insolvency.

Insolvency protection: § 58-67-115 provides that unless the HMO maintains a special deposit or has adequate insurance or a guaranty arrangement, each contract between every HMO and a participating provider must include a hold harmless clause to ensure that in the event the HMO fails to pay for health care services, the subscriber or enrollee will not be liable to the provider for any amount the HMO is unable to pay the provider. The special deposit must be in cash or cash equivalent and is calculated according to specific circumstances. In all cases, the deposit is controlled by and administered by the Commissioner. If the HMO has a guaranty arrangement, it must be approved in writing by the Commissioner.

Continuation of benefits: § 58-67-120 provides that each HMO must have a plan for handling insolvency and for the continuation of benefits. The HMO must ensure that its enrollees continue to receive benefits for the duration of the contract period for which premiums have been paid, or if the enrollee is confined in an inpatient facility until the discharge or expiration of benefits. The Commissioner may require the HMO

- to acquire insurance to cover the expenses to be paid for benefits after an insolvency, or
- to contribute to an insolvency reserve, or
- to submit letters of credit.

Assignment of coverage: § 58-67-125 authorizes the Commissioner, in the event of an insolvency of an HMO, to order all other carriers that participated in the enrollment process with the insolvent HMO to offer enrollees of the insolvent HMO a 30-day enrollment period from the date of insolvency. The coverage and rates must be the same that the carrier had offered to the enrollees of the group at its last regular enrollment period. If no other HMOs participated in the enrollment process with the insolvent HMO or if the Commissioner determines that the other health benefit plan or plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent HMO, then the Commissioner must allocate the insolvent HMO's group and nongroup enrollees among all other HMOs that operate within a portion of the insolvent HMO's service area.

Replacement coverage safeguards: § 58-67-130 provides that any insurer that has contracted with an HMO to provide replacement coverage within a period of 60 days from the date of discontinuance of the HMO contract or policy must immediately cover all enrollees who were validly covered under the previous HMO, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy. Further, the contract for replacement coverage must provide for full benefits for conditions that proceeded the effective date of the succeeding insurer's contract.

Guaranty Associations: HMOs are not required to belong to guaranty associations. Guaranty associations cover claims against insolvent insurance companies by assessing the member companies an amount necessary to cover the claims. These associations can be found in Articles 48 (property and casualty) and 62 (life and health) of GS Chapter 58 and in Article 3 of GS Chapter 97.

BILL ANALYSIS: Section 1 of the act does not establish an HMO guaranty association, but instead authorizes the Commissioner to assess, as necessary, other HMOs for the unpaid obligations of the insolvent HMO. The Commissioner may waive or abate the assessment if the Commissioner determines the assessment would endanger the HMO's ability to continue coverage. The total of all assessments against a solvent HMO in one calendar year may not exceed two percent (2%) of the solvent HMO's average annual premiums during the three (3) calendar years preceding the year the insolvent HMO was declared insolvent. If an HMO fails to pay the assessment within 30 days of notice, it may be fined up to $1,000 per day and have its license suspended or revoked. In addition, assessments will accrue interest at the rate of one percent (1%) per month. Assessments must be reasonably accurate and necessary to protect persons enrolled in an HMO from the consequences of insolvency.

The act authorizes the Commissioner to arrange for continuation of coverage of enrollees of an insolvent HMO. The Commissioner would be authorized to require other HMOs or other indemnity insurers to provide continuation coverage. The continuation coverage could not exceed $300,000 for any one individual and would continue for the duration of the contract period for which premiums have been paid. Coverage of enrollees confined to inpatient facilities would continue until discharge.

Section 2 of the act clarifies the priority under Article 30 of Chapter 58 of claims for benefits and for losses incurred as a result of HMO insolvency. Medical care claims owed by HMO enrollees, including situations where an enrollee is liable to health care providers for services provided under a HMO plan would be paid like other claims under insurance and HMO contracts.

Section 3 provides a severability clause.

Section 4 provides that the act will become effective January 1, 2001.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 22, 2000

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 22, 2000, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Amber Story (Pitt County), Miles Hovis (Gaston County), and Pres Adams (Gaston County). The following Committee members were present: Representatives Barbee, Brubaker, Cole, Dedmon, Dockham, Esposito, Grady, Hall, Redwine, Saunders, Smith, Wainwright, and Warner. Cindy Avrette, Trina Griffin, and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached.

HB 1696, entitled, AN ACT TO CLARIFY THE AUTHORITY OF THE COMMISSIONER OF INSURANCE AND STATE FIRE MARSHAL TO ESTABLISH PUBLIC PROTECTION CLASSIFICATIONS FOR FIRE INSURANCE RATING PURPOSES AND TO APPROPRIATE FUNDS FOR THAT PURPOSE. Representative Wainwright was recognized to present and explain a proposed committee substitute and moved for adoption of the committee substitute for discussion. Motion passed. Patrick McLaughlin, Senior Vice President, and Michael Waters, Assistant Vice President, with the Insurance Services Office (ISO) were recognized to speak against the bill. Tim Bradley with the Department of Insurance was recognized to speak on behalf of the bill. Representative Smith made a motion to give a favorable report to the committee substitute, unfavorable report to the original bill, and recommendation that the committee substitute be re-referred to the Committee on Appropriations. Motion passed.

HB 1529, entitled, AN ACT TO PROTECT PERSONS ENROLLED IN AN HMO FROM THE CONSEQUENCES OF THE INSOLVENCY OF THAT HMO BY AUTHORIZING ASSESSMENTS OF REMAINING HMOs IN THE STATE TO PAY FOR UNCOVERED EXPENDITURES OF AND CONTINUATION OF COVERAGE FOR THE ENROLLEES. Representative Edd Nye was recognized to present the bill. Bill Hale with the Department of Insurance was recognized to briefly review the bill. Representative Warner made a motion to give a favorable report to HB 1529. Motion passed.

