2001

HOUSE INSURANCE

MINUTES

HOUSE COMMITTEE ON INSURANCE
2001 SESSION

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
HURLEY, Bill, Chairman	Melissa Riddle Committee Assistant	733-5601	2215	23
DOCKHAM, Jerry, Chairman	Regina Irwin Committee Assistant	733-5822	1106	66
BARBEE, Bobby, Vice-Chair	Rosa Murray	733-5908	1025	52
BLUE, Daniel	Lin Threatt	715-2528	1227	80
BRUBAKER, Harold	Cindy Coley	715-4946	1229	39
DEDMON, Andrew	Donna AbuHarb	733-5732	2213	12
GRADY, Robert	Peggy Murray	715-9644	616	62
HALL, John D., Vice-Chair	Joan Peacock	733-5898	614	60
HUNTER, Jr., Howard	Barbara Phillips	733-2962	613	68
JOHNSON, Linda P.	Debbie Pons	733-5605	1209	117
JUSTUS, Larry T.	Carolyn Justus	733-5956	2204	13
REDWINE, David	Nancy Brantley	733-5829	635	19
SAUNDERS, Drew	Ruth Fish	733-5606	2217	48
SETZER, Mitchell	Joanna Mills	733-4948	1204	86
SMITH, Ronnie	Ann Jordan	733-5773	2223	2
WAINWRIGHT, William, Vice-Chair	Blinda Edwards	733-5995	532	8
WARNER, Alex	Ann Stancil	733-5853	1206	11
WILSON, Connie	Chris Floyd	733-5903	501	97

Linda Attarian
Frank Folger
Trina Griffin,
Committee Counsel

NORTH CAROLINA GENERAL ASSEMBLY

INSURANCE
2001 – 2002 SESSION



Rep. Dockham
Chair



Rep. Hurley
Chair



Rep. Barbee
Vice-Chair



Rep. Hall
Vice-Chair



Rep. Wainwright
Vice-Chair



Rep. Blue



Rep. Brubaker



Rep. Dedmon



Rep. Grady



Rep. Hunter



Rep. Johnson



Rep. Justus



Rep. Redwine



Rep. Saunders



Rep. Setzer



Rep. Smith



Rep. Warner



Rep. Wilson, C.

ATTENDANCE

INSURANCE

(Name of Committee)

DATES	02-28-01	03-07-01	03-14-01	03-21-01	03-28-01	03-29-01	04-04-01	04-11-01	04-12-01	04-18-01	04-19-01	04-24-01	04-24-01	04-25-01	05-16-01
HURLEY, Bill CHAIR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DOCKHAM, Jerry CHAIR	X	X	X	X	X	X	X		X		X	X	X	X	
BARBEE, Bobby VICE-CHAIR	X	X	X	X					X	X	X	X	X	X	X
BLUE, Daniel	X	X	X	X	X	X	X	X		X	X	X			X
BRUBAKER, Harold			X	X	X	X	X	X		X	X		X	X	X
DEDMON, Andrew	X	X	X		X	X	X	X		X	X	X	X	X	X
GRADY, Robert	X	X	X	X	X	X	X	X	X	X	X	X	X		X
HALL, John VICE-CHAIR	X	X	X	X	X	X	X	X	X	X	X	X		X	X
HUNTER, Howard															
JOHNSON, Linda	X	X	X	X	X	X			X	X		X		X	X
JUSTUS, Larry T.			X	X	X	X	X	X		X		X		X	X
REDWINE, David		X	X	X	X	X	X	X	X	X	X	X	X	X	
SAUNDERS, Drew					X	X	X	X			X	X	X	X	
SETZER, Mitchell	X	X	X	X	X	X	X		X				X	X	X
SMITH, Ronald	X	X	X	X	X	X		X		X	X		X	X	X
WAINWRIGHT, William, VICE-CHAIR				X	X		X			X	X			X	X
WARNER, Alex	X	X	X	X	X	X	X	X		X	X				X
WILSON, Connie	X	X		X	X	X	X	X	X	X	X	X		X	
Ex-Officio Members															
BADDOUR, Phil					X					X	X	X		X	
CUNNINGHAM, W. Pete											X			X	
EARLE, Beverly											X			X	
HACKNEY, Joe					X										

ATTENDANCE

INSURANCE

(Name of Committee)1

DATES	05-23-01	05-30-01	06-13-01	06-20-01	07-11-01	07-25-01	08-01-01	10-17-01							
HURLEY, Bill CHAIR	X	X	X	X	X	X	X	X							
DOCKHAM, Jerry CHAIR	X	X	X	X	X	X	X	X							
BARBEE, Bobby VICE-CHAIR				X	X		X	X							
BLUE, Daniel	X		X				X								
BRUBAKER, Harold			X	X											
DEDMON, Andrew		X	X	X	X	X									
GRADY, Robert	X	X	X	X	X	X	X								
HALL, John VICE-CHAIR	X	X	X	X	X			X							
HUNTER, Howard			X	X											
JOHNSON, Linda	X	X	X			X									
JUSTUS, Larry T.		X	X	X	X	X	X								
REDWINE, David															
SAUNDERS, Drew	X	X	X	X	X			X							
SETZER, Mitchell	X	X	X	X	X	X	X	X							
SMITH, Ronald	X	X		X	X		X								
WAINWRIGHT, William, VICE-CHAIR		X		X											
WARNER, Alex		X	X	X	X	X		X							
WILSON, Connie	X	X	X	X	X		X								
Ex-Officio Members															
BADDOUR, Phil															
CUNNINGHAM, W. Pete															
EARLE, Beverly															
HACKNEY, Joe															

2001-2002 Biennium

Leg. Day: H-179/S-173

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0013=	Sherrill	MOTOR VEHICLE REPAIRS.	*HR	Ch. SL 2001-451	02-20-01	04-19-01
H0013=	Sherrill	MOTOR VEHICLE REPAIRS.	*HR	Ch. SL 2001-451	10-10-01	10-17-01
H0036=	Nye	MANAGED CARE OMBUDSMAN.	H	Ref To Com On Insurance	02-01-01	
H0037=	Nye	HEALTH BENEFIT PLAN DISCLOSURE	H	Ref To Com On Insurance	02-01-01	
H0038=	Nye	DISCLOSE PAYMENT OBLIGATIONS.	H	Ref To Com On Insurance	02-01-01	
H0039=	Nye	PROVIDER DIRECTORIES.	H	Ref To Com On Insurance	02-01-01	
H0048=	Nye	CONTINUITY OF CARE.	H	Ref To Com On Insurance	02-05-01	
H0109=	Alexander	REIMBURSEMENT FOR MARRIAGE/FAMILY THERAPISTS.	HR	Ch. SL 2001-258	03-21-01	03-29-01
H0164	Baker	ACCIDENT PREVENTION COURSE REDUCTION.	*HR	Ch. SL 2001-423	02-19-01	04-24-01
H0181=	Adams	HMO CEASE AND DESIST.	H	Ref To Com On Insurance	02-20-01	
H0191=	Hurley	SELF-EMPLOYED DEDUCT HEALTH INS.	*H	Re-ref Com On Finance	02-22-01	04-09-01
H0232=	Allen	BUDGET REVENUE PROVISIONS-2001	*HR	Ch. SL 2001-427	02-26-01	03-21-01
H0346=	Hurley	INSURANCE PRODUCER LICENSING.	H	Ref To Com On Insurance	03-01-01	
H0347=	Hurley	INSURANCE FINANCIAL AMENDMENTS.	H	Ref To Com On Insurance	03-01-01	
H0348=	Hurley	INSURANCE FEE REPEALS AND INCREASES.	H	Ref To Com On Finance	03-01-01	03-14-01
H0349=	Hurley	INSURANCE INFORMATION PRIVACY.	H	Ref To Com On Insurance	03-01-01	
H0350=	Hurley	GRAMM-LEACH-BLILEY ACT REQUIREMENTS.	HR	Ch. SL 2001-215	03-01-01	04-04-01
H0351=	Hurley	UTILIZATION REVIEW AND GRIEVANCE CHANGES.	*HR	Ch. SL 2001-417	03-01-01	04-23-01
H0352=	Hurley	RISK SHARING PLAN SUNSET REPEAL.	HR	Ch. SL 2001-122	03-01-01	03-14-01
H0353=	Dockham	WORKER'S COMP.CANCELLATIONS AND RENEWALS.	H	Ref To Com On Insurance	03-01-01	
H0354=	Dockham	WORKERS' COMPENSATION AMENDMENTS.	H	Ref To Com On Insurance	03-01-01	
H0355	Dockham	STATE BUILDING CODE CHANGES.	*HR	Ch. SL 2001-421	07-25-01	08-01-01
H0356=	Dockham	COLLECTION AGENCY/ BAIL BOND AMENDMENTS.	*HR	Ch. SL 2001-269	03-01-01	04-10-01
H0357=	Dockham	UMBRELLA INSURANCE IMPROVEMENTS.	*HR	Ch. SL 2001-236	03-01-01	03-14-01
H0358=	Dockham	INSURANCE EXAM LAW AMENDMENTS.	H	Ref To Com On Insurance	03-01-01	
H0359=	Dockham	VIATICAL SETTLEMENTS REWRITE.	*HR	Ch. SL 2001-436	03-01-01	06-19-01
H0360=	Dockham	HEALTH INSURANCE OMNIBUS CHANGES.	*HR	Ch. SL 2001-334	03-01-01	04-24-01
H0462	Owens	WORKERS' COMP/CERTAIN PUBLIC SCHOOL	*H	Re-ref Com On Judiciary III	03-05-01	04-12-01

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

2001-2002 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		STUDENTS.				
H0593=	Alexander	HEALTH INSURANCE/ LICENSED PROF'L COUNSELOR	*HR	Ch. SL 2001-297	03-14-01	03-28-01
H0760	Hurley	CANCER INSURANCE/ WELLNESS BENEFIT RIDER.	H	Ref To Com On Insurance and Consumer Protection	03-26-01	04-12-01
H0790	Starnes	INCREASE DAMAGE LIMITS FOR MV ACCIDENTS.	H	Ref To Com On Insurance	03-26-01	
H0808	Alexander	MENTAL HEALTH/ CHEMICAL DEP. PARITY.	H	Re-ref Com On Insurance	04-11-01	
H1032	Nye	HEALTH INS./UR RETROSPECTIVE REVIEW LIMIT.	H	Ref To Com On Insurance	04-09-01	
H1045=	Baddour	RESTORE WORKERS' COMP. STABILITY.	*HR	Ch. SL 2001-216	04-10-01	04-18-01
H1048=	Redwine	MORATORIUM ON HEALTH INS. MANDATES.	*HR	Ch. SL 2001-453	04-10-01	04-23-01
$ H1077	**Arnold**	**FIREFIGHTERS' AND RESCUE SQUAD WORKERS' RETIRE.**	***H**	**Re-ref Com On Rules, Calendar, and Operations of the House**	**05-23-01**	**07-12-01**
H1088	Saunders	WORKERS' COMP./ DRIVERS OF INTERSTATE CARRIERS.	*H	Ref To Com On Commerce	04-11-01	04-24-01
H1092	Rayfield	HEALTH BENEFIT PLANS/ DISCRIMINATION PROHIBITED.	H	Ref To Com On Insurance	04-11-01	
H1105	Hurley	INSURANCE TECHNICAL CORRECTIONS.	H	Ref To Com On Insurance and Consumer Protection	04-11-01	04-24-01
H1109	Nye	MANAGED CARE/PATIENT ACCESS.	*H	Ref To Com On Health Care	04-11-01	04-12-01
H1120	Nye	FINANCIAL RESP. OF INEXPERIENCED DRIVERS.	H	Ref To Com On Insurance and Consumer Protection	04-12-01	04-24-01
H1122	Allred	WORKERS' COMP LOSS MODIFICATIONS AND STUDY.	H	Ref To Com On Insurance	04-12-01	
H1123	Allred	CHANGE NAME OF N.C. RATE BUREAU.	H	Ref To Com On Insurance	04-12-01	
H1160	Alexander	HEALTH INS./UNIFORM PROVIDER CREDENTIALING.	*HR	Ch. SL 2001-172	04-12-01	04-24-01
H1170	Wilson, C	MEDICAL TREATMENT PROTOCOL.	H	Re-ref Com On Rules, Calendar, and Operations of the House	04-12-01	04-17-01
H1253	Goodwin	UNINSURED MOTORIST COVERAGE.	*H	Re-ref Com On Rules, Calendar, and Operations of the House	04-12-01	04-25-01

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2001-2002 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H1266	Wright	SURGICAL NURSES/3RD PARTY PAYMENT.	H	Ref To Com On Rules and Operations of the Senate	04-12-01	04-25-01
H1326	Blue	AUTO-COMPREHENSIVE DEDUCTTIBLE NO GLASS.	H	Ref To Com On Insurance	04-12-01	
H1329	Carpenter	MV INSURERS-NO MANDATE/NONORIGINAL CRASH PARTS.	H	Re-ref Com On Rules, Calendar, and Operations of the House	04-12-01	04-25-01
S0132	Robert C. Carpen	HEALTH INSURANCE/ COLORECTAL CANCER SCREENING.	*HR	Ch. SL 2001-116	03-20-01	04-12-01
S0168=	Allen H. Wellons	HMO CEASE AND DESIST.	*HR	Ch. SL 2001-5	02-28-01	03-07-01
S0241	Walter H. Dalton	HEALTH INSURANCE TERMINATION NOTICE.	*HR	Ch. SL 2001-422	04-25-01	05-16-01
S0318=	Allen H. Wellons	INSURANCE PRODUCER LICENSING.	*HR	Ch. SL 2001-203	04-26-01	05-29-01
S0321=	Allen H. Wellons	INSURANCE EXAM LAW AMENDMENTS.	*HR	Ch. SL 2001-180	04-26-01	05-29-01
S0459=	Allen H. Wellons	INSURANCE FINANCIAL AMENDMENTS.	*HR	Ch. SL 2001-223	04-23-01	05-31-01
S0461=	Allen H. Wellons	INSURANCE INFORMATION PRIVACY.	*HR	Ch. SL 2001-351	04-26-01	07-18-01
S0466=	Allen H. Wellons	WORKERS COMPENSATION AMENDMENTS.	*HR	Ch. SL 2001-232	04-10-01	05-29-01
S0468=	Allen H. Wellons	WORKERS COMP. CANCELLATIONS AND RENEWALS.	*HR	Ch. SL 2001-241	04-10-01	06-05-01
S0729	John H. Carringt	MOTORCYCLE INSURANCE RATES.	*HR	Ch. SL 2001-389	04-26-01	07-10-01
0729	John H. Carringt	MOTORCYCLE INSURANCE RATES.	*HR	Ch. SL 2001-389	07-11-01	07-31-01
S0801	Stan Bingham	FIREMEN REPORTING.	*HR	Ch. SL 2001-222	04-25-01	05-29-01
S0852	David W. Hoyle	INSURANCE FOR PUBLIC WORKS PROJECTS.	HR	Ch. SL 2001-167	04-26-01	05-16-01

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MINUTES
HOUSE COMMITTEE ON INSURANCE

February 28, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on February 28, 2001, at 12:00 noon. Representative Hurley presided. The following members were present: Co-Chair Jerry Dockham, Vice-Chairs Bobby Barbee and John Hall, Representatives Blue, Dedmon, Grady, Johnson, Setzer, Smith, Warner, and Wilson. A Visitor Registration list is attached and made part of these minutes. (Attachment)

Chairman Hurley called the meeting to order at 12:05 PM; welcomed new member Representative Linda Johnson, and indicated this was to be an introductory meeting. Introductions of Avery Crees (Wake County) and John Chadwick Barefoot (Davidson County), Pages; Charles Williams and Thomas Wilder with the Sergeant of Arms Staff; Linda Attarian, Frank Folger, and Trina Griffin, Research Staff; were made.

Chairman Hurley recognized Representative Jerry Dockham, Co-Chair, who welcomed the committee members and introduced Jackie Hamby, Legislative Services Office, and Regina Irwin, Committee Clerk.

Chairman Hurley also recognized Vice-Chairs Bobby Barbee and John Hall.

