1999-2000

SENATE INSURANCE COMMITTEE

MINUTES

INSURANCE COMMITTEE MEMBERS

SENATOR ALLEN WELLONS, CHAIRMAN

SENATOR OSCAR HARRIS, VICE CHAIRMAN

SENATOR BOB MARTIN, VICE CHAIRMAN

SENATOR ERIC REEVES, VICE CHAIRMAN

SENATOR R. C. SOLES, VICE CHAIRMAN

SENATOR FRANK BALLANCE

SENATOR PATRICK BALLANTINE

SENATOR JOHN CARRINGTON

SENATOR DON EAST

SENATOR STEPHEN METCALF

SENATOR BRAD MILLER

SENATOR TONY RAND

SENATOR HUGH WEBSTER

LYNWOOD JONES – COUNSEL
ED ROSSI – COUNSEL
PEGGY ANNE HOGAN - CLERK

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium — SENATE: INSURANCE — Valid Through 23-AUG-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 165=	REDWINE	JUA REAUTHORIZATION	*R -CH. SL 99-0114	04-05-99	04-08-99
H 276	REDWINE	OMNIBUS ESC CHANGES	R -CH. SL 99-0340	04-22-99	07-01-99
H 277	REDWINE	"FAMILY FRIENDLY" UI EXCEPTION	*R -CH. SL 99-0196	04-26-99	06-01-99
H 294=	HURLEY	LIFE AND HEALTH INS. AMENDMENTS	*R -CH. SL 99-0351	04-14-99	07-07-99
H 296=	HURLEY	INSURANCE TECHNICAL CHANGES	*R -CH. SL 99-0132	04-21-99	05-19-99
H 306=	HARDAWAY	INSURANCE AMENDMENTS	*R -CH. SL 99-0219	04-19-99	05-19-99
H 314	BOYD-MCINTYRE	INSURANCE COVG./BONE MASS MSMT	*R -CH. SL 99-0197	04-29-99	06-02-99
H 714=	ALEXANDER	SUBSTANCE ABUSE/DIRECT PAY	*R -CH. SL 99-0199	04-28-99	06-02-99
H 736	ROGERS	MANAGED CARE/PATIENT ACCESS	*S -RE-REF COM ON COMMERCE	05-03-99	05-04-99
H1025	GARDNER	GROUP HEALTH CONTINUATION INSURANCE	R -CH. SL 99-0273	04-27-99	06-23-99
H1119	WRIGHT	CHILDREN/DISABLE ANESTH. DENTAL CARE	*R -CH. SL 99-0134	04-28-99	05-19-99
H1186	MINER	UNEARNED PREMIUM RESERVES	*R -CH. SL 99-0383	04-28-99	06-02-99
S 167=	SOLES	JUA REAUTHORIZATION	S -REF TO COM ON INSURANC	02-24-99	
S 293	COOPER	PASTORAL COUNSELING REIMB/SUNSET OFF	*R -CH. SL 99-0186	03-08-99	04-01-99
S 345	FORRESTER	URO REVIEWS BY NC PHYSICIANS	R -CH. SL 99-0391	04-07-99	04-21-99
S 347	FORRESTER	PRES.DRUG FORMULARIES	*R -CH. SL 99-0178	03-15-99	04-14-99
S 389	MARTIN R	TOWN/COUNTY FINANCIAL REPORTS	*R -CH. SL 99-0192	03-16-99	04-07-99
S 394	HARTSELL	CREDIT CARD PAYMENT OF INSURANCE	*R -CH. SL 99-0365	03-17-99	04-01-99
S 427=	WELLONS	INSURANCE AMENDMENT	S -REF TO COM ON INSURANC	03-22-99	
S 428=	WELLONS	INSURANCE TECHNICAL CHANGES	S -REF TO COM ON INSURANC	03-22-99	
S 430=	WELLONS	LIFE & HEALTH INS. AMENDMENTS	S -REF TO COM ON INSURANC	03-22-99	
S 513	WELLONS	PRESC. DRUG ID CARD	*R -CH. SL 99-0343	03-25-99	04-28-99
S 533	CARTER	HEALTH CARE PILOT PROGRAM	S -RE-REF COM ON INSURANC	04-26-99	
S 594	MILLER B	MISC. INSURANCE CHANGES	*R -CH. SL 99-0294	03-29-99	04-22-99
S 643=	REEVES	INSURANCE PREMIUM FINANCING	*R -CH. SL 99-0157	03-30-99	04-28-99
S 766	MILLER B	SERVICE CORP. AND HMO LAWS	R -CH. SL 99-0244	04-06-99	04-21-99
S 836=	MARTIN R	MENTAL HEALTH/CHEM. DEP. PARITY	S -REF TO COM ON INSURANC	04-13-99	
S 839	WELLONS	INSURANCE CLAIMS PAYMENTS/Y2K	*R -CH. SL 99-0184	04-13-99	04-28-99
S 880=	MARTIN W	CHILD HEALTH INS./SUPPORT ORDERS	S -REF TO COM ON INSURANC	04-13-99	
S 946=	MARTIN W	SUBSTANCE ABUSE/DIRECT PAY	S -REF TO COM ON INSURANC	04-14-99	

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 SENATE: INSURANCE Valid Through 23-AUG-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
S1089	HARRIS	MANAGED CARE STUDY	*H -REF TO COM ON RULES	04-15-99	04-28-99
S1090	HARRIS	HEALTH INS/ANY WILLING PROVIDER	S -REF TO COM ON INSURANC	04-15-99	
S1108	**HARRIS**	**HEALTH INS./CONSUMER ADVOCATE**	**S -REF TO COM ON INSURANC**	**04-15-99**	
S1109	**HARRIS**	**PRESC. DRUGS FUNDS**	**S -REF TO COM ON INSURANC**	**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.

SENATE INSURANCE COMMITTEE

The Senate Insurance Committee held its first meeting on Wednesday, February 24, 1999, at 10:00 a.m. in room 1027 of the Legislative Building

Senator Allen Wellons, the Chairman, presided.

The members of the committee are: Senators Wellons, Ballance, Ballantine, Carrington East, Harris, Martin, Metcalf, Miller, Rand, Reeves, Soles, and Webster. Linwood Jones, and Ed Rossi are the Committee Counsel.

Senator Wellons began by having the members introduce themselves.

The Chairman called on Commissioner Jim Long who gave a brief overview of the Department, and introduced some of his staff. He then turned to Dascheil Propes, who is the Chief Deputy Commissioner. Mr. Propes spoke about legislation the Department would have an interest in.

After a brief question and answer period, the meeting was adjourned at 10:30.

Senator Allen H. Wellons
Chairman

Margaret M. Hogan
Committee Clerk

VISITOR REGISTRATION SHEET

Senate Committee on Insurance — February 24, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wade Hamrick	NC DOI
Barbara Morales Bourke	NC DOI
John McMillan	MFIS
Susan Valauri	Nationwide
Harry Kaplan	
Joe Selvey	Rutgers Blue Cross
Lisa Piercy	NC Life Underwriters
Katy Michaels	PPOD
John Bowdish	Zeb Alley, P.A.
Jan Ramquist	NCSOS
Andy Ellen	NCRMA
	Smith Anderson
Rick Pierce	Jordan Price Wall

VISITOR REGISTRATION SHEET

Senate Committee on Insurance — February 24, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fran Preston	NCRMA
Paul Wilson	NCMBA
Steve Woodson	NC Farm Bureau
Jack Cozort	PPAB
Amy Fullbright	Hunton & Williams
Joyce Peters	JPAssoc/MANCI
Marie Lewis	NCSA
VL McBride	NCPA
Sheila McKinney	DOI
Bill Hale	DOI
Dascail Propes	DOI
Alan Miles & Ruffin Bailey	Bailey & Dixon LLP
Robert Paschal	Young, Moore & Henderson, P.A.
Lyman Cooper	CSX Corp.

AGENDA

SENATE INSURANCE COMMITTEE MEETING

MARCH 31, 1999

S293	PASTORAL COUNSELING REIMB/SUNSET	SEN. COOPER
S394	CREDIT CARD PAYMENT OF INSURANCE	SEN. HARTSELL
S513	PRESC. DRUG ID CARD	SEN. WELLONS

SENATE INSURANCE COMMITTEE MEETING MINUTES

MARCH 31, 1999

The Senate Insurance Committee met on March 31, 1999 at 10:00 a.m. in room 1027 of the Legislative Building. Senator Allen Wellons, Chairman, presided. Eleven members were present.

Senator Cooper presented his Senate Bill 293, Pastoral Counseling Reimb./Sunset Off. Linwood Jones, Counsel to the Committee had a Proposed Committee Substitute which was technical. After an explanation of the Bill and the Committee Substitute, Senator Ballantine moved that the Committee Substitute be adopted. This motion passed. Senator Soles moved that the Substitute become a part of the bill and given a favorable report. This motion passed.

The next agenda item was Senate Bill 394, Credit Card Payment of Insurance which was introduced by Senator Hartsell. After discussion, Senator Soles moved for a favorable report, and the motion passed.

Senator Wellons asked Senator Reeves to take the Chair so he could explain Senate Bill 513, Presc. Drug ID Card. Senator Wellons explained at the outset that this bill would not be voted on today, just discussed. Fran Preston of the Retail Merchants Association explained the bill and the Proposed Committee Substitute. After discussion, and a question and answer period, the Chairman said the bill would be brought back at a later date.

There being no further business, the meeting was adjourned.

Allen Wellons
mh

Senator Allen Wellons
Chairman

Margaret Hogan

Margaret M. Hogan
Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

SENATE INSURANCE COMMITTEE COMMITTEE REPORT
Senator Allen Wellons, Chair

Thursday, April 01, 1999

Senator Wellons
submits the following with recommendations as to passage:

FAVORABLE

S.B. **394** Credit Card Payment of Insurance.
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **293** Pastoral Counseling Reimb./Sunset Off.
Draft Number: PCS 8576
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comment:

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Insurance** will meet at the following time:

DATE: **Wednesday, March 31**
TIME: **10:00 a.m.**
ROOM: **1027 Legislative Building**

The following bills or resolutions will be considered:
S293 Pastoral Counseling Reimb/Sunset – Sen. Cooper
S394 Credit Card Payment of Insurance – Sen. Hartsell
S513 Presc. Drug ID Card – Sen. Wellons

Senator Wellons, Chair

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 293

Short Title: Pastoral Counseling Reimb./Sunset Off. (Public)

Sponsors: Senator Cooper.

Referred to: Insurance.

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 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 293
Proposed Committee Substitute for S293-PCS8576-RN

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:	Senate Insurance	**Introduced by:**	Sen. Cooper
Date:	March 31, 1999	**Summary by:**	Linwood Jones
Version:	1st		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 *(see attached copy of Chapter 406 of the 1995 Session Laws)* 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 Chapter 406 of the 1995 Session Laws will continue in effect on and after July 1, 1999.

***Note**: G.S. 90-396, which was not affected by the 1995 law, should be reviewed for its consistency with the purpose of this bill.*

AN ACT TO PROVIDE THAT TREATMENT OR SERVICES RENDERED BY CERTIFIED FEE-BASED PRACTICING PASTORAL COUNSELORS 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. G.S. 135-40.7A(c) reads as rewritten:

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

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:

a. Chemical dependency units in facilities licensed after October 1, 1984;
b. Medical units;
c. Psychiatric units; and

(2) The following facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:

a. Chemical dependency units in psychiatric hospitals;
b. Chemical dependency hospitals;
c. Residential chemical dependency treatment facilities;
d. Social setting detoxification facilities or programs;
e. Medical detoxification facilities or programs; and

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

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

Sec. 2. G.S. 135-40.7B(c) reads as rewritten:

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

(1) Licensed psychiatrists;
(2) Licensed or certified doctors of psychology;
(3) Certified clinical social workers;
(4) Psychiatric nurses;
(5) Other social workers under the direct employment and supervision of a licensed psychiatrist or licensed doctor of psychology;
(6) Psychological associates with a master's degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology;
(7) Licensed psychiatric hospitals and licensed general hospitals providing psychiatric treatment programs; ~~and~~
(8) Certified residential treatment facilities, community mental health centers, and partial hospitalization ~~facilities.~~ facilities; and
(9) Certified fee-based practicing pastoral counselors."

Sec. 3. 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, or psychologist, 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 such 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 certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under such policy shall be entitled to payment of or reimbursement for such services, whether such 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 certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in such policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability which 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, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under such policy shall be entitled to payment of or reimbursement for such disability whether such 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, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in such policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of such 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 his practice as defined in G.S. 90-151 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) 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."

Sec. 4. 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, an advanced practice registered nurse, a duly certified clinical social worker, 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, an advanced practice registered nurse, a duly certified clinical social worker, 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.

(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.

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."

Sec. 5. G.S. 122C-3(31) reads as rewritten:

"(31) 'Qualified professional' means any individual with appropriate training or experience as specified by the General Statutes or by rule of the Commission in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors."

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.

In the General Assembly read three times and ratified this the 10th day of July, 1995.

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.

SB 394:
Credit Card Payment of Insurance

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Hartsell
Date:	March 31, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

SUMMARY:

Currently, credit cards cannot be used for the solicitation or payment of insurance premiums in North Carolina except as follows:

- For travel accident insurance policies, including airline flight insurance.
- For credit insurance on the unpaid balance of a credit card account (as provided in G.S. 58-57-105).
- For any other type of insurance ***IF*** the credit card facility (i) is operated by a bank principally domiciled in North Carolina ***AND*** (ii) all of the records relating to the payment of the premium by credit card are maintained in North Carolina. Most banks' credit card facilities are located in other states, which allows them to take advantage of higher interest rates that can be "imported" back into North Carolina for credit cardholders in this State. Thus, few, if any, bank credit card facilities meet the requirement of having the records in North Carolina.

Senate Bill 394 would allow credit cards to also be used for the solicitation and payment of premiums for the following types of policies:

- Homeowners insurance policies (Article 36 of Chapter 58)
- Property insurance policies that cover real property (Article 44 of Chapter 58)
- Property insurance policies covering real property that are issued under the Beach Plan (Article 45 of Chapter 58) and the FAIR Plan (Article 46 of Chapter 58). The Beach Plan and FAIR Plan are statutory joint underwriting associations that provide property insurance coverage to eligible risks that are unable to obtain that coverage in the voluntary market.
- Motor vehicle liability insurance policies

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 513

Short Title: Presc. Drug ID Card. (Public)

Sponsors: Senators Wellons; Albertson, Cochrane, Dalton, Foxx, Garrou, Gulley, Kinnaird, Lucas, Purcell, Reeves, and Weinstein.

Referred to: Insurance.

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 conform to the format adopted by the National Council for Prescription Drug Programs and shall include the following:

(1) Identification number of the insured's dependents covered under the health benefit plan.

(2) Name of the insured's dependents covered under the health benefit plan.

(3) Date of birth of the insured's dependents covered under the health benefit plan.

(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, and
(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."

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 513
PROPOSED COMMITTEE SUBSTITUTE
S513-CSRN-001

Short Title: Presc. Drug ID Card. (Public)

Sponsors:

Referred to: Insurance.

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 conform to the format adopted by the National Council for Prescription Drug Programs and shall include the following:

(1) Identification number of the insured's dependents covered under the health benefit plan.

(2) Name of the insured's dependents covered under the health benefit plan.

(3) Date of birth of the insured's dependents covered under the health benefit plan.

A health benefit plan shall meet the requirements of this section if the data elements and format required under this section are incorporated into an identification card used by the plan for all services covered by the plan.

(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."

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.

S513:
Presc. Drug ID Card

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	
Date:	March 30, 1999	**Summary by:**	Ed Rossi
Version:	Proposed Committee Sub. S513-CSRN-001		Committee Co-Counsel

SUMMARY: ***Senate bill 513 requires health insurers who provide prescription drug coverage to issue "uniform prescription identification cards." These cards must conform to a format adopted by a private corporation that is located in Arizona. This bill does not cover health plans that are covered by ERISA and those that have their own pharmacies.***

The provision giving the Arizona corporation the discretion to determine the format for the cards is constitutionally suspect because: (1) it may allow a private corporation to set the law in North Carolina; (2) it may provide an exclusive or separate emolument or privilege to the Arizona Corporation; (3) it may create a monopoly.

CURRENT LAW: The North Carolina Constitution vests the legislative power of the State in the General Assembly.[1] That power may be delegated, but it may only be delegated to subordinate agencies when adequate standards are provided.[2] The General Assembly cannot delegate its legislative power to private corporations.[3] Nor can the General Assembly grant exclusive or separate emoluments or privileges to persons except in consideration of public service.[4] Moreover, it generally cannot allow perpetuities or monopolies.[5]

BACKGROUND: *NCPDP COSTS* – Senate bill 513 requires prescription drug ID cards to conform to the format adopted by the National Council for Prescription Drug Programs, Inc. ("NCPDP"), a corporation domiciled in Arizona. NCPDP is a private corporation that is not accountable to the General Assembly. Its prescription drug ID card format is not freely available to the general public. That format is copyrighted and costs $250.00. When NCPDP holds meetings to consider changes to that format the public must pay to attend the meeting. The cost of admission is $200.00.

NCPDP FORMAT:

- The current format is a work in progress. The company's general manager indicates that it is in the process of being reworked. Thus, it is not possible to know what data elements will ultimately be required by the card format this bill seeks to adopt.
- The current format does not include any privacy requirements. However, the company is currently in the process working on such requirements. Depending on what data will ultimately be required by the format, privacy concerns may become an issue given that medical information is now being used for marketing purposes. For example, last year a

[1] Article II § 1 of the North Carolina Constitution
[2] See Bulova Watch Company, Inc v. Brand Distributors, 285 N.C. 467 (1974)
[3] Id.
[4] Article I § 32 of the North Carolina Constitution
[5] Article I § 34 of the North Carolina Constitution

lawsuit was filed in Massachusetts against a major pharmaceutical company and drug store chain for presumably using confidential medical information for marketing purposes.[6]

- NCPDP's format does not appear to support the requirement set forth in the bill requiring the cards to include the dates of birth of an insured's covered dependents.
- NCPDP's current format does not support the use of magnetic strips on cards that provide identification for more than one individual.

BILL ANALYSIS: Senate bill 513 requires that the proposed prescription drug ID cards conform to the format adopted by a private corporation that cannot be held accountable to the State. On its face, this would appear to be the type of delegation of legislative power that the North Carolina Supreme Court has held is unconstitutional. The language that allows NCPDP the authority to set the card format, in effect, giving it discretion to decide not only what the format will be, but also what information will be contained in the cards. This could have unintended consequences. For example, if NCPDP adopted a smart card format it could decide that the "format" called for the inclusion of available financial information, social security numbers, medical records, and credit reports. If that were to happen, what would prevent this information from being used for marketing purposes after it was scanned into a drug retailer's computer?

From a more practical standpoint, the bill appears to be inconsistent. It calls for prescription drug ID cards to conform to the format adopted by NCPDP and also calls for the cards to include the dates of birth of an insured's dependents. NCPDP's format however does not appear to permit the inclusion of these dates of birth.

[6] It should be noted that under North Carolina law patient medical information receives very little protection when it is disseminated in connection with insurance transactions.

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE — 3-31-99

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Tommy Worth	Carolina HealthCare Syst.
C. Porter	Bone & Associates
Amy Fullbright	Hunton & Williams
Cindy Sauls	WCSN
John Bowdish	Zebulon PA
Mari Segui	NCSA
Lori Ann Harris	LA Harris & Assoc.
Ken Wright	BCBSNC
Peters	LP Assoc / Mann St
Nancy Thompson	NCCBD
Jan Ramquist	NCDOA
Hugh Tilson	NCHA
Steve Keene	NC Medical Society
Stella McKenney	NC DOI
Catherine Jennings	NC Association of Health Underwriters
Linda Kae Gretter	NC Association of Health Underwriters
Kimberly Martin	NC Assoc. of Health Underwriters
Gerald D. Tomberlin	N.C. Assoc of Health Underwriters
C. Bernard Obie	NC Assn of Health Underwriters
Adam Sears	NCHIAC
Lucius Pullen	Attorney
Paul Mahoney	NC Assn of Health Plans
Lisa Percy	NCALU

Robert Bird — NCFB — Raleigh

John Bode — NAIC — Raleigh

[illegible] — Moore & Van Allen — Raleigh

Bill Nelson — House member

Bobby Barbee — House member

Jeff Hale — NC DOI

Harry Taylor

Susan Valenti — Nationwide

Andrew Barnes — Pharmacy Networks — Raleigh

Nat'l Corp.

[illegible] — NCRPh

Andy Ellen — NCRMA

Fran Preston — NCRMA

[illegible] Jackson — Eckerd Corp.

AGENDA

SENATE INSURANCE COMMITTEE MEETING

APRIL 7, 1999

HB 165	JUA BILL	REP. REDWINE
SB 389	TOWN/COUNTY FINANCIAL REPORTS	SEN. BOB MARTIN
SB 427	INSURANCE AMENDMENTS	SEN. WELLONS
SB 430	LIFE AND HEALTH AMENDMENTS	SEN. WELLONS

SENATE INSURANCE COMMITTEE MEETING MINUTES

APRIL 7, 1999

The Senate Insurance Committee met on April 7, 1999 at 10:00 a.m. in room 1027 of the Legislative Building. Senator Allen Wellons, Chairman, presided. Twelve members were present.

House Bill 165 JUA Reauthorization was the first Agenda Item. This bill was introduced by Representative Redwine, but he was unable to attend the meeting. Linwood Jones, Committee Counsel, explained the bill, and Senator Soles offered an amendment which is attached. Senator Soles then moved that the amendment be adopted and rolled into a Proposed Committee Substitute. This motion passed. He then moved that the bill, as amended be given a favorable report. This motion passed.

The next agenda item was SB 389, Town/County Financial Report, which was introduced by Senator Martin. A Proposed Committee Substitute was offered, and Senator Ballance moved its adoption. This motion passed, and Senator Rand moved for a favorable report for the Committee Substitute.

Senator Wellons called on Bill Hale of the Insurance Department to explain SB 427, Insurance Amendments. Senator Soles was asked to preside since Senator Wellons was the sponsor of the bill. A Proposed Committee Substitute was offered, and Mr. Hale used this for his explanation. Senator Rand raised some questions about Section 1.2. G.S. 58-45-50. Mr. Hale said he would work on the language of that section and make it available.