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 Form, House Bills 1696 and 1529, Proposed Committee Substitute HB 1696, Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 22, 2000 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Hill	North Carolina Society of Fire Service Instructors
Jon R Jacobus	Burlington Fire Dept Burlington, NC
Thomas E. Curry	Rockingham County Fire Marshal Office
F. REED JARVIS	Forsyth Co. Fire Dept. 3000 Aviation Dr. W-S. N.C. 27105
Rick Hall	Summerfield Fire Dept. P.O. Box 429 Summerfield, NC 27358
Aubrey Rivenbark	New Hanover Co Fire Service 414 Chestnut St Wilmington, N.C. 28401
MAX POWELL	SWANSBORO FIRE DEPT. PO BOX 368 SWANSBORO NC 28584
DEB HICKS	NC DEPT. OF INSURANCE RAL. NC
DON DECKER	ONSLOW CO. DEPT. OF EMERGENCY SERVICES 1180 COMMONS DRIVE N. JAX, N.C. 28546
Buster Johnson	NORthwest Harnett Fire Dept. 6056 Christian Lt RD. Fuquay Varina NC.
Spencer Teffeteller	Angier + Black River FD Po Box 389 Angier, NC 27501

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 22, 2000 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Austin F. Tew	City of Dunn F.D. 102 N. Powell Ave. Dunn, NC 28334
Art Tippett	Ferrells Fire Dept. 9589 N.C. 97 W. middlesex N.C. 27557
Chris Brantley	Ferrells Fire & Rescue 9589 N.C. 97 W middlesex N.C. 27557
[signature]	Moore, Van Allen
[signature]	Jordan Price
[signature]	Bowe & Moore
Bob Penrod	Swansboro Fire Dept
Sandra James	Swansboro Fire Dept
Mike Williams	Flat Branch Vol. Fire Dept 2098 Elliott Bridge Rd Bunn Level NC 28323
Keith McLeod	Coats - Grove Fire & Rescue PO Box 853 Coats, N.C. 27521
Ken Dilday	Ahoskie Fire Dept P.O. Box 767 Ahoskie NC 27910

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 22, 2000 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Pharr	Gaston Co Fire Marshal PO Box 1576 Gastonia 28053
G.E.(Eddie) McDaniel	Albemarle Fire Department 121 North Third Street Albemarle 28001
Alan Whorley	Belfast Vol FD 117 N Goldsboro NC. 27530
Steve Sloan	Clemmons FD Clemmons NC Forsyth Co
Chet Hill	Murfreesboro FD Murfreesboro, NC. Hertford Co.
Larry Hughes	West Buncombe FD Asheville N.C. Buncombe Co.
Jay Howell, Chief	Nahunta Fire Dept, Wayne Co
Paul Miller	N.C. State Firemen's Association
[illegible]	NCAHP
Lulenne Bankert	NCAHP
[illegible]	NCRMA

VISITOR REGISTRATION SHEET

INSURANCE — June 22, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Peters	APPSOC/HWISE

2000 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. 1696 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE AUTHORITY OF THE COMMISSIONER OF INSURANCE AND STATE FIRE MARSHAL TO ESTABLISH PUBLIC PROTECTION CLASSIFICATIONS FOR FIRE INSURANCE RATING PURPOSES AND TO APPROPRIATE FUNDS FOR THAT PURPOSE.

☐ 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 and recommendation that the committee substitute bill be re-referred to the Committee on Appropriations.

☐ 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)

5/25/00

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 1696

Short Title: Fire Ins. Public Protection/AB. (Public)

Sponsors: Representative Wainwright.

Referred to: Insurance, if favorable, Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE AUTHORITY OF THE COMMISSIONER OF INSURANCE AND STATE FIRE MARSHAL TO ESTABLISH PUBLIC PROTECTION CLASSIFICATIONS FOR FIRE INSURANCE RATING PURPOSES AND TO APPROPRIATE FUNDS FOR THAT PURPOSE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-36-10(3) reads as rewritten:

"(3) In the case of ~~fire~~ property insurance ~~rates, as are subject to the ratemaking authority of the Bureau,~~ rates under this Article, consideration may be given to the experience of ~~such fire~~ property insurance business during the most recent five-year period for which that experience is available. In the case of ~~fire~~ property insurance rates ~~that are subject to the ratemaking authority of the Bureau,~~ under this Article, consideration shall be given to the insurance public protection classifications of ~~rural fire districts based upon standards~~ fire districts, which classifications shall be established and modified from time to time 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.~~ "

Section 2. G.S. 58-40-25(4) reads as rewritten:

"(4) ~~With respect to fire insurance, to the extent credits are provided for proximity to fire hydrants, insurers 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.~~ In the case of property insurance rates under this Article, consideration shall be given to the insurance public protection classifications of fire districts, which classifications shall be established and modified from time to time by the Commissioner."

Section 3. There is appropriated from the Department of Insurance Fund established in G.S. 58-6-25 to the Department of Insurance the sum of one hundred fifty thousand dollars ($150,000) for the 2000-2001 fiscal year for the expenses of establishing and modifying the insurance public protection classifications of fire districts as provided in G.S. 58-36-10(3) and G.S. 58-40-25(4).

Section 4. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1696
H1696-CSSV-002
Proposed Committee Substitute H1696-CSSV-002
WARNING: LINE NUMBERS MAY CHANGE AFTER ADOPTION

Short Title: Fire Ins. Public Protection/AB. (Public)

Sponsors:

Referred to: Insurance, if favorable, Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE AUTHORITY OF THE COMMISSIONER OF INSURANCE AND STATE FIRE MARSHAL TO ESTABLISH PUBLIC PROTECTION CLASSIFICATIONS FOR FIRE INSURANCE RATING PURPOSES AND TO APPROPRIATE FUNDS FOR THAT PURPOSE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-36-10(3) reads as rewritten:

"(3) In the case of ~~fire~~ property insurance ~~rates, as are subject to the ratemaking authority of the Bureau,~~ rates under this Article, consideration may be given to the experience of ~~such fire~~ property insurance business during the most recent five-year period for which that experience is available. In the case of ~~fire~~ property insurance rates ~~that are subject to the ratemaking authority of the Bureau,~~ under this Article, consideration shall be given to the insurance public protection classifications of ~~rural fire districts based upon standards~~ fire districts 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.~~ The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Planning Officer. In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization."