Chairman Hurley announced that, due to the quantity of bills to be addressed by this Committee, it might be necessary to not only meet on Wednesdays, but also on Thursdays, to address any carry over issues from the previous day. Any such meeting scheduled for Thursdays will be announced at the end of Wednesday's committee meeting.

The Chairman Bill Hurley recognized Bill Hale, Legislative Counsel NC Department of Insurance. Bill Hale introduced himself and gave an overview of the history and duties of the Department of Insurance. The two major goals of the Department are **Solvency** and **Consumer Protection**. The Special Services Division regulates: Bail Bondsmen; Motor Clubs; Collection Agencies; Office of the States Fire Marshall; certifies Building Inspectors; regulates Manufactured Housing (enforces the Federal Manufactured Housing Warranty Program), and staffs the Building Code Council (the Governor appoints the Council Members). The Consumer Services Commission Division addresses issues of concern the Constitutes might have with their Insurance Company. The Managed Care and Health Benefits Division focuses on Managed Care Organizations and third-party administrators. The Senior Health Insurance Information Program is invaluable. It provides seniors with information regarding Medicare, Medicare Supplement and Long Term Care Insurance. This program is available in all 100 counties and is primarily staffed by volunteers.

Bill Hale also addressed and summarized the forthcoming 2001 Department of Insurance Agency Bills (Attachment). These 13 Bills, filed by Chairmen Hurly and Dockham today, will be discussed in more detail when they come before this Committee.

Chairman Hurley requested that committee members consider co-signing some of these bills.

Representative Barbee addressed a question to Bill Hale, inquiring if there will be a change in the education requirements for insurance agents to maintain their insurance license? The response by Bill Hale was no, no change has been considered by the Department of Insurance.

Upon request from Chairman Hurley, Bill Hale addressed Senate Bill 168 introduced by Senator Wellons. The HMO Cease and Desist Bill (SB 168) is a law that gives the Insurance Commissioner authority to issue a cease and desist order against an HMO that is violating or threatens to violate the HMO law (Article 67 of N.C. General Statute Chapter 58). Over time, other laws have been enacted that apply to HMOs but that are not contained in Article 67 (they're elsewhere in N.C. General Statute Chapter 58). SB 168 amends the cease and desist law by giving the Commissioner authority to issue a cease and desist order for any violation of any law in Chapter 58 that expressly applies to HMOs.

In answer to the question posed by Chairman Hurley to Bill Hale, is the Department of Insurance self-sustaining? Bill Hale responded that in 1991 the General Assembly enacted legislation that made fundamental changes in the way in which the Department of Insurance is funded. G.S. 58-6-25 creates a special fund for the Department of Insurance in the State Treasury. It provides for a regulatory charge to be paid by insurance companies, which is a percentage of the dollar amounts of premium taxes they owe the State. The revenue from the charge goes into the special fund to support the operations of the Department. The special fund and the Department are subject to the Executive Budget Act. The General Assembly retains control over the Department's budget. Each year the General Assembly approves the budget for the Department, makes an appropriation to the Department from the General Fund, and sets the percentage amount of the charge to support that budget. The charge is paid at the same times insurers pay their premium taxes. A transfer of money from the special fund pays the General Fund back.

There being no further business, the Chair adjourned the meeting at 12:35 PM.

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Form
2001 Department of Insurance Agency Bills Outline

VISITOR REGISTRATION SHEET

INSURANCE — 2-28-01

Name of Committee — Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cam Cover	BPMHL
[signature]	NCAHP
[signature]	HR Assoc.
[signature]	NCAHP
John Bowdish	Alley Associates
Mari Swift	GSK
Amy TO Bain	NCMS
Cristy Porter	Bone & Associates
Susan Valaur	Nationwide
[signature]	Moore & Van Allen
ANN LOVE	OUHS
Tammy Lester	OSBPM
Warren Wakeland	Wilm-Cape Fear HBA
Lori Ann Hairr	L/Hamrick Assoc
[signature]	NCAHP
[signature]	NASW-NC
Ken Melton	Alley Associates

2001 DEPARTMENT OF INSURANCE BILLS

Federal Gramm-Leach-Bliley Act (GLBA)

Producer Licensing Act ***(Separate Bill)***

- Incorporation of NAIC model act into NC law
- Licensing of insurance agents and brokers
- GLBA strongly encourages uniform licensing procedures throughout the US

Information & Privacy Protection Act Amendments ***(Separate Bill)***

- GLBA requires certain privacy law enactments
- NC law already addresses many of these
- NC law just needs a handful of changes

Information Sharing with Banking Regulators

- GLBA requirement
- Provide for free flow of information between insurance regulators and banking regulators

Holding Company Act and Investment Law Amendments

- GLBA requirements
- Provide shorter timetable for insurance regulator approval of acquisition of domestic insurer by financial institution
- Allow more latitude for investments in financial institutions

Insurance Company Financial Solvency Bill

Protected Cells

- Allow for creation of financial cells that are protected from other company operations
- Companies would issue bonds, etc., for capital infusion

Credit for Reinsurance

- Update NC law
- Provides incentive for domestic companies to deal with reputable and solvent reinsurers

Insurance Company Investments

- Five-year study of NC and other states' laws governing permitted investments by insurance companies
- Allow more liberal investments without compromising financial integrity of investing company
- Companies are strongly in favor of these changes

Omnibus Financial Changes

- Updating and improvements of other laws relating to insurance company finances
- Strengthening of demutualization law – more policyholder protections
- Background checks on persons forming domestic insurance companies
- Places HMOs and service corporations under risk-based capital law
- Increases trust fund amount for alien surplus lines insurers (e.g., Lloyds of London)
- Additional protection for residents of continuing care retirement communities
- Allows Commissioner to require additional HMO net worth

Workers' Comp Self-Insured TPA License Law Repeal

- Law was enacted in 1998 to provide for licensing of third party administrators for group self-insured workers' compensation plans, at the insistence of the guaranty association for those plans
- Funding is required to implement this law
- Effective date of law has been delayed twice for this reason
- This licensing law is not really needed now, and the guaranty association agrees

Life and Health Insurance Bill

Viatical Settlements Law Rewrite ***(Separate Bill)***

- Industry has changed dramatically over the last three years
- There is rampant fraud in the industry
- This bill addresses the changes and the fraud

Medicare Supplement Insurance

- Disabled under Medicare are not entitled to Medicare supplement insurance policies as are persons age 65 and older (within six months after enrollment in Medicare Part B)
- This would provide for guaranteed issuance of Plans A, C, and J during six-month enrollment period
- Since 1998 NC law provides for Plan A
- Plan C is better and Plan J provides prescription drug coverage
- Repeal sunset date of October 1, 2001 – rates have not increased for Plan A, which was the reason for the sunset
- Temporary Rules to Comply With Federal Requirements – Congress and US Department of Health and Human Services are often changing the rules, and states must comply within timeframes shorter than NC's APA allows for rulemaking

Long Term Care Insurance

- Temporary Rules to Comply With Federal Requirements – Congress and US Department of Health and Human Services are often changing the rules, and states must comply within timeframes shorter than NC's APA allows for rulemaking

Omnibus Recommendations

- Allow non-binding arbitration provisions in life and health insurance policies
- Promote alcohol and narcotic screening intervention
- Technical amendments
- 45-day notice of HMO premium increase (group policies)
- Newborn and adopted child coverage amendment – automatic coverage if a family policy
- Credit given by successor employer group plan for pre-existing condition first diagnosed under previous employer group plan
- Group continuation coverage 60-day election period after end of employer group plan coverage

Investigations Bill

Insurance Fiduciary Premium Payment Law Changes

- Present law requires person responsible for paying group health premiums to give employees 45 days' notice before terminating coverage by nonpayment of premiums
- Law was enacted because persons covered would incur medical expenses thinking they were still covered, when actually coverage had ceased because of nonpayment of premium
- Change violation from Class H to Class G felony
- Make law applicable to ERISA self-insured group health plans
- Require insurer to publish notice of nonpayment of premium in newspaper in employer's geographic area to put employees on notice
- Provide civil lawsuit immunity to insurer for publication

Special Services Bill

Collection Agencies

- Changes in calculation of bond requirement
- New bond to reimburse the State for expenses incurred in dealing with insolvent out-of-state collection agencies

Bail Bondsmen Licensing

- Technical Changes
- No new or renewal license of any kind for professional bail bondsman while there is insufficient deposit with Department

Market Examinations Bill

- Exam Law Changes
- Facilitate Sharing of Information with NAIC and Other Insurance Regulators
- Clarify that examination law applies to all entities regulated by the Insurance Commissioner

Property and Casualty

Umbrella Clarification & Reinsurance Facility Cession Limits

Risk Sharing Plan Law Sunset Date ***(Separate Bill)***

Workers' Compensation Insurance Bill

Policy Terminations and Changes ***(Separate Bill)***

- Apply same provisions for cancellation, nonrenewal, and premium increase notices to workers compensation that apply to other business insurance (property and liability)

Loss Costs Amendment

- Semi-technical change to rate filing law

P&C Guaranty Fund (1992 Workers' Compensation Legislation Error)

- 1992 law repealing solvency funds and transferring responsibility to Insurance Guaranty Association
- Law placed a deadline on claims payments, unintentionally cutting off workers' compensation payments for latent diseases

Fees Bill

- Repeal Miscellaneous Fees and Increase Company License Application and Renewal Fees

Managed Care Bill

- Utilization Review and Grievance Laws
- Technical and Substantive Changes

ATTENDANCE

INSURANCE

(Name of Committee)

DATES	02-28-01	03-07-01													
HURLEY, Bill **CHAIR**	X														
DOCKHAM, Jerry **CHAIR**	X														
BARBEE, Bobby **VICE-CHAIR**	X														
BLUE, Daniel	X														
BRUBAKER, Harold															
DEDMON, Andrew	X														
GRADY, Robert	X														
HALL, John **VICE-CHAIR**	X														
HUNTER, Howard															
JOHNSON, Linda	X														
JUSTUS, Larry T.															
REDWINE, David															
SAUNDERS, Drew															
SETZER, Mitchell	X														
SMITH, Ronald	X														
WAINWRIGHT, William, **VICE-CHAIR**															
WARNER, Alex	X														
WILSON, Connie	X														
Ex-Officio Members															
BADDOUR, Phil															
CUNNINGHAM, W. Pete															
EARLE, Beverly															
HACKNEY, Joe															

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 7, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 7, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the pages, Avery Atkinson and Ivy Smith (Wake County), and the Sergeant at Arms Charles Williams. The following Committee members were present: Co-Chair Bill Hurley, Vice-Chairs Bobby Barbee and John Hall, Representatives Blue, Dedmon, Grady, Johnson, Redwine, Setzer, Smith, Warner, and Wilson. A Visitor Registration list is attached and made part of these minutes (Attachment). The following bill was considered.

SB 168, entitled, AN ACT TO UPDATE THE PENALTIES AND ENFORCEMENT PROVISIONS IN THE HMO LAWS. Senator Wellons, sponsor of the bill, was recognized to present the bill and provide background information on the bill (Attachment, Bill Analysis by Linda Attarian, Committee Counsel). Chairman Dockham recognized Dascheil Propes, Chief Deputy Commissioner NC Department of Insurance, who reported that the Department of Insurance has received verbal information that an agreement has been reached with WellPath, however the Department is awaiting the return of the signed document. Representative Wilson made a motion to give favorable report to the bill. Representative Hall seconded the motion. The motion passed. The bill was reported out of committee.

Representative Hall was recognized and addressed a question to the Department of Insurance representatives: "Can an insurance company arbitrarily decide to stop operating within the State without any repercussions?"

Bill Hale, Chief Legislative Council NC Department of Insurance, was recognized and responded to the question put forth by Rep. Hall as follows: "It depends of the type of insurance involved i.e., a health insurance company withdrawing from a particular market, a 180 days notice must be given to the insured. However, the general rule is, excluding health insurance coverage, a company can stop writing policies without giving extended notice to the insured."

Representative Hall inquired, "when the insurance company grants a 180 days notice, how will this affect a pre-existing condition?"

Bill Hale replied, "the waiting period the insured has satisfied is portable; and the subsequent policy issuer will give credit for that period."

There being no further business, the Chair adjourned the meeting at 12:08 PM.

Respectfully submitted,

Representative Jerry C. Dockham
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Form
Bill Analysis, by Linda Attarian (Committee Counsel)

VISITOR REGISTRATION SHEET

INSURANCE — March 7, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Harry Kaplan	NC Bikers Coalition ☺
Jeanne Doorey	NCMHP
Ann Duncan (Q)	NCAHP
Robt Pasahal	Young, Moore & Henderson
Joyce Peters	APDSSOC/MAMIST
Lynn Legan	Moore & Van Allen
Sherry Melton	SEANC
Frank Lewis	OSBPM
Mike Causey	NC Glass Assn.
Margaret Westbrook	NC LH
Colette Newman	NC Assoc of Health Underwriters

VISITOR REGISTRATION SHEET

INSURANCE — March 7, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carey Wright, FNP	Nurse of the Day NCNA
Forrest Galyean	Fringe Benefit Adm., Inc. PO Box 5334, Winston-Salem, NC 27113

AGENDA

HOUSE COMMITTEE ON INSURANCE

March 7, 2001
Room 1228
12:00 Noon

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

SB 168 HMO CEASE AND DESIST
Senator Allen H. Wellons, Sponsor

COMMENTS AND DISCUSSION FROM COMMITTEE MEMBERS

ADJOURNMENT

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
S.B. 168 A BILL TO BE ENTITLED AN ACT TO UPDATE THE PENALTIES AND ENFORCEMENT PROVISIONS IN THE HMO LAWS.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 168

Insurance and Consumer Protection Committee Substitute Adopted 2/20/01

Short Title: HMO Cease and Desist. (Public)

Sponsors:

Referred to:

February 15, 2001

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE PENALTIES AND ENFORCEMENT PROVISIONS IN THE HMO LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-67-165 reads as rewritten:

"**§ 58-67-165. Penalties and enforcement.**

(a) The Commissioner may, in addition to or in lieu of suspending or revoking a ~~certificate of authority~~ license under G.S. 58-67-140, proceed under G.S. 58-2-70, provided that the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Any person who violates this ~~Article~~ Article or any other provision of this Chapter that expressly applies to health maintenance organizations shall be guilty of a Class 1 misdemeanor.

(c) (1) If the Commissioner shall for any reason have cause to believe that any violation of this ~~Article~~ Article or any other provision of this Chapter that expressly applies to health maintenance organizations has occurred or is threatened, the Commissioner may give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the Commissioner may deem appropriate under the circumstances.

(d) (1) The Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization

to cease and desist from engaging in any act or practice in violation of the provisions of this ~~Article.~~Article or any other provision of this Chapter that expressly applies to health maintenance organizations.

(2) Within 30 days after service of the ~~order of cease and desist,~~ cease and desist order, the respondent may request a hearing on the question of whether acts or practices have occurred that are in violation of this ~~Article have occurred.~~Article or any other provision of this Chapter that expressly applies to health maintenance organizations. ~~Such~~ The hearing shall be conducted ~~pursuant to~~ under Article 3A of Chapter 150B of the General Statutes, and judicial review shall be available as provided by ~~the said Chapter 150B.~~Article 4 of Chapter 150B of the General Statutes.

(e) In the case of any violation of the provisions of this ~~Article,~~ Article or any other provision of this Chapter that expressly applies to health maintenance organizations, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued ~~pursuant to subsection (d),~~ under subsection (d) of this section, the Commissioner may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County."

SECTION 2. G.S. 58-67-170 reads as rewritten:

"**§ 58-67-170. Statutory construction and relationship to other laws.**

(a) Except as otherwise provided in this ~~Article,~~ Chapter, provisions of the insurance laws and ~~provisions of hospital or medical~~ service corporation laws ~~shall not be applicable~~do not apply to any health maintenance organization ~~granted a certificate of authority~~ licensed under this Article. This ~~provision shall~~ subsection does not apply to an insurer or ~~hospital or medical~~ service corporation licensed and regulated ~~pursuant to~~ under the insurance laws or the ~~hospital or medical~~ service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated ~~pursuant to~~ under this ~~Article.~~Article or any other provision of this Chapter that expressly applies to health maintenance organizations.