Senator Wellons offered an amendment, but after discussion, decided to withdraw it. He proposed that the bill be held until the next meeting, and the members agreed.

There being no further business, the meeting was adjourned.

Senator Allen Wellons
Chairman

Margaret Hogan

Margaret M. Hogan
Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

SENATE INSURANCE COMMITTEE COMMITTEE REPORT
Senator Allen Wellons, Chair

Wednesday, April 07, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **389** Town/County Financial Reports

Draft Number:	PCS 1658
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

SENATE INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Thursday, April 08, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)**165** JUA Reauthorization

Draft Number:	PCS4177
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment:

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.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 165

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

H165-ARN-001

Page 1 of __

Date _____ ,1999

Comm. Sub. [YES]
Amends Title [YES]
Second Edition

Sen. Soles

moves to amend the bill on page 1, line 4, by inserting after "PLANS," the phrase "TO EXTEND THE BEACH PLAN RATE CAP ON WIND POLICIES ISSUED IN THE COASTAL AREA FOR TWO YEARS,";

and on page 3, between lines 25 and 26, by inserting the following:

"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:"

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HB 165:
Joint Underwriting Assoc. Reauthorization

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Rep. Redwine
Date:	April 6, 1999	**Summary by:**	Linwood Jones
Version:	Second Edition		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, and makes an additional technical amendment concerning the Beach Plan.

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 8 is a severability clause.

Section 9 makes this act effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 389

Short Title: Town/County Financial Reports. (Public)

Sponsors: Senators Martin of Pitt; and Kerr.

Referred to: Insurance.

March 16, 1999

A BILL TO BE ENTITLED

AN ACT TO REVISE THE REQUIREMENTS OF FINANCIAL REPORTS OF CERTAIN 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) 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.

(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 when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 389
PROPOSED COMMITTEE SUBSTITUTE
S389-CSRN-001

Short Title: Town/County Financial Reports. (Public)

Sponsors:

Referred to: Insurance.

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:	Senate Insurance	**Introduced by:**	Sen. R.L. Martin
Date:	April 7, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 1st 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 proposed committee substitute makes clear that these small farm mutuals are not required to use the NAIC form. Although no question has reportedly arisen about the first issue – not requiring the monthly, quarterly, and semi-annual reports – the proposed committee substitute adds addiitonal language about these reports not being required. Finally, the proposed committee substitute 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. Although NAIC forms may be in an electronically-readable format, audit reports are not.

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 (as discussed above).

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE — APRIL 7, 1999

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Mike Causey	NCAHSA
Bob Price	Jordan Price Wall
Lisa Percy	NC Assn Life Underwriters
Robert PASchal	Young, Moore & Henderson
Alicia Gregory	Poyner & Spruill
Carry Jo Bain	NCMS
Porter	Bone & Assoc.
Sheila H. McHenry	NC DOI
Mark Briggs	Capitol Group
Mike Miller	NCSA
Vandana Shah	NC DOJustice.
Scott Hannah	NCATL
Charles Archer	NCATL
Dick Taylor	NCAHC
John Bordish	Zeb Alley PA.
Jeff Jones	JD Attorney
Will Lang	AAHC
Gary Flannery	NCHCFA
John McMillan	MF&S PA
Dave Hare	Smith Anderson

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE — APRIL 7, 1999

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Glenda Ingram	Insurance + Consumer Assn. of N.C.
Susan Valaun	Nationwide
M.K. Mann	JSI
Lucius Pullen	Attorney
Tom Covey	BPMHL
Lori Ann Harris	LANA
Roger Bone	Bone & Assoc.
Heath Tilson	NCHA
Tony Rand	

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 427*

Short Title: Insurance Amendments/AB. (Public)

Sponsors: Senator Wellons.

Referred to: Insurance.

March 22, 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 a 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 CFR 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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SENATE BILL 427
PROPOSED COMMITTEE SUBSTITUTE
S427-CSRN-001

Short Title: Insurance Amendments/AB. (Public)

Sponsors:

Referred to: Insurance.

March 22, 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.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 427

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

S427-ARN-001

Page 1 of __

Date_____,1999

Comm. Sub. [YES]
Amends Title [YES]
PCS Edition

Sen. _____

moves to amend the bill on page 1, lines 15-16, by deleting the language "TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE,";

and on page 17, lines 15 through 31 by deleting those lines (being all of PART VIII), and by renumbering the remaining Parts and Sections accordingly;

and on page 18, line 31 by deleting "11" and inserting "10".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

AGENDA

SENATE INSURANCE COMMITTEE

APRIL 14, 1999

S 347	PRES. DRUG FORMULARIES	SEN. FORRESTER
S 427	INSURANCE AMENDMENT	SEN. WELLONS
S 430	LIFE & HEALTH INS. AMENDMENTS	SEN. WELLONS

SENATE INSURANCE COMMITTEE MEETING MINUTES

APRIL 14, 1999

The Senate Insurance Committee met on April 14, 1999 at 10:00 a.m. in room 1027 of the Legislative Building. Senator Allen Wellons, Chairman, presided. Nine members were present.

The first item on the Agenda was S 347, Pres. Drug Formularies, which was introduced by Senator Forrester. He presented a Proposed Committee Substitute, and Senator Carrington moved its adoption. This motion passed. Senator Forrester explained his bill, and after a short discussion, Senator Carrington moved for a Favorable Report for the Proposed Committee Substitute. This motion also passed.

Senate Bill 427, Insurance Amendment, was introduced by Senator Wellons. He asked Senator Soles to preside while he handled this bill and S430. Senator Wellons asked Bill Hale of the Insurance Department to explain the bill. An amendment was offered by Senator Ballance, and Senator Wellons moved the adoption of the amendment Senator Wellons moved that the amendment be rolled into a Committee Substitute and, subsequently, given a Favorable Report. This motion passed.

Senate Bill 430, Life & Health Ins. Amendments, was introduced by Senator Wellons, and explained by Bill Hale. Senator Wellons moved the Adoption of the Proposed Committee Substitute. After an explanation of the Substitute, Senator Wellons moved that it be given a favorable report. This motion passed unanimously.

Senate Bill 427 and Senate Bill 430 will be held until their House Companion Bills come over.

There being no further business, the meeting was adjourned.

Allen H. Wellons
Chairman

Margaret M. Hogan
Clerk

REVISED REPORT

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

SENATE INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Wednesday, April 14, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **347** Pres. Drug Formularies

Draft Number:	PCS 2637
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment:

SB 347:
Prescription Drug Formularies

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Forrester
Date:	April 14, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

Senate Bill 347 provides that if an insurer, service corporation, or HMO has one or more restrictive drug formularies for prescription drugs or devices in its health benefit plan, it must:

- Provide the formulary list, showing all covered drugs and devices, to each provider and pharmacist that participates in the plan.
- Identify the drugs and devices on the formulary by major therapeutic category, including whether a particular drug or device is preferred over other drugs or devices.
- Allow each enrollee in the plan to obtain medically necessary and appropriate drugs and devices that are not on the formulary without incurring additional cost-sharing or penalties. The primary care physician determines whether the drug or device is medically necessary.

In addition, the insurer cannot terminate or nonrenew a managed care contract with a provider because the provider has prescribed a medically necessary and appropriate nonformulary drug or device.

This act applies to health benefit plans. Health benefit plans include plans offered by insurers, service corporations, HMOs, and multiple employer welfare arrangements. The term does not include more specialized types of health and health-related insurance, such as disability income insurance, specified disease policies, etc. This definition of health benefit plan is consistent with the definition of health benefit plans generaly in the insurance laws.

This act would begin to apply to plans issued or renewed on or after January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 347

Short Title: Pres. Drug Formularies. (Public)

Sponsors: Senators Forrester, Purcell; and Carpenter.

Referred to: Insurance.

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 restrictive formularies for prescription drugs or devices, then the insurer shall do the following:

(1) Disseminate to participating providers and pharmacists the complete drug and 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.

(2) 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 primary care physician without prior approval from the insurer.

(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.

SB 347 (PCS): Prescription Drug Formularies

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Forrester
Date:	April 14, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 1st Edition		Committee Counsel

SUMMARY:

Senate Bill 347 provides that if an insurer maintains a closed formulary for prescription drugs and devices, the insurer must do the following:

- Develop the formulary in conjunction with and with the approval of a pharmacy and therapeutics committee that is comprised of participating providers who are licensed to prescribe drugs and medical devices
- Make the formulary list available to participating providers, 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 cost, 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 347
Proposed Committee Substitute S347-PCS2637-LN

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.

SB 427:
Insurance Amendments/AB

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Wellons
Date:	April 6, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 1st Edition		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.

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 GENERAL ASSEMBLY
AMENDMENT
Senate Bill 427

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

S427-ARN-002

Page 1 of __

Date _____, 1999

Comm. Sub. [YES]
Amends Title []
PCS Edition

Sen. Ballance

moves to amend the bill on page 2, line 36 and page 3, line 40, by striking through "20" each time it appears and inserting "10";

and on page 3, lines 1-9 by rewriting those lines to read:

"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";

and on page 4, lines 4-12 by rewriting those lines to read:

"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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 427

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

S427-ARN-002 Page 2 of __

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".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 427
PROPOSED COMMITTEE SUBSTITUTE
S427-CSRN-001

Short Title: Insurance Amendments/AB. (Public)

Sponsors:

Referred to: Insurance.

March 22, 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

S 1

SENATE BILL 427*

Short Title: Insurance Amendments/AB. (Public)

Sponsors: Senator Wellons.

Referred to: Insurance.

March 22, 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 a 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 CFR 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.

SB 430:
Life and Health Insurance Amendments

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Wellons
Date:	April 7, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 1st Edition		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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 430
PROPOSED COMMITTEE SUBTITUTE
S430-CSRN-001

Short Title: Life & Health Ins. Amendments/AB. (Public)

Sponsors:

Referred to: Insurance.

March 22, 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. -- 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.~~ 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

S 1

SENATE BILL 430*

Short Title: Life & Health Ins. Amendments/AB. (Public)

Sponsors: Senator Wellons.

Referred to: Insurance.

March 22, 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.

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE — APRIL14, 1999

Name of Committee — Date

INSURANCE — 4-14-99

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Harry Taylor	
Robert Pasahal	Young, Moore & Henderson
Tommy Worthy	Carolina Ass of Ins Agts
Mary Seitz	Glaxo-Wellcome
Bob Prow	Jordan Price Wall
Susan Valauri	Nationwide
Mary Fant	NC Insurance News Service
John McMillan	MFAS
John Phelps	NCLM
Alan Miles	Bradley & Dixon LLP
Amy Jo Bain	NC Medical Society
Steve Keene	" "
Lisa Pelicy	Assn of Life Underwriters
Dan Ramsey	NCSOS
Estella McGregor	NC DOI
Lori Ann Flanders	LHHA, Inc.
	UCSR
William H. Potter Jr	NCDS & NCPTA

AGENDA

SENATE INSURANCE COMMITTEE MEETING

APRIL 21, 1999

S345	URO REVIEWS BY NC PHYSICIANS	SENATOR FORRESTER
S594	MISC. INSURANCE CHANGES	SENATOR MILLER
S643	INSURANCE PREMIUM FINANCING	SENATOR REEVES
S766	SERVICE CORP. AND HMO LAWS	SENATOR MILLER

SENATE INSURANCE COMMITTEE

MINUTES

APRIL 21, 1999

The Senate Insurance Committee held its meeting on April 21, 1999 at 10:00 a.m. in room 1027 of the Legislative Building.

The Chairman, Senator Wellons, presided, and eleven members were present.

The first Agenda item was Senate Bill 345, URO Reviews By NC Physicians, presented by Senator Jim Forrester. After a short discussion, Senator Soles moved that the bill receive a Favorable Report. This motion passed unanimously.

Senate Bill 594 was presented by Senator Brad Miller. Senator Miller moved the adoption of a Proposed Committee Substitute which is attached. An amendment, which is attached, was also offered. It was adopted, and rolled into a new Committee Substitute. Senator Ballance moved that the Committee Substitute, as amended, be given a Favorable Report. This motion passed.

Senate Bill 766, Service Corp. and HMO Laws, was also presented by Senator Miller. After a few questions, Senator Carrington moved for a Favorable Report. This motion passed unanimously.

Senate Bill 643, Insurance Premium Financing, which was sponsored by Senator Reeves was put off until the next meeting.

There being no further business, the meeting was adjourned.

Senator Allen Wellons
Chairman

Margaret M. Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Wednesday, April 21, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **345** URO Reviews By NC Physicians
Sequential Referral: None
Recommended Referral: None

S.B. **766** Service Corp. and HMO Laws
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE COMMITTEE REPORT
Senator Allen Wellons, Chair

Thursday, April 22, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **594** Miscellaneous Ins. Changes

Draft Number:	PCS4682
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

SB 345:
Utilization Review Organization Reviews

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Forrester
Date:	April 20, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

Senate Bill 345 provides for the following:

Section 1 amends the law to require that only MDs licensed in North Carolina can evaluate the clinical appropriateness of certification denials under an insurer's utilization review program.

Section 2 provides that insurers can designate only those MDs licensed in North Carolina to participate in informal reconsideration of certification denials.

Section 3 provides that insurers can designate only MDs licensed in North Carolina to evaluate appeals of certification denials.

Section 4 provides that insurers can consult only with MDs licensed in North Carolina to provide an expedited review of a certification denial.

Section 5 makes this act effective when it becomes law and applicable to utilization reviews conducted on or after January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 345

Short Title: URO Reviews by NC Physicians. (Public)

Sponsors: Senators Forrester, Purcell; and Carpenter.

Referred to: Health Care.

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT RECONSIDERATION AND APPEAL OF UTILIZATION REVIEW NONCERTIFICATION BE EVALUATED BY MEDICAL DOCTORS LICENSED TO PRACTICE IN THIS STATE.

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. 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; and issue the decision in a timely manner pursuant to this section."

Section 2. G.S. 58-50-61(i) reads as rewritten:

"(i) Requests for Reconsideration. -- An insurer may establish procedures for informal reconsideration of noncertifications. 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. 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."

Section 3. G.S. 58-50-61(j) reads as rewritten:

"(j) Appeals of Noncertifications. -- Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification."

Section 4. G.S. 58-50-61(l) reads as rewritten:

"(l) Expedited Appeals. -- An expedited appeal of a noncertification may be requested by a covered person or his or her provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical ~~doctor,~~ doctor licensed to practice medicine in this State, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications."

Section 5. This act is effective when it becomes law and applies to utilization reviews conducted on or after January 1, 2000.

SB 594:
Miscellaneous Insurance Changes

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Miller
Date:	April 21, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 1st Edition		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 currently 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.

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 the manner in which those terms have typically been defined in health insurance legislation.

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 insurance 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 this act effective October 1, 1999.

§ 58-16-5. Conditions of admission.

A foreign or alien insurance company may be admitted and authorized to do business when it:

(1) Deposits with the Commissioner a certified copy of its charter or certificate of organization and a statement of its financial condition and business, in such form and detail as he requires, signed and sworn to by its president and secretary or other proper officer, and pays for the filing of this statement the sum required by law.

(2) Satisfies the Commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact, and that it has been successful in the conduct of such business; that it has, if a stock company, a free surplus and a fully paid-up and unimpaired capital, exclusive of stockholders' obligations of any description of an amount not less than that required for the organization of a domestic company writing the same kinds of business; and if a mutual company that its free surplus is not less than that required for the organization of a domestic company writing the same kind of business, and that such capital, surplus, and other funds are invested in substantial accordance with the requirements of Articles 1 through 64 of this Chapter.

(3) [Note: Repealed by Session Laws 1995, c. 517, s. 6, effective July 29, 1995.]

(4) [Note: Repealed by Session Laws 1987, c. 629, s. 20, effective February 1, 1988.]

(5) Files with the Commissioner a certificate that it has complied with the laws of the state or government under which it was organized and is authorized to make contracts of insurance.

(6) Satisfies the Commissioner that it is in substantial compliance with the provisions of G.S. 58-7-21, 58-7-26, 58-7-30, and 58-7-31 and Article 13 of this Chapter.

(7) Satisfies the Commissioner that it is in compliance with the company name requirements of G.S. 58-7-35.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 594

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

S594-ARN-001

Date_____,1999

Comm. Sub. [X]
Amends Title [X]
First Edition

Sen.

moves to amend the bill on page 1, line 9, by inserting before the word "AND" the following: ", TO AMEND THE LAW GOVERNING AN INSURER'S ACKNOWLEDGEMENT OF A CLAIM,"

and on page 6, between lines 43 and 44, by inserting the following:

"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.'"

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 594

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

S594-ARN-001

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 594

Short Title: Miscellaneous Ins. Changes. (Public)

Sponsors: Senator Miller.

Referred to: Insurance.

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; AND TO PROVIDE FOR UNIFORM APPLICATION OF NEW LAWS TO HEALTH BENEFIT PLANS.

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. 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. This act becomes effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 594
Proposed Committee Substitute S594-PCS4682-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 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 DEPARTMENT OF INSURANCE
MEMORANDUM

April 21, 1999

TO: Senate Insurance Committee

FROM: William K. Hale WKH

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.

S.B. 766: Sections 1 and 2

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.

SB 766:
Service Corporation and HMO Laws

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Miller
Date:	April 20, 1999	**Summary by:**	Linwood Jones
Version:	1st		Committee Counsel

Senate Bill 766 provides that several different insurance laws apply to hospital, medical, and dental service corporations (such as Blue Cross and Delta Dental) and HMOs (Sections 1 and 2).

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 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 HMOs.

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 insurance agents generally, regardless of whether those laws are in the primary Article governing agents (Article 33 of Chapter 58 of the General Statutes) or elsewhere.

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 service corporations, HMOs, multiple employer welfare arrangements, and self-insured workers' compensation arrangements.

Section 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 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.

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.

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE — April 21, 1999

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Cinnie Ramquist	NCSOS
Carey Johnson Betts	NCNA
Joe Johnson	N/A
Paul Stock	NC Bankers ASSN.
Sam Johnson	atty
Michael B Shivar	Insurance Premium Finance
Harold H. Webb	" " "
Maureen Dorsey	NCNA / NC American College of Nurse Midwives
Joanne Kelly	NC Nurses Association
Bob Price	Jordan Price Wall
Rick Pierce	NC Assn. of Ins Services Co.
Ronnie Finn	" " " " "
Amy Fulbright	Hunton & Williams
BF Seagle	The Travelers
Greg Fortin	NCINS
Mary Shaw	NCSA
Michelle McPherson	NC Atty Gen
Ken Wright	BCBSNC
Paul Mahoney	NC ASSN of HEALTH PLANS
Alicia Gregory	Poyner & Spruill
Terry Allen	State Treasurer
B Summers	NC Equity

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE — APRIL 21, 1999

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Lee Hines	Dept. of State Treasurer
Margaret Mulkey	NCNA
Rachel Morgan	Dept. of Ins.
Curt Willis	NC Bd Ins. Assoc.
John Johnson	Liberty Corp
Robert Jernigan	N.C. Property & Casualty Assn.

SENATE INSURANCE COMMITTEE MEETING AGENDA

APRIL 28, 1999

S513	PRES. DRUG ID CARD	SEN. WELLONS
S643	INSURANCE PREMIUM FINANCING	SEN. REEVES
S839	INSURANCE CLAIMS PAYMENTS/Y2K	SEN. WELLONS
S946	SUBSTANCE ABUSE/DIRECT PAY	SEN. W. MARTIN
S1089	HEALTH INS. REPORT	SEN. HARRIS
S1090	HEALTH INS./ANY WILLING PROVIDER	SEN. HARRIS
S1108	HEALTH INS./CONSUMER ADVOCATE	SEN. HARRIS
S1109	PRES. DRUGS FUNDS	SEN. HARRIS

SENATE INSURANCE COMMITTEE

MINUTES

APRIL 28, 1999

The Senate Insurance Committee held its meeting on April 28, 1999 at 10:00 a.m. in room 1027 of the Legislative Building.

The Chairman, Senator Wellons, presided, and ten members were present.

Senate Bill 643, Insurance Premium Financing, was proposed by Senator Reeves. Senator Harris moved the adoption of the Proposed Committee Substitute, and the members approved. Senator Reeves called on Sam Johnson, an attorney, to explain the bill. Senator Harris then moved that the Proposed Committee Substitute be given a favorable report. This motion passed unanimously.

Senator Wellons asked Senator Reeves to Chair the Committee while he presented S839, Insurance Claims Payments/Y2K. Senator Ballantine moved the adoption of the Proposed Committee Substitute. Bill Hale, of the Insurance Department, gave a brief explanation, and Senator Rand moved for a favorable report for the Proposed Committee Substitute.

Senator Wellons presented S513 Pres. Drug ID Card. Senator Ballantine moved to adopt the Proposed Committee Substitute, and the members agreed. Linwood Jones, the Committee Counsel explained the Committee Substitute. Senator Wellons offered an amendment, and moved its adoption. This motion carried. Fran Preston, of the Retail Merchants Bureau, explained the bill, and the Committee voted to give the Proposed Committee Substitute, as amended, a favorable report.

Senator Harris, the sponsor of Senate Bills 1089, 1090, 1108, and 1109 presented a Proposed Committee Substitute, and Senator Metcalf moved its adoption. The title of the Substitute was Managed Care Study. This would authorize the Legislative Research Commission to study issues of managed care which are addressed in these bills. Senator Rand moved the adoption of the Committee Substitute, and that it be given a favorable report. The members concurred.

The Chairman announced that Senate Bill 946 Substance Abuse/Direct Pay would not be considered today due to the time constraints of Crossover, and since the Companion Bill has passed the House.

Senator Harris moved to amend the Agenda so that S533 Health Care Pilot Program which was introduced by Senator Carter could be presented. After a brief discussion by the Committee, the Chairman decided to hold the bill.

There being no further business, the meeting was adjourned.

Allen Wellons MH

Senator Allen Wellons
Chairman

Margaret M. Hogan

Margaret M. Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE COMMITTEE REPORT
Senator Allen Wellons, Chair

Wednesday, April 28, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **513** Presc. Drug ID Card

Draft Number:	PCS7678
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **643** Insurance Premium Financing

Draft Number:	PCS4687
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **839** Insurance Claims Payments/Y2K

Draft Number:	PCS4690
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **1089** Commisioner of Insurance/Health Ins. Rpt.