Section 2. G.S. 58-40-25(4) reads as rewritten:

"(4) ~~With respect to fire insurance, to the extent credits are provided for proximity to fire hydrants, insurers 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.~~ In the case of property insurance rates under this Article, consideration shall be given to the insurance public protection classifications of fire districts established by the Commissioner. The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Planning Officer. In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization."

Section 3. There is appropriated from the Department of Insurance Fund established in G.S. 58-6-25 to the Department of Insurance the sum of one hundred fifty thousand dollars ($150,000) for the 2000-2001 fiscal year for the expenses of establishing and modifying the insurance public protection

classifications of fire districts as provided in G.S. 58-36-10(3) and G.S. 58-40-25(4).

Section 4. This act becomes effective July 1, 2000.

HOUSE BILL 1696:
FIRE INS. PUBLIC PROTECTION

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Wainwright
Date:	June 20, 2000	**Summary by:**	Trina Griffin Committee Counsel
Version:	Proposed Committee Substitute H1696-CSSV-001		

SUMMARY: ***This bill clarifies the authority of the Commissioner of Insurance, who is also the State Fire Marshal, to establish public protection classifications for commercial and residential property insurance rating purposes and to appropriate $150,000 for that purpose. This bill also authorizes the Commissioner to establish and modify public protection districts for cities with populations of 100,000 or fewer in addition to rural areas.***

CURRENT LAW: Under the current law, the Commissioner of Insurance establishes public protection classifications in rural fire districts for residential property insurance. The Insurance Services Office, a private corporation, has traditionally provided this service for cities. With regard to G.S. 58-40-25(4), which deals with commercial property insurance, the language does not specifically state that the Commissioner of Insurance has the authority to establish and modify public protection classifications of fire districts. It states only that the Commissioner may approve classifications made and credits provided by insurers due to proximity to water sources. This bill would, in part, clarify the Commissioner's authority with regard to commercial property insurance.

BILL ANALYSIS:

Section 1. This section authorizes the Commissioner to establish and modify public protection districts for cities with populations of 100,000 or fewer and for all rural areas with regard to residential property insurance. In addition, the specific reference to "fire" insurance, which is too narrow and somewhat outdated, is replaced by the broader term "property" insurance.

Section 2. This section clarifies that the Commissioner of Insurance has the authority to establish and modify public protection classifications for fire districts with regard to commercial property insurance for property located in cities with populations of 100,000 or fewer and in all rural areas.

Section 3. This section appropriates $150,000 to the Department of Insurance for the expenses associated with establishing and modifying the insurance public protection classification of fire districts.

This act would become effective on July 1, 2000.

2000 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. 1529 A BILL TO BE ENTITLED AN ACT TO PROTECT PERSONS ENROLLED IN AN HMO FROM THE CONSEQUENCES OF THE INSOLVENCY OF THAT HMO BY AUTHORIZING ASSESSMENTS OF REMAINING HMOs IN THE STATE TO PAY FOR UNCOVERED EXPENDITURES OF AND CONTINUATION OF COVERAGE FOR THE ENROLLEES.

☒ 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)

5/25/00

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 1529*

Short Title: HMO Insolvency. (Public)

Sponsors: Representatives Nye, Insko, Nesbitt, and Cunningham.

Referred to: Insurance.

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO PROTECT PERSONS ENROLLED IN AN HMO FROM THE CONSEQUENCES OF THE INSOLVENCY OF THAT HMO BY AUTHORIZING ASSESSMENTS OF REMAINING HMOs IN THE STATE TO PAY FOR UNCOVERED EXPENDITURES OF AND CONTINUATION OF COVERAGE FOR THE ENROLLEES.

The General Assembly of North Carolina enacts:

Section 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-126. Insolvency protection; assessment.**

(a) When an HMO in this State is declared insolvent by a court of competent jurisdiction, the Commissioner may levy an assessment on solvent HMOs doing business in this State to pay claims for uncovered expenditures for enrollees who are residents of this State and to provide continuation of coverage for enrollees not covered under G.S. 58-67-120, 58-67-125, or 58-67-130. Assessments against an HMO may not exceed two percent (2%) of that HMO's average annual premiums received in North Carolina on policies and contracts during the three calendar years immediately preceding the year in which the insolvent HMO was declared insolvent.

(b) To provide the funds necessary to carry out the powers and duties of the Commissioner under this section, the Commissioner shall assess the HMOs at such time and for such amounts, as the Commissioner finds necessary. Assessments not paid within 30 days of the written notice shall accrue interest at the rate of one percent (1%) per month, or any part thereof. Assessments shall not be made until necessary to implement the purposes of this section. Computation of assessments

under this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(c) The Commissioner may use funds obtained under subsection (a) of this section to pay claims for uncovered expenditures for enrollees of an insolvent HMO who are residents of this State, provide for continuation of coverage for enrollees who are residents of this State and are not covered under G.S. 58-67-120, 58-67-125, or 58-67-130, and administrative costs. The Commissioner may by rule prescribe the time, manner, and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver. A receiver or liquidator of an insolvent HMO shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(d) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the Commissioner to the extent of the benefits received. The Commissioner may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon that person. The Commissioner is subrogated to these rights against the assets of an insolvent HMO held by a receiver or liquidator of another jurisdiction.

(e) The assignment of subrogation rights of the Commissioner and allowed claim under this section have the same priority against the assets of the insolvent HMO as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

(f) When assessed funds are unused following the completion of the liquidation of an HMO, the Commissioner will distribute on a pro rata basis any unused amounts received under subsection (a) of this section to the HMOs that have been assessed under this section.