(b) Solicitation of enrollees by a health maintenance organization granted a ~~certificate of authority,~~ license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this Article shall not be deemed to be practicing medicine or dentistry and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine and dentistry; provided, however, that this exemption does not apply to individual providers under contract with or employed by the health maintenance organization."

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

SENATE BILL 168:
HMO Cease and Desist

BILL ANALYSIS

Committee:	Senate Consumer Protection and Insurance	**Introduced by:**	Senator Wellons
Date:	March 7 2001	**Summary by:**	Linda Attarian Committee Counsel
Version:	Second		

SUMMARY: ***SB168, if enacted, would expand the Insurance Commissioner's authority to issue an order to an HMO to cease and desist from engaging in an act or practice that violates any provision in Chapter 58 that expressly applies to HMOs. Currently, the Commissioner's authority to issue the order is limited to violations of provisions codified in Article 67 of Chapter 58,which includes most, but not all, provisions of law applicable to HMOs. The act is effective when it becomes law.***

CURRENT LAW: Insurance and related laws are codified in Chapter 58 of the General Statutes. Most laws pertaining to HMOs are codified in Article 67 of Chapter 58. In the last decade however, many provisions have been enacted that expressly apply to HMOs but are located in other articles of Chapter 58. Currently, the Commissioner of Insurance's authority to take action against an HMO when the Commissioner believes that the HMO is engaging in an act or violation of law is limited to violations of provisions found only in Article 67. The Commissioner currently does not have statutory authority to take action against an HMO that violates any laws that regulate HMO activities but that are codified outside Article 67.

BILL ANALYSIS:

Section 1. Makes stylistic changes to G.S. 58-67-165 and updates this section to make the section applicable to a violation of any provision in Chapter 58 that expressly applies to HMOs.

Section 2. Makes stylistic and conforming changes to G.S. 58-67-170. The amended provision provides that any provision in Chapter 58 that is applicable to HMOs shall also be applicable to HMO activities or products of insurers and service corporations.

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

BACKGROUND:

Current events precipitating the filing of SB 168: A dispute involving the State Health Plan and WellPath Select, Inc.:

HMOs are subject to laws enacted in 1997 to provide consumer protections relating to the portability, access and renewability of health insurance coverage. These provisions mirror the federal Health Insurance Portability and Accountability Act and are codified in Article 68 of Chapter 58. Under that law if an insurer, including by definition an HMO, offers coverage in the small or large group market, the general rule is that the HMO may not drop an employer from coverage on a selective basis. If an HMO elects to discontinue coverage in a small group or large group market (or both), it must drop coverage with *all* employers in that market and the HMO must provide notice to the Commissioner and to each policyholder, participant, and beneficiary covered under the coverage of the discontinuance at least 180 days before the date of discontinuance. Further, the HMO may not provide any health insurance coverage in that market in NC for at least five years.

The State Health Plan and WellPath Select, Inc. are in a contract dispute regarding WellPath's desire to discontinue coverage to State Health Plan members in 13 of the 22 counties it currently serves. Those counties include: Franklin, Guilford, Harnett, Iredell, Johnston, Lincoln, Nash, Person, Randolph, Rockingham, Rowan, Stanly, and Warren.

The State Health Plan contends that WellPath agreed to provide coverage to members in all 22 counties for a 12-month period from October 1, 2000 through September 30, 2001.

WellPath contends it has the authority to drop these counties under the terms of its contract with the State Health Plan, giving 30 days notice to Plan members. WellPath has sent a letter to nearly 11,000 Plan members giving notice of its intent to terminate coverage effective March 12, 2001.

If the Commissioner of Insurance makes a determination that there is cause to believe that WellPath is in violation, or is threatening to violate a provision of the NC Health Insurance Portability and Accountability Act codified in Article 68, the Commissioner currently lacks the statutory authority to proceed against it.

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 14, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 14, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the pages, Ali Hannen (Transylvania County – Rep. Walend), Latoya Hinton (Wake County - Rep. Hensley), Krystle Medlin (Johnston County - Rep. Creech), and Sarah Sharpe (Alamance County – Rep. Cole). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Barbee, Blue, Brubaker, Dedmon, Grady, Hall, Johnson, Justus, Redwine, Setzer, Smith, and Warner. Frank Folger and Trina Griffin, Staff Counsels, were in attendance. A list of visitors attending is attached.

Representative Dockham indicated that since the two Co-Chairs (Representatives Hurley and Dockham) were the primary sponsors for the bills under consideration, Representative Barbee, Vice-Chair, had been asked to preside over the remaining portion of the meeting. The following bills were considered:

HB 357, entitled, AN ACT TO INCREASE THE AMOUNTS OF LIABILITY INSURANCE THAT MAY BE CEDED TO THE NORTH CAROLINA MOTOR VEHICLE REINSURANCE FACILITY TO FACILITATE THE PURCHASE OF EXCESS OR UMBRELLA COVERAGE BY MOTOR VEHICLE OWNERS AND TO CLARIFY OTHER LAWS RELATING TO UMBRELLA INSURANCE. Representative Barbee introduced Bill Hale, Chief Legislative Counsel, with the North Carolina Department of Insurance to explain the bill. HB 357 would increase the amounts of auto insurance that can be placed in the automobile insurance high-risk pool. Section 1 amends G.S. 58-37-35(b)(2) to increase the dollar amounts of auto insurance that can be provided by the NC Motor Vehicle Reinsurance Facility. Section 2 adds personal excess liability insurance or "umbrella insurance" to G.S. 58-36-1(3) to provide that this type of insurance does not fall under the jurisdiction of the NC Rate Bureau. Section 3 adds personal excess liability insurance or "umbrella insurance" to the list of kinds of insurance that may be authorized to write in NC. Representative Dockham moved to give the bill a favorable report. Motion passed.

HB 352, entitled, AN ACT TO REPEAL THE EXPIRATION DATE IN THE RISK SHARING PLAN LAW. Representative Barbee recognized Bill Hale with the NC Department of Insurance to explain the bill. This bill repeals the expiration date in the risk sharing plan law, which would keep the law in place indefinitely. After some discussion Representative Brubaker moved to give the bill a favorable report. Motion passed.

HB 348, entitled, AN ACT TO REPEAL MISCELLANEOUS FEES PAID BY INSURANCE COMPANIES TO THE DEPARTMENT OF INSURANCE; AND TO INCREASE THE INSURANCE COMPANY LICENSE APPLICATION AND RENEWAL FEES TO MAKE THE REPEALS REVENUE NEUTRAL.
Representative Barbee recognized Bill Hale with the NC Department of Insurance to explain the bill. This bill would repeal miscellaneous fees paid by insurance companies to the Department of Insurance but increase insurance companies' license application and renewal fees to make the enactment revenue neutral. Dascheil Propes, Chief Deputy Commissioner, NC Department of Insurance, indicated North Carolina does have a relatively high rate of refusal for companies wanting to do business here. Mr. Propes also indicated this does not affect the availability of insurance in certain areas. If a company indicates they can fulfill a marketing need in North Carolina, they go to the top of the list. Representative Blue moved to give the bill a favorable report and be re-referred to the Committee on Finance. Representative Hurley seconded the motion. Motion passed.

There being no further business, the meeting was adjourned at 12:35 p.m.

Respectfully submitted,

Representative Jerry Dockham
Presiding Co-Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
HB 357, HB 352, and 348
Handouts
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — 03-14-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Glenn Jernigan	BMAC Insurance
Susan Valenni	Nationwide
Bob Price	Jordan Price Wall
Joyce Pitts	NPRSSEC/NAMSI
[illegible]	NCAHP
Bill Scoggin	KCCH
Steve Woodson	NC Farm Bureau Federation
PERRI MORGAN	NFIB
Warren Savage	Bailey & Dixon
Paula H. Hopper	Moore & VanAllen
Stephanie Manna	NC Realtors

VISITOR REGISTRATION SHEET

INSURANCE — 03-14-01

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Emily Fulghum	Smith Anderson
Harry Taylor	NCAHP
Tim Minton	NC Home Builders Assn

Reported out 3-14-01

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 348 A BILL TO BE ENTITLED AN ACT TO REPEAL MISCELLANEOUS FEES PAID BY INSURANCE COMPANIES TO THE DEPARTMENT OF INSURANCE; AND TO INCREASE THE INSURANCE COMPANY LICENSE APPLICATION AND RENEWAL FEES TO MAKE THE REPEALS REVENUE NEUTRAL.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

HOUSE BILL 348*

Short Title:	Insurance Fee Repeals and Increases-AB.	(Public)
Sponsors:	Representatives Hurley and Dockham (Primary Sponsors).	
Referred to:	Insurance, if favorable, Finance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REPEAL MISCELLANEOUS FEES PAID BY INSURANCE COMPANIES TO THE DEPARTMENT OF INSURANCE; AND TO INCREASE THE INSURANCE COMPANY LICENSE APPLICATION AND RENEWAL FEES TO MAKE THE REPEALS REVENUE NEUTRAL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-6-5 reads as rewritten:

"**§ 58-6-5. Schedule of fees and charges.**

The Commissioner shall collect and pay into the State treasury fees and charges as follows:

(1) For filing and examining an insurance company application for admission, a nonrefundable fee of ~~two hundred fifty dollars ($250.00),~~ one thousand dollars ($1,000), to be submitted with ~~such filing; for filing and auditing annual statement, one hundred dollars ($100.00); for filing any other papers required by law, twenty-five dollars ($25.00); for each certificate of examination, condition, or qualification of company or association, fifteen dollars ($15.00); for each seal when required, ten dollars ($10.00); for a list of licensed insurance companies, ten dollars ($10.00).~~ the filing.

(2) Repealed by Session Laws 1977, c. 376, s. 2.

(3) The Commissioner shall receive for copy of any record or paper in his office fifty cents (50¢) per ~~copy sheet and ten dollars ($10.00) for certifying same, or any fact or data from the records of his office and for the examination and approval of charters of companies, twenty-five dollars ($25.00).~~ copy.

(4) He shall collect all other fees and charges due and payable into the State treasury by any company, association, order, or individual under his Department.

(5) Repealed by Session Laws 1999-435, s. 1."

SECTION 2. G.S. 58-6-7 reads as rewritten:

"**§ 58-6-7. Annual license fees for insurance companies.**

(a) In order to do business in this State, an insurance company shall apply for and obtain a license from the Commissioner by March 1 of each year. The license shall become effective the following July 1 and shall remain in effect for one year. Except as provided in subsection (b) of this section, the insurance company shall pay an annual fee for the license as follows:

For each domestic farmer's mutual assessment fire insurance company ..... $ 25.00
For each fraternal order 100.00
For each of all other insurance companies, except mutual burial associations taxed under G.S.105-121.1 ..... ~~1,000.00~~ 1,200

The fees levied in this subsection are in addition to those specified in G.S. 58-6-5.

(b) When the paid-in capital stock or surplus, or both, of an insurance company, other than a farmer's mutual assessment company or a fraternal order, does not exceed one hundred thousand dollars ($100,000), the fee levied in this section shall be one-half the amount specified.

(c) Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or ~~agency, shall be~~ agency is entitled to do the types of business specified in ~~Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars ($100.00) for each such additional classification of business done.~~ this Chapter. All fees and charges collected by the Commissioner under this Chapter are nonrefundable.

(d) Any rating bureau established by action of the General Assembly of North Carolina shall be exempt from the fees in this section."

SECTION 3. G.S. 58-24-125(a) reads as rewritten:

"(a) Every society transacting business in this State shall annually, on or before the first day of March, unless for cause shown such time has been extended by the Commissioner, file with the Commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar ~~year and pay the fee specified in G.S. 58-6-5 for filing same.~~ year. The statement shall be in general form and context as approved by the NAIC for fraternal benefit societies and as supplemented by additional information required by the Commissioner."

SECTION 4. G.S.58-24-130 reads as rewritten:

"**§ 58-24-130. Annual license.**

Societies which are now authorized to transact business in this State may continue such business until the 30th day of June next succeeding January 1, 1988. The authority of such societies and all societies hereafter licensed, may thereafter be renewed

annually, but in all cases to terminate on the 30th day of the succeeding June. However, a license so issued shall continue in full force and effect until the new license be issued or specifically refused. For each such license or renewal the society shall pay the Commissioner the fee specified in ~~G.S. 58-6-5.~~ G.S. 58-6-7. A duly certified copy or duplicate of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of Articles 1 through 64 of this Chapter."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 348:
Insurance Fee Repeals and Increases-AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representatives Hurley and Dockham
Date:	March 14, 2001		
Version:	First Edition	**Summary by:**	Frank W. Folger Committee Counsel

SUMMARY: ***This bill would repeal miscellaneous fees paid by insurance companies to the Dept. of Insurance but increase insurance companies' license application and renewal fees to make the enactment revenue neutral.***

BILL ANALYSIS: Section 1. would:

- Increase insurance company new application fee from $250 to $1000;
- Eliminate: $100 annual statement filing fee, $25 other paper filing fee, $15 certification fee, $10 seal fee, $10 company list fee, $10 photocopy certification fee, $25 charter exam and approval fee

Section 2. would:

- Increase annual insurance company license fee from $1000 to $1200;
- Eliminate $100 additional special classification fee for life insurance companies, fire and marine insurance companies, and casualty and fidelity and surety insurance companies.

Sections 3. and 4. would clarify that fraternal benefit societies pay an annual license renewal fee of $100.

This bill is inapplicable to hospital, medical, and dental service corporations under Article 65 and HMOs.

EFFECTIVE DATE: Effective when it becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 14, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 348 – Fee Repeals and Increases

This bill would repeal a number of statutory provisions setting fees for various services performed by the Department of Insurance. Some are fees for filing statements and papers with the Department and others are fees for providing certifications of documents, lists of companies, or sealed documents. Insurance companies for the most part pay these fees throughout the year.

To recover the revenue lost by these repeals, the bill raises the annual license renewal fee paid by these same companies and raises the company admission fee paid by foreign companies that desire to do business in North Carolina.

The result of this bill would be a reduction in the administrative burdens of multiple check writing and multiple check cashing for insurance companies and the Department.

A spreadsheet is attached that shows the repeals and increases in detail.

Proposed Legislative Changes Annual License and Other Fees Financial Evaluation Division				
Description of Fee	Purpose	Statute	Current Fee	Proposed Fee
Seal Fee	Administrative Fee	58-6-5 (1)	$ 10	$ 0
Company List	Administrative Fee	58-6-5 (1)	$ 10	$ 0
Certification	Administrative Fee	58-6-5 (1)	$ 15	$ 0
Foreign Compliance Fees	Administrative Fee	58-6-5 (1)	$ 25	$ 0
Filing Other Papers	Administrative Fee	58-6-5 (1)	$ 25	$ 0
Quarterly Statement Filing Fees	Filing Fee	58-6-5 (1)	$ 25	$ 0
Annual Statement Filing Fees	Filing Fee	58-6-5 (1)	$ 100	$ 0
New Company	Application Fee	58-6-5 (1)	$ 250	$ 1,000
Photocopies	Administrative Fee	58-6-5 (3)	$ 0.50	N/C
Certification of Photocopies	Administrative Fee	58-6-5 (3)	$ 10	$ 0
Bylaws	Administrative Fee	58-6-5 (3)	$ 25	$ 0
County Farm Mutual	Renewal Fees	58-6-7 (a)	$ 25	N/C
Fraternal	Renewal Fees	58-6-7 (a)	$ 100	N/C
Life	Annual License Fees	58-6-7 (a)	$ 1,000	$ 1,200
Reciprocal	Renewal Fees	58-6-7 (a)	$ 1,000	$ 1,200
Title	Renewal Fees	58-6-7 (a)	$ 1,000	$ 1,200
Factory Mutual	Renewal Fees	58-6-7 (a)	$ 1,000	$ 1,200
Reciprocal Non-Asses	Renewal Fees	58-6-7 (a)	$ 1,000	$ 1,200
Health Services	Renewal Fees	58-6-7 (a)	$ 1,000	$ 1,200
P&C	Annual License Fees	58-6-7 (a) & (c)	$ 1,100	$ 1,200
Accredited Reinsurers	Annual Filing Fee	58-7-21 (b) 2 d	$ 500	N/C
Consolidation of a Domestic Co	Application Fee	58-7-150	$ 250	N/C
Redomestication	Application Fee	58-7-155	$ 200	N/C
Surplus Lines	Application Fee	58-21-20 (c)	$ 250	N/C
Surplus Lines	Renewal Fees	58-21-20 (c)	$ 500	N/C
Purchasing Groups	Application Fee	58-22-70	$ 50	N/C
Purchasing Groups	Renewal Fees	58-22-70	$ 50	N/C
Risk Retention Group	Application Fee	58-22-70	$ 250	N/C
Risk Retention Group	Renewal Fees	58-22-70	$ 1,000	N/C
Continuing Care	Application Fee	58-64-05 (b)	$ 200	N/C
Continuing Care	Renewal Fees	58-64-30 (b)	$ 100	N/C
HMO	Renewal Fees	58-67-160	$ 1,000	N/C

Legend:

N/C - No change is proposed.