Draft Number:	PCS3806
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 4

Committee Clerk Comment: None

SB 643:
Insurance Premium Financing

BILL ANALYSIS

Committee:	Insurance	**Introduced by:**	Sen. Reeves
Date:	April 27, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 1st 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.

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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 643

Short Title: Insurance Premium Financing. (Public)

Sponsors: Senator Reeves.

Referred to: Insurance.

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 3.1. G.S. 58-35-55 is amended by adding a new subsection to read:

"(g) A premium finance company, insurance company, or insurance agent or agency that commits a de minimis technical violation of this section is not liable to a third party absent a showing of (i) willful misconduct or (ii) material damages proximately caused by the violation."

Section 4. G.S. 58-35-65 reads as rewritten:

"**§ 58-35-65. Delivery of copy of insurance premium finance agreement to insured.**

Before the due date of the first installment payable under an insurance premium finance agreement, the insurance premium finance company holding the agreement or the insurance agent shall ~~deliver~~ cause to be delivered to the insured, or mail to ~~him~~ the insured at ~~his~~ the insured's address as shown in the agreement, a copy of the agreement."

Section 5. G.S. 58-35-80(b) reads as rewritten:

"(b) The amount of any such refund credit shall represent at least as great proportion of the service charge, if any, as the sum of the periodic balances after the month in which prepayment is made bears to the sum of all periodic balances under the schedule of installments in the agreement. Where the amount of the refund credit for anticipation of payment is less than ~~one dollar ($1.00),~~ five dollars ($5.00), no refund need be made. This section does not relieve the premium finance company of its duty to report and deliver these unrefunded monies to the State Treasurer in accordance with G.S. 116B-29(b)."

Section 6. G.S. 58-35-85 reads as rewritten:

"**§ 58-35-85. Procedure for cancellation of insurance contract upon default; return of unearned premiums; collection of cash surrender value.**

When an insurance premium finance agreement contains a power of attorney or other authority enabling the insurance premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be cancelled unless the cancellation is effectuated in accordance with the following provisions:

(1) Not less than 10 days' written notice ~~be mailed~~ is sent by personal delivery, first-class mail, electronic mail, or facsimile transmission to the last known address of the insured or insureds shown on the insurance premium finance agreement of the intent of the insurance premium finance company to cancel his or their insurance contract or contracts unless the defaulted installment payment is received. ~~A notice~~ Notification thereof shall also be ~~sent~~ provided to the insurance agent.

(2) After expiration of the 10-day period, the insurance premium finance company shall send the insurer a request for cancellation 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. If a mortgagee or other loss payee is shown on the insurance contract, the insurer shall notify the mortgagee or loss payee in accordance with G.S. 58-41-15(b).

(4a) If an insurer receives notification from an insurance agent or premium finance company that the initial down payment for the premium being financed has been dishonored by a financial institution or 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~~ contract, computed pro rata, 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 gross unearned premium shall be calculated upon the deposit premium and the insurer shall return the gross unearned premium, calculated on a pro rata basis, to the premium finance company no later than 30 days after the effective date of cancellation.

(6) The provisions of this section relating to request for cancellation by the insurance premium finance company of an insurance contract and the return by an insurer of unearned premiums to the insurance premium finance company, also apply to the surrender by the insurance premium finance company of an insurance contract providing life insurance and the payment by the insurer of the cash value of the contract to the insurance premium finance company, except that the insurer may require the surrender of the insurance contract.

(7) The insurer shall not deduct from any return premiums any amount owed to the insurer for any other indebtedness owed to the insurer by the insured on any policy or policies other than those being financed under the premium finance agreement.

(8) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund the excess to the insured as soon as possible, but in no event later than 30 days of receipt of the return premium, provided that no refund shall be required if it is in an amount less than five dollars ($5.00). This subdivision does not relieve the premium finance company of its duty to report and deliver these unrefunded monies to the State Treasurer in accordance with G.S. 116B-29(b).

(9) In the event that a balance due the premium finance company remains on the account after the cancellation of the agreement, the outstanding balance may earn interest at the rate stated in the agreement until paid in full."

Section 7. G.S. 58-35-40 reads as rewritten:

"**§ 58-35-40. Rebates and inducements prohibited; assignment of insurance premium finance agreements.**

(a) ~~No insurance premium finance company, and no employee of such a company shall pay, allow, or offer to pay or allow in any manner whatsoever to an insurance agent or any employee of an insurance agent, or to any other person, or as an inducement to the financing of an insurance policy with the insurance premium finance company or after any such policy has been financed, any rebate whatsoever, either from the service charge for financing specified in the insurance premium finance agreement or otherwise, or~~ No insurance premium finance company shall pay, allow, or offer to pay or allow payment to an insurance agent, and no insurance agent shall accept from a company, a rebate as an inducement to the financing of an insurance policy with the company. No insurance premium finance company shall give or offer to give to an insurance agent, and no insurance agent shall accept from a company, any valuable consideration or inducement of any ~~kind~~ kind, directly or indirectly, other than an article of merchandise not exceeding one dollar ($1.00) in value which shall have thereon the advertisement of the insurance premium finance ~~company; but an~~ company. An insurance premium finance company may purchase or otherwise acquire an insurance premium finance agreement ~~provided that it conforms to this Article in all respects,~~ from another insurance premium finance company with recourse against the insurance premium finance company on such terms and conditions as may be mutually agreed upon by the parties, if the agreement complies with the requirements of this Article. ~~and such terms~~ The terms and conditions of the agreement shall be subject to the approval of the Commissioner.

(b) No filing of the assignment or notice thereof to the insured shall be necessary to the validity of the written assignment of an insurance premium finance agreement as against creditors or subsequent purchases, pledges, or encumbrancers of the assignor.

(c) As used in this section, the term 'insurance premium finance company' includes employees of the company; the term 'insurance agent' includes employees of the insurance agent; and the word 'company' means an insurance premium finance company."

Section 8. This act becomes effective October 1, 1999, and applies to premium finance agreements or contracts entered into on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 643
Proposed Committee Substitute S643-PCS4687-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."

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.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

April 28 , 1999

TO: Senator Allen Wellons

FROM: William K. Hale WKH

SUBJECT: S.B. 839 – Insurance Claims Payments/Y2K

This is in response to questions about the need for this bill and whether the Department of Insurance needs additional funding to administer the proposed law.

First, it is not clear whether there is authority in existing law for the Commissioner of Insurance to require insurers or third party administrators to make interim claims payments as the bill provides. Therefore, I believe this temporary measure is a good idea and should be enacted by the General Assembly. Its purpose, to prevent the disruption of the delivery of health care services, is very worthwhile.

Second, after analyzing the bill, it is my conclusion that the Department of Insurance would be able to administer this measure without requiring additional resources.

The Commissioner, as well as almost every other state insurance regulator, has taken some steps to try to assure that there will be few, if any, problems because of Year 2000 computer problems. Earlier this year the Commissioner sent a bulletin to North Carolina insurers requiring certain information about their efforts to avoid Year 2000 problems. The bulletin appears on the other side of this memorandum.

North Carolina Department of Insurance

Jim Long, Commissioner

LEGAL DIRECTIVE

Number 99-D-1

To: All North Carolina Domestic Insurance Companies and Entities ("Domestic Insurers")

Subject: Management Discussion and Analysis Disclosure of Year 2000 Information

Date: February 4, 1999

ATTENTION: PRESIDENT OR CHIEF EXECUTIVE OFFICER

This directive is to emphasize the requirement for adequate and appropriate management discussion and analysis (MD&A) disclosure specifically related to the issue(s) surrounding the Year 2000. In addition to the guidance provided in the NAIC Annual Statement Instructions, North Carolina provides the following instructions:

- Domestic insurers filing annual statements for calendar year 1998 with the Department must include within the MD&A an analysis of their Year 2000 issues. The disclosure shall contain meaningful information and is expected to address the following in detail and quantified, as applicable:

    1. the Domestic Insurer's preparedness for the Year 2000;

    2. cost incurred in the periods presented in the Annual Statement and cost to be incurred in future reporting periods to address Year 2000 issues;

    3. risks associated with Year 2000; and

    4. the Domestic Insurer's contingency plan.

- Members of an affiliated insurance group that have a single Year 2000 plan may use the same disclosure statements in the MD&A.

Domestic Insurers may want to utilize the Securities and Exchange Commission's Release Number 33-7558. Section III (A) as a guide for the types and form of disclosures. The release provides pertinent information and is enclosed for reference. The entire release may be accessed at http://www.sec.gov/rules/concept/33-7558.htm.

Any questions concerning this directive should be directed to Mr. Raymond Martinez, Deputy Commissioner of the Financial Evaluation Division at RMartine@mail.doi.state.nc.us or at (919) 733-5633, extension 240.

James E. Long
Commissioner of Insurance

SB 839:
Insurance Claims Payments/Y2K

BILL ANALYSIS

Committee:	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 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 839

Short Title: Insurance Claims Payments/Y2K. (Public)

Sponsors: Senator Wellons.

Referred to: Insurance.

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 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, and 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 839
Proposed Committee Substitute S839-PCS4690-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, 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 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 513

Short Title: Presc. Drug ID Card. (Public)

Sponsors: Senators Wellons; Albertson, Cochrane, Dalton, Foxx, Garrou, Gulley, Kinnaird, Lucas, Purcell, Reeves, and Weinstein.

Referred to: Insurance.

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 conform to the format adopted by the National Council for Prescription Drug Programs and shall include the following:

(1) Identification number of the insured's dependents covered under the health benefit plan.

(2) Name of the insured's dependents covered under the health benefit plan.

(3) Date of birth of the insured's dependents covered under the health benefit plan.

(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, and
(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."

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
Senate Bill 513

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

S513-ARN-001 Page 1 of __

Date 4-28 ,1999

Comm. Sub. [ ]
Amends Title [ ]
PCS Edition

Sen. Wellons

moves to amend the bill on page 2, lines 5-7 by deleting those lines;

and on page 2, line 44, by adding the following sentence after the period: "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."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 513
Proposed Committee Substitute S513-PCS2752-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 (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.

A health benefit plan shall meet the requirements of this section if the data elements and format required under this section are incorporated into an identification card used by the plan for all new services covered by the plan. 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."

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 1089:
Managed Care Study

BILL ANALYSIS

Committee:	Insurance	**Introduced by:**	Sen. Harris
Date:	April 28, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 1st Edition		Committee Counsel

The Proposed Committee Substitute for Senate Bill 1089 rolls together four bills (SB 1089, 1090, 1108, and 1109) into an LRC study on managed care.

The bill authorizes the Legislative Research Commission to study the following issues:

- Quality of care
- Cost of care and cost-containment measures used by managed care (such as utilization review, case management, etc.)
- Provider selection by plans, including a study of "any willing provider" legislation
- A consumer insurance advocate to represent consumers on insurance issues
- Periodic reporting by the Commissioner of Insurance to the General Assembly and Governor on the status of managed care in North Carolina
- Funding a program to provide prescription drugs to financially-needy individuals who have life-threatening conditions or illnesses
- Liability of providers and managed care plans
- Any other relevant issues on managed care

The study, if funded by the LRC, would report back to the short session next year. In its discretion, the Commission chairs may appoint the members of the House and Senate Insurance Committees to study these issues, although they are free to appoint anyone to the committees.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1089
Proposed Committee Substitute
S1089-CSRN-001

Short Title: Managed Care Study. (Public)

Sponsors:

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A STUDY OF MANAGED CARE.

The General Assembly of North Carolina enacts:

Section 1. The Legislative Research Commission may study the following issues relating to managed care:

(1) Quality of care.

(2) Cost of care and cost-containment measures of managed care plans.

(3) Provider selection and retention, including whether any provider willing to meet the terms, conditions, and standards, including the terms of reimbursement, of a managed care plan should be allowed to participate in the plan (SB 1090).

(4) The establishment of a consumer's insurance advocate to appear on behalf of consumers in actions and proceedings involving insurance products and services, to publish consumer-oriented insurance information, to respond to consumer complaints, to advocate on behalf of State employees with respect to insurance products and

services provided to those employees, and to report on its activities (SB 1108).

(5) Requiring the Commissioner of Insurance to submit reports on the status of managed care to the General Assembly and Governor, including information on outcome data, utilization review, provider access, and related matters (SB 1089).

(6) Providing funds to pay for prescription drugs for certain persons ineligible for Medicaid but whose income is no more than 200% above poverty level, and who has a life-threatening disease or condition for which the the drugs have been prescribed (SB 1109).

(7) Liability of providers and managed care plans.

(8) Any other issues concerning the delivery of managed care.

Section 2. In order to facilitate deliberation on any legislation recommended to the 2000 Regular Session, the Commission may consider appointing members of the Insurance Committees of the House and Senate to the study committee that examines the issues in Section 1 of this act.

Section 3. The Commission may report its findings and recommendations to the 2000 Regular Session of the 1999-2000 General Assembly.

Section 4. This act becomes effective July 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1089

Short Title: Commissioner of Insurance/Health Ins. Rpt. (Public)

Sponsors: Senator Harris.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE COMMISSIONER OF INSURANCE TO REPORT TO THE GENERAL ASSEMBLY AND THE GENERAL PUBLIC ON THE STATUS OF HEALTH INSURANCE.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2001, G.S. 58-2-120 reads as rewritten:

"**§ 58-2-120. Reports of Commissioner to the Governor and General Assembly.**

(a) 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 General Assembly any change which in his 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.

(b) The Commissioner shall biennially submit to the General Assembly, through the Governor, a report on health benefit plans regulated by this Chapter. The report shall include information on outcome data, utilization review, access to providers, enrollee and provider use of and satisfaction with grievance procedures, and insurer compliance with other requirements of this Chapter. The Commissioner shall make the report available to the general public through its consumer services office."

Section 2. This act is effective when it becomes law.

S1090:
Health Ins/Any Willing Provider

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Sen. Harris
Date:	April 23, 1999	**Summary by:**	Ed Rossi
Version:	1st Ed.		Committee Co-Counsel

SUMMARY: ***Senate bill 1090 allows patients obtain coverage for treatment rendered by health care providers who have no contractual relations with the patient's insurer or managed care organization. In order to obtain reimbursement under the provisions of this bill, out-of-network providers must agree to the terms and conditions of the plan that are applicable to all in-network-providers.***

BILL ANALYSIS: Under the provisions of this bill, before an out-of-network provider can obtain reimbursement from a patient's health plan, the provider must accept all the terms and conditions that apply to providers that are in the patient's health benefit plan provider network. This means that the out-of-network provider has to agree to:

1. Charge the fees charged by network providers.
2. Accept the reimbursement accepted by network providers.
3. Conform to the utilization review criteria that apply to network providers.

BACKGROUND: The provisions in Senate bill 1090 are similar to the provisions found in G.S. § 58-51-37, which apply only to pharmacies.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1090

Short Title: Health Ins/Any Willing Provider. (Public)

Sponsors: Senator Harris.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE GROUP HEALTH BENEFIT PLANS TO PERMIT ENROLLEES TO RECEIVE HEALTH CARE SERVICES FROM ANY PROVIDER WILLING TO ACCEPT THE TERMS AND CONDITIONS OF THE HEALTH BENEFIT PLAN.

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. Health benefit plans to allow services to be provided by any provider willing to accept terms and conditions.**

(a) Every insurer providing a health benefit plan shall allow its insureds or enrollees to receive health care covered under the plan from any provider of the insured's or enrollee's choice if the provider agrees to accept and abide by the terms and conditions of the health benefit plan related to provider fees and reimbursement, utilization review, and any other terms, conditions, standards, and procedures applicable to all providers under the health benefit plan. If the health benefit plan provides health services through a provider network, the fee paid by an insurer to a provider outside of the plan's network shall be not less than the fee paid to a provider within the plan's network for the same service.

(b) Nothing in this section shall be construed to require a health benefit plan to reimburse a provider for services not covered under the plan.

(c) As used in this section, the terms 'health benefit plan' and 'insurer' have the same meaning as applied to those terms by G.S. 58-3-200."

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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1108

Short Title: Health Ins./Consumer Advocate. (Public)

Sponsors: Senator Harris.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH IN THE DEPARTMENT OF ADMINISTRATION THE OFFICE OF CONSUMERS' INSURANCE ADVOCATE.

The General Assembly of North Carolina enacts:

Section 1. Article 9 of Chapter 143B of the General Statutes is amended by adding the following new Part to read:

"Part 14B. Office of Consumers' Insurance Advocate.

"**§ 143B-403.10. Office of Consumers' Insurance Advocate.**

(a) There is established in the Department of Administration the Office of Consumers' Insurance Advocate. The Office shall consist of an advocate who shall be an attorney licensed to practice in this State. The advocate shall be appointed by and serve at the pleasure of the Governor. The advocate may employ an individual in the position of deputy advocate, and other personnel, if funds are appropriated for these positions. No person employed as advocate or deputy advocate shall engage in the private practice of law while employed as advocate or deputy advocate.

(b) The duties and responsibilities of the Consumers' Insurance Advocate are as follows:

(1) To appear as a party or otherwise, on behalf of consumers of this State of products or services provided by an insurance company subject to the jurisdiction of the Commissioner of Insurance and to the provisions of Chapter 58 of the General Statutes;

(2) To appear in the same representative capacity as specified in subdivision (1) of this subsection in similar administrative

proceedings affecting the consumers of this State before any federal administrative agency or body which has regulatory authority over products or services purchased by consumers;

(3) To initiate proceedings, in the same representative capacity as specified in subdivision (1) of this subsection, by complaint or otherwise, before any federal or State administrative agency before which the advocate may be otherwise authorized to appear, with respect to matters properly within the cognizance of those agencies;

(4) To initiate or intervene, in the same representative capacity as specified in subdivision (1) of this subsection, as of right or otherwise appear in any judicial proceeding involving or arising out of any action taken by an administrative agency in a proceeding in which the advocate is authorized to appear under this subsection;

(5) To publish by available means, including Internet access, information the advocate deems to be in the public interest relating to the duties and purposes of the Office of Consumers' Insurance Advocate, and relating to findings, research, and studies conducted by the Office, except for information that is confidential or privileged as otherwise provided by law;

(6) To receive and respond to consumer complaints pertaining to insurance matters;

(7) To hear complaints and to present and advocate positions affecting rates or benefits for any insurance products and services afforded to State employees and may for this purpose appear before any State office or agency providing or administering the benefits;

(8) To report quarterly activities, decisions, information obtained, and expenditures of the advocate's office. The report shall be submitted to the Governor and to the Commissioner of Insurance. The advocate shall report annually to the General Assembly, upon its convening, on its activities and expenditures."

Section 2. There is appropriated from the General Fund to the Department of Administration the sum of one hundred forty-three thousand two hundred eighteen dollars ($143,218) for the 1999-2000 fiscal year and the sum of one hundred forty-three thousand two hundred eighteen dollars ($143,218) for the 2000-2001 fiscal year for the Office of Consumers' Insurance Advocate established under this act.

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

S1109:
Funds for Prescription Drugs

BILL ANALYSIS.

Committee:	Senate Insurance	**Introduced by:**	Sen. Harris
Date:	April 27, 1999	**Summary by:**	Ed Rossi
Version:	1st. Ed.		Committee Co-Counsel

SUMMARY: Senate bill 1109 seeks to appropriate $4,000,000 to the Department of Health and Human Services ($2,000,000 FY 1999-2000 / $2,000,000 FY 2000-20001). This money is to be used to pay for prescriptions for people who:

- *Have been prescribed medication to treat a life threatening illness.*
- *Are over age 55 and not eligible for full Medicaid benefits and not covered for prescription drugs by insurance.*
- *Whose income is not more than 200% of the federal poverty level.*

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1109

Short Title: Funds for Presc. Drugs. (Public)

Sponsors: Senator Harris.

Referred to: Insurance.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO PROVIDE PRESCRIPTION DRUGS TO CERTAIN PERSONS NOT ELIGIBLE FOR MEDICAID AND WHO HAVE LIFE-THREATENING MEDICAL CONDITIONS.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health, the sum of two million dollars ($2,000,000) for the 1999-2000 fiscal year, and the sum of two million dollars ($2,000,000), for the 2000-2001 fiscal year. These funds shall be used to pay the cost of prescription drugs for persons:

(1) Over the age of 55, not eligible for full Medicaid benefits, and not receiving coverage for prescription drugs under any other program or policy of insurance;

(2) Whose income is not more than two hundred percent (200%) of the federal poverty level; and

(3) Who have been diagnosed with a life-threatening disease or condition for which the drugs have been prescribed.

These funds shall be used to pay the cost of prescription drugs for the treatment of a life-threatening disease or condition. Payment shall be not more than Medicaid cost including rebates. The Division shall develop criteria to maximize the efficient and effective distribution of these drugs.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 533
Proposed Committee Substitute S533-PCS7676-LN

Short Title: Health Care Pilot Program. (Public)

Sponsors:

Referred to:

March 25, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A HEALTH CARE PILOT PROGRAM IN BUNCOMBE COUNTY.

Whereas, it is essential that the health care delivery and benefit system is tailored to meet a particular community's needs while maintaining safeguards so as to increase the affordability, efficiency, and fairness of health care coverage for small employers; and

Whereas, an area small business health care purchasing alliance pilot program would allow for a limited time and in a control manner the relaxation of some State mandates in order to inject flexibility and advantages to small employers and their employees while maintaining supervision by appropriate State agencies; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. The Buncombe County Area Small Business Health Care Purchasing Alliance Pilot Project is hereby established as follows:

(1) The State Health Plan Purchasing Alliance Board shall establish the Buncombe County Area Small Business Health Care Purchasing Alliance (the "Alliance") pursuant to G.S. 143-627 that shall possess the powers and duties of the Alliance as set forth in G.S. 143-628.

(2) The Buncombe County Medical Society shall serve as the Community Sponsor for the Buncombe County Area Small Business Health Care Purchasing Alliance.

(3) The Alliance shall design benefit plans tailored to the designated market area's needs.

(4) The Alliance shall coordinate enrollment of member small employers into the Alliance and notify them of the availability of coverage.

(5) The Alliance may solicit competitive bids from Accountable Health Carriers to offer the plan or plans developed by the Alliance to employees of member small employers.

(6) The Pilot Project shall at all times remain subject to the jurisdiction in regulation of the North Carolina Department of Insurance and the State Health Plan Purchasing Alliance Board.

(7) The Alliance shall have the flexibility to develop reasonable measures to ensure enrollment stability and fiscal solvency while encouraging efficiency.