(g) The aggregate coverage of uncovered expenditures under this section shall not exceed three hundred thousand dollars ($300,000) with respect to one individual. Continuation of coverage for an enrollee shall continue for the duration of the contract period for which premiums have been paid and continuation of coverage for an enrollee who is confined in an inpatient facility shall continue until his or her discharge or expiration of benefits. The Commissioner may provide continuation of coverage on any reasonable basis; including continuation of the HMO contract or substitution of indemnity coverage in a form determined by the Commissioner.

(h) The Commissioner may abate or defer, in whole or in part, the assessment of an HMO if, in the Commissioner's opinion, payment of the assessment would endanger the HMO's ability to fulfill its contractual obligations. If an assessment against an HMO is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other HMOs in a manner consistent with the basis for assessments set forth in this section. An HMO that fails to pay an assessment within 30 days after notice is subject to a civil penalty of not more than one thousand dollars ($1,000) per day, or suspension or revocation of its license, or both.

(i) It is proper for any HMO, in determining its premium rates and policy owner dividends, to consider the amount reasonably necessary to meet its assessment obligations under this section."

Section 2. G.S. 58-30-220(2) reads as rewritten:

"(2) Claims or portions of claims for benefits under policies and for losses incurred, including claims of third parties under liability policies; claims of HMO enrollees and HMO enrollees' beneficiaries; beneficiaries, including situations where an enrollee or beneficiary is liable to a health care provider for services provided under the HMO plan; claims for unearned premiums; claims for funds or consideration held under funding agreements, as defined in G.S. 58-7-16; claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values; and claims of domestic and foreign guaranty associations, including claims for the reasonable administrative expenses of domestic and foreign guaranty associations; but excluding claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements, claims of other insurers for subrogation, and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages."

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 the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act becomes effective January 1, 2001.

HB 1529:
HMO INSOLVENCY

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Nye
Date:	June 13, 2000	**Summary by:**	Linda Attarian Committee Counsel for Managed Care LRC
Version:	1st edition		

SUMMARY: ***The act would amend Article 67 of Chapter 58 pertaining to the regulation of health maintenance organizations (HMOs) to provide a mechanism with which the Commissioner of Insurance may ensure that uncovered claims against an insolvent HMO are covered and health care coverage for enrollees is continued.***

CURRENT LAW:

Warning of financial instability: § 58-67-105 authorizes the Commissioner of Insurance to order an HMO that is experiencing financial instability to take reasonable actions to rectify the situation. The Commissioner is authorized to adopt rules to set uniform standards and criteria for the early warning that the continued operation of any HMO might be hazardous to its enrollees, creditors, or the general public.

Net worth: § 58-67-110 requires each full service HMO to maintain a minimum net worth of not less than one million dollars ($1,000,000). This amount is increased annually, depending on the amount of the HMO's contingency reserves. The statute further requires every full service HMO to have and maintain at all times an adequate plan, acceptable to the Commissioner, for protection against insolvency.

Insolvency protection: § 58-67-115 provides that unless the HMO maintains a special deposit or has adequate insurance or a guaranty arrangement, each contract between every HMO and a participating provider must include a hold harmless clause to ensure that in the event the HMO fails to pay for health care services, the subscriber or enrollee will not be liable to the provider for any amount the HMO is unable to pay the provider. The special deposit must be in cash or cash equivalent and is calculated according to specific circumstances. In all cases, the deposit is controlled by and administered by the Commissioner. If the HMO has a guaranty arrangement, it must be approved in writing by the Commissioner.

Continuation of benefits: § 58-67-120 provides that each HMO must have a plan for handling insolvency and for the continuation of benefits. The HMO must ensure that its enrollees continue to receive benefits for the duration of the contract period for which premiums have been paid, or if the enrollee is confined in an inpatient facility until the discharge or expiration of benefits. The Commissioner may require the HMO

- to acquire insurance to cover the expenses to be paid for benefits after an insolvency, or
- to contribute to an insolvency reserve, or
- to submit letters of credit.

Assignment of coverage: § 58-67-125 authorizes the Commissioner, in the event of an insolvency of an HMO, to order all other carriers that participated in the enrollment process with the insolvent HMO to offer enrollees of the insolvent HMO a 30-day enrollment period from the date of insolvency. The coverage and rates must be the same that the carrier had offered to the enrollees of the group at its last regular enrollment period. If no other HMOs participated in the enrollment process with the insolvent HMO or if the Commissioner determines that the other health benefit plan or plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent HMO, then the Commissioner must allocate the insolvent HMO's group and nongroup enrollees among all other HMOs that operate within a portion of the insolvent HMO's service area.

Replacement coverage safeguards: § 58-67-130 provides that any insurer that has contracted with an HMO to provide replacement coverage within a period of 60 days from the date of discontinuance of the HMO contract or policy must immediately cover all enrollees who were validly covered under the previous HMO, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy. Further, the contract for replacement coverage must provide for full benefits for conditions that proceeded the effective date of the succeeding insurer's contract.

Guaranty Associations: HMOs are not required to belong to guaranty associations. Guaranty associations cover claims against insolvent insurance companies by assessing the member companies an amount necessary to cover the claims. These associations can be found in Articles 48 (property and casualty) and 62 (life and health) of GS Chapter 58 and in Article 3 of GS Chapter 97.

BILL ANALYSIS: Section 1 of the act does not establish an HMO guaranty association, but instead authorizes the Commissioner to assess, as necessary, other HMOs for the unpaid obligations of the insolvent HMO. The Commissioner may waive or abate the assessment if the Commissioner determines the assessment would endanger the HMO's ability to continue coverage. The total of all assessments against a solvent HMO in one calendar year may not exceed two percent (2%) of the solvent HMO's average annual premiums during the three (3) calendar years preceding the year the insolvent HMO was declared insolvent. If an HMO fails to pay the assessment within 30 days of notice, it may be fined up to $1,000 per day and have its license suspended or revoked. In addition, assessments will accrue interest at the rate of one percent (1%) per month. Assessments must be reasonably accurate and necessary to protect persons enrolled in an HMO from the consequences of insolvency.