Reported out 3-14-01

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 352 A BILL TO BE ENTITLED AN ACT TO REPEAL THE EXPIRATION DATE IN THE RISK SHARING PLAN LAW.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

H 1

HOUSE BILL 352*

Short Title:	Risk Sharing Plan Sunset Repeal-AB.	(Public)
Sponsors:	Representatives Hurley and Dockham (Primary Sponsors).	
Referred to:	Insurance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE EXPIRATION DATE IN THE RISK SHARING PLAN LAW.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-42-55 is repealed.

SECTION 2. This act becomes effective June 30, 2001.

HOUSE BILL 352:
Risk Sharing Plan Sunset Repeal

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Reps. Hurley and Dockham
Date:	March 13, 2001	**Summary by:**	Trina Griffin
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 352 repeals the sunset in the Risk Sharing Plan law. The act would become effective on June 30, 2001.***

BILL ANALYSIS: House Bill 352 repeals the expiration date in the risk sharing plan law, which would keep the law in place indefinitely.

BACKGROUND: In 1986 during a one-day extra session that addressed a real crisis in the availability of property and liability insurance, a law was enacted that enabled the Commissioner and the insurance industry to provide insurance coverage that was unavailable in all or part of the State if the public interest required the availability of that particular coverage. When the law was enacted it was set to expire after one year. The General Assembly has extended the sunset on this Article six times since its enactment prior to each expiration date that has been in place.

CURRENT LAW:

Purpose of Risk Sharing Plan

Article 42 of Chapter 58 and governs mandatory and voluntary risk sharing plans. The risk sharing plan law is designed to address any inadequacy or unavailability of amounts and kinds of property and liability insurance (all insurance except life and health insurance) that are needed by citizens of North Carolina. It does not address the issue of affordable insurance.

Establishment of Plans

The law authorizes the Commissioner of Insurance to create risk-sharing plans or call upon insurance companies to prepare risk-sharing plans for his approval. Nothing in the law precludes insurers from establishing plans on their own; and the law is not intended to discourage participation in voluntary programs, such as market assistance programs. In fact, another statute (G.S. 58-40-75) authorizes insurers to act in concert in creating and administering market assistance programs. This alleviates any concerns of insurers that they might be violating any antitrust laws.

According to the law, the Commissioner must first determine, after a hearing, (1) that an amount or kind of property or liability insurance is not readily available in the voluntary market and (2) that the public interest requires the availability of that insurance. Persons in the State who would, *under reasonable underwriting standards*, be entitled to coverage but are otherwise unable to obtain the coverage, could be insured under a risk sharing plan.

Persons Required to Participate

All companies that are licensed to write the particular coverage, their agents, and any rating organizations that propose rates and policy forms for the coverage, would be required to participate in a risk-sharing plan. The Commissioner must grant exclusions for anyone whose solvency would be impaired by participation in a risk-sharing plan. Insurers and reinsurers that are not required to participate could volunteer to join a risk-sharing plan. Each participating insurer and agent would have to provide information to applicants about all services prescribed in the risk-sharing plan.

Contents & Operation of Risk Sharing Plans

Each risk-sharing plan would provide for its own: risk classifications; premium rates, which can not be inadequate, unfairly discriminatory, or excessive; policy forms; agents' and brokers' commissions; the bases of participation of insurers and agents; marketing facilities; the conditions under which risks will be accepted; and equitable apportionment of profits or losses experienced by the risk sharing plan. The Administrative Procedure Act applies to the adoption and approval of risk-sharing plans. In addition, procedures would be established in each risk-sharing plan for applicants and participants to have grievances reviewed by an impartial body. Also, the Commissioner is required to inform and report to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations if he exercises his authority under this law.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 14, 2001

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: H.B. 352 – Risk Sharing Plan Sunset Repeal

In 1986 during a one-day extra session that addressed a real crisis in the availability of property and liability insurance, a law was enacted that enabled the Commissioner and the insurance industry to provide insurance coverage that was unavailable in all or part of the State if the public interest required the availability of that particular coverage.

The risk sharing plan law is designed to address any inadequacy or unavailability of amounts and kinds of property and liability insurance (all insurance except life and health insurance) that are needed by citizens of North Carolina. It must be emphasized that this law does not and can not address the issue of affordable insurance.

The law authorizes the Commissioner of Insurance to create risk-sharing plans or call upon insurance companies to prepare risk-sharing plans for his approval. Nothing in the law precludes insurers from establishing plans on their own; and the law is not intended to discourage participation in voluntary programs, such as market assistance programs. In fact, another statute (G.S. 58-40-75) authorizes insurers to act in concert in creating and administering market assistance programs. This alleviates any concerns of insurers that they might be violating any antitrust laws.

According to the law, the Commissioner must first determine, after a hearing, (1) that an amount or kind of property or liability insurance is not readily available in the voluntary market and (2) that the public interest requires the availability of that insurance. Persons in the State who would, *under reasonable underwriting standards*, be entitled to coverage but are otherwise unable to obtain the coverage, could be insured under a risk sharing plan.

[CONTINUED ON OTHER SIDE]

All companies that are licensed to write the particular coverage, their agents, and any rating organizations that propose rates and policy forms for the coverage, would be required to participate in a risk-sharing plan. The Commissioner must grant exclusions for anyone whose solvency would be impaired by participation in a risk-sharing plan. Insurers and reinsurers that are not required to participate could volunteer to join a risk-sharing plan. Each participating insurer and agent would have to provide information to applicants about all services prescribed in the risk-sharing plan.

Each risk-sharing plan would provide for its own: risk classifications; premium rates, which can not be inadequate, unfairly discriminatory, or excessive; policy forms; agents' and brokers' commissions; the bases of participation of insurers and agents; marketing facilities; the conditions under which risks will be accepted; and equitable apportionment of profits or losses experienced by the risk sharing plan. The Administrative Procedure Act applies to the adoption and approval of risk-sharing plans. In addition, procedures would be established in each risk-sharing plan for applicants and participants to have grievances reviewed by an impartial body. Also, the Commissioner is required to inform and report to the Joint Legislative Administrative Procedure Oversight Committee and to the Joint Legislative Commission on Governmental Operations if he exercises his authority under this law.

ARTICLE 42.
Mandatory or Voluntary Risk Sharing Plans.

(Expires July 1, 2001)

§ 58-42-1. (Expires July 1, 2001) Establishment of plans.

(a) If the Commissioner finds, after a hearing held in accordance with 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.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, ss. 1, 2.)

Editor's Note. - Session Laws 1999-114, s. 2, effective May 28, 1999, reenacted this Article, which had expired July 1, 1997, pursuant to Session Laws 1995, c. 517, s. 26. For expiration of this Article, see § 58-42-55.

Session Laws 1999-114, s. 8, contains a severability clause.

Effect of Amendments. - Session Laws 1999-114, s. 2, effective May 28, 1999, designated the former paragraph as subsection (a) and substituted "Article 3A of Chapter 150B of the General Statutes" for "G.S. 58-2-50" in subsection (a); and added subsection (b).

§ 58-42-5. (Expires July 1, 2001) Purposes, contents, and operation of risk sharing plans.

(a) Each plan promulgated or prepared pursuant to G.S. 58-42-1 shall:

(1) Give consideration to:

a. The need for adequate and readily accessible coverage;

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b. Optional methods of improving the market affected;

c. The inherent limitations of the insurance mechanism;

d. The need for reasonable underwriting standards; and

e. The requirement of reasonable loss prevention measures;

(2) Establish procedures that will create minimum interference with the voluntary market;

(3) Distribute the obligations imposed by the plan, and any profits or losses experienced by the plan, equitably and efficiently among the participating insurers; and

(4) Establish procedures for applicants and participants to have their grievances reviewed by an impartial body. The filing and processing of a grievance pursuant to this subdivision does not stay the requirement for participation in a plan mandated by G.S. 58-42-10.

(b) Each plan may, on behalf of its participants:

(1) Issue policies of insurance to eligible applicants;

(2) Underwrite, adjust, and pay losses on insurance issued by the plan;

(3) Appoint a service company or companies to perform the functions enumerated in this subsection; and

(4) Obtain reinsurance for any part or all of its risks.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

§ 58-42-10. (Expires July 1, 2001) Persons required to participate.

(a) Each plan shall require participation:

(1) By all insurers licensed in this State to write the kinds of insurance covered by the specific plan;

(2) By all agents licensed to represent those insurers for that kind of insurance; and

(3) By every rating organization that makes rates for that ind of insurance.

(b) The Commissioner shall exclude from each plan any person if participation would impair the solvency of that person.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

§ 58-42-15. (Expires July 1, 2001) Voluntary participation.

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Each plan may provide for participation by:

(1) Insurers that are not required to participate by G.S. 58-42-10;

(2) Eligible surplus lines insurers as defined in G.S. 58-21-10(3); or

(3) Reinsurers approved by the Commissioner.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

§ 58-42-20. (Expires July 1, 2001) Classification and rates.

Each plan shall provide for:

(1) The method of classifying risks;

(2) The making and filing of rates 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.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

Effect of Amendments. - Session Laws 1999-114, s. 2 in subdivision (2) inserted "and that are calculated on an actuarially sound basis" and made a stylistic change.

§ 58-42-25. (Expires July 1, 2001) Basis for participation.

Each plan shall specify the basis for participation by insurers, agents, rating organizations, and other participants and shall specify the conditions under which risks shall be accepted and underwritten by the plan.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

§ 58-42-30. (Expires July 1, 2001) Duty to provide information.

Every participating insurer and agent shall provide to any person seeking the insurance available in each plan, information about the services prescribed in the plan, including full

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information on the requirements and procedures for obtaining insurance under the plan, whenever the insurance is not readily available in the voluntary market.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

§ 58-42-35. (Expires July 1, 2001) Provision of marketing facilities.

If the Commissioner finds that the lack of participating insurers or agents in a geographic area makes the functioning of a plan difficult, he may order that the plan appoint agents on such terms as he designates or that the plan take other appropriate steps to guarantee that service is available.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

§ 58-42-40. (Expires July 1, 2001) Voluntary risk sharing plans.

Insurers doing business within this State or reinsurers approved by the Commissioner may prepare voluntary plans that will provide any specific amount or kind of insurance or component thereof for all or any part of this State in which that insurance is not readily available in the voluntary market and in which the public interest requires the availability of the coverage. These plans shall be submitted to the Commissioner and, if approved by him, may be put into operation.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

§ 58-42-45. (Expires July 1, 2001) Article subject to Administrative Procedure Act; legislative oversight of plans.

(a) The provisions of Chapter 150B of the General Statutes shall apply to this 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).

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1; 2000-140, s. 15.)

Effect of Amendments. - Session Laws 1999-114, s. 3 rewrote this section.

Session Laws 2000-140, s. 15, effective July 21, 2000, deleted "shall pursuant to" following subsection (a). This language had been inadvertently retained when the section was amended by Session Laws 1999-114, s. 3.

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§ 58-42-50. (Expires July 1, 2001) Immunity of Commissioner and plan participants.

There shall be no liability on the part of, and no cause of action shall arise against the Commissioner, his representatives, or any plan, its participants, or its employee for any good faith action taken by them in the performance of their powers and duties in creating any plan pursuant to this Article.

(1986, Ex. Sess., c. 7, s. 1; 1999-114, s. 1.)

§ 58-42-55. (Expires July 1, 2001) Expiration.

This Article shall expire on July 1, 2001.

(1987, c. 731, s. 2; 1989, c. 137; 1991, c. 644, s. 33; 1993, c. 409, s. 5; 1995, c. 517, s. 26; 1999-114, s. 1.)

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Reported out 3-14-01

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 357 A BILL TO BE ENTITLED AN ACT TO INCREASE THE AMOUNTS OF LIABILITY INSURANCE THAT MAY BE CEDED TO THE NORTH CAROLINA MOTOR VEHICLE REINSURANCE FACILITY TO FACILITATE THE PURCHASE OF EXCESS OR UMBRELLA COVERAGE BY MOTOR VEHICLE OWNERS AND TO CLARIFY OTHER LAWS RELATING TO UMBRELLA INSURANCE.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

HOUSE BILL 357*

Short Title: Umbrella Insurance Improvements-AB. (Public)

Sponsors: Representatives Dockham and Hurley (Primary Sponsors).

Referred to: Insurance.

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE AMOUNTS OF LIABILITY INSURANCE THAT MAY BE CEDED TO THE NORTH CAROLINA MOTOR VEHICLE REINSURANCE FACILITY TO FACILITATE THE PURCHASE OF EXCESS OR UMBRELLA COVERAGE BY MOTOR VEHICLE OWNERS AND TO CLARIFY OTHER LAWS RELATING TO UMBRELLA INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-37-35(b) reads as rewritten:

"(b) The Facility shall reinsure for each coverage available ~~therein~~ in the Facility to the standard percentage of one hundred percent (100%) or lesser equitable percentage established in the Facility's plan of operation as follows:

(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

a. Bodily injury liability: thirty thousand dollars ($30,000) each person, sixty thousand dollars ($60,000) each accident;

b. Property damage liability: twenty-five thousand dollars ($25,000) each person;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall not be available for motorcycles;

d. Uninsured motorist: thirty thousand dollars ($30,000) each person; sixty thousand dollars ($60,000) each accident for bodily injury; twenty-five thousand dollars ($25,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly

adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission.

(2) Additional ceding privileges for motor vehicle insurance shall be provided by the Board of Governors ~~if there is a substantial public demand for a coverage or coverage limit of any component of motor vehicle insurance~~ up to the following:

a. Bodily injury liability: ~~one hundred thousand dollars ($100,000)~~ two hundred fifty thousand dollars ($250,000) each person, ~~three hundred thousand dollars ($300,000)~~ five hundred thousand dollars ($500,000) each accident;

b. Property damage liability: ~~fifty thousand dollars ($50,000)~~ one hundred thousand dollars ($100,000) each accident;

c. Medical payments: ~~two thousand dollars ($2,000)~~ five thousand dollars ($5,000) each person;

d. Underinsured motorist: one million dollars ($1,000,000) each person and each accident for bodily injury liability; and

e. Uninsured motorist: one million dollars ($1,000,000) each person and each accident for bodily injury and fifty thousand dollars ($50,000) for property damage (one hundred dollars ($100.00) deductible).

(3) Whenever the additional ceding privileges are provided as in G.S. 58-37-35(b)(2) for any component of motor vehicle insurance, the same additional ceding privileges shall be available to "all other" types of risks subject to the rating jurisdiction of the North Carolina Rate Bureau."

SECTION 2. G.S. 58-36-1(3) reads as rewritten:

"(3) The Bureau shall 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 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. This subdivision 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 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; personal excess liability or personal "umbrella" insurance; 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."

SECTION 3. G.S. 58-7-15(13) reads as rewritten:

"(13) "Personal injury liability insurance," meaning insurance against legal liability of the insured, and against loss, damage, or expense incident to a claim of such liability; including personal excess liability or personal "umbrella" insurance; and including an obligation of the insurer to pay medical, hospital, surgical, or funeral benefits; and in the case of ~~automobile~~ motor vehicle liability insurance including also disability and death benefits to injured persons, irrespective of legal liability of the insured, arising out of the death or injury of any person, or arising out of injury to the economic interests of any person as a result of negligence in rendering expert, fiduciary, or professional service; but not including any kind of insurance specified in subdivision ~~(15).~~(15) of this section."

SECTION 4. This act becomes effective July 1, 2001.