Section 2. The Pilot Project is exempt from only such general or local law or rule to the contrary, including inter alia, contrary provisions of G.S. 143-621 through G.S. 143-636 (Health Care Purchasing Alliance Act), G.S. 58-49-30 through G.S. 58-49-65 (Multiple Employer Welfare Arrangements). The Pilot Project is exempt from G.S. 58-50-100 through G.S. 58-50-155 (North Carolina Small Employer Group Health Coverage Reform Act) when the number of employee enrollees exceeds 150.

Section 3. Commencing upon the date this act becomes law, the Pilot Project shall be created and remain in existence for a period of four years, at which time it may be continued, modified, or terminated upon the decision of the General Assembly. The Alliance shall present a report with recommendations to the Board before the expiration of that time. The North Carolina Department of Insurance may provide input and findings to the Board, in its discretion. The Board shall report to this General Assembly on or before the fifth year after passage of this act, presenting its findings and recommendations as to whether the Pilot Project should be extended, or extended as modified, to other parts of North Carolina for the benefit of employees of small employers.

Section 4. The Pilot project may receive funds pursuant to G.S. 143-628(17).

Section 5. The community sponsor shall submit to the State Health Plan Purchasing Alliance Board a proposed plan of operation of the Alliance.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 533

Short Title: Health Care Pilot Program. (Public)

Sponsors: Senators Carter and Metcalf.

Referred to: Rules and Operations of the Senate.

March 25, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A HEALTH CARE PILOT PROGRAM IN BUNCOMBE COUNTY.

The General Assembly of North Carolina enacts:

Section 1. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

4-28-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Michael Shivar	NC Assoc of Premium Serv Cos
Ronnie Finn	" " " "
[illegible]	[illegible]
[illegible]	Premium Insurance
[illegible]	NCSOS
Paul Stock	NC Bankers
[illegible]	Moore & Van Allen
[illegible]	Poyner & Spruill
Perri Morgan	NFIB
Oak McKee	Scenic North Carolina, Inc.
Starla McKinney	NC DOT
[illegible]	MOMSI
[illegible]	UNC-CH
Walter Price	Charlotte Chamber
BF Seagle III	Travelers

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Schoen	NCNA
Hugh Tilson	NC hosp. Assoc
Bill Lamb	Div. of Agings
Steve Wadsworth	NC Farm Bureau
Robert Joyce	State Health Plan
John Phelps	NCLM
Amy Jo Bain	NC Medical Society
Vandana Shah	N.C. Atty Gen's Office.
Robert PASchal	Young, Moore & Henderson
Stephen D. Keene	NC Medical Society
Alan Miles	Bailey & Dixon LLP
John McMillan	BCBS
Ellen DePue	Novartis
Jim Carey	Novartis
Alicia Gregory	Poyner & Spruill

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Ken Wright	BCASNC
Brad Gelbach	BC BSNC

SENATE INSURANCE COMMITTEE MEETING

MAY 19, 1999

AGENDA

H294	LIFE AND HEALTH INS. AMENDMENTS -	REP. HURLEY
H296	INSURANCE TECHNICAL CHANGES	REP. HURLEY
H306	INSURANCE AMENDMENTS	REP. HARDAWAY
H1119	CHILDREN/DISABLE ANESTH. DENTAL C	REP. WRIGHT

SENATE INSURANCE COMMITTEE MEETING MINUTES

MAY 19, 1999

The Senate Insurance Committee held a meeting on Wednesday, May 19, 1999 at 10:00 a.m. in room 1027 of the Legislative Building.

The Chairman, Senator Wellons, presided. He began by announcing that H 294, Life and Health Ins. Amendments, which was introduced by Rep. Hurley would not be taken up today.

House Bill 296, Insurance Technical Changes, was the next agenda item. Rep. Hurley, the bill sponsor called on Bill Hale of the Insurance Department to explain the bill. After the explanation, Senator Soles moved for a Favorable Report and the Committee concurred.

House Bill 306, Insurance Amendments, was introduced by Rep. Hardaway. Bill Hale of the Insurance Department also explained this bill. A Proposed Committee Substitute was adopted. After the explanation, and a discussion about mortality and annuity tables, Senator Miller moved for a Favorable Report for the Proposed Committee Substitute. This motion passed.

House Bill 1119, Children/Disable Anesth. Dental C, was introduced by Rep. Wright. Senator Wellons handled the bill for the sponsor, and he asked Senator Reeves to take the Chair. After a brief explanation, Senator Webster moved for a Favorable Report and the motion passed.

There being no further business, the meeting was adjourned.

Senator Allen Wellons
Chairman

Margaret Hogan

Margaret M. Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Wednesday, May 19, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS)**296** Insurance Technical Changes/AB
Sequential Referral: None
Recommended Referral: None

H.B.(CS)**1119** Children/Disable Anesth.Dental Care.
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)**306** Insurance Amendments/AB
Draft Number: PCS 7237
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 3

Committee Clerk Comment: None

HB 296:
Insurance Technical Changes/AB

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Rep. Hurley
Date:	May 12, 1999	**Summary by:**	Linwood Jones
Version:	Second Edition		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 58-71-90, 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 makes a conforming change relating to the repeal of G.S. 58-3-125 in 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 added 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 existing 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).

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 Reinsurance Facility. This section also increases the quorum of the board from 5 to 7 members, increases the number 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. Reserved. The original version of the bill would have deleted references to "Articles 1 through 64 of this Chapter" and replaced 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 language 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, except for Part III, which becomes effective September 1, 1999..

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.

HB 306 (2ND EDITION): Insurance Amendments

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Rep. Hurley
Date:	May 12, 1999	**Summary by:**	Linwood Jones Committee Counsel

SUMMARY: ***This bill makes substantive changes to various insurance laws.***

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.

Note: SB 427, the Senate companion bill to this bill, was amended by the Senate Insurance Committee to change the method for determining who bears the costs of transcripts in Beach and FAIR Plan hearings.

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 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. 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.

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 (e) 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
Committee Substitute Favorable 4/12/99
Third Edition Engrossed 4/13/99
Proposed Senate Committee Substitute H306-PCS7237-RN

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 pre-existing 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 (e) 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 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 306
Committee Substitute Favorable 4/12/99
Third Edition Engrossed 4/13/99
Proposed Senate Committee Substitute H306-PCS7237-RN

Short Title: Insurance Amendments/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT HEARINGS AND ADOPT CERTAIN RULES RELATED TO THE BEACH AND FAIR PLANS, TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPROVE ADDITIONAL BEDS FOR CONTINUING CARE RETIREMENT FACILITIES UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE LAW PROHIBITING DISCRIMINATION IN THE TREATMENT OF HANDICAPPED AND DISABLED PERSONS, TO GOVERN MANAGED CARE WITH REGARD TO WORKERS' COMPENSATION, TO EXEMPT COMMERCIAL AIRCRAFT INSURANCE FROM STATE REGULATION, TO REQUIRE ADDITIONAL INFORMATION FROM SURPLUS LINES LICENSEES, TO CLARIFY WHICH SECTIONS OF THE GENERAL STATUTES APPLY TO SURPLUS LINES INSURANCE, TO AUTHORIZE THE SECRETARY OF REVENUE TO PROVIDE THE NORTH CAROLINA SELF-INSURANCE GUARANTY ASSOCIATION WITH INFORMATION ON SELF-INSURERS' PREMIUMS, TO REPEAL THE REQUIREMENT FOR A BIENNIAL REPORT FROM THE DEPARTMENT OF INSURANCE, TO REPEAL THE AGENCY BUSINESS CESSATION LAW, TO AUTHORIZE THE COMMISSIONER TO ADOPT RULES RECOGNIZING NEW ANNUITY MORTALITY TABLES, AND TO CLARIFY THAT MECHANICAL BREAKDOWN AND RELATED

INSURANCE ARE NOT UNDER THE JURISDICTION OF THE RATE BUREAU.

The General Assembly of North Carolina enacts:

PART I. HEARINGS AND FAIR AND BEACH PLANS APPEALS.

Section 1.1. G.S. 58-2-50 reads as rewritten:

"**§ 58-2-50. ~~Examinations~~ Examinations, hearings, and investigations.**

All ~~examinations~~ examinations, hearings, and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. All hearings shall, unless otherwise specially provided, be held in accordance with this Article and Article 3A of Chapter 150B of the General Statutes and at a time and place designated in a written notice given by the Commissioner to the person cited to appear. The notice shall state the subject of inquiry and the specific charges, if any."

Section 1.2. G.S. 58-45-50 reads as rewritten:

"**§ 58-45-50. Appeal from acts of Association to Commissioner; appeal from Commissioner to superior court.**

Any person or any insurer who may be aggrieved by an act, ruling or decision of the Association other than an act, ruling or decision relating to the cause or amount of a claimed loss, may, within 30 days after ~~such ruling~~ the ruling, appeal to the Commissioner. Any hearings held by the Commissioner ~~pursuant to such an~~ under the appeal shall be in accordance with ~~the procedure set forth in G.S. 58-2-50.~~ rules adopted by the Commissioner: Provided, however, the Commissioner is authorized to appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ those appeals and a ruling based upon ~~such~~ the hearing shall have the same effect as if heard by the Commissioner. All persons or insureds aggrieved by any order or decision of the Commissioner may appeal as is provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than ~~20~~ 10 days before each hearing, the appellant shall file with the Commissioner or ~~his~~ the Commissioner's designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. Each ~~such~~ hearing shall be recorded and may be transcribed. ~~The~~ If the matter is between an insurer and the Association, the cost of ~~such~~ the recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by the other party. If the matter is between an insured and the Association, the

cost of transcribing shall be borne equally by the appellant and appellee; provided that the Commissioner may order the Association to pay recording or transcribing costs for which the insured is financially unable to pay. Each party shall, on a date determined by the Commissioner or ~~his~~ the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or ~~his~~ the designated hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the designated hearing officer shall then issue an order."

Section 1.3. G.S. 58-46-30 reads as rewritten:

"**§ 58-46-30. Appeals; judicial review.**

The association shall provide reasonable means, to be approved by the Commissioner, whereby any person or insurer affected by any act or decision of the administrators of the Plan or underwriting association, other than an act or decision relating to the cause or amount of a claimed loss, may be heard in person or by an authorized representative, before the governing board of the association or a designated committee. Any person or insurer aggrieved by any decision of the governing board or designated committee, may be appealed to the Commissioner within 30 days ~~from~~ after the date of ~~such~~ the ruling or decision. The Commissioner, after a hearing held ~~pursuant to the procedure set forth in G.S. 58-2-50,~~ under rules adopted by the Commissioner, shall issue an order approving or disapproving the act or decision with respect to the matter ~~which~~ that is the subject of appeal. The Commissioner ~~is authorized to~~ may appoint a member of ~~his~~ the Commissioner's staff as deputy commissioner for the purpose of hearing ~~such~~ the appeals and a ruling based on ~~such~~ the hearing ~~shall have~~ has the same effect as if heard by the ~~Commissioner personally.~~ Commissioner. All persons or insurers or their representatives aggrieved by any order or decision of the Commissioner may appeal as provided ~~by the provisions of~~ in G.S. 58-2-75.

No later than ~~20~~ 10 days before each hearing, the appellant shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellee a written statement of ~~his~~ the appellant's case and any evidence ~~he~~ that the appellant intends to offer at the hearing. No later than five days before ~~such~~ the hearing, the appellee shall file with the Commissioner or ~~his~~ the designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ that the appellee intends to offer at the hearing. Each ~~such~~ hearing shall be recorded and may be transcribed. ~~The~~ If the matter is between an insurer and the Association, the cost of ~~such~~ the recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by the other party. If the matter is between an insured and the Association, the cost of transcribing shall be borne equally by the appellant and appellee; provided that the Commissioner may order the Association to pay recording or transcribing costs for which the insured is financially unable to pay. Each party shall, on a date determined by the Commissioner or ~~his~~ the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or ~~his~~ the designated

hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the designated hearing officer shall then issue an order."

PART II. CONTINUING CARE RETIREMENT RECEIVERSHIPS.

Section 2. Article 64 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-64-46. Receiverships; exception for facility beds.**

When the Commissioner has been appointed as a receiver under Article 30 of this Chapter for a provider or facility subject to this Article, the Department of Health and Human Services may, notwithstanding any other provision of law, accept and approve the addition of adult care home beds for that facility if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the facility or (ii) the welfare of persons who have previously contracted with the provider or may contract with the facility, may be best served by the addition of adult care home beds."

PART III. HANDICAPPED PERSONS.

Section 3.1. G.S. 168-10 reads as rewritten:

"**§ 168-10. Eliminate discrimination in treatment of handicapped and disabled.**

Each handicapped person shall have the same consideration as any other person for individual accident and health insurance coverage, and no insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes solely on the basis of ~~such~~ the person's handicap, shall deny such coverage or benefits. The availability of ~~such insurance~~ coverage or benefits shall not be denied solely ~~due to~~ because of the ~~handicap, provided, however, that no such insurer shall be prohibited from excluding by waiver or otherwise, any pre-existing conditions from such coverage, and further provided that~~ handicap; however, any such insurer may charge the appropriate premiums or fees for the risk insured on the same basis and conditions as insurance issued to other ~~persons.~~ persons, in accordance with actuarial and underwriting principles and other coverage provisions prescribed in Chapter 58 of the General Statutes. ~~Nothing contained herein or in any other statute shall restrict or preclude any insurer governed by Chapter 58 of the General Statutes from setting and charging a premium or fee based upon the class or classes of risks and on sound actuarial and underwriting principles as determined by such insurer, or from applying its regular underwriting standards applicable to all classes of risks. The provisions of this section shall apply to both corporations governed by Chapter 58 of the General Statutes.~~ No insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes shall be prohibited from excluding by waiver or otherwise, any preexisting conditions from coverage as prescribed in G.S. 58-51-15(a)(2)b."

Section 3.2. G.S. 168-22(b) reads as rewritten:

"(b) A family care home shall be deemed a residential use of property for the purposes of determining charges or assessments imposed by political subdivisions or

businesses for water, sewer, power, telephone service, cable television, garbage and trash collection, repairs or improvements to roads, streets, and sidewalks, and other services, utilities, and ~~improvements, and for purposes of classification for insurance.~~ improvements."

PART IV. WORKERS' COMPENSATION MANAGED CARE.

Section 4.1. G.S. 58-50-65(a) reads as rewritten:

"(a) Nothing in Articles 50 through 55 of this Chapter ~~shall apply~~ applies to or ~~affect~~ affects any policy of liability or workers' compensation insurance, except that the provisions of ~~G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55~~ G.S. 58-50-56(g) and (h) ~~shall~~ apply to policies of workers' compensation ~~insurance.~~ insurance and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care provisions of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation insurance, the provisions of Chapter 97 govern."

Section 4.2. G.S. 97-2(21) reads as rewritten:

"(21) Managed care organization. -- The term 'managed care organization' means a preferred provider organization or a health maintenance organization regulated under Chapter 58 of the General Statutes. 'Managed care organization' also means a preferred provider benefit plan of an insurance company, hospital, or medical service corporation in which utilization review or quality management programs are used to manage the provision of health care services and benefits under this Chapter."

PART V. COMMERCIAL AIRCRAFT INSURANCE.

Section 5.1. G.S. 58-7-15(19) reads as rewritten:

"(19) 'Motor vehicle ~~and~~ or aircraft insurance,' meaning insurance against loss of or damage resulting from any cause to motor vehicles or aircraft and their equipment, and against legal liability of the insured for loss or damage to another's property resulting from the ownership, maintenance or use of motor vehicles or aircraft and against loss, damage or expense incident to a claim of such liability. This subdivision does not apply to commercial aircraft as defined in G.S. 58-1-5."

Section 5.2. G.S. 58-41-10(a) reads as rewritten:

"(a) Except as otherwise provided, this Article applies to all kinds of insurance authorized by G.S. 58-7-15(4) through (14) and G.S. 58-7-15(18) through (22), and to all insurance companies licensed by the Commissioner to write those kinds of insurance. This Article does not apply to insurance written under Articles 21, 36, 37, 45 or 46 of this Chapter; insurance written for residential risks in conjunction with insurance written under Article 36 of this Chapter; to marine insurance as defined in G.S. 58-40-15(3); to personal inland marine insurance; to ~~aviation~~ commercial aircraft insurance; to policies issued in this State covering risks with multistate locations,

except with respect to coverages applicable to locations within this State; to any town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State; nor to domestic insurance companies, associations, orders, or fraternal benefit societies doing business in this State on the assessment plan."

Section 5.3. G.S. 58-21-10(8) reads as rewritten:

"(8) 'Surplus lines insurance' means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, ~~aviation~~ commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities."

Section 5.4. G.S. 58-28-5(a) reads as rewritten:

"(a) Except as ~~hereinafter provided,~~ otherwise provided in this section, it ~~shall be~~ is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in G.S. 58-28-10, without a ~~certificate of authority~~ license issued by the Commissioner. This section ~~shall~~ does not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this ~~Chapter;~~ Chapter.

(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the ~~Commissioner;~~ Commissioner.

(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such ~~policy;~~ policy.

(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or franchise accident and health insurance where the master policy ~~of such~~ for the insurance was lawfully issued and delivered in a state ~~where~~ in which the company was authorized to transact ~~business;~~ business.

(5) Transactions in this State involving all policies of insurance issued ~~prior to~~ before July 1, ~~1967;~~ 1967.

(6) The procuring of contracts of insurance issued to a nuclear ~~insured;~~ insured. As used in this subdivision, 'nuclear insured' means a public utility procuring insurance against radioactive

contamination and other risks of direct physical loss at a nuclear electric generating plant.

(7) Insurance independently procured, as specified in subsection (b) of this ~~section;~~ section.

(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.

(9) Transactions in this State involving commercial aircraft insurance, meaning insurance against (i) loss of or damage resulting from any cause to commercial aircraft and its equipment, (ii) legal liability of the insured for loss or damage to another person's property resulting from the ownership, maintenance, or use of commercial aircraft, and (iii) loss, damage, or expense incident to a liability claim."

Section 5.5. G.S. 58-1-5 reads as rewritten:

"**§ 58-1-5. Definitions.**

In this Chapter, unless the context clearly requires otherwise:

(1) 'Alien company' means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(1a) 'Commercial aircraft' means aircraft used in domestic, flag, supplemental, commuter, or on-demand operations, as defined in Federal Aviation Administration Regulations, 14 C.F.R. § 119.3, as amended.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina or an authorized designee of the Commissioner.

(3) 'Company' or 'insurance company' or 'insurer' includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations. 'Company' or 'insurance company' or 'insurer' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(4) 'Department' means the Department of Insurance of North Carolina.

(5) 'Domestic company' means a company incorporated or organized under the laws of this State.

(6) 'Foreign company' means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State.

(7) 'NAIC' means the National Association of Insurance Commissioners.

~~(8) "Nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.~~

(9) 'Person' means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert. 'Person' does not mean the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina.

(10) The singular form ~~shall include~~ includes the plural, and the masculine form ~~shall include~~ includes the feminine wherever appropriate."

PART VI. SURPLUS LINES FILINGS.

Section 6.1. G.S. 58-21-35 reads as rewritten:

"**§ 58-21-35. Duty to file ~~evidence of insurance and affidavits.~~ reports and retain affidavits.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall ~~execute and~~ file with the ~~Commissioner:~~ Commissioner a

~~(1)~~ ~~A written~~ report in a format prescribed by the Commissioner regarding the insurance and including the following information:

~~a.~~(1) The name ~~and address~~ of the ~~insured;~~ insured.

~~b.~~(2) The identity of the insurer or ~~insurers;~~ insurers.

~~c.~~(3) A description of the subject and location of the ~~risk;~~ risk.

~~d.~~(4) The amount of premium charged for the ~~insurance; and~~ insurance.

~~e. Such other pertinent information as the Commissioner may reasonably require; and~~

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

~~(2) An~~

(b) The licensee shall complete and retain an affidavit as to the efforts to place the coverage with admitted insurers and the results ~~thereof~~ of the efforts, in accordance with G.S. 58-21-15. The report and affidavit required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

Section 6.2. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-2. Relationship to other insurance laws.**

Unless surplus lines insurance, surplus lines licensees, or nonadmitted insurers are specifically referenced in a particular section of this Chapter, no sections contained in Articles of this Chapter other than this Article apply to surplus lines insurance, surplus lines licensees, or nonadmitted insurers."

PART VII. WORKERS' COMPENSATION SELF-INSURANCE.

Section 7.1. G.S. 105-259(b) is amended by adding a new subdivision to read:

"(16a) To provide the North Carolina Self-Insurance Guaranty Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of collecting the assessments authorized in G.S. 97-133(a)."

Section 7.2. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

~~(1) Obtain from each member self-insurer and file with the Commissioner individual reports specifying the aggregate benefits each member paid during the previous calendar year, and the annual standard premium that would have been paid by the individual member self-insurer during the previous calendar year, pursuant to manual rates established by the North Carolina Rate Bureau and using the experience rating procedure approved by the Commissioner for that member self-insurer or the annual premium collected by each group member self-insurer during the prior calendar year. These reports shall be due on or before July 15 following the close of that calendar year, except that this deadline may be extended by the Commissioner for up to three additional months for good cause shown.~~

(2) Assess each member of the Association as follows:

a. Each individual member self-insurer shall be annually assessed an amount equal to one-quarter of one percent (0.25%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual ~~standard premium~~ gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual ~~standard premium.~~ gross premiums. Each group member self-insurer shall be annually assessed an amount equal to one-quarter of

one percent (0.25%) of the annual ~~premium collected by~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than September 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this one-quarter of one percent (0.25%) assessment. Assessments paid by members pursuant to this subdivision shall be credited toward the tax paid by self-insurers under Article 8B of Chapter 105 of the General Statutes. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll information as determined under G.S. 105-228.5(b), (b1), and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.

b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

c. If a self-insurer is a member of the Association for less than a full calendar year, the annual ~~standard premium~~ gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.

d. If application of the contribution rates referenced in ~~sub-subdivisions a. and b.~~ sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.

(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund

should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.

The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;

(4) Be obligated to the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter. The Association shall pay claims against a self-insurer that are not or have not been paid as a result of a determination of insolvency or the institution of bankruptcy or receivership proceedings that occurred prior to the effective date of this Article.