The act authorizes the Commissioner to arrange for continuation of coverage of enrollees of an insolvent HMO. The Commissioner would be authorized to require other HMOs or other indemnity insurers to provide continuation coverage. The continuation coverage could not exceed $300,000 for any one individual and would continue for the duration of the contract period for which premiums have been paid. Coverage of enrollees confined to inpatient facilities would continue until discharge.

Section 2 of the act clarifies the priority under Article 30 of Chapter 58 of claims for benefits and for losses incurred as a result of HMO insolvency. Medical care claims owed by HMO enrollees, including situations where an enrollee is liable to health care providers for services provided under a HMO plan would be paid like other claims under insurance and HMO contracts.

Section 3 provides a severability clause.

Section 4 provides that the act will become effective January 1, 2001.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 30, 2000

The House Committee on Insurance met around the chamber desk of Representative Hurley, Committee Chair, immediately after the 12:15 recess of the House session on Friday, June 30, 2000. The Chair called the meeting to order. The following Committee members were present: Representatives Barbee, Cole, Dedmon, Dockham, Esposito, Hall, Howard, Saunders, Wainwright, Warner, and Wright.

Representative Hurley indicated the following bills were to be considered:

HB 322, entitled, AN ACT TO PROHIBIT INSURERS FROM USING PERSONS' CREDIT RECORDS, HISTORIES, OR RATINGS IN WRITING CERTAIN LINES OF INSURANCE.

HB 1530, entitled, AN ACT TO REQUIRE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES PURSUANT TO G.S. 58-50-61 AND G.S. 58-50-62 TO INCLUDE ON THE REVIEW OR GRIEVANCE PANEL PROVIDERS LICENSED, CERTIFIED, OR REGISTERED IN NORTH CAROLINA IN THE SAME MEDICAL OR ALLIED OCCUPATION AS THE PROVIDERS WHO ARE PARTIES TO THE REVIEW OR GRIEVANCE.

HB 1567, entitled, AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY TREATMENT.

HB 1589, 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.

Representative Saunders moved that the six House bills listed above (HB 322, 1530, 1567, and 1589) be given an indefinite postponement report. The motion passed.

Representative Hurley indicated the following bill was also under consideration:

HB 1123, entitled, AN ACT TO PROVIDE THAT THE TEACHERS'AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN PROVIDES BENEFITS ON A CALENDAR YEAR BASIS, AND TO PROVIDE FOR A PRESCRIPTION DRUG CARD BENEFIT. Representative Wright requested that no action be taken on this bill, and that it be re-referred to the Committee on Health.

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:

HB 322, 1123, 1530, 1567, 1589

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. 322 A BILL TO BE ENTITLED AN ACT TO PROHIBIT INSURERS FROM USING PERSONS' CREDIT RECORDS, HISTORIES, OR RATINGS IN WRITING CERTAIN LINES OF 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) (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 322

Short Title: Credit History in Insurance/AB. (Public)

Sponsors: Representatives Wright; Luebke and Hunter.

Referred to: Insurance.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT INSURERS FROM USING PERSONS' CREDIT RECORDS, HISTORIES, OR RATINGS IN WRITING CERTAIN LINES OF INSURANCE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-3-25 is amended by adding a new subsection to read:

"(c1) No insurer shall refuse to insure or refuse to continue to insure an individual; limit the amount, extent, or kind of coverage available to an individual; or charge an individual a different rate for the same coverage, because of the credit record, history, or rating of that individual. This subsection supplements the provisions of G.S. 58-3-120, 58-33-80, 58-58-35, and 58-63-15(7). This subsection does not apply to fidelity and surety insurance as defined in G.S. 58-7-15(16), to credit insurance as defined in G.S. 58-7-15(17), or to insurance written under Article 57 of this Chapter."

Section 2. G.S. 58-65-85 reads as rewritten:

"**§ 58-65-85. Discriminatory practices prohibited.**

No person subject to this Article and Article 66 of this Chapter shall refuse to issue or refuse to reissue to an individual any certificate, plan, or contract governed by this Article and Article 66 of this Chapter; limit the amount, extent, or kind of services available to an individual; or charge an individual a different rate for the same services, because of the credit record, history, or rating of that individual or because of the race, color, or national or ethnic origin of that individual."

Section 3. G.S. 58-67-65(f) reads as rewritten:

"(f) No health maintenance organization shall refuse to enroll an individual or refuse to continue enrollment of an individual in a health care plan; limit the amount, extent, or kinds of health care plans available to an individual; or charge an individual a different rate for the same health plan, because of the credit record, history, or rating of that individual or because of the race, color, or national or ethnic origin of that individual."

Section 4. This act becomes effective October 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. 1530 A BILL TO BE ENTITLED AN ACT TO REQUIRE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES PURSUANT TO G.S. 58-50-61 AND G.S. 58-50-62 TO INCLUDE ON THE REVIEW OR GRIEVANCE PANEL PROVIDERS LICENSED, CERTIFIED, OR REGISTERED IN NORTH CAROLINA IN THE SAME MEDICAL OR ALLIED OCCUPATION AS THE PROVIDERS WHO ARE PARTIES TO THE REVIEW OR GRIEVANCE.

☐ 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 1530*

Short Title: Internal Review Panelists. (Public)

Sponsors: Representatives Nye, Insko, Nesbitt, Cunningham, and Justus.

Referred to: Insurance.

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO REQUIRE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES PURSUANT TO G.S. 58-50-61 AND G.S. 58-50-62 TO INCLUDE ON THE REVIEW OR GRIEVANCE PANEL PROVIDERS LICENSED, CERTIFIED, OR REGISTERED IN NORTH CAROLINA IN THE SAME MEDICAL OR ALLIED OCCUPATION AS THE PROVIDERS WHO ARE PARTIES TO THE REVIEW OR GRIEVANCE.