HOUSE BILL 357:
Umbrella Insurance Improvements-AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Reps. Dockham and Hurley
Date:	March 14, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: House Bill 357, if enacted, would increase the amounts of auto insurance that can be placed in the automobile insurance high-risk pool (NC Motor Vehicle Reinsurance Facility).

CURRENT LAW: In 1973, the General Assembly created a nonprofit unincorporated legal entity known as the NC Motor Vehicle Reinsurance Facility. All insurers licensed to write motor vehicle insurance in NC are required to join the Facility and are bound by rules established by its Board of Governors. G.S. 58-37-35 governs the operation and functions of the Facility. G.S. 58-57-35(b)(1) requires the Facility to reinsure for each motor vehicle coverage available in the Facility to high risk individuals at certain minimum amounts for certain components of the coverage. In addition, G.S. 58-37-35(b)(2) requires the Facility to provide reinsurance coverage for any component of motor vehicle insurance up to certain dollar amounts. The bill proposes to amend subsection (b)(2) to increase those amounts.

BILL ANALYSIS: **Section 1** amends G.S. 58-37-35(b)(2) to increase the dollar amounts of auto insurance that can be provided by the NC Motor Vehicle Reinsurance Facility.

Section 2 adds personal excess liability insurance or "umbrella insurance" to G.S. 58-36-1(3) to provide that this type of insurance does not fall under the jurisdiction of the NC Rate Bureau.

Section 3 adds personal excess liability insurance or "umbrella insurance" to the list of kinds of insurance that may be authorized to write in NC.

Section 4 Effective date: July 1, 2001.

BACKGROUND:

According to the Department of Insurance, there are many people who want higher liability coverage to protect their assets and for peace of mind, but can't get the higher limits from their insurers because of the limit on the amount the high-risk pool will accept. Today there are many more families that need these higher limits than when the maximum limit was set in 1973.

There are also many people who carry personal umbrella policies who will benefit from an increase in the limits the high-risk pool will accept. Almost every personal umbrella insurer requires an applicant to have higher liability limits in his or her auto insurance policy than the high-risk pool will accept. As a result, the consumer is required to purchase a "gap" insurance policy to make up the difference between the auto policy amount and the amount required by the umbrella insurer. Sometimes "gap" coverage is available and sometimes customers cannot even obtain "gap coverage". If it is available, this "gap" policy is very expensive, requires more paperwork for the consumer, and is normally sold non-licensed but authorized insurers (e.g., Lloyds of London).

A family with "youthful" drivers is the population hardest hit by not having higher limits available through the high-risk pool. Parents, in this situation, often have a greater need and desire for higher limits for peace of mind and to protect their assets, but can't usually get it from a carrier or can't find it at affordable prices.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

March 14, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 357 -- Umbrella Insurance Improvements

This bill would increase the amounts of auto insurance that can be placed in the automobile insurance high-risk pool (NC Motor Vehicle Reinsurance Facility).

There are many people who want higher liability coverage to protect their assets and for peace of mind, but can't get the higher limits from their insurers because of the limit on the amount the high-risk pool will accept. Today there are many more families that need these higher limits than when the maximum limit was set in 1973.

There are also many people who carry personal umbrella policies who will benefit from an increase in the limits the high-risk pool will accept. Almost every personal umbrella insurer requires an applicant to have higher liability limits in his or her auto insurance policy than the high-risk pool will accept. As a result, the consumer is required to purchase a "gap" insurance policy to make up the difference between the auto policy amount and the amount required by the umbrella insurer. Sometimes "gap" coverage is available and sometimes customers cannot even obtain "gap coverage". If it is available, this "gap" policy is very expensive, requires more paperwork for the consumer, and is normally sold non-licensed but authorized insurers (e.g., Lloyds of London).

A family with "youthful" drivers is the population hardest hit by not having higher limits available through the high-risk pool. Parents, in this situation, often have a greater need and desire for higher limits for peace of mind and to protect their assets, but can't usually get it from a carrier or can't find it at affordable prices.

If this bill is enacted, persons whose auto insurers think they belong in the high-risk pool will be able to purchase umbrella insurance and, in that way, protect them and you.

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 21, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 14, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Juliana Berde (Wake County – Rep. Eddins) and Monica Hodges (Wake County - Rep. Capps). The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Barbee, Blue, Brubaker, Grady, Hall, Johnson, Justus, Redwine, Setzer, Smith, Wainwright, Warner, and C. Wilson. Linda Attarian and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached.

Representative Hurley indicated that HB 350, GRAMM-LEACH-BLILEY ACT Requirements would not be considered as originally scheduled at the request of staff counsel who indicated they need more time to delve into the Federal law portion of this bill.

The following bills were considered:

HB 232, entitled, AN ACT TO SET THE INSURANCE REGULATORY CHARGE FOR CALENDAR YEAR 2001. Representative Gordon Allen was recognized and he introduced Bill Hale with the NC Department of Insurance to explain the bill. This bill would set the annual charge levied on each insurance company regulated by the Department of Insurance for the purpose of funding the Insurance Regulatory Fund at seven percent (7%) of the annual premium taxes paid by those insurers. Representative Barbee moved to give the bill a favorable report and be re-referred to the Committee on Finance. Representative Warner seconded the motion. Motion passed.

Representative Hurley indicated that since the two Co-Chairs (Representatives Hurley and Dockham) were the primary sponsors for the next bill under consideration, Representative Hall, Vice-Chair, had been asked to preside over the next portion of the meeting.

HB 359, entitled, AN ACT TO REVISE NORTH CAROLINA'S LAW REGULATING VIATICAL SETTLEMENTS IN ACCORDANCE WITH A MODEL ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. Representative Hall recognized Bill Hale with the NC Department of Insurance to explain the bill. This bill would create the Viatical Settlements Act, a new Part to Article 58 of Chapter 58 of the General Statutes. The Act, based on the pending NAIC (National Association of Insurance Commissioners) model act, would comprehensively govern viatical settlements and the business of entering into viatical settlements in this State. The NAIC meeting is to be held next week and the Department of Insurance is waiting to hear if the model act will be adopted and if changes are going to be made to it. If changes were made, the Department would like to

incorporate the changes into HB 359. Basically a viatical settlement is when someone has a life insurance policy and they are chronically or terminally ill and need cash for medical bills, etc., they can sell the policy to a special company with a discount on it and can obtain cash up front. There are individuals who invest in these types of companies, and unfortunately there has been rampant fraud in this industry in recent years. A law was first enacted in 1995 regulating this industry. The committee decided to hold this bill until a future meeting when the results of the NAIC meeting will have been determined.

The meeting was turned back over to Representative Hurley.

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

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
HB 232, HB 350, and 359
Handouts
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — March 21, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Massey	SEC. OF STATE
Forrest Caldwell	Secretary of State
Bob Price	Jordan Price
Robert PASchall	Young, Moore
Andy Ellen	NCRMA
Fran Preston	NCRMA
Gil Scoggin	Kennedy Covington
Dana Pope	NCINS
Warren Savage	Bailey + Dixon
Amy Fullbright	Hunton! Williams
Joe Johnson	Ragsdale Liggett

VISITOR REGISTRATION SHEET

INSURANCE — March 21, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Harry Kaplan	NCAHP
Henry Jones	Attorney Raleigh
[signature]	NCHHP
Dan Taylor	Delta Dental

Reported out 3-21-01

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 232 A BILL TO BE ENTITLED AN ACT TO SET THE INSURANCE REGULATORY CHARGE FOR CALENDAR YEAR 2001.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

H 1

HOUSE BILL 232*

Short Title:	Insurance Regulatory Charge.	(Public)
Sponsors:	Representatives Allen; and Wainwright.	
Referred to:	Insurance.	

February 26, 2001

A BILL TO BE ENTITLED

AN ACT TO SET THE INSURANCE REGULATORY CHARGE FOR CALENDAR YEAR 2001.

The General Assembly of North Carolina enacts:

SECTION 1. The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven percent (7%) for the 2001 calendar year.

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

HOUSE BILL 232:
Insurance Reg. Charge

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Allen
Date:	March 21, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: House Bill 232, if enacted, would set the annual charge levied on each insurance company regulated by the Department of Insurance for the purpose of funding The Insurance Regulatory Fund at seven percent (7%) of the annual premium taxes paid by those insurers.

CURRENT LAW: In 1991, the General Assembly enacted G.S. 58-6-25 to create The Insurance Regulatory Fund in the State Treasury to be used to support the operations of the Department of Insurance. The statute provides for an annual regulatory charge to be levied on each insurance company regulated by the Department of Insurance. The annual charge is set by the General Assembly each year, based upon the Department's budget request for each upcoming year. The General Assembly appropriates operating funds to the Department from the General Fund, and then transfers monies from The Insurance Regulatory Fund to pay the General Fund back.

The charge is in the form of a percentage rate of the dollar amounts of premium taxes the insurance companies owe the State each year. For example, the premium tax on most types of insurance is a flat 1.9% of the premium dollars collected by an insurance company in a calendar year. If a company collects ten million dollars in premium, it owes the State $190,000 in premium tax. The regulatory charge for calendar year 1999 was 6% of the tax ($190,000), or $11,400. The tax ($190,000) goes to the General Fund to support State government, and the regulatory charge ($11,400) goes to The Insurance Regulatory Fund to support the operations of the Department of Insurance.

In setting the percentage rate, the General Assembly must consider all relevant factors that may affect the cost of operating the Department, possible unanticipated increase or decrease in North Carolina premiums, or other fee revenue.

BILL ANALYSIS:

Section 1 establishes the annual rate to use in calculating the annual charge to be levied on each insurer pursuant to G.S. 58-6-25 to be seven percent for the calendar year 2001.

Section 2 makes the act effective when it becomes law.

BACKGROUND: INSURANCE REGULATORY CHARGE 1991-1999:

Section 3. The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven percent (7%) for the 2000 calendar year. (HB 1854 – SL 2000-109)

Section 3. The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven percent (7%) for the 1999 calendar year. (HB 1289 – SL 1999-413)

Section 29A.7. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is six percent (6%) for the 1998 calendar year. (SB 1366 -- SL 1998-212)

Section 2.1. The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is eight and seventy-five hundredths percent (8.75%) for the 1997 calendar year. (SB 727 -- SL 1997-475)

Sec. 1. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1996 calendar year. (HB 1345 -- Chapter 670)

Sec. 1. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1995 calendar year. (HB 993 -- Chapter 178)

Sec. 2. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1994 calendar year. (SB 1700 -- Chapter 664)

Sec. 2. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1993 calendar year. (HB 1355--Chapter 320)

Sec. 7. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1992 taxable year. (HB 945--Chapter 811)

The rate of the charge for the 1991 taxable year shall be six and five-tenths percent (6.5%) (HB 83--Chapter 689, Sec. 289)

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

March 21, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 232 -- Insurance Regulatory Charge

In 1991 the General Assembly enacted legislation that made fundamental changes in the way in which the Department of Insurance is funded. G.S. 58-6-25 creates a special fund for the Department of Insurance in the State Treasury. It provides for a regulatory charge to be paid by insurance companies, which is a percentage of the dollar amounts of premium taxes they owe the State. The revenue from the charge goes into the special fund to support the operations of the Department. The special fund and the Department are subject to the Executive Budget Act.

The General Assembly retains control over the Department's budget. Each year the General Assembly approves the budget for the Department, makes an appropriation to the Department from the General Fund, and sets the percentage amount of the charge to support that budget. The charge is paid at the same times insurers pay their premium taxes. A transfer of money from the special fund pays the General Fund back.

For example, the premium tax rate on most types of insurance is a flat 1.9% of the premium dollars collected by an insurance company in a calendar year. If a company collects ten million dollars in premium, it owes the State $190,000 in premium tax. The regulatory charge for calendar year 1999 set by the 1999 General Assembly would be 6% of the tax ($190,000), or $11,400. The tax ($190,000) goes to the General Fund to support State Government and the charge ($11,400) goes to the special fund to support the Department of Insurance.

INSURANCE REGULATORY CHARGE 1991-1999

Section 3. The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven percent (7%) for the 2000 calendar year. (HB 1854 – SL 2000-109)

Section 3. The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven percent (7%) for the 1999 calendar year. (HB 1289 – SL 1999-413)

Section 29A.7. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is six percent (6%) for the 1998 calendar year. (SB 1366 – SL 1998-212)

Section 2.1. The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is eight and seventy-five hundredths percent (8.75%) for the 1997 calendar year. (SB 727 – SL 1997-475)

Sec. 1. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1996 calendar year. (HB 1345 – Chapter 670)

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Sec. 2. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1994 calendar year. (SB 1700 --Chapter 664)

Sec. 2. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1993 calendar year. (HB 1355--Chapter 320)

Sec. 7. (a) The percentage rate to be used in calculating the insurance regulatory charge under G.S. 58-6-25 is seven and twenty-five hundredths percent (7.25%) for the 1992 taxable year. (HB 945--Chapter 811)

The rate of the charge for the 1991 taxable year shall be six and five-tenths percent (6.5%) . (HB 83--Chapter 689, Sec. 289)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 350*

Short Title:	Gramm-Leach-Bliley Act Requirements-AB.	(Public)
Sponsors:	Representatives Hurley and Dockham (Primary Sponsors).	
Referred to:	Insurance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO SHARE WITH THE FEDERAL AND STATE FINANCIAL INSTITUTION REGULATORS INFORMATION ABOUT INSURANCE COMPANIES THAT ARE AFFILIATES OF DEPOSITORY INSTITUTIONS OR OF FINANCIAL HOLDING COMPANIES; TO AMEND THE INSURANCE HOLDING COMPANY ACT AND AN INSURANCE COMPANY INVESTMENT STATUTE TO COMPLY WITH FEDERAL LAW, IN ACCORDANCE WITH THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-2-128. Interagency consultation.**

(a) Purpose. -- It is the stated intention of the Congress in P.L. 106-102, the Gramm-Leach-Bliley Act, that the Board of Governors of the Federal Reserve System, as the umbrella supervisor for financial holding companies, and the Commissioner, as the functional regulator of persons engaged in insurance activities, coordinate efforts to supervise persons that control both a depository institution and a person engaged in insurance activities regulated under State law. In particular, Congress believes that the Board and the Commissioner should share, on a confidential basis, information relevant to the supervision of persons that control both a depository institution and a person engaged in insurance activities, including information regarding the financial health of the consolidated organization and information regarding transactions and relationships between persons engaged in insurance activities and affiliated depository institutions. The purpose of this section is to encourage this coordination and confidential sharing of information and to thereby improve both the efficiency and the quality of the supervision of financial holding companies and their affiliated depository institutions and persons engaged in insurance activities.

(b) Commissioner's Authority. -- Upon the request of the Board or the appropriate federal banking agency, the North Carolina Secretary of State, or the North Carolina Commissioner of Banks, the Commissioner may provide any examination or other reports, records, or other information to which the Commissioner has access with respect to a person that:

(1) Is engaged in insurance activities and regulated by the Commissioner.

(2) Is an affiliate of a depository institution or financial holding company.

Upon the request of the Board or the appropriate federal banking agency, the North Carolina Secretary of State, or the North Carolina Commissioner of Banks, the Commissioner may provide any examination or other reports, records, or other information to which the Commissioner has access with respect to any insurance producer.

(c) Privilege. -- The provision of information or material under this section by the Commissioner does not constitute a waiver of, or otherwise affect, any privilege to which the information or material is otherwise subject.

(d) Definitions. -- As used in this section, the terms:

(1) "Appropriate federal banking agency" and "depository institution" have the same meanings as in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813.

(2) "Board" and "financial holding company" have the same meanings as in section 2 of the Bank Holding Company Act of 1956, 12 U.S.C. § 1841, et seq.

(3) "Insurance producer" or "producer" means a person required to be licensed under this Article to sell, solicit, or negotiate insurance. "Insurance producer" or "producer" includes an agent, a broker, and a limited representative."

SECTION 2. Article 19 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-19-2. Compliance with federal law.**

(a) As used in this section, "depository institution" has the same meaning as in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813, and includes any foreign bank that maintains a branch, an agency, or a commercial lending company in the United States.

(b) With respect to affiliations between a depository institution or any affiliate of a depository institution and any insurer, the provisions of section 104(c) of the Gramm-Leach-Bliley Act, P.L. 106-102, shall apply to this Article."