(5) After paying any claim resulting from a self-insurer's insolvency, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer by any appropriate action brought in its own name or in the name of the injured employee and dependents;

(6) Assess the Fund in an amount necessary to pay only:

a. The obligations for the Association under this Article subsequent to an insolvency;

b. The expenses of handling covered claims subsequent to an insolvency;

c. The cost of examinations under G.S. 97-137; and

d. Other expenses authorized by this Article;

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent self-insurer was a party to determine the extent to which such settlements may be properly contested;

(8) Notify such persons as the Commissioner directs under G.S. 97-136;

(9) Handle claims through its employees or through one or more self-insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member self-insurer as a servicing facility may be declined by such self-insurer;

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association;

(11) Pay the other expenses of the Association authorized by this section; and

(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions ~~(1), (2),~~ (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association;

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section; and

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post-insolvency assessment which shall be imposed as follows:

(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the individual member self-insurer for the premium calendar year bears to the annual ~~standard premium~~ gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual ~~collected premium~~ gross premiums of the group member self-insurer for the premium calendar year bears to the annual ~~collected premium~~ gross premiums of all group member self-insurers for the preceding calendar year.

(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.

(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.

(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.

(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.

(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual ~~standard premium~~ gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an

amount greater than two and one-half percent (2.5%) of the annual ~~premium collected by~~ gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year."

PART VIII. REPEAL REQUIREMENT OF BIENNIAL REPORT.

Section 8. G.S. 58-2-120 reads as rewritten:

"**§ 58-2-120. Reports of Commissioner to the Governor and General Assembly.**

~~The Commissioner shall biennially submit to the General Assembly, through the Governor, a report of his official acts, including a summary of official rulings and regulations.~~ The Commissioner shall, from time to time, report to the Governor and the General Assembly any change or changes ~~which~~ that in ~~his~~ the Commissioner's opinion should be made in the laws relating to insurance and other subjects pertaining to ~~his department. On or before the first day of February of each year in which the General Assembly is in session he shall make to the Governor the recommendations called for in this section, to be transmitted to the General Assembly, with the last annual report of this Department, including receipts and disbursements.~~ the Department."

PART IX. REPEAL THE AGENCY BUSINESS CESSATION LAW.

Section 9. G.S. 58-41-35 is repealed.

Section 9.1. G.S. 58-41-40(a) reads as rewritten:

"(a) There is no liability on the part of and no cause of action for defamation or invasion of privacy arises against any insurer or its authorized representatives, agents, or employees, or any licensed insurance agent or broker, for any communication or statement made, unless shown to have been made in bad faith with malice, in any of the following:

(1) A written notice of cancellation under ~~G.S. 58-41-15,~~ G.S. 58-41-15 or of nonrenewal under G.S. 58-41-20, ~~or of cessation of business through an agency under G.S. 58-41-35,~~ specifying the reasons ~~therefor;~~ for cancellation.

(2) Communications providing information pertaining to ~~such cancellation, nonrenewal, or cessation of business through an agency;~~ the cancellation or nonrenewal.

(3) Evidence submitted at any court proceeding, administrative hearing, or informal inquiry in which ~~such cancellation, nonrenewal, or cessation of business through an agency~~ the cancellation or nonrenewal is an issue."

PART X. MORTALITY TABLE AND RESERVES UPDATE.

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

"(k) The Commissioner shall adopt rules containing the minimum standards applicable to the valuation of health plans. The Commissioner may also adopt rules for the purpose of recognizing new annuity mortality tables for use in determining reserve liabilities for annuities and may adopt rules that govern minimum valuation standards for reserves of life insurance companies. In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC."

PART XI. MECHANICAL BREAKDOWN INSURANCE.

Section 11. G.S. 58-36-1(3) reads as rewritten:

"(3) The Bureau shall ~~have the duty and responsibility of promulgating and proposing~~ promulgate and propose rates for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; for insurance against theft of or physical damage to nonfleet private passenger ~~(nonfleet)~~ motor vehicles; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured and underinsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and, as provided in G.S. 58-36-100, for loss costs and residual market rate filings for workers' compensation and employers' liability insurance written in connection therewith. ~~The provisions of this~~ This subdivision ~~shall~~ does not apply to motor vehicles operated under certificates of authority from the Utilities Commission, the Interstate Commerce Commission, or their successor agencies, where insurance or other proof of financial responsibility is required by law or by regulations specifically applicable to such certificated vehicles. The Bureau shall have no jurisdiction over excess workers' compensation insurance for employers qualifying as self-insurers as provided in ~~G.S. 97-93;~~ Article 47 of this Chapter or Article 5 of Chapter 97 of the General Statutes; nor shall the Bureau's jurisdiction include farm buildings, farm dwellings and their appurtenant structures, farm personal property or other coverages written in connection with farm real or personal property; travel or camper trailers designed to be pulled by private passenger motor vehicles, unless insured under policies covering nonfleet private passenger motor vehicles; mechanical breakdown insurance covering nonfleet private passenger motor vehicles and other incidental coverages written in connection with this insurance, including emergency road service assistance, trip interruption reimbursement, rental car reimbursement, and tire

coverage; residential real and personal property insured in multiple line insurance policies covering business activities as the primary insurable interest; and marine, general liability, burglary and theft, glass, and animal collision insurance, except when such coverages are written as an integral part of a multiple line insurance policy for which there is an indivisible premium."

PART XII. EFFECT OF HEADINGS.

Section 12. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART XIII. EFFECTIVE DATE.

Section 13. Sections 5.1 through 5.5 of this act become effective October 1, 1999. Section 6.1 of this act becomes effective January 1, 2000. The remainder of this act is effective when it becomes law, but Sections 1.1, 1.2, and 1.3 of this act shall not apply to appeals pending on the date this act becomes law.

HB 1119:
Children/Disabled Anesthesia Dental Care

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Rep. Wright
Date:	May 19, 1999	**Summary by:**	Linwood Jones
Version:	2nd		Committee Counsel

House Bill 1119 requires health plans to cover hospital or facility charges and anesthesia charges for certain persons who undergo a needed dental procedure in a hospital or ambulatory surgical facility. 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, and the patient's age or condition necessitates, for reasons of safety or effectiveness, hospitalization or performing the dental procedure in the hospital or ambulatory surgical facility with 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.

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.

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE 5-19-99

Name of Committee Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Cheryl M Beaty	NCNA
Tanya Rapala	
Estelle Shirley	Easter Seals
Sammy Hinge	Easter Seals South Mills NC 27976
Elizabeth Clements	Easter Seals 323 Richmond Dr. Fayetteville Conn
Suzanne Hadden	Easter Seals Shannon, NC
Guy Rowland	American Bankers Insurance
Andy Ellis	NCRMA
Alicia Gregory	Poyner & Spruill
Joyce Ellis	NAMIC
[illegible]	NCAHP
Ken Wyatt	BCBSNC
Cindy Lamb	WCSR
Dick Moore	Mayor of Dillon
Charles F. Willson MD	North Carolina Medical Society
[illegible]	NC Medical Society
George Farthing	NC Insurance News Service

SENATE INSURANCE COMMITTEE MEETING

MAY 26, 1999

AGENDA

H 277	FAMILY FRIENDLY UI EXCEPTION	REP. REDWINE
H 714	SUBSTANCE ABUSE/DIRECT PAY	REP. ALEXANDER
H 1186	UNEARNED PREMIUM RESERVES	REP. MINER

THE SENATE INSURANCE COMMITTEE MEETING MINUTES

MAY 26, 1999

The Senate Insurance Committee held its meeting on Wednesday, May 26, 1999 at 10:00 a.m. in room 1027 of the Legislative Building. Ten members were present.

Senator Allen Wellons, Chairman, called on Representative Martha Alexander to explain H 714, Substance Abuse/Direct Pay. A technical amendment was offered by Senator Wellons, and it was adopted. A copy of the amendment is attached. Representative Alexander asked Linwood Jones, the Committee Counsel, to explain the amendment. After discussion, Senator Ballance moved that the amendment be rolled into a Proposed Committee Substitute, and the bill be given a favorable report.

The next Agenda item was H1186, Unearned Premium Reserves which was sponsored by Representative Miner. He offered a Proposed Committee Substitute which the Committee adopted. After an explanation of the bill, Senator Ballantine moved for a favorable report for the Proposed Committee Substitute. This motion passed unanimously.

Representative Redwine, who was the sponsor of H 277, Family Friendly UI Exception, was unable to attend the meeting because he was presenting a bill at another meeting. Senator Wellons offered a technical amendment which was adopted by the Committee, and explained by Linwood Jones. A copy of the amendment is attached. Senator Wellons asked David L. Clegg, Director of Governmental Relations with the Employment Security Commission, to explain the bill in Representative Redwine's absence. After explaining the bill, Mr. Clegg answered questions. Senator Ballance moved that the amendment be rolled into a Proposed Committee Substitute and be given a favorable report. This motion passed.

There being no further business, the meeting was adjourned.

Senator Allen Wellons
Committee Chairman

Margaret Hogan
Margaret M. Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE COMMITTEE REPORT
Senator Allen Wellons, Chair

Tuesday, June 01, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)**277** "Family Friendly" UI Exception/AB

Draft Number:	PCSA148
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 714

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

H714-ARN-001

Page 1 of __

Date 5-26 ,1999

Comm. Sub. [ ]
Amends Title [ ]
1st Edition

Sen. Wellons

moves to amend the bill on page 3, line 2, and on page 5, line 37 by deleting "Professionals" eahc time it appears and inserting "Professional";

and on page 8, between lines 16 and 17, by inserting the following:

"Section 3.1. G.S. 90-113.47 is repealed."

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.

<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 277:
Family Friendly UI Exception

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Rep. Redwine
Date:	May 25, 1999	**Summary by:**	Linwood Jones
Version:	2nd		Committee Counsel

Under current law, unemployed individuals seeking unemployment benefits must be available for "work" and must not have been separated or discharged from employment without good cause attributable to the employer.

House Bill 277 provides that a person unable to work a certain shift because of an *undue family hardship* is not thereby disqualified from unemployment benefits:

- If an individual is separated or discharged from work solely because he or she was unable to accept work for a particular shift due to an *undue family hardship*, the employee is considered to have left work for good cause (*see Section 4*).
- An individual is considered "available for work" even though an *undue family hardship* prevents the individual from accepting a particular shift at a potential job (*see Section 2*).

"*Undue family hardship*" means that an individual is unable, as determined by the Employment Security Commission, to accept a particular work shift because the individual cannot obtain (a) child care during that shift for a minor child under 14 years of age who is in the legal custody of the individual or (b) elder care for an aged or disabled parent of the individual.

Section 3 of the bill provides that unemployment benefits paid out under the *undue family hardship* exception are not charged against the account of the employer from whom the employee was separated or discharged.

Section 5 makes this act effective July 1, 1999. This act expires June 30, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 3

HOUSE BILL 277
Committee Substitute Favorable 4/19/99
Senate Insurance Committee Substitute Adopted 6/1/99

Short Title: "Family Friendly" UI Exception/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT AMENDING THE EMPLOYMENT SECURITY LAWS TO PROVIDE THAT AN INDIVIDUAL MAY NOT BE DISQUALIFIED FOR UNEMPLOYMENT INSURANCE BENEFITS WHEN THE INDIVIDUAL'S INABILITY TO ACCEPT BONA FIDE PERMANENT EMPLOYMENT DURING A PARTICULAR SHIFT WOULD RESULT IN AN UNDUE FAMILY HARDSHIP AND TO PROVIDE THAT AN INDIVIDUAL MAY NOT BE DISQUALIFIED FOR UNEMPLOYMENT INSURANCE BENEFITS WHEN THE INDIVIDUAL'S DISCHARGE IS SOLELY DUE TO AN INABILITY TO ACCEPT WORK DURING A PARTICULAR SHIFT AS THE RESULT OF AN UNDUE FAMILY HARDSHIP.

The General Assembly of North Carolina enacts:

Section 1. G.S. 96-8 is amended by adding a new subdivision to read:

"(10a) 'Undue family hardship' arises when an individual is unable to accept a particular shift because the individual is unable to obtain (i) child care during that shift for a minor child under 14 years of age who is in the legally recognized custody of the individual or (ii) elder care during that shift for an aged or disabled parent of the individual."

Section 2. G.S. 96-8(24) reads as rewritten:

"(24) Work, for purposes of this Chapter, means any bona fide permanent ~~employment.~~ employment the acceptance of which

would not result in an undue family hardship as defined in G.S. 96-8(10a). For purposes of this definition, 'bona fide permanent employment' is presumed to include only those employments of greater than 30 consecutive calendar days duration (regardless of whether work is performed on all those days) provided: (a) the presumption that an employment lasting 30 days or less is not bona fide permanent employment may be rebutted by a finding by the Commission, either on its own motion or upon a clear and convincing showing by an interested party that the application of the presumption would work a substantial injustice in view of the intent of this Chapter; (b) Any decision of the Commission on the question of bona fide employment may be disturbed on judicial review only upon a finding of plain error."

Section 3. G.S. 96-9(c)(2)b. reads as rewritten:

"b. Any benefits paid to any claimant under a claim filed for a period occurring after the date of such separations as are set forth in this paragraph and based on wages paid prior to the date of (i) the leaving of work by the claimant without good cause attributable to the employer; (ii) the discharge of claimant for misconduct in connection with his work; (iii) the discharge of the claimant for substantial fault as that term may be defined in G.S. 96-14; (iv) the discharge of the claimant solely for a bona fide inability to do the work for which he was hired but only where the claimant was hired pursuant to a job order placed with a local office of the Commission for referrals to probationary employment (with a probationary period no longer than 100 days), which job order was placed in such circumstances and which satisfies such conditions as the Commission may by regulation prescribe and only to the extent of the wages paid during such probationary employment; (v) separations made disqualifying under G.S. 96-14(2b) and (6a); ~~or~~ (vi) separation due to leaving for disability or health ~~condition~~ condition; or (vii) separation of claimant solely as the result of an undue family hardship shall not be charged to the account of the employer by whom the claimant was employed at the time of such separation; provided, however, said employer promptly furnishes the Commission with such notices regarding any separation of the individual from work as are or may be required by the regulations of the Commission.

No benefit charges shall be made to the account of any employer who has furnished work to an individual who, because of the loss of employment with one or more other

employers, becomes eligible for partial benefits while still being furnished work by such employer on substantially the same basis and substantially the same amount as had been made available to such individual during his base period whether the employments were simultaneous or successive; provided, that such employer makes a written request for noncharging of benefits in accordance with Commission regulations and procedures.

No benefit charges shall be made to the account of any employer for benefit years ending on or before June 30, 1992, where benefits were paid as a result of a discharge due directly to the reemployment of a veteran mandated by the Veteran's Reemployment Rights Law, 38 USCA § 2021, et seq.

No benefit charges shall be made to the account of any employer where benefits are paid as a result of a decision by an Adjudicator, Appeals Referee or the Commission if such decision to pay benefits is ultimately reversed; nor shall any such benefits paid be deemed to constitute an overpayment under G.S. 96-18(g)(2), the provisions thereof notwithstanding. Provided, an overpayment of benefits paid shall be established in order to provide for the waiting period required by G.S. 96-13(c)."

Section 4. G.S. 96-14 is amended by adding a new subdivision to read:

"(1g) For purposes of this Chapter, separation or discharge solely due to an inability to accept work during a particular shift as a result of an undue family hardship shall constitute good cause for leaving work. Benefits paid on the basis of this section shall not be charged to the account of the employer."

Section 5. This act becomes effective July 1, 1999, and applies to unemployment insurance claims filed on or after that date. This act expires June 30, 2001.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

H. B. No. 277 DATE 5-26-99

S. B. No. _____ Amendment No. _____

(to be filled in by Principal Clerk)

~~Rep.~~)
) Wellons
Sen.)

moves to amend the bill on page 3, line 24

by deleting "(g)" and inserting "(1g)";

and on page 2, line 34 and page 3, line 26 by deleting the phrase "as defined in G.S. 96-8(10a)" each time it appears.

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 277
Committee Substitute Favorable 4/19/99

Short Title: "Family Friendly" UI Exception/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT AMENDING THE EMPLOYMENT SECURITY LAWS TO PROVIDE THAT AN INDIVIDUAL MAY NOT BE DISQUALIFIED FOR UNEMPLOYMENT INSURANCE BENEFITS WHEN THE INDIVIDUAL'S INABILITY TO ACCEPT BONA FIDE PERMANENT EMPLOYMENT DURING A PARTICULAR SHIFT WOULD RESULT IN AN UNDUE FAMILY HARDSHIP AND TO PROVIDE THAT AN INDIVIDUAL MAY NOT BE DISQUALIFIED FOR UNEMPLOYMENT INSURANCE BENEFITS WHEN THE INDIVIDUAL'S DISCHARGE IS SOLELY DUE TO AN INABILITY TO ACCEPT WORK DURING A PARTICULAR SHIFT AS THE RESULT OF AN UNDUE FAMILY HARDSHIP.

The General Assembly of North Carolina enacts:

Section 1. G.S. 96-8 is amended by adding a new subdivision to read:

"(10a) 'Undue family hardship' arises when an individual is unable to accept a particular shift because the individual is unable to obtain (i) child care during that shift for a minor child under 14 years of age who is in the legally recognized custody of the individual or (ii) elder care during that shift for an aged or disabled parent of the individual."

Section 2. G.S. 96-8(24) reads as rewritten:

"(24) Work, for purposes of this Chapter, means any bona fide permanent ~~employment.~~ employment the acceptance of which would not result in an undue family hardship as defined in G.S.

96-8(10a). For purposes of this definition, 'bona fide permanent employment' is presumed to include only those employments of greater than 30 consecutive calendar days duration (regardless of whether work is performed on all those days) provided: (a) the presumption that an employment lasting 30 days or less is not bona fide permanent employment may be rebutted by a finding by the Commission, either on its own motion or upon a clear and convincing showing by an interested party that the application of the presumption would work a substantial injustice in view of the intent of this Chapter; (b) Any decision of the Commission on the question of bona fide employment may be disturbed on judicial review only upon a finding of plain error."

Section 3. G.S. 96-9(c)(2)b. reads as rewritten:

"b. Any benefits paid to any claimant under a claim filed for a period occurring after the date of such separations as are set forth in this paragraph and based on wages paid prior to the date of (i) the leaving of work by the claimant without good cause attributable to the employer; (ii) the discharge of claimant for misconduct in connection with his work; (iii) the discharge of the claimant for substantial fault as that term may be defined in G.S. 96-14; (iv) the discharge of the claimant solely for a bona fide inability to do the work for which he was hired but only where the claimant was hired pursuant to a job order placed with a local office of the Commission for referrals to probationary employment (with a probationary period no longer than 100 days), which job order was placed in such circumstances and which satisfies such conditions as the Commission may by regulation prescribe and only to the extent of the wages paid during such probationary employment; (v) separations made disqualifying under G.S. 96-14(2b) and (6a); ~~or~~ (vi) separation due to leaving for disability or health ~~condition~~ condition; or (vii) separation of claimant solely as the result of an undue family hardship as defined in G.S. 96-8(10a) shall not be charged to the account of the employer by whom the claimant was employed at the time of such separation; provided, however, said employer promptly furnishes the Commission with such notices regarding any separation of the individual from work as are or may be required by the regulations of the Commission.

No benefit charges shall be made to the account of any employer who has furnished work to an individual who, because of the loss of employment with one or more other employers, becomes eligible for partial benefits while still

being furnished work by such employer on substantially the same basis and substantially the same amount as had been made available to such individual during his base period whether the employments were simultaneous or successive; provided, that such employer makes a written request for noncharging of benefits in accordance with Commission regulations and procedures.

No benefit charges shall be made to the account of any employer for benefit years ending on or before June 30, 1992, where benefits were paid as a result of a discharge due directly to the reemployment of a veteran mandated by the Veteran's Reemployment Rights Law, 38 USCA § 2021, et seq.

No benefit charges shall be made to the account of any employer where benefits are paid as a result of a decision by an Adjudicator, Appeals Referee or the Commission if such decision to pay benefits is ultimately reversed; nor shall any such benefits paid be deemed to constitute an overpayment under G.S. 96-18(g)(2), the provisions thereof notwithstanding. Provided, an overpayment of benefits paid shall be established in order to provide for the waiting period required by G.S. 96-13(c)."

Section 4. G.S. 96-14 is amended by adding a new subdivision to read:

"(g) For purposes of this Chapter, separation or discharge solely due to an inability to accept work during a particular shift as a result of an undue family hardship as defined in G.S. 96-8(10a) shall constitute good cause for leaving work. Benefits paid on the basis of this section shall not be charged to the account of the employer."

Section 5. This act becomes effective July 1, 1999, and applies to unemployment insurance claims filed on or after that date. This act expires June 30, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1186
Committee Substitute Favorable 4/23/99
Proposed Senate Committee Substitute H1186-PCS7243-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. G.S. 58-26-20 reads as rewritten:

"**§ 58-26-20. Unearned premium reserve.**

Every domestic title insurance company shall, in addition to other reserves, establish and maintain a reserve to be known as the 'unearned premium reserve' for title insurance, which shall at all times and for all purposes be considered and constitute unearned portions of ~~the original risk premiums~~ direct premiums written and premiums for reinsurance assumed less premiums for reinsurance ceded and shall be charged as a reserve liability of such title insurance company in determining its financial conditions. The unearned premium reserve shall be withdrawn from the use of the insurer for its general purposes and placed in a trust account, as approved

by the Commissioner, in favor of the holders of title policies and held available for reinsurance of the title policies in the event of insolvency of the insurer. Nothing herein contained shall preclude such an insurer from investing said reserve in investments authorized by law for such an insurer, and the income from such invested reserve shall be included in the general income of the insurer to be used by such insurer for any lawful purpose."

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

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.

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE — 5-26-99

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
John M May	NC CWA Council
Richard Westhead	UTU
Mike Owen	NC State AFL-CIO
Brenda Simmons	NC Equity
Anne Wynne	NCJCDC
Roslyn Scott	NC Child Care Coalition
Alan Miles	Bailey & Dixon LLP
David Cragg	ESC
Stace Sisco	State AFL-CIO
Crissy Porter	Bone and Associates
[illegible]	[illegible]
[illegible]	NCAHP
[illegible]	BC BS NC
Lori A Harris	
Patrice Scales	NCACC
Beth Melcher	NAMI NC
Susan Valaer	Nationwide
Jack Cogan	Parker Poe Adams & Bernstein
Jamie Norton	APNC
Tony Melvin	ADCNC
Katherine Miller	Harry Kaplan

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
James Andrews	NC State AFL-CIO

SENATE INSURANCE COMMITTEE MEETING

AGENDA

JUNE 2, 1999

H 314	Insurance Covg./Bone Mass Msmt	Rep. Boyd-McIntyre
H 714	Substance Abuse/Direct Pay	Rep. Alexander
H 1186	Unearned Premium Reserves	Rep. Miner

SENATE INSURANCE COMMITTEE MEETING

JUNE 2, 1999

MINUTES

The Senate Insurance Committee held its meeting on Wednesday, June 2, 1999 at 10:00 a.m. in room 1027 of the Legislative Building. Eight members were present.