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 either (i) 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 (ii) criteria 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 licensed to practice medicine in this State 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; ensure that at least one provider holding a valid North Carolina license, registration, or certification in the same medical or allied health occupation as the providers who are parties to the review, or if the provider is a medical doctor, at least one clinical peer of the party provider; and issue the decision in a timely manner pursuant to this section."

Section 2. G.S. 58-50-62 reads as rewritten:

"**§ 58-50-62. Insurer grievance procedures.**

(a) Purpose and Intent. -- The purpose of this section is to provide standards for the establishment and maintenance of procedures by insurers to assure that covered persons have the opportunity for appropriate resolutions of their grievances.

(b) Availability of Grievance Process. -- Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. The grievance process may provide for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first- and second-level reviews of grievances; except that an appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section.

(c) Grievance Procedures. -- Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office.

(d) Maintenance of Records. -- Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(e) First-Level Grievance Review. -- A grievance may be submitted by a covered person or his or her provider acting on the covered person's behalf.

(1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written

material. Within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.

(2) An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a ~~medical doctor~~ provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the providers who are parties to the grievance, or if the provider is a medical doctor, at least one clinical peer of the party provider with appropriate expertise to evaluate the matter. The written decision issued in a first-level grievance review shall contain:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.

b. A statement of the reviewers' understanding of the grievance.

c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.

(f) Second-Level Grievance Review. -- An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision.

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:

a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.

b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask

questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.

(2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one ~~clinical peer.~~ provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the providers who are parties to the grievance, or if the provider is a medical doctor, at least one clinical peer of the party provider. ~~Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section~~ An insurer may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

(g) Second-Level Grievance Review Procedures. -- An insurer's procedures for conducting a second-level grievance review shall include:

(1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.

(2) The covered person shall be notified in writing at least 15 days before the review meeting date.

(3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.

(h) Second-Level Grievance Review Decisions. -- An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:

(1) The professional qualifications and licensure of the members of the review panel.

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

(3) The review panel's recommendation to the insurer and the rationale behind that recommendation.

(4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.

(5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.

(6) The rationale for the insurer's decision if it differs from the review panel's recommendation.

(7) A statement that the decision is the insurer's final determination in the matter.

(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

(i) Expedited Second-Level Procedures. -- An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the insurer shall conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

(j) No insurer shall discriminate against any provider based on any action taken by the provider under this section or G.S. 58-50-61 on behalf of a covered person.

(k) Violation. -- A violation of this section subjects an insurer to G.S. 58-2-70."

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

2000 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. 1567 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)

5/25/00

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

HOUSE BILL 1567*

Short Title: Mental Health/Chem. Dep. Parity. (Public)

Sponsors: Representatives Alexander, Barefoot, Crawford, Insko; Adams, Allen, Baddour, Blue, Bonner, Boyd-McIntyre, Buchanan, Church, Cole, Cox, Cunningham, Davis, Earle, Easterling, Edwards, Fitch, Ford, Fox, Goodwin, Hackney, Haire, Hensley, Hill, Hunter, Jarrell, Jeffus, Luebke, McAllister, McCrary, Melton, Michaux, Miller, Nesbitt, Oldham, Rogers, Saunders, Sutton, Tolson, Wainwright, Warner, Weiss, G. Wilson, Womble, Wright, and Yongue.

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

May 17, 2000

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 for Health Insurance Contracts Covering Ten or More Employees. -- ~~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

covering 10 or more employees 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 day and visit 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(c) Chemical Dependency Parity Requirement for Health Insurance Contracts Covering Less Than Ten Employees. -- Every health insurer shall provide, in each group health benefit plan covering less than 10 employees, benefits for the necessary care and treatment of chemical dependency. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors, and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(d) 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.

(e) 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.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) 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 (ii) criteria

adopted by the insurer or its utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

~~(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)~~(g) 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~~ This subsection does not 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. Effective January 1, 2004, G.S. 58-51-50, as amended by Section 1 of this act, reads as rewritten:

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

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

(1) '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 for Health Insurance Contracts Covering 10 or More Employees.~~ Requirement. -- Every health insurer shall provide in each group health benefit plan ~~covering 10 or more employees~~ benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

~~(c) Chemical Dependency Parity Requirement for Health Insurance Contracts Covering Less Than 10 Employees. -- Every health insurer shall provide in each group health benefit plan covering less than 10 employees benefits for the necessary care and treatment of chemical dependency. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.~~

(d) 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.

(e) 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.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) 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 (ii) criteria adopted by the insurer or its utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

(g) 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 Chapter 131E of the General Statutes:
   a. Chemical dependency units in licensed facilities;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed under Article 2 of 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 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 under Article 2 of Chapter 122C of the General Statutes.

This subsection does not 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."

Section 3. 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, 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. 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 Illness Parity Requirement for Health Benefit Plans Covering Ten or More Employees. -- A health insurer shall provide, in each group health benefit plan covering 10 or more employees, 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 day and visit 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 prior to reaching any out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be

in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(b) Mental Illness Parity Requirement for Health Benefit Plans Covering Less Than Ten Employees. -- Every health insurer shall provide, in each group health benefit plan covering less than 10 employees, benefits for the necessary care and treatment of mental illness. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors, and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(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.
m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(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 5. Effective January 1, 2004, G.S. 58-3-220, as enacted by this act, reads as rewritten:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Illness Parity ~~Requirement for Health Benefit Plans Covering 10 or More Employees.~~ Requirement. -- A health insurer shall provide in each group health benefit plan ~~covering 10 or more employees~~ 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 day and visit 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 prior to reaching any out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

~~(b) Mental Illness Parity Requirement for Health Benefit Plans Covering Less Than 10 Employees. -- Every health insurer shall provide in each group health benefit plan covering less than 10 employees benefits for the necessary care and treatment of mental illness. Benefits for treatment of mental illness shall be subject to the same~~

~~limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.~~

(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.
m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(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 6. 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 for Group Insurance Certificate or Group Subscriber Contracts Covering Ten or More Employees. -- Every group insurance certificate or group subscriber contract covering 10 or more employees 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~~ 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 day and visit 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(c) Chemical Dependency Parity Requirement for Group Insurance Certificate or Group Subscriber Contracts Covering Less Than Ten Employees. -- Every group insurance certificate or group subscriber contract covering less than 10 employees under any hospital or medical plan governed by this Article and Article 66 of this Chapter shall provide to its insureds benefits for the necessary care and treatment of chemical dependency benefits for the necessary care and treatment of chemical dependency. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors, and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(d) 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.