SECTION 3. G.S.58-7-170(b)(1) reads as rewritten:

"(1) The cost of investments made by insurers in stock authorized by G.S. 58-7-173 shall not exceed twenty-five percent (25%) of the insurer's admitted assets, provided that no more than twenty percent (20%) of the insurer's admitted assets shall be invested in common stock; and the cost of an investment in stock of any one corporation shall not exceed three percent (3%) of the insurer's admitted assets. Notwithstanding any other provision in this Chapter, the financial

statement carrying value of all stock investments shall be used for the purpose of determining the asset value against which the percentage limitations are to be applied. Investments in the voting securities of a depository institution, or any company that controls a depository institution, shall not exceed five percent (5%) of the insurer's admitted assets. As used in this subdivision, "depository institution" has the same meaning as in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813; and includes any foreign bank that maintains a branch, an agency, or a commercial lending company in the United States."

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

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

March 21, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 350 – Gramm-Leach-Bliley Act Requirements

The following are the reasons for the provisions in this bill:

SECTION 1. *Confidentiality and information sharing.* Under P.L. 106-102, state law must allow state regulators to give assurances to federal regulators that they can maintain the confidentiality of information shared in confidence by federal banking regulators to facilitate interagency consultation, in accordance with Sections 111, 112, and 307 of the Gramm-Leach-Bliley Act.

SECTION 2. *North Carolina Holding Company Act.* The period for review and action by the Department of Insurance on proposed affiliations is limited to 60 days before the effective date of the transaction, for transactions falling under the Gramm-Leach-Bliley Act. Under Section 104(c)(2), states have only a 60-day period "preceding the effective date of the acquisition or change or continuation of control" in which to collect information and take action. With respect to required capital infusions related to change in control, Section104(c)(2) of the Gramm-Leach-Bliley Act also provides that states will have only 60 days before the effective date of the transaction to require "restoration of capital" in connection with a change in control.

SECTION 3. *Investments in affiliate banks and bank controlling affiliates.* Section 306 of the Gramm-Leach-Bliley Act provides that state law cannot restrict investment by insurers in the voting securities of a depository institution or companies controlling the bank, except that the insurer's state of domicile may limit those investments to five percent (5%) of the insurer's admitted assets.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 359*

Short Title:	Viatical Settlements Rewrite-AB.	(Public)
Sponsors:	Representatives Dockham and Hurley (Primary Sponsors).	
Referred to:	Insurance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REVISE NORTH CAROLINA'S LAW REGULATING VIATICAL SETTLEMENTS IN ACCORDANCE WITH A MODEL ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

The General Assembly of North Carolina enacts:

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

"Article 58.

~~General Regulations of Business Life Insurance.~~Life Insurance and Viatical Settlements."

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

(1) By designating G.S. 58-58-1 through G.S. 58-58-40 as Part 1 with the heading "General Provisions."

(2) By designating G.S. 58-58-45 through G.S. 58-58-65 as Part 2 with the heading "Financial Provisions."

(3) By designating G.S. 58-58-70 through G.S. 58-58-120 as Part 3 with the heading "Insurable Interests and Other Rights."

(4) By designating G.S. 58-58-125 through G.S. 58-58-170 as Part 4 with the heading "Miscellaneous Provisions."

(5) By reserving G.S. 58-58-175 through G.S. 58-58-195 for future codification.

SECTION 3. Article 58 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 5. Viatical Settlements.

"**§ 58-58-200. Short title.**

This Part may be cited as the Viatical Settlements Act.

"**§ 58-58-205. Definitions.**

(1) 'Advertising' means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to purchase or sell a life insurance policy or an interest in a life insurance policy under a viatical settlement contract or a viatical settlement purchase agreement.

(2) 'Business of viatical settlements' means an activity involved in, but not limited to, the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating, or in any other manner, of viatical settlement contracts or purchase agreements.

(3) 'Chronically ill' means:

a. Being unable to perform at least two activities of daily living (i.e., eating, toileting, transferring, bathing, dressing, or continence);

b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

c. Having a level of disability similar to that described in sub-subdivision a. of this subdivision as determined by the Secretary of Health and Human Services;

(4) '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 entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but:

a. Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and

b. Who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. Financing entity does not include a nonaccredited investor or viatical settlement purchaser.

(5) 'Fraudulent viatical settlement act' includes:

a. Acts or omissions committed by any person who, knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including:

1. Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by a

viatical settlement provider, viatical settlement broker, viatical settlement purchaser, viatical settlement investment agent, financing entity, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of or concerning a fact material to one or more of the following:

I. An application for the issuance of a viatical settlement contract or insurance policy.

II. The underwriting of a viatical settlement contract or insurance policy.

III. A claim for payment or benefit under a viatical settlement contract or insurance policy.

IV. Premiums paid on an insurance policy or as a result of a viatical settlement purchase agreement.

V. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract, viatical settlement purchase agreement, or insurance policy.

VI. The reinstatement or conversion of an insurance policy.

VII. In the solicitation, offer, effectuation, or sale of a viatical settlement contract, insurance policy, or viatical settlement purchase agreement.

VIII. The issuance of written evidence of viatical settlement contract, viatical settlement purchase agreement or insurance.

IX. A financing transaction.

2. Employing any device, scheme, or artifice to defraud related to viaticated policies;

b. In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to:

1. Remove, conceal, alter, destroy, or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

2. Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

3. Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

4. File with the Commissioner or the insurance regulator of another jurisdiction a document containing false

information or otherwise conceals information about a material fact from the Commissioner.

c. Embezzlement, theft, misappropriation, or conversion of monies, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policy owner or any other person engaged in the business of viatical settlements or insurance; or

d. Recklessly entering into, brokering, otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator's agent intended to defraud the policy's issuer. 'Recklessly' means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct;

e. Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

(6) 'Policy' means an individual or group policy, group certificate, contract or arrangement of life insurance affecting the rights of a resident of this State or bearing a reasonable relation to this State, regardless of whether delivered or issued for delivery in this State.

(7) 'Related provider trust' means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the Commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

(8) 'Special purpose entity' means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or licensed viatical settlement provider.

(9) 'Terminally ill' means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

(10) 'Viatical settlement investment agent' means a person who is an appointed or contracted agent of a licensed viatical settlement provider

who solicits or arranges the funding for the purchase of a viatical settlement by a viatical settlement purchaser and who is acting on behalf of a viatical settlement provider.

a. A viatical settlement investment agent shall not have any contact directly or indirectly with the viator or have knowledge of the identity of the viator.

b. A viatical settlement investment agent is deemed to represent the viatical settlement provider of whom the viatical settlement investment agent is an appointed or contracted agent.

(11) '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 contracts between a viator and one or more viatical settlement providers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent 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. The term does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

(12) 'Viatical settlement contract' means a written agreement establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. A viatical settlement contract also includes a contract for a loan or other financing transaction with a viator secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company under the terms of the life insurance contract, or a loan secured by the cash value of a policy. A viatical settlement contract includes an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator.

(13) 'Viatical settlement provider' means a person, other than a viator, that enters into or effectuates a viatical settlement contract. Viatical settlement provider does not include:

a. A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

b. The issuer of a life insurance policy providing accelerated benefits under rules adopted by the Commissioner and under the contract;

c. An authorized or eligible insurer that provides stop loss coverage to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;
d. A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;
e. A financing entity;
f. A special purpose entity;
g. A related provider trust;
h. A viatical settlement purchaser; or
i. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, and who purchases a viaticated policy from a viatical settlement provider.

(14) 'Viatical settlement purchase agreement' means a contract or agreement, entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, that is entered into for the purpose of deriving an economic benefit.

(15) 'Viatical settlement purchaser means' a person who gives a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit. Viatical settlement purchaser does not include:
a. A licensee under this Part;
b. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;
c. A financing entity;
d. A special purpose entity; or
e. A related provider trust.

(16) 'Viaticated policy' means a life insurance policy or certificate that has been acquired by a viatical settlement provider under a viatical settlement contract.

(17) 'Viator' means the owner of a life insurance policy or a certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract. For the purposes of this Part, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal

or chronic illness or condition except where specifically addressed. Viator does not include:

a. A licensee under this Part;

b. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;

c. A financing entity;

d. A special purpose entity; or

e. A related provider trust.

"**§ 58-58-210. License requirements.**

(a) No person shall operate as a viatical settlement provider or viatical settlement broker without first obtaining a license from the insurance regulator of the state of residence of the viator. If there is more than one viator on a single policy and the viators are residents of different states, the viatical settlement shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all viators.

(b) A person shall not operate as a viatical settlement investment agent without first obtaining a license from the Commissioner of the state of residence of the viatical settlement purchaser. If there is more than one purchaser of a single policy and the purchasers are residents of different states, the viatical settlement purchase agreement shall be governed by the law of the state in which the purchaser having the largest percentage ownership resides or, if the purchasers hold equal ownership, the state of residence of one purchaser agreed upon in writing by all purchasers.

(c) Application for a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent license shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner, and these applications shall be accompanied by a fee of one hundred dollars ($100.00).

(d) Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fee of one hundred dollars ($100.00). Failure to pay the fees by the renewal date results in expiration of the license.

(e) The applicant shall provide information on forms required by the Commissioner. The Commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members, and employees, and the Commissioner may, in the exercise of the Commissioner's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner, or member thereof who may materially influence the applicant's conduct meets the standards of this Part.

(f) A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers, viatical settlement brokers, or viatical settlement investment agents, as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

(g) Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and issue a license if the Commissioner finds that the applicant:

(1) If a viatical settlement provider, 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 legal entity, provides a certificate of good standing from the state of its domicile; and

(5) If a viatical settlement provider or viatical settlement broker, has provided an antifraud plan that meets the requirements of G.S. 58-58-275.

(h) The Commissioner shall not issue a license to a 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.

(i) A viatical settlement provider, viatical settlement broker, or viatical settlement investment agent shall provide to the Commissioner new or revised information about officers, ten percent (10%) or more stockholders, partners, directors, members, or designated employees within 10 days after the change.

"**§ 58-58-215. License revocation and denial.**

(a) The Commissioner may refuse to issue, suspend, revoke, or refuse to renew the license of a viatical settlement provider, viatical settlement broker or viatical settlement investment agent if the Commissioner finds that:

(1) There was any material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member, or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

(4) The licensee or any officer, partner, member, or key management personnel has been found guilty of, or has pleaded guilty or *nolo contendere* to, any felony, or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(5) The viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to this Part;

(6) The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract or a viatical settlement purchase agreement;

(7) The licensee no longer meets the requirements for initial licensure;

(8) The viatical settlement provider has assigned, transferred, or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this State, viatical settlement purchaser, an accredited investor, or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; or

(9) The licensee or any officer, partner, member, or key management personnel has violated any provision of this Part.

(b) If the Commissioner denies a license application or suspends, revokes, or refuses to renew the license of a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent the Commissioner shall conduct a hearing in accordance with Chapter 150B of the General Statutes.

"**§ 58-58-220. Approval of viatical settlement contracts and disclosure statements.**

A person shall not use a viatical settlement contract or provide to a viator a disclosure statement form in this State unless filed with and approved by the Commissioner. The Commissioner shall disapprove a viatical settlement contract form or disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained therein are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the viator. At the Commissioner's discretion, the Commissioner may require the submission of advertising material.

"**§ 58-58-225. Reporting requirements and privacy.**

(a) Each licensee shall file with the Commissioner on or before June 1 of each year an annual statement containing such information as the Commissioner may prescribe by regulation.

(b) Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, viatical settlement investment agent, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information 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 and insured have provided prior written consent to the disclosure;

(2) Is necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(3) Is provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of G.S. 58-58-269;

(4) Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

(5) Is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(6) Is necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status; or

(7) Is required to purchase stop loss coverage.

"**§ 58-58-230. Authority, scope and scheduling of examinations.**

(a) The Commissioner may conduct an examination under this Part of a licensee as often as the Commissioner in his or her sole discretion deems appropriate.

(b) For purposes of completing an examination of a licensee under this Part, the Commissioner may examine or investigate any person, or the business of any person, in so far as the examination or investigation is, in the sole discretion of the Commissioner, necessary or material to the examination of the licensee.

(c) In lieu of an examination under this Part of any foreign or alien licensee licensed in this State, the Commissioner may, at the Commissioner's discretion, accept an examination report on the licensee as prepared by the Commissioner for the licensee's state of domicile or port-of-entry state.

"**§ 58-58-232. Record retention requirements.**

(a) A person required to be licensed by this Part shall for five years retain copies of all:

(1) Proposed, offered, or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of the contract or purchase agreement, whichever is later;

(2) Checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the transaction; and

(3) Other records and documents related to the requirements of this Part.

(b) This section does not relieve a person of the obligation to produce these documents to the Commissioner after the retention period has expired if the person has retained the documents.

(c) Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

"**§ 58-58-234. Conduct of examinations.**

(a) Upon determining that an examination should be conducted, the Commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the *Examiners' Handbook* adopted by the NAIC. The Commissioner may also employ such other guidelines or procedures as the Commissioner may deem appropriate.

(b) Every licensee or person from whom information is sought, its officers, directors, and agents shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Commissioner shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to G.S. 58-2-50.

(c) The Commissioner may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the Commissioner may petition the Wake County Superior Court, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

(d) When making an examination under this Part, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(e) Nothing in this Part limits the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action under this Chapter. Findings of fact and conclusions made under any examination shall be *prima facie* evidence in any legal or regulatory action.

(f) Nothing contained in this Part shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee working papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

"**§ 58-58-235. Examination reports.**

(a) Examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the licensee, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined

concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(b) No later than 60 days after completion of the examination, the examiner in charge shall file with the Commissioner a verified written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(c) If the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

"**§ 58-58-237. Confidentiality of examination information.**

(a) Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the Commissioner, unless required by law.

(b) Except as otherwise provided in this Part, all examination reports, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an examination made under this Part, or in the course of analysis or investigation by the Commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to Chapter 132 of the General Statutes or G.S. 58-2-100, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

(c) Documents, materials, or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the NAIC and its affiliates and subsidiaries are confidential and privileged, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action if they are:

(1) Created, produced, or obtained by or disclosed to the NAIC and its affiliates and subsidiaries in the course of assisting an examination made under this Part, or assisting a Commissioner in the analysis or investigation of the financial condition or market conduct of a licensee; or

(2) Disclosed to the NAIC and its affiliates and subsidiaries under subsection (d) of this section by a Commissioner;

(3) For the purposes of subsection (b) of this section, 'Part' includes the law of another state or jurisdiction that is substantially similar to this Part.

(d) Neither the Commissioner nor any person that received the documents, material, or other information while acting under the authority of the Commissioner, including the NAIC and its affiliates and subsidiaries, shall be permitted to testify in any

private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(e) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (a) of this section, with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(2) May receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) May enter into agreements governing sharing and use of information consistent with this subsection.

(f) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (d) of this section.

(g) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this State.

(h) Nothing contained in this Part shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the Commissioner of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time or to the NAIC, as long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this Part.

"**§ 58-58-239. Conflict of interest.**

(a) The Commissioner may not appoint an examiner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Part. This section shall not be construed to automatically preclude an examiner from being:

(1) A viator;

(2) An insured in a viaticated insurance policy; or

(3) A beneficiary in an insurance policy that is proposed to be viaticated.

(b) Notwithstanding the requirements of this subsection, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this Part.

"**§ 58-58-241. Immunity from liability.**

(a) No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives, or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Part.

(b) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this Part, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This subsection does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (a) of this section.

(c) A person identified in subsection (a) or (b) of this section shall be entitled to an award of attorneys' fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this Part and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is 'substantially justified' if it had a reasonable basis in law or fact at the time that it was initiated.

"**§ 58-58-243. Investigative authority of the Commissioner.**

The Commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

"**§ 58-58-245. Disclosure.**

(a) With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosures no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker and shall provide the following information:

(1) There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.

(2) Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and State franchise and income taxes, and assistance should be sought from a professional tax advisor.

(3) Proceeds of the viatical settlement could be subject to the claims of creditors.