Senator Allen Wellons, Chairman, called the meeting to order.

Senator Reeves asked that the vote by which H1186 was given a favorable report for the proposed Senate Committee Substitute be reconsidered. This motion passed.

Senator Wellons stated that Representative Alexander's bill, H714 Substance Abuse/Direct Pay would not be taken as an Agenda item. It would be reported out as per the motion at the May 26, 1999 meeting.

Representative Boyd-McIntyre, the sponsor of H314, Insurance Covg./Bone Mass Msmt. explained the bill. Senator Metcalf moved that the bill be given a favorable report, and this received unanimous approval.

There being no further business, the meeting was adjourned.

Allen H. Wellons
Committee Chairman

Margaret Hogan

Margaret M. Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Wednesday, June 02, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1)**314** Insurance Covg./Bone Mass Msmt.
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE C.S. BILL

H.B. **0714** Substance Abuse/Direct Pay
Draft Number: PCS3428
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comment: None

HB 314:
Insurance Coverage/Bone Mass Measurement

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Rep. Boyd-McIntyre
Date:	June 2, 1999	**Summary by:**	Linwood Jones
Version:	2nd		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 *for qualified individuals*. The same deductibles and other limitations applicable to similar services provided under the health benefit plan would also apply.

The coverage is required when all of the following conditions are met:

- The bone mass measurement procedure is a radiological, radioisotopic or other scientifically-proven 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. Conditions under which follow-up tests may be medically necessary include (but are not limited to):
    - Monitoring beneficiaries on long-term glucocorticoid therapy of more than 3 months.
    - Allowing for a central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified person with low bone mass if the measurement is performed within 12 to 18 months of the start of the additional regimen.

The bill applies to insurers, service corporations (Blue Cross), HMOs, and multiple employer welfare arrangements. It also applies to the "standard" group policies marketed to small employers. The bill does not apply to health benefit plans self-funded by employers because those employers are exempt from State regulation pursuant to ERISA, nor dies it apply to the State Health Plan or specialized health insurance policies, such as MedSupp, specified disease, and disability income.

The bill would take effect January 1, 2000, and would apply to policies issued or renewed on or after that date. Renewal of a policy is presumed to occur on the anniversary date that the insured was first covered under the plan.

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.

HB 714:
Substance Abuse/Direct Pay

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Rep. Alexander
Date:	May 26, 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 D

HOUSE BILL 714
Proposed Senate Committee Substitute H714-PCS3428-RN

Short Title: Substance Abuse/Direct Pay. (Public)

Sponsors:

Referred to:

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 Professional 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 Professional 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 3.1. G.S. 90-113.47 is repealed.

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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 714
Senate Insurance Committee Substitute Adopted 6/2/99

Short Title: Substance Abuse/Direct Pay. (Public)

Sponsors:

Referred to:

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 Professional 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 Professional 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 3.1. G.S. 90-113.47 is repealed.

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.

VISITOR REGISTRATION SHEET

Senate Insurance — 6-2-99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Gayle Lester	UNC-CH CB#7055 Chapel Hill NC 27599
Suzette Sowell	DA&N Service - Dir of Older Health
Glenn Miller	DHHS/Public Health
Bob Paschal	Young Moore
Alan Miles	Bailey & Dixon LLP
Sondra Hiers	NCALU
[illegible]	[illegible]
Glenn Jernigan	Colonial Life and Accident
Katherine Miller	Harry Kaplan
Alicia Mullen Gregory	Poyner & Spruill
Carrie Porter	Bode & Associates
Jo Ann Harris	CAHA, INC
Steve Woodson	NC Farm Bureau Federation
Christina Medlin	NC Equity
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

SENATE INSURANCE COMMITTEE — June 7, 1999

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Tom Keegan	Moore & Van Allen
Ken Wyatt	BCBSNC
Dascheil Propes	NC DOI
Jim Dorsett	NC AHP
John McMillan	NFIPA.
Dr. Elaine Yarbrough	Saint Augustine's College
Keith Stewart	St. Augustine's College.
Lamont Robert	Saint Augustine's College
LOYD O. MULBAH	ST. AUGUSTINE'S COLLEGE
Robin Branch	St. Augustine's College
Andrea Mooke	St. Augustines College
Shakeerah Wilson	St Augustine's College

SENATE INSURANCE COMMITTEE MEETING

AGENDA

JUNE 23, 1999

H276	OMNIBUS ESC CHANGES	REP. REDWINE
H1025	GROUP HEALTH CONTINUATION INSURANCE	REP. GARDNER

SENATE INSURANCE COMMITTEE MEETING

MINUTES

JUNE 23, 1999

The Senate Insurance Committee held its meeting at 10:00 a.m. on June 23, 1999 in room 1027 of the Legislative Building. Ten members were present.

The Chairman, Senator Wellons, presided.

In the absence of Representative Gardner, Lynwood Jones, Committee Counsel, explained House Bill 1025, Group Health Continuation Insurance. After an explanation and a few questions, Senator Webster moved for a favorable report. This motion passed unanimously.

The second agenda item was House Bill 276, Omnibus ESC Changes. In the absence of the Sponsor, Representative Redwine, David Clegg of the Employment Security Commission explained the bill. Mr. Clegg referred to the Bill Summary, which is attached.

Mr. Clegg went through the Summary and arrived at Section 8, which refers to the N. C. Work Study which is a component of Welfare Reform Legislation that was enacted several sessions ago. The Employment Security Commission has been administering the N.C. Work Study as Chapter 1088.29 has directed it. As a result of administering this Study, it has become clear they were looking at data for individual taxpayers, and it became difficult to put a family unit together if a husband and wife were filing separate returns. They felt that in order to truly understand the child care issues, the health care issues, and the aggregate amount of family income to make sure the family was earning 150% or below the Federal Poverty Level there was a need for the Spouse's Social Security Number.

Senator Wellons asked what the penalty would be if the spouse did not want to give her Social Security Number. Mr. Clegg said that they receive this information from the Deparment of Revenue. The individual does not furnish them the information. Senator Webster, who is a Certified Public Accountant, was asked about this. He said that under the law there were only supposed to be two categories if you are married - married, filing jointly, and married filing separately. Both social security numbers appear in either case. The only exception is under the "abandoned spouse rule".

Senator Webster asked Mr. Clegg who had access to this information. Mr. Clegg said that three people who are compiling the data would have this information. It is confidential. He said the information is purely statistical, non-identifying. It is simply a demographic tool.

Senator Ballantine asked if Mr. Clegg could say, categorically, that this information was not sold to anyone. Mr. Clegg responded affirmatively. Senator Webster asked if any of the information was sold anywhere. Mr. Clegg said it was not. Mr. Tom Whitaker, Deputy Chairman of the Employment Security Commission, said that there was a confidentiality provision in Chapter 96 which would prohibit this.

Senator Wellons asked if the information was compiled, and the State has it, how was it exempted from the Freedom of Information Act? Mr. Whitaker said that he believed that the provisions in Chapter 96 would be an exception to the public records law.

Senator Ballantine said that there was going to be a Study Commission chaired by Senator Reeves, which would, with the State Auditor, look at every state agency to determine how many were releasing this type of information. He said the practice was pervasive in state government.

Mr. Whitaker, of the Employment Security Commission, stated that a number of years ago, the Commission was authorized by the General Assembly to operate a common follow up system, and to receive data from other state agencies, but only in confidence. This data is not subject to public records or any other release. It can only be maintained at the Commission and no one can be identified as an individual. Its purpose is for use in compiling and tracking programs. At a later date, this was amended to authorize the ESC to provide extract data to the State Budget Office for the purpose of analyzing state budgets and programs. This is non-public data, non-identifying data. This is just a place where data is reported.

Senator Soles asked about the number of Job Service Employer Committees which is found in Section 9. Senator Webster asked if there were not some counties who did not have a Job Service Office. Mr. Clegg said that some of the counties did not have a staffed office. Senator Webster wondered if the ones that did not have a Job Service Office were the counties that had the most unemployment. He called attention to the fact that Wake County, that had almost no unemployment, had two offices and Caswell County had zero.

Senator Webster than referred to Page 2, Section 2, lines 7 and 8. He questioned this section which requires employers with 100 or more employees to file their Employer's Quarterly Tax and Wage Reports on magnetic tapes or diskettes.

Senator Webster then moved for an unfavorable report.

Senator Soles made a substitute motion that the bill be carried over until the next meeting. He said that he would like to know if his counties had Job Service Employer Committees. Senator Harris said that he would like to amend the bill to phase in the requirement that every employer with 100 or more employees must file their "Employer's Quarterly Tax and Wage Report" on magnetic tapes or diskettes in a format prescribed by the Commission.

Senator Wellons called for a vote on Senator Soles' substitute motion. This motion passed, and the bill will be carried over.

The meeting was adjourned.

Senator Allen Wellons
Chairman

Margaret Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Thursday, July 01, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

FAVORABLE

H.B. 1025 Group Health Continuation Insurance
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

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.

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.

SENATE INSURANCE COMMITTEE MEETING

AGENDA

JUNE 30, 1999

H276	OMNIBUS ESC CHANGES	REP. REDWINE
H294	LIFE AND HEALTH INS. AMENDMENTS	REP. HURLEY

SENATE INSURANCE COMMITTEE MEETING

JUNE 30, 1999

MINUTES

The Senate Insurance Committee held its meeting at 10:00 a.m. on June 30, 1999 in room 1027 of the Legislative Building.

Senator Allen Wellons, chairman, presided.

The first Agenda item was H276 Omnibus ESC Changes sponsored by Rep. Redwine. Senator Wellons offered an amendment which would tighten up the confidentiality of information contained in records and reports. A copy of this amendment is attached. Senator Metcalf moved the adoption of the amendment, and the motion passed.

Senator Soles moved that the bill receive a favorable report as amended.

Senator Webster asked if he could make an editorial comment. He said that this bill was tightening the bureaucratic noose for the small businessman, and he made a substitute motion that the bill not be given a favorable report. Senator Soles said that this motion was diametrically opposed to the previous motion and against the Senate rules. Senator Wellons called for a vote on Senator Soles' motion, and this motion passed. Senator Webster voted "no".

Senator Wellons said that H294 Life and Health Ins. Amendments would be carried over.

The meeting was adjourned.

Senator Allen Wellons
Chairman

Margaret Hogan
Margaret M. Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Thursday, July 01, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)**276** Omnibus ESC Changes

Draft Number:	PCS 1309
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

HOUSE BILL 276:
Omnibus ESC Changes/AB

BILL ANALYSIS

Committee:	Senate Insurance Committee	**Introduced by:**	Rep. Redwine
Date:	June 15, 1999	**Summary by:**	Jeff Hudson, Ed Rossi & Linwood Jones Legislative Counsel
Version:	Proposed Committee Substitute		

SUMMARY: ***House Bill 276 makes various changes to Employment Security statutes in Chapter 96 of the General Statutes.***

Section by Section Bill Summary:

- **Section 1** authorizes employers to pay their unemployment insurance taxes by electronic transfer. Section 1 also authorizes the Employment Security Commission (ESC) to establish a procedure by which unemployment taxes may be payable by credit card. The bill provides that whenever payment is made by credit card, the payment must be for the full amount due, including penalties and interest. The bill also requires the Commission to tack on any charges that it incurs due to an employer's payment by credit card.
- **Section 2** requires employers with 100 or more employees, rather than the current 250 or more employees, to file their Employer's Quarterly Tax and Wage Reports on magnetic tapes or diskettes.
- **Section 3** cross references the standard beginning rate of contribution set out in G.S. 96-9(b)(1) as the beginning contribution rate for a transferring employer.
- **Section 4 and 5** amend the extended benefits statute so that it complies with the federal requirement that an individual must have had 20 weeks of full-time insured employment in order to be eligible for extended unemployment insurance benefits.[1]
- **Section 6** provides that in cases of partial unemployment, employers may file claims for employees through automation.
- **Section 7** provides 15 days, rather than 10 working days, to file a written appeal of adjudication or to protest a claim. This section also changes, from 20 working days to 45 days, the time during which the Commission may raise an issue as to the eligibility or disqualification of a claimant. Typically this situation that triggers the 20-day rule arises when the Commission learns, either through an interview or hearing, of information that could affect a claimant's ability to collect unemployment insurance benefits. Under current law, the 20-day period frequently provides insufficient time to raise issues of disqualification or ineligibility. This sometimes results in the payment of benefits to claimants that would otherwise not be entitled to receive benefits -- but for the Commission's failure to raise the issue within 20days.

[1] See generally 26USCA § 3304.

- **Section 8** expands the information from North Carolina income tax forms that may be furnished to the ESC for its NC WORKS study of the working poor. NC WORKS was part of the State's welfare reform initiative.
- **Section 9** directs the Chairman of the ESC to appoint the members of the county Job Service Employer Committees. Section 9 also directs the ESC to adopt rules and regulations for the meetings of each Job Service Employer Committee.
- **Section 10** changes the test for qualifying wages for second year benefits found in G.S. 96-12(b)(4) so that it is consistent with the test used for qualifying wages for the first year of benefits.
- **Section 11** amends the laws governing workers' compensation fraud and other violations related to workers' compensation claims. Currently, the Industrial Commission is authorized to investigate workers' compensation fraud and violations related to workers' compensation claims (GS 97-88.2). The Commission also enforces the law requiring employers to maintain workers' compensation coverage (unless they're otherwise exempt). Section 11 allows the Commission to designate fraud investigators and gives these fraud investigators the power to serve subpoenas, execute search warrants, and execute arrest warrants in cases of suspected fraud and other violations related to workers' compensation claims. A fraud investigator could make a warrantless arrest if the investigator has probable cause to believe that (1) a felony violation of the workers' compensation laws has occurred or (2) a misdemeanor violation of the workers' compensation laws has occurred and there is probably cause to believe that the suspect will not be apprehended unless immediately arrested.
- **Section 12** makes Sections 3, 7, and 10 of this act effective July 1, 1999, and provides that Sections 7 and 10 apply only to unemployment insurance claims filed on or after July 1, 1999. All other sections of this act are effective when the act becomes law.

Mary Shuping, Research Division, and Richard Bostic, Fiscal Research Division, also contributed to the preparation of this summary.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill No. 276

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

H276-ASD-001

Date_____,1999

Comm. Sub. []
Amends Title []
Second Edition

moves to amend the bill on page 6, lines 11 and 12, by inserting the following new section and renumbering the remaining sections:

" Section 10. G.S. 96-4(t)(1) reads as rewritten:

' (t) Confidentiality of Records, Reports, and Information Obtained from ~~Claimants and Employers.~~ Claimants, Employers, and Units of Government.

(1) Confidentiality of Information Contained in Records and Reports. -- (i) Except as hereinafter otherwise provided, it shall be unlawful for any person to obtain, disclose, or use, or to authorize or permit the use of any information which is obtained from any employing ~~unit or individual~~ unit, individual, or unit of government pursuant to the administration of this ~~Chapter.~~ Chapter or G.S. 108A-29. (ii) Any claimant or employer or their legal representatives shall be supplied with information from the records of the Employment Security Commission to the extent necessary for the proper presentation of claims or defenses in any proceeding under this Chapter. Notwithstanding any other provision of law, any claimant may be supplied, subject to restrictions as the Commission may by regulation prescribe, with any information contained in his payment record or on his most recent monetary determination, and any individual, as well as any interested employer, may be supplied with information as to the individual's potential benefit rights from claim records. (iii) Subject to restrictions as the

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill No. 276

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

H276-ASD-001

Commission may by regulation provide, information from the records of the Employment Security Commission may be made available to any agency or public official for any purpose for which disclosure is required by statute or regulation. (iv) The Commission may, in its sole discretion, permit the use of information in its possession by public officials in the performance of their public duties. (v) The Commission shall release the payment and the amount of unemployment compensation benefits upon receipt of a subpoena in proceeding involving child support. (vi) The Commission shall furnish to the State Controller any information the State Controller needs to prepare and publish a comprehensive annual financial report of the State or to track debtors of the State.'"

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 276
Committee Substitute Favorable 4/19/99

Short Title: Omnibus ESC Changes. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT MAKING VARIOUS CHANGES TO THE EMPLOYMENT SECURITY LAWS OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Section 1. G.S. 96-9(a) is amended by adding two new subdivisions to read:

"(10) Employers electing to do so may pay their quarterly tax contributions by electronic funds transfer. When an electronic funds transfer cannot be completed due to insufficient funds or the nonexistence of an account of the transferor, the Commission shall assess a penalty equal to ten percent (10%) of the amount of the transfer, subject to a minimum of one dollar ($1.00) and a maximum of one thousand dollars ($1,000). The Commission may waive this penalty for good cause shown. As used in this section, the term 'electronic funds transfer' means a transfer of funds initiated by using an electronic terminal, a telephone, a computer, or magnetic tape to instruct or authorize a financial institution or its agent to credit or debit an account.

(11) The Commission may establish policies to allow taxes to be payable under certain conditions by credit card. A condition of payment by credit card is receipt by the Commission of the full amount of taxes, penalties, and interest due. The Commission shall require an employer who pays by credit card to include an

amount equal to any fee charged the Commission for the use of the card. A payment of taxes that is made by credit card and is not honored by the card issuer does not relieve the employer of the obligation to pay the taxes."

Section 2. G.S. 96-9(a)(7) reads as rewritten:

"(7) Effective with the quarter ending September 30, ~~1992,~~ 1999, every employer with ~~250~~ 100 or more employees, and every person or organization that, as agent, reports wages on a total of ~~250~~ 100 or more employees on behalf of one or more subject employers, shall file that portion of the "Employer's Quarterly Tax and Wage Report" that contains the name, social security number, and gross wages of each individual in employment on magnetic tapes or diskettes in a format prescribed by the Commission.

For failure of an employer to comply with this subdivision, there shall be added to the amount required to be shown as tax in the reports a penalty of twenty-five dollars ($25.00). For failure of an agent to comply with this subdivision, the Commission may deny the agent the right to report wages and file reports for the employer for whom the agent filed an improper report for a period of one year following the calendar quarter in which that agent filed the improper report. The Commission may reduce or waive a penalty for good cause shown."

Section 3. G.S. 96-9(c)(4)b. reads as rewritten:

"b. Notwithstanding any other provisions of this section, if the successor employer was an employer subject to this Chapter prior to the date of acquisition of the business, ~~his~~ the successor's rate of contribution for the period from ~~such~~ that date to the end of the then current contribution year shall be the same as ~~his~~ the successor's rate in effect on the date of ~~such~~ the acquisition. If the successor was not an employer prior to the date of the acquisition of the ~~business he~~ business, the successor shall be assigned a standard beginning rate of contribution set forth in G.S. 96-9(b)(1) for the remainder of the year in which ~~he~~ the successor acquired the business of the predecessor; however, if ~~such~~ the successor makes application for the transfer of the account within 60 days after notification by the Commission of ~~his~~ the right to do so and the account is transferred, or meets the requirements for mandatory transfer, ~~he~~ the successor shall be assigned for the remainder of ~~such~~ the year the rate applicable to the predecessor employer or employers on the date of acquisition of the business, ~~provided~~ as long as there was only one predecessor ~~or if more than one and~~ or, if more than one, the predecessors

had identical rates. In the event the rates of the predecessor were not identical, the rate of the successor shall be the highest rate applicable to any of the predecessor employers on the date of acquisition of the business.

Irrespective of any other provisions of this Chapter, when an account is transferred in its entirety by an employer to a successor, the transferring employer shall thereafter pay the standard beginning rate of contributions ~~of two and seven tenths percent (2.7%)~~ set forth in G.S. 96-9(b)(1) and shall continue to pay at ~~such rate until he~~ that rate until the transferring employer qualifies for a reduction, reacquires the account ~~he~~ transferred or acquires the experience rating account of another employer, or is subject to an increase in rate under the conditions prescribed in G.S. 96-9(b)(2) and (3). ~~However, when an account is transferred in its entirety by an employer to a successor on or after January 1, 1987, the transferring employer shall thereafter pay the standard beginning rate of contributions of two and twenty-five hundredths percent (2.25%) and shall continue to pay at such rate until he qualifies for a reduction, reacquires the account he transferred or acquires the experience rating account of another employer, or is subject to an increase in rate under the conditions prescribed in G.S. 96-9(b)(2) and (3).~~"

Section 4. G.S. 96-12.01(b) reads as rewritten:

"(b) Effect of State Law Provisions Relating to Regular Benefits on Claims for, and for Payment of, Extended Benefits. -- Except when the result would be inconsistent with ~~G.S. 96-12 or~~ the other provisions of this ~~section,~~ section and in matters of eligibility determination, as provided in the regulations of the Commission, the provisions of this Chapter which apply to claims for, or the payment of, regular benefits shall apply to claims for, and the payment of, extended benefits."

Section 5. G.S. 96-12.01(c) is amended by adding a new subdivision to read:

"(5) An individual shall not be eligible for extended compensation unless the individual had 20 weeks of full-time insured employment, or the equivalent in insured wages, as determined by a calculation of base period wages based upon total hours worked during each quarter of the base period and the hourly wage rate for each quarter of the base period. For the purposes of this paragraph, the equivalent in insured wages shall be earnings covered by the State law for compensation purposes which exceed 40 times the individual's most recent weekly benefit amount or one and one-half times the individual's insured wages in that calendar

quarter of the base period in which the individual's insured wages were the highest."

Section 6. G.S. 96-15(a) reads as rewritten:

"(a) Filing. -- Claims for benefits shall be made in accordance with such regulations as the Commission may prescribe. Employers may file claims for employees through the use of automation in the case of Partial Unemployment. Each employing unit shall post and maintain in places readily accessible to individuals performing services for it printed statements, concerning benefit rights, claims for benefits, and such other matters relating to the administration of this Chapter as the Commission may direct. Each employing unit shall supply to such individuals copies of such printed statements or other materials relating to claims for benefits as the Commission may direct. Such printed statements and other materials shall be supplied by the Commission to each employing unit without cost to the employing unit."