(e) Medical Necessity. -- Nothing in this section prohibits a group 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.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) 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 (ii) criteria adopted by the insurer or its utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

~~(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)~~(g) 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~~ This section does not 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 7. Effective January 1, 2004, G.S. 58-65-75, as amended by Section 6 of this act, 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 for Group Insurance Certificate or Group Subscriber Contracts Covering 10 or More Employees.~~ Requirement. -- Every group insurance certificate or group subscriber contract ~~covering 10 or more employees~~ under any hospital or medical plan governed by this Article and Article 66 of this Chapter 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. Benefits for chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

~~(c) Chemical Dependency Parity Requirement for Group Insurance Certificate or Group Subscriber Contracts Covering Less Than 10 Employees. -- Every group insurance certificate or group subscriber contract covering less than 10 employees under any hospital or medical plan governed by this Article and Article 66 of this Chapter shall provide to its insureds benefits for the necessary care and treatment of chemical dependency benefits for the necessary care and treatment of chemical dependency. Benefits for treatment of chemical dependency shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.~~

(d) 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.

(e) 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.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) 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 (ii) criteria adopted by the insurer or its utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

(g) 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 Chapter 131E of the General Statutes:
   a. Chemical dependency units in licensed facilities;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed under Article 2 of 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 under Article 2 of Chapter 122C of the General Statutes. 'Duly licensed psychologists' are defined as licensed psychologists who hold permanent licensure and certification as health services provider psychologist issued by the North Carolina Psychology Board.

This subsection does not 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."

Section 8. 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, 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 9. 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 For Health Care Plans Covering Ten or More Employees. -- Every health maintenance organization that writes a health care plan on a group basis covering 10 or more employees 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 day and visit 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(c) Chemical Dependency Parity Requirement For Health Care Plans Covering Less Than Ten Employees. -- Every health maintenance organization that writes a health care plan on a group basis covering less than 10 employees and that is subject to this Article shall provide benefits for the necessary care and treatment of chemical dependency. Benefits for chemical dependency shall be subject to the same limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors, and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness, and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

(d) 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.

(e) 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.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) 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 (ii) criteria adopted by the insurer or its utilization review organization. The Department, in

consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

~~(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)~~(g) 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~~ This subsection does not prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

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

~~(f)~~(h) 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 10. Effective January 1, 2004, G.S. 58-67-70, as amended by Section 9 of this act, 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) Chemical Dependency Parity ~~Requirement For Health Care Plans Covering 10 or More Employees.~~ Requirement. -- Every health maintenance organization that writes a health care plan on a group basis ~~covering 10 or more employees~~ and that is subject to this Article shall provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits under the health care plan generally. Benefits for chemical dependency shall be subject to the same limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes day and visit 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 prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.

~~(c) Chemical Dependency Parity Requirement For Health Care Plans Covering Less Than 10 Employees. -- Every health maintenance organization that writes a health care plan on a group basis covering less than 10 employees and that is subject to this Article shall provide benefits for the necessary care and treatment of chemical dependency. Benefits for chemical dependency shall be subject to the same limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes day and visit limits, maximum out-of-pocket limits, and annual and lifetime dollar limits. 'Limits' does not include deductibles, co-payments, coinsurance factors and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of chemical dependency, mental illness and~~

~~physical health conditions. A health benefit plan shall be construed to be in compliance with this subsection if at least one of the patient's choice of treatment options within the patient's policy meets the requirements of this subsection.~~

(d) 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.

(e) 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.

(f) Utilization Review Criteria. -- Notwithstanding any other provision in this section, the criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) 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 (ii) criteria adopted by the insurer or its utilization review organization. The Department, in consultation with the Department of Health and Human Services, may require a health plan or utilization review organization to show compliance with this subsection.

(g) 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 Chapter 131E of the General Statutes:
   a. Chemical dependency units in licensed facilities;
   b. Medical units;
   c. Psychiatric units; and

(2) The following facilities or programs licensed under Article 2 of 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 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 under Article 2 of Chapter 122C of the General Statutes.

This subsection does not 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.

(h) 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 11. 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, 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 12. 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 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.

(5) 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. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Treatment of chemical dependency and mental illness 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."

Section 13. The Legislative Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall study the issue of requiring mental illness and chemical dependency benefits in health benefit plans for groups with less than 10 employees in parity to physical illness benefits to the extent required under this act. The study may review the health benefits and the cost effectiveness of the parity requirements provided for in this act for these plans. In conducting the study, the Commission shall consult with the North Carolina Institute of Medicine and other interested entities. The Commission shall report its recommendations to the General Assembly upon the convening of the 2003 Regular Session.

Section 14. Sections 2, 5, 7, and 10 of this act are effective January 1, 2004, and apply to health benefit plans that are delivered, issued for delivery, or renewed on and after that date. The remainder of 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, 2001. 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.

2000 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. 1589 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.

☐ 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)

5/25/00

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 1589*

Short Title: Managed Care Entities Liable for Damages. (Public)

Sponsors: Representatives Hackney, Nye; and Goodwin.

Referred to: Insurance.

May 18, 2000

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. Legislative findings and intent.**

(a) The General Assembly finds that a wide variety of entities are integrating the functions of paying for health care, determining what health care is paid for, and providing the care. This integration of functions is breaking down traditional distinctions. Increasingly, payor determinations are governing health care and controlling decisions that in the past were the exclusive domain of health care providers and patients. The General Assembly further finds that this integration of functions makes it imperative that managed care entities be held fully responsible for the consequences of their decisions, much as health care professionals have been held responsible for the consequences of their decisions.