(4) Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

(5) The viator has the right to rescind a viatical settlement contract for 15 days after the receipt of the viatical settlement proceeds by the viator, as provided in G.S. 58-58-250(h). If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement provider or purchaser.

(6) Funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

(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 or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser.

(8) Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used unless the Commissioner develops one.

(9) The disclosure document shall contain the following language: 'All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.'

(10) The insured may be contacted by either the viatical settlement provider or viatical settlement broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

(b) A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement

contract or in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker, and provide the following information:

(1) State the affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated.

(2) The document shall include the name, address, and telephone number of the viatical settlement provider.

(3) A viatical settlement broker shall disclose to a prospective viator the amount and method of calculating the broker's compensation. The term 'compensation' includes anything of value paid or given to a viatical settlement broker for the placement of a policy.

(4) If an insurance 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 under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy, and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement.

(5) State the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, 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 or certificate, and the viatical settlement provider's interest in those benefits.

(6) State the name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

(c) If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change in ownership or beneficiary to the insured within 20 days after the change.

(d) A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures before the date the viatical settlement purchase agreement is signed by all parties. The disclosures shall be conspicuously displayed in any viatical purchase contract or in a separate document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent and shall make the following disclosure to the viatical settlement purchaser:

(1) The purchaser will receive no returns (i.e., dividends and interest) until the insured dies.

(2) The actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual 'guaranteed' rate of return is not determinable.

(3) The viaticated life insurance contract should not be considered a liquid purchase since it is impossible to predict the exact timing of its maturity and the funds probably are not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser.

(4) The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

(5) The purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party also shall be disclosed.

(6) If the purchaser is responsible for payment of the insurance premiums or other costs related to the policy or if the insured returns to health, the amount of the premiums, if applicable.

(7) State the name and address of any person providing escrow services and the relationship to the broker.

(8) The amount of any trust fees or other expenses to be charged to the viatical settlement purchaser shall be disclosed.

(9) State whether the purchaser is entitled to a refund of all or part of his or her investment under the settlement contract if the policy is later determined to be null and void.

(10) Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage.

(11) Disclose the risks associated with policy contestability including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.

(12) Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including, but not limited to, the risk that the beneficiary may be changed or the premium may not be paid.

(13) Describe the experience and qualifications of the person who determines the life expectancy of the insured, i.e., in-house staff, independent physicians, and specialty firms that weigh medical and actuarial data; the information this projection is based on; and the relationship of the projection maker to the viatical settlement provider, if any.

(14) Disclosure to an investor shall include distribution of a brochure describing the process of investment in viatical settlements. The NAIC's form for the brochure shall be used unless the Commissioner develops one.

(e) A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures no later than at the time of the assignment, transfer, or sale of all or a portion of an insurance policy. The disclosures shall be contained in a document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent and shall make the following disclosures to the viatical settlement purchaser:

(1) Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator.

(2) State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums.

(3) State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums.

(4) Disclose the type of policy offered or sold, i.e., whole life, term life, universal life, or a group policy certificate, any additional benefits contained in the policy, and the current status of the policy.

(5) If the policy is term insurance, disclose the special risks associated with term insurance including, but not limited to, the purchaser's responsibility for additional premiums if the viator continues the term policy at the end of the current term.

(6) State whether the policy is contestable.

(7) State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are, and under what conditions these rights are activated.

(8) State the name and address of the person responsible for monitoring the insured's condition. Describe how often the monitoring of the insured's condition is done, how the date of death is determined, and how and when this information will be transmitted to the purchaser.

(f) The viatical settlement purchase agreement is voidable by the purchaser at any time within three days after the disclosures mandated by subsections (d) and (e) of this section are received by the purchaser.

"**§ 58-58-250. General rules.**

(a) A viatical settlement provider entering into a viatical settlement contract shall first obtain:

(1) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

(2) A document in which the insured consents to the release of his or her medical records to a viatical settlement provider or viatical settlement broker and the insurance company that issued the life insurance policy covering the life of the insured.

(b) Within 20 days after a viator executes documents necessary to transfer any rights under an insurance policy or within 20 days after entering any agreement, option, promise, or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by subsection (c) of this section.

(c) The viatical provider shall deliver a copy of the medical release required under subdivision (a)(2) of this section, a copy of the viator's application for the viatical settlement contract, the notice required under subsection (b) of this section, and a request for verification of coverage to the insurer that issued the life insurance policy that is the subject of the viatical transaction. The NAIC's form for verification shall be used unless the Commissioner develops standards for verification.

(d) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider within 30 days after the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(e) Before or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract which:

(1) Represents that the viator has a full and complete understanding of the viatical settlement contract;

(2) Represents that the viator has a full and complete understanding of the benefits of the life insurance policy;

(3) Acknowledges that the viator is entering into the viatical settlement freely and voluntarily; and

(4) For persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness or condition and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(f) If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

(g) All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of State law relating to confidentiality of medical information.

(h) All viatical settlement contracts entered into in this State shall provide the viator with an unconditional right to rescind the contract for at least 15 days after the receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans, and loan interest that have been paid by the viatical settlement provider or purchaser.

(i) The purchaser may rescind a viatical settlement contract within three days after the purchaser receives the disclosures required by G.S. 58-58-245(d) and G.S. 58-58-245(e).

(j) The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment, or change in beneficiary directly to the independent escrow agent. Within three business days after the date the escrow agent receives the document (or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider), the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the viatical settlement provider or related provider trust. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

(k) Failure to tender consideration to the viator for the viatical settlement contract within the time disclosed under G.S. 58-58-245(a)(6) renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator.

(l) Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider, or viatical settlement broker after the viatical settlement has occurred shall only be made by the viatical settlement provider or broker licensed in this State or its authorized representatives and shall be limited to once every three months for insureds with a life expectancy of more than one year, and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

"**§ 58-58-255. Prohibited practices.**

(a) It is a violation of this Part for any person to enter into a viatical settlement contract within a two-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement

provider that one or more of the following conditions have been met within the two-year period:

(1) The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

(2) The viator is a charitable organization exempt from taxation under 26 U.S.C. § 501 (c)(3);

(3) The viator is not a natural person (e.g., the owner is a corporation, limited liability company, partnership, etc.);

(4) The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the two-year period:

a. The viator or insured is terminally or chronically ill;

b. The viator's spouse dies;

c. The viator divorces his or her spouse;

d. The viator retires from full-time employment;

e. The viator becomes physically or mentally disabled, and a physician determines that the disability prevents the viator from maintaining full-time employment;

f. The viator was the insured's employer at the time the policy or certificate was issued, and the employment relationship terminated;

g. A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets;

h. The viator experiences a significant decrease in income that is unexpected and that impairs the viator's reasonable ability to pay the policy premium; or

i. The viator or insured disposes of his or her ownership interests in a closely held corporation.

(b) Copies of the independent evidence described in subdivision (a)(4) of this subsection and documents required by G.S. 58-58-250(a) shall be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(c) If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification described in subdivision (a)(4) and subsection (b) of this section when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

"**§ 58-58-260. Advertising for viatical settlements and viatical settlements purchase agreements.**

(a) The purpose of this section is to provide prospective viators and viatical settlement purchasers with clear and unambiguous statements in the advertisement of viatical settlements and to assure the clear, truthful, and adequate disclosure of the benefits, risks, limitations, and exclusions of any viatical settlement contract or viatical settlement purchase agreement bought or sold. This purpose is intended to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of viatical settlements to assure that product descriptions are presented in a manner that prevents unfair, deceptive, or misleading advertising and is conducive to accurate presentation and description of viatical settlements through the advertising media and material used by viatical settlement licensees.

(b) This section shall apply to any advertising of viatical settlement contracts, viatical purchase agreements or related products or services intended for dissemination in this State, including Internet advertising viewed by persons located in this State. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

(c) Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its contracts, products, and services. All advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the viatical settlement licensee, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval before the use of any advertisements not furnished by the viatical settlement licensee.

(d) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract or viatical settlement purchase agreement, product, or service shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(e) Certain viatical settlement advertisements are deemed false and misleading on their face and are prohibited. False and misleading viatical settlement advertisements include, but are not limited to, the following representations:

(1) 'Guaranteed', 'fully secured', '100 percent secured', 'fully insured', 'secure', 'safe', 'backed by rated insurance companies', 'backed by federal law', 'backed by state law', or state guaranty funds, or similar representations;

(2) 'No risk', 'minimal risk', 'low risk', 'no speculation', 'no fluctuation', or similar representations;

(3) 'Qualified or approved for individual retirement accounts (IRAs), Roth IRAs, 401(k) plans, simplified employee pensions (SEP), 403(b), Keogh plans, TSA, other retirement account rollovers,' 'tax deferred,' or similar representations;

(4) Utilization of the word 'guaranteed' to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations;

(5) 'No sales charges or fees' or similar representations;

(6) 'High yield', 'superior return', 'excellent return', 'high return', 'quick profit', or similar representations;

(7) Purported favorable representations or testimonials about the benefits of viatical settlement contracts or viatical settlement purchase agreements as an investment, taken out of context from newspapers, trade papers, journals, radio and television programs, and all other forms of print and electronic media.

(f) The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(g) An advertisement shall not:

(1) Omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving viators, purchasers, or prospective purchasers as to the nature or extent of any benefit, loss covered, premium payable, or State or federal tax consequence. The fact that the viatical settlement contract or viatical settlement purchase agreement offered is made available for inspection before consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied or that the viatical settlement contract or viatical settlement purchase agreement includes a 'free look' period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(2) Use the name or title of a life insurance company or a life insurance policy unless the insurer has approved the advertisement.

(3) Represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a viatical settlement

contract or viatical settlement purchase agreement in order to maintain that policy, unless that is the fact.

(4) State or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

(5) State or imply that a viatical settlement contract or viatical settlement purchase agreement, benefit, or service has been approved or endorsed by a group of individuals, society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(6) Contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

(7) Disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services, or methods of marketing.

(8) Use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contractor viatical settlement purchase agreement.

(9) Use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators or purchasers into believing that the solicitation is in some manner connected with a government program or agency.

(10) Create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its viatical settlement contracts or viatical settlement purchase agreement forms are recommended or endorsed by any government entity.

(h) The words 'free', 'no cost', 'without cost', 'no additional cost', 'at no extra cost' or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(i) Testimonials, appraisals, or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the viatical settlement contract or viatical settlement purchase agreement, product, or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators or purchasers as to the nature or scope of the testimonials, appraisal, analysis, or endorsement. In using testimonials, appraisals, or analysis, the viatical settlement licensee makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

(j) If the individual making a testimonial, appraisal, analysis, or an endorsement has a financial interest in the viatical settlement provider or related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(k) When an endorsement refers to benefits received under a viatical settlement contract or viatical settlement purchase agreement all pertinent information shall be retained for a period of five years after its use.

(l) The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contract or viatical settlement purchase agreements, products, or services, and if any specific viatical settlement contract or viatical settlement purchase agreement is advertised, the viatical settlement contract or viatical settlement purchase agreement shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

(m) An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that competing viatical settlement licensee may not be so licensed. The advertisement may ask the audience to consult the licensee's web site or contact the department of insurance to find out if the state requires licensing and, if so, whether the viatical settlement provider, viatical settlement broker, or viatical settlement investment agent is licensed.

(n) The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

(o) An advertisement shall not directly or indirectly create the impression that any division or agency of the State or of the U. S. government endorses, approves, or favors:

(1) Any viatical settlement licensee or its business practices or methods of operation;

(2) The merits, desirability, or advisability of any viatical settlement contract or viatical settlement purchase agreement;

(3) Any viatical settlement contract or viatical settlement purchase agreement; or

(4) Any life insurance policy or life insurance company.

(p) If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(q) If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six months.

"**§ 58-58-265. Fraudulent viatical settlement acts, interference, and participation of convicted felons prohibited.**

(a) A person shall not commit a fraudulent viatical settlement act.

(b) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this Part or investigations of suspected or actual violations of this Part.

(c) A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

"**§ 58-58-267. Fraud warning required.**

(a) Viatical settlements contracts and purchase agreement forms and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

'Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a crime and may be subject to fines and confinement in prison.'

(b) The lack of a statement as required in subsection (a) of this section does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

"**§ 58-58-269. Mandatory reporting of fraudulent viatical settlement acts.**

(a) Any person engaged in the business of viatical settlements having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

(b) Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

"**§ 58-58-270. Immunity from liability.**

(a) No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(1) The Commissioner or the Commissioner's employees, agents, or representatives;

(2) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(3) A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees, or representatives;

(4) The NAIC, National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents, or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities, or investment fraud; or

(5) The life insurer that issued the life insurance policy covering the life of the insured.

(b) Subsection (a) of this section does not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that subsection (a) of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

(c) A person identified in subsection (a) of this section shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this Part, and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is 'substantially justified' if it had a reasonable basis in law or fact at the time that it was initiated.

(d) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subsection (a) of this section.

"**§ 58-58-272. Confidentiality.**

(a) The documents and evidence provided under G.S. 58-58-270 or obtained by the Commissioner in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential, is not a public record, and is not subject to discovery or subpoena in a civil or criminal action.

(b) Subsection (a) of this section does not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(1) In administrative or judicial proceedings to enforce laws administered by the Commissioner;

(2) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the NAIC; or

(3) At the discretion of the Commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(c) Release of documents and evidence under subsection (b) of this section does not abrogate or modify the privilege granted in subsection (a) of this section.

"**§ 58-58-274. Other law enforcement or regulatory authority.**

This Part does not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(2) Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the insurance department; or

(3) Limit the powers granted elsewhere by the laws of this State to the Commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

"**§ 58-58-275. Viatical settlement antifraud initiatives.**

(a) Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts. At the discretion of the Commissioner, the Commissioner may order, or a licensee may request and the Commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section.

(b) Antifraud initiatives shall include:

(1) Fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors; and

(2) An antifraud plan, which shall be submitted to the Commissioner. The antifraud plan shall include, but not be limited to:

a. A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

b. A description of the procedures for reporting possible fraudulent viatical settlement acts to the Commissioner;

c. A description of the plan for antifraud education and training of underwriters and other personnel; and

d. A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the

investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(c) Antifraud plans submitted to the Commissioner are privileged and confidential, are not public records, and are not subject to discovery or subpoena in a civil or criminal action.

"**§ 58-58-280. Injunctions; civil remedies; cease and desist.**

(a) In addition to the penalties and other enforcement provisions of this Part, if any person violates this Part or any rule implementing this Part, the Commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the Commissioner determines are necessary to restrain the person from committing the violation.

(b) Any person damaged by the acts of a person in violation of this Part may bring a civil action against the person committing the violation in a court of competent jurisdiction.

(c) A violation of this Part attendant to the execution of a viatical settlement purchase agreement renders the viatical settlement purchase agreement voidable and subject to rescission by the viatical settlement purchaser, upon return of the policy received to the viatical settlement provider. Suit for rescission may be brought in a court of competent jurisdiction or where the alleged violator resides or has a principal place of business or where the alleged violation occurred.

(d) The Commissioner may issue, in accordance with Chapter 150B of the General Statutes, a cease and desist order upon a person that violates any provision of this Part, any rule or order adopted by the Commissioner, or any written agreement entered into with the Commissioner.

(e) When the Commissioner finds that an activity in violation of this Part presents an immediate danger to the public that requires an immediate final order, the Commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for 90 days. If the Commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction in accordance with Chapter 150B of the General Statutes.

(f) In addition to the penalties and other enforcement provisions of this Part, any person who violates this Part is subject to G.S. 58-2-70.

(g) A person convicted of a violation of this Part by a court of competent jurisdiction is guilty of a Class H felony. A person convicted of a violation of this Part shall be ordered to pay restitution to persons aggrieved by the violation of this Part. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

"**§ 58-58-285. Unfair trade practices.**

A violation of this Part is an unfair trade practice under Article 63 of this Chapter.

"**§ 58-58-290. Authority to adopt rules.**

The Commissioner may:

(1) Adopt rules implementing this Part;

(2) Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons who are terminally or chronically ill. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy;

(3) Establish appropriate licensing requirements, fees, and standards for continued licensure for viatical settlement providers and investment agents;

(4) Require a bond or other mechanism for financial accountability for viatical settlement providers and brokers; and

(5) Adopt rules governing the relationship and responsibilities of insurers and viatical settlement providers, viatical settlement brokers, and viatical settlement investment agents during the viatication of a life insurance policy or certificate.