Section 7. G.S. 96-15(b)(2) reads as rewritten:

"(2) Adjudication. -- When a protest is made by the claimant to the initial or monetary determination, or a question or issue is raised or presented as to the eligibility of a claimant under G.S. 96-13, or whether any disqualification should be imposed under G.S. 96-14, or benefits denied or adjusted pursuant to G.S. 96-18, the matter shall be referred to an adjudicator. The adjudicator may consider any matter, document or statement deemed to be pertinent to the issues, including telephone conversations, and after such consideration shall render a conclusion as to the claimant's benefit entitlements. The adjudicator shall notify the claimant and all other interested parties of the conclusion reached. The conclusion of the adjudicator shall be deemed the final decision of the Commission unless within ~~10 working~~ 15 days after the date of notification or mailing of the conclusion, whichever is earlier, a written appeal is filed pursuant to such regulations as the Commission may adopt. The Commission shall be deemed an interested party for such purposes and may remove to itself or transfer to an appeals referee the proceedings involving any claim pending before an adjudicator.

Provided, any interested employer shall be allowed ~~10 working~~ 15 days from the earlier of mailing or delivery of the notice of the filing of a claim against the employer's account to protest the claim and have the claim referred to an adjudicator for a decision on the question or issue raised. Provided further, no question or issue may be raised or presented by the Commission as to the eligibility of a claimant under G.S. 96-13, or whether any disqualification should be imposed under G.S. 96-14, after ~~20 working~~ 45 days from the first day of the first week after the question or issue occurs with respect to which week an individual filed a claim for

benefits. None of the provisions of this subsection shall have the force and effect nor shall the same be construed or interested as repealing any of the provisions of G.S. 96-18."

Section 8. G.S. 105-259(b)(9a) reads as rewritten:

"(9a) To furnish information to the Employment Security Commission to the extent required for its NC WORKS study of the working poor pursuant to G.S. 108A-29(r). The Employment Security Commission shall use information furnished to it under this subdivision only in a nonidentifying form for statistical and analytical purposes related to its NC WORKS study. The information that may be furnished under this subdivision is the following with respect to individual income taxpayers, as shown on the North Carolina income tax forms:

a. Name, social security number, spouse's name, spouse's social security number, and county of residence.

b. Filing status and federal personal exemptions.

c. Federal taxable income, additions to federal taxable income, and total of federal taxable income plus additional income.

d. Income while a North Carolina resident, total income from North Carolina sources while a nonresident, and total income from all sources.

e. Exemption for children, nonresidents' and part-year residents' exemption for children, and credit for children.

f. Expenses for child and dependent care, portion of expenses paid while a resident of North Carolina, portion of expenses paid while a resident of North Carolina that was incurred for dependents who were under the age of seven and dependents who were physically or mentally incapable of caring for themselves, credit for child and dependent care expenses, other qualifying expenses, credit for other qualifying expenses, total credit for child and dependent care expenses."

Section 9. G.S. 108A-29(q) reads as rewritten:

"(q) Each county Employment Security Commission local or branch office shall organize a Job Service Employer ~~Committee, based on the membership makeup of the Job Service Employer Committees in existence at the time this act becomes law.~~ Committee. The Chairman of the Employment Security Commission shall appoint the Job Service Employer Committee members, each of whom shall serve two-year terms, from persons nominated by the local Job Service Employer Committee. The Employment Security Commission shall organize a State Job Service Employer Committee consisting of eight members who shall serve two-year terms. The Chairman of the Employment Security Commission shall appoint the State Job Service Employer Committee members after consultation with the Governor. The Employment Security Commission shall adopt rules and regulations concerning the

meeting schedule and the conduct of meetings of each Job Service Employer Committee. Each Job Service Employer Committee in counties participating in the First Stop Employment Program shall oversee the operation of the First Stop Employment Program in that county and shall report to the local Employment Security Commission quarterly on its recommendations to improve the First Stop Employment Program. The Employment Security Commission shall develop the reporting method and time frame and shall coordinate a full report to be presented to the Joint Legislative Public Assistance Commission by the end of each calendar year. ~~Counties having a Workforce Development Board may designate the Board to perform the duties described in this section rather than organizing a Job Service Employer Committee.~~"

Section 10. G.S. 96-12(b)(4) reads as rewritten:

"(4) Qualifying Wages for Second Benefit Year. -- An individual whose prior benefit year has expired and who files a new benefit claim is not entitled to benefits unless the individual has been paid qualifying wages since the beginning date of the prior benefit year and before the date the new benefit claim was filed equal to at least ~~10 times the individual's weekly benefit amount under the new benefit claim.~~ six times the average weekly insured wage, obtained in accordance with G.S. 96-8(22), and has been paid wages in at least two quarters of the individual's base period. "Qualifying wages" are wages earned with an employer subject to the provisions of this Chapter or some other state employment security law or in federal service as defined in 5 U.S.C. Chapter 85."

Section 11. Sections 3, 7, and 10 of this act become effective July 1, 1999, with Sections 7 and 10 applying to unemployment insurance claims filed on or after that date. The remainder of this act is effective when it becomes law.

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

6-30-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Robert Paschal	Young, Moore & Henderson, P.A.
Tom Whitaker	ESC
David Clegg	ESC
Parker Chesson	ESC
Steve Woodson	NC Farm Bureau
Fran Piercy	NC Assn of Life Underwriters
"Bubba" Marion Smith	Lobbyist Extraordinaire
Jeanie Hart	NCAHP
LARRY PETERS	MERITOR AUTOMOTIVE, FLETCHER, NC
JOHN WISHART	ALAMAC KNIT FABRICS, LUMBERTON, NC
JOSEPH A SZAKASITS	RETIRED (THORN APPLE VALLEY)
Patrice Fells	ESC
Alan Miles	Bailey & Dixon LLP
Jerry Gno Bain	NCMS
Hugh Wilson	NCHA

SENATE INSURANCE COMMITTEE MEETING

JULY 7, 1999

AGENDA

H294	LIFE AND HEALTH INS. AMENDMENTS	REP. HURLEY

SENATE INSURANCE COMMITTEE MEETING MINUTES

JULY 7, 1999

The Senate Insurance Committee held its meeting on July 7, 1999, at 10:00 a.m. in room 1027 of the Legislative Building.

Senator Allen Wellons, Chairman, presided. Seven members were present.

The first agenda item was H294 Life and Health Ins. Amendments, which was introduced by Representative Hurley. Senator Harris moved the adoption of a Proposed Committee Substitute and the motion carried. Representative Hurley asked Bill Hale of the Insurance Department to explain the Committee Substitute. After the explanation, Senator Wellons offered two amendments. Amendment #1 is technical and was explained by Linwood Jones, Committee Counsel. Senator Reeves moved that the amendment be adopted and this motion passed. Amendment #2 was explained by Bill Hale and Senator Miller moved its adoption. This motion passed.

Senator Miller then moved that the amendments be rolled into a Committee Substitute, and given a favorable report. This motion passed.

The meeting was adjourned at 10:30.

Senator Allen Wellons
Chairman

Margaret Hogan

Margaret M. Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Wednesday, July 07, 1999

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)**294** Life & Health Ins. Amendments/AB

Draft Number:	PCS 1313
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 294

AMENDMENT NO. 1
(to be filled in by
Principal Clerk)

H294-ARN-003

Page 1 of __

Date July 7 ,1999

Comm. Sub. [X]
Amends Title [X]
PCS Edition

Sen. Wellons

moves to amend the bill on page 1, line 13, by deleting the word "AND";

and on page 1, line 15, by inserting the following after the word "COUNSELORS" and before the period: "; AND TO MAKE A TECHNICAL CHANGE CONCERNING THE CLAIMS ACKNOWLEDGEMENT STATUTE;"

and on page 17, line 40, by inserting the following:

"**PART 8A. TECHNICAL CHANGE/CLAIMS SETTLEMENT STATUTE**

Section 8.1. If ratified Senate Bill 766 (1999 Session) becomes law, then G.S. 58-65-125(c), as enacted by Section 3 of that act, is repealed."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 294

AMENDMENT NO. 2
(to be filled in by
Principal Clerk)

H294-ARN-001

Page 1 of __

Date July 7 ,1999

Comm. Sub. [X]
Amends Title [X]
PCS Edition

Sen. Wellons

moves to amend the bill on page 1, lines 9-10, by deleting the phrase "TO PROVIDE NOTICE OF CANCELLATION OF SURPLUS LINES POLICIES;";

and on page 14, line 44, through page 16, line 2, by deleting those lines (being all of PART 6), and renumbering the remaining Parts and sections accordingly;

and on page 18, line 5, by deleting "Section 8" and inserting "Section 7";

and on page 18, line 5 by deleting the following sentence:
"Section 6 of this act becomes effective July 1, 2000."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 294:
Life and Health Insurance Amendments

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Rep. Hurley
Date:	June 30, 1999	**Summary by:**	Linwood Jones
Version:	PCS for 2nd Edition		Committee Counsel

SUMMARY: This bill makes changes to various insurance laws, primarily life and health insurance provisions.

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 contest coverage or deny benefits if the insured fraudulently misstated his or her health condition during the application/enrollment 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 provider," and "viatical settlement representative." A viatical settlement provider does not include a lending institution that takes an assignment of a policy as collateral for a loan, an insurer that issues a policy providing accelerated death benefits, a natural person who enters into no more than one viatical settlement transfer per year, and a financing entity that contracts with viatical settlement providers to fund the viatical settlement. 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 *void.* (SB 430, the companion bill to this bill, provides that failure to provide the consideration into escrow when due renders the contract *voidable*).

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, provides coverage for 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. The benefits are paid to the creditor to reduce the indebtedness. 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. To be eligible for coverage, the employee must be less than 71 and must have worked at least 30 hours per week for the previous 5 consecutive weeks.

The rates charged by insurers for this coverage must be based on a 60% loss ratio. Rates must be approved by the Commissioner of Insurance. Benefits are paid out on a monthly basis, at a level amount, although lump-sum payments are allowed. The insurer must also file claims and loss information annually with the Commissioner.

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 leave credit insurance.

PART 6. SURPLUS LINES CANCELLATION

Section 6 provides for notice of cancellation of surplus lines policies. The surplus lines company must give 30 days notice of cancellation to the policyholder, except that 15 days notice can be given for nonpayment of premium, material misrepresentation under the policy, unexpected change in risk under the policy, a breach of contract, fraud, or conviction of a crime that materially affects insurability, failure to exercise reasonable loss control measures that materially affects insurability, and certain other instances. Thirty days notice is also required for nonrenewal of a surplus lines policy. The reason for nonrenewal or cancellation must be included in the notice. The notice of cancellation or nonrenewal must also be sent to the designated mortgagee or other loss payee on the policy; failure to do so invalidates the cancellation or nonrenewal with respect to the mortgagee or loss payee's interest.

This section becomes effective July 1, 2000.

PART 7. LOCAL GOVERNMENT RISK POOL CLARIFICATION

Section 7 clarifies that local government risk pools (under which local governments can pool their property, liability, or workers' compensation risks) are regulated exclusively under Article 23 of the insurance laws (Chapter 58) and are not subject to the other provisions of Chapter 58 unless those laws specifically refer to the pools. Article 23 makes the pools subject to a number of solvency and investment laws applicable to insurance companies.

PART 8. CONFORMING CHANGES FOR STATE HEALTH PLAN REIMBURSEMENT FOR PASTORAL COUNSELORS

Section 8 makes conforming changes to statutes that were inadvertently omitted from Senate Bill 293, which was enacted earlier this session. Senate Bill 293 removed a July 1, 1999, expiration date on pastoral counselors being able to receive insurance reimbursement from insurance companies and under the State Health Plan. However, there were two additional reimbursement provisions for pastoral counselors under the State Health Plan that had a July 1, 1999, expiration date that matched the expiration date of the other provisions. Section 8 removes these additional expiration dates to conform to SB 293.

PART 9. EFFECT OF HEADINGS

Section 9 provides that the headings in the bill are merely a reference.

PART 10. EFFECTIVE DATE

Section 10 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. Section 8 of the bill, which makes the conforming change to the State Health Plan, is retroactively effective to June 30, 1999. Section 6 of the act, relating to notice of cancellation and nonrenewal of surplus lines insurance policies, becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 294
Committee Substitute Favorable 4/12/99
Proposed Committee Substitute H294-PCS1301-RN

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; TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE; TO PROVIDE NOTICE OF CANCELLATION OF SURPLUS LINES POLICIES; TO CLARIFY THAT LOCAL GOVERNMENT INSURANCE RISK POOLS ARE SUBJECT TO INSURANCE LAWS IN CHAPTER 58 ONLY WHEN SPECIFICALLY REFERRED TO IN THOSE LAWS; AND TO MAKE CONFORMING CHANGES IN THE STATE HEALTH PLAN REIMBURSEMENT FOR PASTORAL COUNSELORS.

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, reinsurer, 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.

d. A financing entity (i) whose sole activity related to the transaction is providing funds to effect the viatical settlement provider and (ii) that has a written agreement with a licensed viatical settlement provider to act as a participant in a financing transaction.

(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,~~ stockholders directly or indirectly holding ten percent (10%) or more of the voting securities of the viatical settlement provider, partners, officers, and employees. The Commissioner may refuse registration of any partnership, corporation, or other business entity if not satisfied that any stockholder directly or indirectly holding ten percent (10%) or more of the voting securities of the viatical settlement provider, 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 of the insured person.

(3) 'Placement in the foster home' means physically residing with the insured person appointed as the guardian or custodian of a foster child or children as long as the insured person has assumed the legal obligation for total or partial support of the foster child or children with the intent that the foster child or children reside with the insured person 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 granted upon the occurrence of any of the qualifying events in subsection (d) of this section. The insured person 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 person's indebtedness.

(c) Eligibility. -- Coverage may be provided or offered to any debtor who has not yet reached his or her 71st birthday and has been working for wages for at least 30 hours per week for the past five consecutive weeks.

(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 person to attend to the family member's needs.

(2) Birth of a child or children of the insured person.

(3) Adoption of a child or children of the insured person.

(4) Placement in the foster home of a foster child or children.

(5) The insured person's principal residence is in a federally declared disaster area.

(6) The insured person is called to active military duty.

(7) The insured person is called to petit or grand jury duty.

(e) Exclusions. -- Coverage shall not contain any exclusions except:

(1) Retirement of the insured person from employment.

(2) Voluntary resignation of the insured person from employment.

(3) Seasonal unemployment of the insured person.

(4) Involuntary unemployment of the insured person.

(5) Disability of the insured person.

(6) Employment termination because of willful or criminal misconduct of the insured person.

(f) Notice. -- The insurer shall send a notice to the insured person at the insured person's home address to inform the insured person that benefits have been paid, including the dates and the amount of payment. The notice shall be sent to the insured person 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 may be paid. 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%) incurred 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 31 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 earned premium, total number of incurred claims, total incurred claims, total number of incurred claims for each qualifying event, average monthly benefit per claim for each qualifying 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 leave credit 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 payments 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. SURPLUS LINES CANCELLATION.

Section 6. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-51. Cancellations and nonrenewals, notice requirement.**

(a) Any cancellation of a surplus lines policy is not effective unless written notice of the cancellation has been delivered or mailed to the insured, no fewer than 30 days before the proposed effective date of cancellation.

(b) A surplus lines insurer may give 15 days' notice of cancellation of a surplus lines policy if the cancellation is for any of the following reasons:

(1) Nonpayment of premium in accordance with the policy terms.

(2) An act or omission by the insured or his representative that constitutes material misrepresentation or nondisclosure of a material fact in obtaining the policy, continuing the policy, or presenting a claim under the policy.

(3) Increased hazard or material change in the risk assumed that could not have been reasonably contemplated by the parties at the time of assumption of the risk.

(4) Substantial breach of contractual duties, conditions, or warranties that materially affects the insurability of the risk.

(5) A fraudulent act against the company by the insured or his representative that materially affects the insurability of the risk.

(6) Willful failure by the insured or his representative to institute reasonable loss control measures that materially affect the insurability of the risk after written notice by the insurer.

(7) Loss of facultative reinsurance, or loss of or substantial changes in applicable reinsurance as provided in G.S. 58-41-30.

(8) Conviction of the insured of a crime arising out of acts that materially affect the insurability of the risk.

(9) A determination by the Commissioner that the continuation of the policy would place the insurer in violation of the laws of this State.

A cancellation of a surplus lines policy under this subsection is not effective unless written notice of the cancellation has been delivered or mailed to the insured.

(c) A surplus lines insurer may refuse to renew a policy that has been written for a term of one year or less at the policy's expiration date by giving or mailing written notice of nonrenewal to the insured no fewer than 30 days before the expiration date of the policy.

(d) A surplus lines insurer may refuse to renew a policy that has been written for a term of more than one year or for an indefinite term at the policy anniversary date by giving or mailing written notice of nonrenewal to the insured no fewer than 30 days before the anniversary date of the policy.

(e) The notice required by this section must be given or mailed to the insured and any designated mortgagee or lost payee at their addresses shown in the policy or, if not indicated in the policy, at their last known addresses. Proof of mailing is sufficient proof of notice. The notice of cancellation or nonrenewal must state the precise reason for cancellation or nonrenewal. Failure to send this notice to any

designated mortgagee or loss payee invalidates the cancellation or nonrenewal only as to the mortgagee's or loss payee's interest."

PART 7. LOCAL GOVERNMENT RISK POOL CLARIFICATION.

Section 7. Article 23 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-23-45. Relationship to other insurance laws.**

Unless local government risk pools are specifically referenced in a particular section of this Chapter, no provisions in this Chapter other than this Article apply to local government risk pools."

PART 8. CONFORMING CHANGES FOR STATE HEALTH PLAN REIMBURSEMENT FOR PASTORAL COUNSELORS.

Section 8. 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.~~ counselors.

(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~~ Certified fee-based practicing pastoral ~~counselors until July 1, 1999;~~ counselors; and
k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:
   1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
   2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
   3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

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

PART 9. EFFECT OF HEADINGS.

Section 9. 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 10. EFFECTIVE DATE.

Section 10. Sections 2, 4, 5.1, 5.2, and 5.3 of this act become effective October 1, 1999. Section 8 of this act is retroactively effective to June 30, 1999. Section 6 of this act becomes effective July 1, 2000. The remainder of this act is effective when it becomes law.

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.

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

7-6-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Joe Johnson	Ridgdale Insurance
Rita Pashal	Young, Morris
Bobby Penn	Jordan Price
Jane Ramquist	NCSOS
Joyce Peters	JPAssoc / MAMSI
Cam Cover	BPMHL
Max Nunnelee	Poyner & Spruill
Larry Heckner	Household Financial Group
Anne Dixon	NCJCDC
John Cyrus	NC State Grange
Jim Dorsett	NCAHIP
Ken Kimin	Amer General

SENATE

INSURANCE COMMITTEE MEMBERS

SENATOR ALLEN WELLONS, CHAIRMAN

SENATOR OSCAR HARRIS, VICE CHAIRMAN

SENATOR BOB MARTIN, VICE CHAIRMAN

SENATOR ERIC REEVES, VICE CHAIRMAN

SENATOR R. C. SOLES, VICE CHAIRMAN

SENATOR FRANK BALLANCE

SENATOR PATRICK BALLANTINE

SENATOR JOHN CARRINGTON

SENATOR DON EAST

SENATOR STEPHEN METCALF

SENATOR BRAD MILLER

SENATOR TONY RAND

SENATOR HUGH WEBSTER

CINDY AVRETTE – COUNSEL
TRINA GRIFFIN – COUNSEL
FRANK FOLGER – COUNSEL
PEGGY ANNE HOGAN - CLERK

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium — SENATE: 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	04-05-99	04-08-99
H 276	REDWINE	OMNIBUS ESC CHANGES	R -CH. SL 99-0340	04-22-99	07-01-99
H 277	REDWINE	"FAMILY FRIENDLY" UI EXCEPTION	*R -CH. SL 99-0196	04-26-99	06-01-99
H 294=	HURLEY	LIFE AND HEALTH INS. AMENDMENTS	*R -CH. SL 99-0351	04-14-99	07-07-99
H 296=	HURLEY	INSURANCE TECHNICAL CHANGES	*R -CH. SL 99-0132	04-21-99	05-19-99
H 306=	HARDAWAY	INSURANCE AMENDMENTS	*R -CH. SL 99-0219	04-19-99	05-19-99
H 314	BOYD-MCINTYRE	INSURANCE COVG./BONE MASS MSMT	*R -CH. SL 99-0197	04-29-99	06-02-99
H 714=	ALEXANDER	SUBSTANCE ABUSE/DIRECT PAY	*R -CH. SL 99-0199	04-28-99	06-02-99
H 736	ROGERS	MANAGED CARE/PATIENT ACCESS	*S -RE-REF COM ON COMMERCE	05-03-99	05-04-99
H1025	GARDNER	GROUP HEALTH CONTINUATION INSURANCE	R -CH. SL 99-0273	04-27-99	06-23-99
H1119	WRIGHT	CHILDREN/DISABLE ANESTH. DENTAL CARE	*R -CH. SL 99-0134	04-28-99	05-19-99
H1186	MINER	UNEARNED PREMIUM RESERVES	*R -CH. SL 99-0383	04-28-99	06-02-99
H1518=	CHURCH	CREDIT INS. CLARIFICATION	*R -CH. SL 00-0132	00-07-05	00-07-06
H1529=	NYE	HMO INSOLVENCY	*S -RE-REF COM ON FINANCE	00-06-28	00-07-06
H1696	**WAINWRIGHT**	**FIRE INS PUBLIC PROTECTION**	**H -PRES. TO GOV. 07-11**	**00-07-04**	**00-07-06**
H1696	**WAINWRIGHT**	**FIRE INS PUBLIC PROTECTION**	**H -PRES. TO GOV. 07-11**	**00-07-06**	**00-07-06**
S 167=	SOLES	JUA REAUTHORIZATION	S -REF TO COM ON INSURANC	02-24-99	
S 293	COOPER	PASTORAL COUNSELING REIMB/SUNSET OFF	*R -CH. SL 99-0186	03-08-99	04-01-99
S 345	FORRESTER	URO REVIEWS BY NC PHYSICIANS	R -CH. SL 99-0391	04-07-99	04-21-99
S 347	FORRESTER	PRES.DRUG FORMULARIES	*R -CH. SL 99-0178	03-15-99	04-14-99
S 389	MARTIN R	TOWN/COUNTY FINANCIAL REPORTS	*R -CH. SL 99-0192	03-16-99	04-07-99
S 394	HARTSELL	CREDIT CARD PAYMENT OF INSURANCE	*R -CH. SL 99-0365	03-17-99	04-01-99
S 427=	WELLONS	INSURANCE AMENDMENT	S -REF TO COM ON INSURANC	03-22-99	
S 428=	WELLONS	INSURANCE TECHNICAL CHANGES	S -REF TO COM ON INSURANC	03-22-99	
S 430=	WELLONS	LIFE & HEALTH INS. AMENDMENTS	S -REF TO COM ON INSURANC	03-22-99	
S 513	WELLONS	PRESC. DRUG ID CARD	*R -CH. SL 99-0343	03-25-99	04-28-99
S 533	CARTER	HEALTH CARE PILOT PROGRAM	S -RE-REF COM ON INSURANC	04-26-99	
S 594	MILLER B	MISC. INSURANCE CHANGES	*R -CH. SL 99-0294	03-29-99	04-22-99
S 643=	REEVES	INSURANCE PREMIUM FINANCING	*R -CH. SL 99-0157	03-30-99	04-28-99
S 766	MILLER B	SERVICE CORP. AND HMO LAWS	R -CH. SL 99-0244	04-06-99	04-21-99

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

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

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

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
S 836=	MARTIN R	MENTAL HEALTH/CHEM. DEP. PARITY	S -REF TO COM ON INSURANC	04-13-99	
S 839	WELLONS	INSURANCE CLAIMS PAYMENTS/Y2K	*R -CH. SL 99-0184	04-13-99	04-28-99
S 880=	MARTIN W	CHILD HEALTH INS./SUPPORT ORDERS	S -REF TO COM ON INSURANC	04-13-99	
S 946=	MARTIN W	SUBSTANCE ABUSE/DIRECT PAY	S -REF TO COM ON INSURANC	04-14-99	
S1089	HARRIS	MANAGED CARE STUDY	*HF-POSTPONED INDEFINITELY	04-15-99	04-28-99
S1090	HARRIS	HEALTH INS/ANY WILLING PROVIDER	S -REF TO COM ON INSURANC	04-15-99	
S1108	**HARRIS**	**HEALTH INS./CONSUMER ADVOCATE**	**S -REF TO COM ON INSURANC**	**04-15-99**	
S1109	**HARRIS**	**PRESC. DRUGS FUNDS**	**S -REF TO COM ON INSURANC**	**04-15-99**	
S1398=	WELLONS	INSURANCE LICENSE FEES/RECIPROCITY	*S -RE-REF COM ON FINANCE	00-05-23	00-06-12

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.