(b) The State's interest in regulating the business of insurance as provided in this Article is to protect insurance purchasers and their beneficiaries, including employees, their dependents and families, and any other patients covered by private employer-sponsored benefit plans, from the harm that may occur when managed care

entities act improperly. To this end, health care providers rather than managed care entities are in charge of patient care.

(c) It is the intent of the General Assembly in enacting this Article to ensure that adequate State law remedies exist for all persons who are subject to the wrongful acts of those entities that contract to provide insurance for the health of North Carolina citizens. The existence of these remedies and the deterrent effects of these remedies are necessary to protect the health and safety of the residents of this State.

"§ 90-21.51. 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. '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) '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 Chapter 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 any entity that is or should be licensed under Article 6, 7, 16, 49, 65, or 67 of this Chapter.

(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:

a. For a carrier or managed care entity, that degree of care that a carrier or managed care entity of ordinary prudence would use under the same or similar circumstances.

b. For a person that is an agent or employee of a carrier 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 as a medical doctor under Article 1 of this Chapter to practice medicine in this State;

b. A professional association or corporation comprising medical doctors and organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by medical doctors.

"**§ 90-21.52. 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, ostensible agents, or employees; or

(2) Representatives that are acting on its behalf and over whom it has the right to exercise influence or control 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 or representative 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 enrollee.

(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 laws that prohibit the practice of medicine by a corporate entity or by a health maintenance organization.

(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 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 purchasing 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.

(i) A managed care entity shall not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

"§ 90-21.53. No liability under this Article on the part of an employer or employer group purchasing 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 a health benefit plan or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of an employer of an enrollee or insured or that employer's employees, unless the employer is the enrollee's or insured's managed care entity and makes coverage determinations under a managed care plan. This Article does not create any liability on the part of an employee organization, a voluntary employee beneficiary organization, or a similar organization, unless such organization is the enrollee's or insured's managed care entity and makes coverage determinations under a managed care plan.

(c) 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.

"§ 90-21.54. 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.

"**§ 90-21.55. Punitive damages.**

An action brought under this Article is subject to the provisions and limitations of Chapter 1D of the General Statutes for recovery of punitive damages.

"**§ 90-21.56. Exhaustion of administrative remedies and appeals.**

(a) Except as provided in this section, no action shall be commenced under this Article until the plaintiff has exhausted all internal and external administrative remedies established under Parts 2 and 4 of Article 50 of Chapter 58 of the General Statutes.

(b) The plaintiff may file a claim without exhausting all internal and external administrative remedies established under Parts 2 and 4 of Article 50 of Chapter 58 of the General Statutes if the plaintiff proves the following to the court:

(1) Harm to the plaintiff has already occurred because of the conduct of the managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of the managed care entity for whose conduct the managed care entity is liable.

(2) The administrative review would not be beneficial to the plaintiff.

(c) This Article does not prohibit a plaintiff from pursuing other appropriate remedies for relief."

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 July 1, 2001, and applies to causes of action arising on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1123*

Short Title: State Health Plan Amendments. (Public)

Sponsors: Representatives Mosley; Baddour, Barefoot, Cox, Sutton, and Womble.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN PROVIDES BENEFITS ON A CALENDAR YEAR BASIS, AND TO PROVIDE FOR A PRESCRIPTION DRUG CARD BENEFIT

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.1(7b) reads as rewritten:

"(7b) Fiscal Year. -- The period beginning ~~July 1~~ January 1 and ending on ~~June 30 of the succeeding calendar year.~~ December 31."

Section 2. Notwithstanding G.S. 135-40.1(7b), the period from July 1, 1999, through December 31, 2000, shall be a fiscal year. For that period, any deductibles and aggregate maximums under Article 3 of Chapter 135 of the General Statutes which are calculated on a fiscal year basis shall, for the special 18-month fiscal year, under this section shall be applied at one hundred fifty percent (150%) of the stated statutory amounts.

Section 3. The Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan shall provide an open enrollment period for Prepaid Plans (HMOs) under G.S. 135-39.5B for coverage either:

(1) October 1, 1999, through December 31, 2000; or

(2) October 1, 2000, through December 31, 2001,

so as to align the HMO plan year with that of the State Health Plan.

Section 4. The introductory language of G.S. 135-40.6 reads as rewritten:

"§ 135-40.6. Benefits subject to deductible and coinsurance (comprehensive benefits).

~~The~~ Other than prescription drugs under subdivision (8)a. of this section, the following benefits are subject to a deductible of two hundred fifty dollars ($250.00) per covered individual to an aggregate maximum of seven hundred fifty dollars ($750.00) per family per fiscal year and are payable on the basis of eighty percent (80%) by the Plan and twenty percent (20%) by the covered individual up to a maximum of one thousand dollars ($1,000) out-of-pocket per fiscal year:"

Section 5. G.S. 135-40.6(8)a. reads as rewritten:

a. Prescription Drugs: The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility are ninety percent (90%) of the average wholesale price. Each covered individual shall pay ten dollars ($10.00) for each generic drug, fifteen dollars ($15.00) for each brand-name drug, and an additional five dollars ($5.00) for a brand-name drug for which there is a generic equivalent. There is no deductible or percentage co-payment by the covered individual. A dispensing fee for qualified providers shall be determined by the Executive Administrator and Board of Trustees. ~~The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the provider dispensing fee set by the Executive Administrator and Board of Trustees.~~ A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though prescription is not required."

Section 6. G.S. 135-40.8(a) reads as rewritten:

"(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in G.S. ~~135-40.6.~~ 135-40.6, other than prescription drugs covered under G.S. 135-40.6(8)a. The covered individual is then responsible for the remaining twenty percent (20%) until one thousand dollars ($1,000), in excess of the deductible, has been paid out-of-pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses."

Section 7. Sections 5 and 6 of this act become effective July 1, 1999. The remainder of this act is effective when it becomes law.