SENATE INSURANCE COMMITTEE MEETING

MINUTES

MAY 31, 2000

The Senate Insurance Committee held its first meeting of the Short Session at 10:00 a.m. on May 31, 2000, in room 1026 of the Legislative Building.

The chairman, Senator Wellons called the meeting in order to hear from different entities of the insurance industry regarding flood insurance.

The speakers were Phil Letsinger of the Division of Emergency Management of the NC Department of Crime Control & Public Safety. He is the National Flood Insurance Program Branch Manager, NFIP State Coordinator; Ed Baird, Director of Property Claims, Nationwide Insurance; and Rick Riddle of Royal Insurance Company.

After a very informative meeting, it was adjourned at 11:00 a.m.

Allen H. Wellons
Chairman

Margaret Hogan

Margaret M. Hogan
Clerk

SENATE INSURANCE COMMITTEE MEETING

AGENDA

MAY 31, 2000

Phil Letsinger – Division of Emergency Management of the NC Department Of Crime Control & Public Safety. National Flood Insurance Program Branch Manager, NFIP State Coordinator

Ed Baird Director of Property Claims, Nationwide Insurance

Allen Miles Royall Insurance Company

VISITOR REGISTRATION SHEET

SENATE INSURANCE — Name of Committee

5-31-00 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Rebecca Smith	Freedom News
Greg Retsinas	NY Times Group
Alan Briggs	Save Our State
J. STEVEN LEE	NC League of Municipalities
Jim Ailsworth	"
John McMillan	Manning, Fulton & Skinner PA
Steve Woodson	NC Farm Bureau Fed.
David Meredith	NC State Grange
Glenn Lamm	UTU.
Doris Weaver	N.C. CWA Political Council
Bill Truitt	Young More Henderson PA
Tim Lucas	4908 Deer Garden Ct, Raleigh, NC

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June 28, 2000

The Honorable Allen B. Wellons
North Carolina State Senate
Legislative Building, Room 1026
Raleigh, North Carolina 27601-2808

Dear Senator Wellons:

Thank you for giving me the opportunity to address your committee last week. Since we did not have time to cover all of the information I had planned to share with you, I thought a list of facts might be helpful to you and the insurance committee.

- In 1998 (the most recent year available), the insurance industry wrote $771,000,000 of homeowners' premium in North Carolina.

- The total insured losses resulting from Hurricane Floyd exceeded $773 million, approximately $400 million paid by conventional (non-flood) personal insurance and $373 million paid by the National Flood Insurance Program for both personal and commercial claims.

- Homeowners' policies do cover certain claims for water damage, despite the exclusion for flood coverage. An example of a type of water damage claim caused by Floyd that would be covered by homeowners' insurance is if the wind blows a portion of the roof off of a house and rain enters the house causing water damage to the internal construction and contents of the house.

- The average loss ratio of the insurance industry for homeowner's insurance in North Carolina for the three years from 1996 to 1998 was 111.5. This means that for every premium dollar collected, 111.5 cents were paid out in losses. The figure does not include expenses such as agent commissions, employee salaries, claims adjustment expenses, legal fees etc.

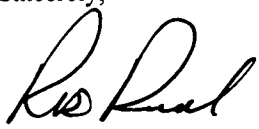
- For 1998 alone, that loss ratio figure for the insurance industry for homeowners' insurance in North Carolina was 76.3.

- The North Carolina Department of Insurance is requiring all insurers to attach the enclosed notice, effective with July 1st new business and August 15th renewals, to all North Carolina homeowners' policies.

- Nearly all of the adjusters that Royal & SunAlliance used in the aftermath of Hurricane Floyd were independent adjusters who were also "flood certified". As a result, these adjusters were able to adjust the homeowners' portion and the flood portion of each claim simultaneously.

I hope this information is helpful to you and the committee. Please feel free to call on me if I maybe of additional service to you.

Sincerely,



Richard B. Riddle, CPCU, CLU
General Manager, Southeast Territory

Enclosure

FLOOD INSURANCE NOTICE

The North Carolina Department of Insurance has requested the North Carolina Insurance Underwriting Association, the North Carolina Joint Underwriting Association, and all property and casualty companies to advise their policyholders that the **type of policy does not provide coverage for floods. You will not have coverage for property damage from floods unless you take steps to purchase a separate policy of flood insurance.**

This Notice does not expand or increase coverage in any **type of policy policy or endorsement. That policy and accompanying endorsements remain subject to all exclusions, limitations and conditions.**

If you would like more information about obtaining flood insurance, please contact your agent at _____ (please furnish telephone number of agent) or this company/association at _____ (please furnish telephone number of company/association).

SENATE INSURANCE COMMITTEE MEETING

MINUTES

JUNE 7, 2000

The Senate Insurance Committee held its meeting at 10:00 a.m. on June 7, 2000, in room 1027 of the Legislative Building.

Senate Bill 1398, Insurance License Fees/Reciprocity/AB was sponsored by Senator Wellons. Senator Wellons moved the adoption of a Proposed Committee Substitute. This motion passed, and the Chairman called on Bill Hale of the Insurance Department to explain the bill. Mr. Hale gave a brief explanation and background and called on Jim Kerr who represents the National Club to explain Section 7 which is found on page 6, line 31.

After a brief discussion, Senator Wellons turned the chair over to Senator Harris who called for a vote. Senator Reeves moved for a Favorable Report for the Proposed Committee Substitute, and the motion passed unanimously. The bill will then be sent to Finance.

There being no further business, the meeting was adjourned.

Senator Allen Wellons
Chairman

Margaret Hogan
Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Tuesday, June ~~20~~ 12, 2000

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **1398** Insurance License Fees/Reciprocity/AB

Draft Number:	PCSA687
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment:

AGENDA

SENATE INSURANCE COMMITTEE MEETING

JUNE 7, 2000

S1398 INSURANCE LICENSE FEES/RECIPROCITY SEN. WELLONS

PCS FOR SENATE BILL 1398 : INSURANCE LICENSE FEES/RECIPROCITY

BILL ANALYSIS

Committee:	Senate Insurance	**Introduced by:**	Senator Wellons
Date:	June 7, 2000	**Summary by:**	Trina Griffin*
Version:	PCS 1st Edition		Committee Counsel

SUMMARY: ***This bill reduces the annual licensing fee for nonresident insurance brokers. This bill 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. These provisions are modeled after the Producer Licensing Model Act drafted and adopted by the National Association of Insurance Commissioners. This bill also makes some technical changes and clarifications of miscellaneous insurance provisions.***

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 these requirements 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 law.

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 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.

The following sections were not included in the original bill:

Section 4 of the bill changes the applicable examination requirements for financial analysts and examiners who work for the Department of Insurance. The bill proposes that a financial analyst or examiner must have taken all courses necessary to qualify for the CPA examination based on the examination requirements ***in effect at the time the applicant graduated from an accredited college or university*** (in addition to satisfying the minimum education requirements). The current law requires that the analyst or examiner have taken the courses required for the CPA examination in effect at the time of employment by the Department.

Sections 5 and 6 of the bill clarify the definition of "person" as used in two Articles in the Chapter on Insurance: Essential Property Insurance for Beach Area Property (Article 45) and Fair Access to Insurance Requirements (Article 46). Both Articles involve the NC Insurance Underwriting Association which was established as a market of last resort for customers who have difficulty obtaining property insurance in the voluntary market. The bill states that "person" as used in these Articles shall include the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina. For Article 45, the proposed definition would clarify that cities and counties with an insurable interest in beach property are eligible to apply to the Association for coverage. For Article 46, the proposed definition would ensure that cities and counties were eligible for coverage under the FAIR Plan which covers all other property.

Section 7 of the bill refines the definition of a motor club or association "branch or district office," which must be licensed by the Commissioner of Insurance. The current law defines a branch or district office as ***any physical location, other than the home office, where representatives conduct business***. This bill would change that definition to any physical location, other than the home office, that is used as a ***principal place of business and a place of business used by clients in meeting or dealing with motor club representatives in the normal course of business***.

This act would become effective when it becomes law.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1398
Proposed Committee Substitute S1398-PCSA687-SV001

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

Sponsors:

Referred to:

May 23, 2000

A BILL TO BE ENTITLED

AN ACT TO EQUALIZE RESIDENT AND NONRESIDENT INSURANCE BROKER LICENSE FEES; TO MAKE NORTH CAROLINA INSURANCE PRODUCER LICENSING LAWS COMPLY WITH THE RECIPROCITY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102; TO AMEND THE MINIMUM EDUCATION REQUIREMENTS FOR THE DEPARTMENT OF INSURANCE FINANCIAL EXAMINER AND ANALYST APPLICANTS; TO AMEND THE DEFINITION OF "PERSON" IN THE BEACH AND FAIR PLAN LAWS; AND TO AMEND THE DEFINITION OF "BRANCH OFFICE" IN THE MOTOR CLUB LAWS.

The General Assembly of North Carolina enacts:

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

"(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)."

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. G.S. 58-2-25(b) reads as rewritten:

"(b) The minimum education requirements for financial analysts and examiners referred to in subsection (a) of this section are a bachelors degree, with the appropriate courses in accounting as defined in 21 NCAC 8A.0309, and other courses that are required to qualify the applicant as a candidate for the uniform certified public accountant examination, based on the examination requirements in effect at the time of ~~employment by the Department of the analyst or examiner.~~ graduation by the analyst or examiner from an accredited college or university."

Section 5. Article 45 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-45-6. Persons who can be insured by the Association.**

As used in this Article, 'person' includes the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina."

Section 6. Article 46 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-46-2. Persons who can be insured by the Association.**

As used in this Article, 'person' includes the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina."

Section 7. G.S. 58-69-2(1) reads as rewritten:

"(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~~ office, that is used by the motor club or its representatives as a principal place of business for conducting any type of business authorized under this ~~Article.~~ Article and as a place of business that is used by clients or prospective clients in meeting or dealing with the motor club or its representatives in the normal course of business authorized under this Article."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1398
Proposed Committee Substitute S1398-CSSV-001
WARNING: LINE NUMBERS MAY CHANGE AFTER ADOPTION.

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

Sponsors:

Referred to:

June 7, 2000

A BILL TO BE ENTITLED

AN ACT TO EQUALIZE RESIDENT AND NONRESIDENT INSURANCE BROKER LICENSE FEES; TO MAKE NORTH CAROLINA INSURANCE PRODUCER LICENSING LAWS COMPLY WITH THE RECIPROCITY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102; TO AMEND THE MINIMUM EDUCATION REQUIREMENTS FOR THE DEPARTMENT OF INSURANCE FINANCIAL EXAMINER AND ANALYST APPLICANTS; TO AMEND THE DEFINITION OF "PERSON" IN THE BEACH AND FAIR PLAN LAWS; AND TO AMEND THE DEFINITION OF "BRANCH OFFICE" IN THE MOTOR CLUB LAWS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-33-125(a) 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)."

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. G.S. 58-2-25(b) reads as rewritten:

"(b) The minimum education requirements for financial analysts and examiners referred to in subsection (a) of this section are a bachelors degree, with the appropriate courses in accounting as defined in 21 NCAC 8A.0309, and other courses that are required to qualify the applicant as a candidate for the uniform certified public accountant examination, based on the examination requirements in effect at the time of ~~employment by the Department of the analyst or examiner.~~ graduation by the analyst or examiner from an accredited college or university."

Section 5. Article 45 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-45-6. Persons who can be insured by the Association.**

As used in this Article, 'person' includes the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina."

Section 6. Article 46 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-46-2. Persons who can be insured by the Association.**

As used in this Article, 'person' includes the State of North Carolina or any county, city, or other political subdivision of the State of North Carolina."

Section 7. G.S. 58-69-2(1) reads as rewritten:

"(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~~ office, that is used by the motor club or its representatives as a principal place of business for conducting any type of business authorized under this ~~Article.~~ Article and as a place of business that is used by clients or prospective clients in meeting or dealing with the motor club or its representatives in the normal course of business authorized under this Article."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1398

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

Sponsors: Senator Wellons.

Referred to: Insurance.

May 23, 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.

VISITOR REGISTRATION SHEET

SENATE INSURANCE — 6-7-00

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Stella McKinney	NC Dept. of Insurance
John Peterson	NCINS
Susan Valaoras	Nationwide
John McMillan	Manning Fulton & Skinner P.A.
Lisa Pierce	Ans. & Financial Advisors
Bob Prum	Jaden Prum
Robert Pasahal	Young, Moore & Henderson, P.A.
Alan Miles	Bailey & Dixon LLP
Boyd Cauble	City of Charlotte

SENATE INSURANCE COMMITTEE MEETING

July 5, 2000

The Senate Insurance Committee held a meeting on July 5, 2000 around Senator Wellons' desk in the Senate Chamber

House Bill 1529, HMO Insolvency was considered. A Proposed Senate Committee Substitute was adopted and Senator Harris moved for a favorable report. This motion passed unanimously. Senator Rand stated that the bill should go to Finance.

There being no further business, the meeting was adjourned.

Allen H. Wellons
Committee Chairman

Margaret Hogan
Margaret M. Hogan
Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Thursday, July 06, 2000

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1)**1518** Credit Ins. Clarification
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE C.S. BILL

H.B. **1529** HMO Insolvency
Draft Number: PCS 2455
Sequential Referral: None
Recommended Referral: Finance
Long Title Amended: No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2)**1696** Fire Ins. Public Protection/AB
Draft Number: PCS2457
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 3

Committee Clerk Comment:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1529*
Second Edition Engrossed 6/27/00

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 and notify in writing 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1529*
Second Edition Engrossed 6/27/00
Proposed Senate Committee Substitute H1529-PCS2455

Short Title: HMO Insolvency. (Public)

Sponsors:

Referred to:

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 and notify in writing 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 October 1, 2001.

SENATE INSURANCE COMMITTEE MEETING

JULY 6, 2000

The Senate Insurance Committee met on July 6, 2000 in the Senate Chamber around Senator Wellons' desk.

House Bill 1518, Credit Ins. Clarification, was considered, and Senator Metcalf moved for a favorable report. This passed unanimously.

House Bill 1696, Fire Ins. Public Protection/AB was considered. Senator Miller moved the adoption of a Proposed Committee Substitute. This was approved, and upon a motion by Senator Reeves, it was given a favorable report.

There being no further business, the meeting was adjourned.

Allen H. Wellons
Committee Chairman

Margaret Hogan
Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Allen Wellons, Chair

Thursday, July 06, 2000

SENATOR ALLEN WELLONS,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1)**1518** Credit Ins. Clarification
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE C.S. BILL

H.B. **1529** HMO Insolvency
Draft Number: PCS 2455
Sequential Referral: None
Recommended Referral: Finance
Long Title Amended: No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2)**1696** Fire Ins. Public Protection/AB
Draft Number: PCS2457
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 3

Committee Clerk Comment:

House Bill 1518 makes clarifications in the insurance code to facilitate new monthly premiums for voluntary credit accident and health insurance on longer term loans; longer than 15 years.

This law is required to comply with the consumer protections of our new high cost mortgage lending law.

The Department of Insurance and the Attorney General's Office have worked with insurance companies and consumer interest groups to refine the recommendations of a study committee I co-chaired.

This version remains a technical change and does not amend any current rates or coverage. Everyone is in agreement to have this bill pass.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1518
Committee Substitute Favorable 6/30/00

Short Title: Credit Ins. Clarification. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT GROUP CREDIT ACCIDENT AND HEALTH INSURANCE MAY BE ISSUED TO A CREDITOR TO INSURE DEBTORS OF THE CREDITOR.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-51-80(b) reads as rewritten:

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

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

agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

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

c. Repealed by Session Laws 1997-259, s. 8.

(1b) Under a policy issued to a creditor as defined in G.S. 58-57-5 who shall be deemed the policyholder, to insure debtors as defined in G.S. 58-57-5 of the creditor to provide indemnity for payments becoming due on a specific loan or other credit transaction as defined in G.S. 58-51-100, with or without insurance against death by accident, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations, and the debtors of one or more

affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise.

b. The premium for the policy shall be paid from the creditor's funds, from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors or identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless the group is structured on an actuarially sound basis. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least 100 persons yearly, or may reasonably be expected to receive at least 100 new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent (75%) of the new entrants become insured.

d. Premiums for this coverage shall be actuarially equivalent to the rates authorized under Article 57 of Chapter 58 of the General Statutes for credit accident and health insurance.

(2), (3) Repealed by Session Laws 1997-259, s. 8."

Section 2. This act is effective on and after July 1, 2000.

HOUSE BILL 1696 – FIRE INSURANCE PUBLIC PROTECTION DISTRICTS

FOR MANY YEARS THE INSURANCE SERVICES OFFICE (ISO), A PRIVATE CORPORATION FUNDED BY THE INSURANCE INDUSTRY, WOULD ESTABLISH PUBLIC PROTECTION DISTRICTS FOR THE PURPOSE OF SETTING PREMIUM RATES FOR HOMEOWNERS' AND PROPERTY INSURANCE. ISO WOULD VISIT FIRE DEPARTMENTS, EVALUATE THEIR ABILITIES TO RESPOND TO FIRES, AS WELL AS THE QUALITY OF THEIR EQUIPMENT, AND SET THE FIRE DISTRICT RATING.

IN THE 1980's, THE JOB ISO WAS DOING IN THE RURAL AREAS OF THE STATE DETERIORATED. THE GENERAL ASSEMBLY GAVE THE COMMISSIONER OF INSURANCE (WHO ALSO THE STATE FIRE MARSHAL) THE DUTY OF RATING THE FIRE DEPARTMENTS.

THE JOB ISO HAS BEEN DOING IN THE SMALL CITIES AND TOWNS HAS FURTHER DETERIORATED. AS A RESULT, FIRE DEPARTMENTS ARE NOT BEING RATED PROPERLY AFTER THEY HAVE UPGRADED THEIR EQUIPMENT AND RESPONSE ABILITIES, AND THE PEOPLE IN THOSE FIRE DISTRICTS ARE PAYING MORE FOR THEIR HOMEOWNERS AND PROPERTY INSURANCE THAN THEY SHOULD BE.

THIS BILL SIMPLY GIVES THE COMMISSIONER THE AUTHORITY TO RATE FIRE DEPARTMENTS IN CITIES WITH POPULATIONS OF 10,000 OR FEWER PEOPLE. THE COMMISSIONER CAN DO A MUCH BETTER JOB THAN ISO, AND PEOPLE IN THESE FIRE DISTRICTS THAT ARE IMPROVED WILL PAY LESS FOR THEIR INSURANCE.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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HOUSE BILL 1696
Committee Substitute Favorable 6/22/00
Committee Substitute #2 Favorable 6/29/00

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

Sponsors:

Referred to:

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.

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. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1696
Committee Substitute Favorable 6/22/00
Committee Substitute #2 Favorable 6/29/00
Proposed Senate Committee Substitute H1696-PCS2457-SO002

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

Sponsors:

Referred to:

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 INSURANCE RATING PURPOSES.

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. The standards developed by the Commissioner are subject to Article 2A of Chapter 150B of the General Statutes. The insurance public protection classifications established by the Commissioner issued pursuant to the provisions of this Article shall be subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions stated in G.S. 58-2-75(a) do not apply."

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. The standards developed by the Commissioner are subject to Article 2A of Chapter 150B of the General Statutes. The insurance public protection classifications established by the Commissioner issued pursuant to the provisions of this Article shall be subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions stated in G.S. 58-2-75(a) do not apply."

Section 3. This act is effective when it becomes law and expires July 1, 2005. Any changes to classifications of insurance public protection districts issued by the Commissioner pursuant to this act shall become effective no sooner than 90 days after the standards for public protection district classifications are adopted by the Department and shall apply to insurance policies issued or renewed on or after that date.