"**§ 58-58-295. Effective date.**

A viatical settlement provider, viatical settlement broker, or viatical settlement investment agent transacting business in this State on the effective date of this act may continue to do so pending approval of the provider's, broker's, or investment agent's application for a license as long as the application is filed with the Commissioner no later than three months from the effective date of this act. If such application is disapproved then the viatical settlement provider, viatical settlement broker, or viatical settlement investment agent shall cease transacting viatical business in this State.

"**§ 58-58-300. Disclaimer.**

Notwithstanding any provision of this Part, nothing in this Part affects the jurisdiction of the North Carolina Secretary of State or the North Carolina Securities Act."

SECTION 4. This act becomes effective October 1, 2001.

HOUSE BILL 359:
Viatical Settlements Rewrite

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representatives Dockham and Hurley
Date:	March 21, 2001		
Version:	First Edition	**Summary by:**	Frank W. Folger Committee Counsel

SUMMARY: ***This bill would create the Viatical Settlements Act, a new Part to Article 58 of Chapter 58 of the General Statutes. The Act, based on the NAIC model act, would comprehensively govern viatical settlements and the business of entering into viatical settlements in this State.***

CURRENT LAW: Viatical Settlements are currently governed by the N.C.G.S. § 58-55-42; Title 11, Chapter 12, Section .1700 of the North Carolina Administrative Code; and other generally applicable laws regarding insurance and civil matters.

BILL ANALYSIS: Section 1. would rewrite the title of Article 58 of Chapter 58 of the General Statutes as "Life Insurance and Viatical Settlements"

Section 2. would reorganize Article 58 of Chapter 58 of the General Statutes with Part designations and titles.

Section 3. contains the substantive content of the bill.

This section would establish the Viatical Settlements Act in a newly created Part 5 of Article 58 of Chapter 58 of the General Statutes. It defines key players in the viatical settlements business context: viatical settlement provider, viatical settlement broker, viatical settlement purchaser, viatical settlements investment agent, and viator. It defines other important provisions including: fraudulent viatical settlement act, viatical settlement contract, viatical settlement purchase agreement, viaticated policy, chronically ill and terminally ill.

It would prohibit operation as a viatical settlement provider, broker, or investment agent without proper State licensure, establish standards for the issuance of a license, and grant the Commissioner of Insurance authority to revoke or refuse to issue or renew a license. It would require prior Commissioner approval of viatical settlement contracts and disclosure statements required by the Act. It would impose annual reporting by viatical settlement licensees and prohibit disclosure of an insured's identity, financial information or medical information except as provided.

It would grant the Commissioner authority to examine and investigate a licensee when in the Commissioner's sole discretion it is deemed appropriate and allow the Commissioner to accept an examination report from another jurisdiction in lieu of the in-state examination. It would require persons required to be licensed under the Act to keep its records for five (5) years in a legible and complete manner. Regarding examination by the Commissioner: refusal of a licensee to submit to examination or to comply with reasonable written request of the Commissioner would be grounds for suspension of or refusal to renew a license; the Commissioner would have authority to issue subpoenas, administer oaths, and examine witnesses under oath and seek an order from the Wake County Superior Court for failure to comply with the subpoena; the Commissioner would be able to pursue legal or regulatory action at any time and findings and conclusions made under examination would be *prima facie* evidence in such proceeding. Examination information would be confidential and privileged, except sharing for several

specified regulatory purposes would be allowed. The Commissioner would be prohibited from appointing an examiner to a case where the examiner has a conflict of interest; however, being a viator, an insured in a viaticated policy, or a beneficiary under a viaticated policy would not of itself preclude appointment. Civil immunity would exist for the Commissioner or his agent in carrying out the Act in good faith and for any person delivering information and data to the Commissioner in good faith, without fraudulent intent, or the intent to deceive, and it would mandate attorneys' fees for a prevailing party in a tort action brought without substantial justification.

It would grant the Commissioner authority to investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

It would require certain disclosures to be made to the viator no later than the signing of the viatical settlement contract and to the viatical settlement purchaser at the viatical settlement agreement signing and at the policy assignment, transfer or sale. It would require the viatical settlement provider, prior to the contract execution, to obtain a written statement that the viator, if the insured, is competent to enter the contract, and the insured's consent to release of medical records. It would require notice of the proposed viatication of the policy to the insurer within 20 days of the execution of transfer documents. The insurer would have 30 days to respond and give notice of intent, if any, to investigate the validity of the insurance contract. The viatical settlement provider would have to obtain a witnessed document from the viator at the time of execution of the contract with certain disclosures and information provided. It would also validate a broker performing any of these activities. Medical records would still be subject to State and federal confidentiality provisions.

It would provide the viator a 15-day right of rescission of the viatical settlement contract and would deem the contract rescinded if the insured died within the rescission period. A viatical settlement purchaser would have a 3-day right of rescission following the required disclosures. Failure to tender the viator's money to the viator within three (3) days of the escrow agent receipt of acknowledgements of the complete transfer of the policy would render the contract voidable until the consideration is tendered. The Act would prohibit entering into a viatical settlement contract within 2 years of the issuance of the policy except under four (4) specified situations.

It would prohibit false, deceptive and misleading advertising regarding the business of viatical settlements in whatever medium is used, require a system of controls over advertising by each licensee, and would grant the Commissioner authority to determine whether advertising has the capacity or tendency to mislead or deceive based on an "average education and intelligence of the targeted public" standard. It would deem the use of certain statements and advertising as false and misleading. It would prohibit the use in advertising of certain statements of opinion, disparaging commentary, and inferences. It would require certain disclosures by endorsers.

The Act would prohibit a fraudulent viatical settlement act, knowing and intentional interference with enforcement of or investigation conducted pursuant to the Act, or knowing or intentional allowance of a person with felony involving dishonesty or breach of trust to participate in the business of viatical settlements. It would require a fraud warning on all contracts, applications and purchase agreements regarding viatical settlements. It would require persons in the business of viatical settlements to provide information to the Commissioner when that person has knowledge or reasonable belief that a fraudulent act has been, is, or will be committed, and would allow any other person with that knowledge or reasonable belief to provide the Commissioner with the information. It would provide civil immunity to those persons, except in the case of statements made in actual malice, and attorneys' fees under certain circumstances. It would provide for confidentiality and privilege for documents and evidence obtained by

the Commissioner in an investigation of fraud, but would not prohibit release by the Commissioner for administrative or judicial proceedings, to State and federal agencies to detect and prevent fraud, or to a person in the business of viatical settlements who is aggrieved by a fraudulent act. The Act would not preempt other law enforcement or regulatory authority from carrying out their duties. Viatical settlement providers and brokers would be required to establish antifraud initiatives.

The Act would allow the Commissioner to enforce the Act via injunction, a cease and desist order and/or an emergency cease and desist order; it would allow for a private right of action for a violation; in the case of violation of provisions regarding a viatical settlement purchase agreement, it would render the agreement voidable; and it would make violation of the Act a Class H felony with mandatory restitution in addition to but not in place of fine or imprisonment. It would make a violation of the Act an unfair and deceptive trade practice under Article 63 of Chapter 58 of the General Statutes. It would grant the Commissioner authority to adopt rules to carry out the provisions of the Act. Persons required to be licensed under the Act would have three (3) months from the effective date of the Act to apply for a license and during this time period would be able to continue business.

The Act would not affect the jurisdiction of the North Carolina Secretary of State or the North Carolina Securities Act.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

March 21, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 359 -- Viatical Settlements Rewrite

The following are highlights of this bill:

- Requires viatical settlement providers, brokers, and investment agents to be licensed and sets forth licensing requirements and fees.
- Prohibits persons convicted of a felony involving dishonesty or breach of trust from participating in the business of viatical settlements.
- Requires viatical settlement contracts and disclosure statement forms to be filed with and approved by the Commissioner of Insurance.
- Requires viatical settlement providers, brokers, and investment agents to keep confidential the identity of insureds and their financial and medical information except in specified circumstances.
- Authorizes Commissioner to investigate or examine any licensee and sets forth procedures for examinations.

(Continued on other side.)

- Immunizes the Commissioner, the Commissioner's representatives, examiners appointed by the Commissioner, and persons who provide information to those people from liability for statements made or conduct performed in good faith while carrying out provisions of the Act.

- Specifies disclosures viatical settlement providers and brokers must make to viators (persons entering viatical settlement contracts), including disclosures pertaining to alternatives to viatical settlement contracts, the right to rescind the contract within 15 days, and potential adverse consequences of the settlement.

- Sets forth general rules for viatical settlements that include, among other things, requirements to ensure that a viator consents to the contract, is of sound mind and under no constraint or undue influence.

- Prohibits any person from entering into a viatical settlement contract within a two-year period after an insurance policy or certificate is issued unless certain conditions are met. Requires advertising for viatical settlements to be truthful and not misleading or deceptive, as determined by the Commissioner.

- Deems specified representations in advertising as false and misleading and prohibits them. Sets forth additional detailed requirements for advertising.

- Defines and prohibits fraudulent viatical settlement acts and authorizes Commissioner to investigate when such acts are suspected. Requires those engaged in the viatical settlement business to report to the Commissioner when they know or reasonably believe that a fraudulent viatical settlement act has been or will be committed, and immunizes reporters from liability, unless they acted with actual malice.

- Requires viatical settlement providers and brokers to have in place specified antifraud initiatives.

- Provides that a person convicted of a violation of the Act is guilty of a Class H felony and may be ordered to pay restitution in addition to a fine or imprisonment.

- Makes a violation of the Act an unfair trade practice under GS Ch. 58, Art. 63.

- Authorizes Commissioner to adopt rules implementing the Act.

§ 58-58-200. Short title.
§ 58-58-205. Definitions.
§ 58-58-210. License requirements.
§ 58-58-215. License revocation and denial.
§ 58-58-220. Approval of viatical settlement contracts and disclosure statements.
§ 58-58-225. Reporting requirements and privacy.
§ 58-58-230. Authority, scope and scheduling of examinations.
§ 58-58-232. Record retention requirements.
§ 58-58-234. Conduct of examinations.
§ 58-58-235. Examination reports.
§ 58-58-237. Confidentiality of examination information.
§ 58-58-239. Conflict of interest.
§ 58-58-241. Immunity from liability.
§ 58-58-243. Investigative authority of the Commissioner.
§ 58-58-245. Disclosure.
§ 58-58-250. General rules.
§ 58-58-255. Prohibited practices.
§ 58-58-260. Advertising for viatical settlements and viatical settlements purchase agreements.
§ 58-58-265. Fraudulent viatical settlement acts, interference, and participation of convicted felons prohibited.
§ 58-58-267. Fraud warning required.
§ 58-58-269. Mandatory reporting of fraudulent viatical settlement acts.
§ 58-58-270. Immunity from liability.
§ 58-58-272. Confidentiality.
§ 58-58-274. Other law enforcement or regulatory authority.
§ 58-58-275. Viatical settlement antifraud initiatives.
§ 58-58-280. Injunctions; civil remedies; cease and desist.
§ 58-58-285. Unfair trade practices.
§ 58-58-290. Authority to adopt rules.
§ 58-58-295. Effective date.
§ 58-58-300. Disclaimer.

MINUTES
HOUSE COMMITTEE ON INSURANCE
MARCH 28, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 28, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the pages, Amanda Smith (Mitchell County – Rep. Charles Buchanan) and Emily Troutman (Lee County – Rep. Leslie Cox). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Hall, Wainwright, Blue, Baddour, Brubaker, Dedmon, Grady, Hackney, Hunter, Johnson, Justus, Redwine, Saunders, Setzer, Smith, Warner, and C. Wilson. Linda Attarian, Frank Folger, and Trina Griffin, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes.

Representative Dockham announced, due to time constraints, **HB 191, A BILL TO BE ENTITLED AN ACT TO ALLOW AN ADDITIONAL INCOME TAX DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS** will be rescheduled for consideration on Wednesday, April 4, 2001.

The following bills were considered:

HB 593, entitled, AN ACT TO PROVIDE FOR DIRECT PAYMENT OF LICENSED PROFESSIONAL COUNSELORS UNDER HEALTH INSURANCE POLICIES AND PLANS. Representative Martha Alexander, sponsor of the bill, was recognized to present the bill and provide background information on the bill. Over the last several years, the legislature has passed a series of bills that require health insurance companies to pay for covered health care whenever a provider who is licensed to provide the care delivers it. These bills are called provider anti-discrimination bills, because they keep insurance companies from saying, "We're not going to pay for this service, because it was provided by the wrong type of health care provider." The purpose of this bill is to assure consumers that they actually receive the coverage they believe they had purchased. Anti-discrimination bills have been passed for optometrist, podiatrists, dentists, chiropractors, pharmacists, advanced practice nurses, and physician assistants. In the mental health field, anti-discrimination bills have been enacted covering psychologist, substance abuse professionals, clinical social workers, and pastoral counselors. However, there are still some mental health providers who are not protected by the anti-discrimination statue. Providers who are not protected are at a disadvantage compared to providers covered by the statute because patients who see protected providers know they will be reimbursed, while patients who see providers who are not protected by the statute may not be reimbursed. There is no difference between the core mental health services provided by licensed professional counselor and other master-level mental health providers who are already covered by the anti-discrimination statue. LPCs are licensed by the State of North Carolina. Most receive education and training provided by our state universities. Wherever they are trained, LPC's training is at least as extensive as other masters-level mental health providers that are protected by the anti-discrimination law.
LPCs have been losing patients in recent years because the anti-discrimination statute gives their competitors in other mental health professions the advantage of guaranteed reimbursement. Patients who see psychologists, clinical social workers, certified

substance abuse counselors and free-based pastoral counselors know they will get reimbursed. Patients who see LPCs do not. House Bill 593 would bring licensed professional counselors into the existing anti-discrimination statute, so that when patients see an LPC for covered mental health services they will be paid. It will also correct the unfairness of existing anti-discrimination statute by giving LPCs the same rights to reimbursements as are enjoyed by other master-level health providers. Representative Dockham recognized Linda Attarian, Staff Counsel, to comment on the bill. In addition to the bill summary and legislative history of the anti-discrimination provision (G.S. 58-50-30), (see attachments), Ms. Attarian indicated that the State Employee Health Plan is currently reimbursing LPCs. Samuel Taylor, representing the Licensed Professional Counselors Association of North Carolina, was recognized to speak in favor of the bill (see attachment). After much discussion, Representative Dedmon moved to give the bill a favorable report. The motion passed.

Representative Dockham indicated since the two Co-Chairs (Representative Hurly and Dockham) were the primary sponsors for HB 350 and HB 356 under consideration, Representative Hall, Vice-Chair, had been asked to preside over the remaining portion of the meeting.

HB 350, entitled, AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO SHARE WITH THE FEDERAL AND STATE FINANCIAL INSTITUTION REGULATORS INFORMATION ABOUT INSURANCE COMPANIES THAT ARE AFFILIATES OF DEPOSITORY INSTITUTIONS OR OF FINANCIAL HOLDING COMPANIES; TO AMEND THE INSURANCE HOLDING COMPANY ACT AND AN INSURANCE COMPANY INVESTMENT STATUTE TO COMPLY WITH FEDERAL LAW, IN ACCORDANCE WITH THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102. Representative Hall introduced Bill Hale, Chief Legislative Counsel with the North Carolina Department of Insurance to explain the bill (see attached memo). Bill Hale advised that federal law requires a certification of legislation for HB 350 (Gramm-Leach-Bliley Act Requirements). This memorandum must be attached to the bill "at the time of its consideration by the General Assembly," when it is considered on the floor. G.S. 120-36.8 requires the certification to be attached to the bill that is reported favorably by committee but that it be separate from the bill. A certification is not considered part of the bill and is not an expression of legislative intent. Representative Wainwright moved to give the bill a favorable report. The motion passed.

HB 356 A BILL TO BE ENTITLED AN ACT TO UPDATE THE BOND REQUIREMENTS FOR COLLECTION AGENCIES; TO REQUIRE NONRESIDENT COLLECTION AGENCIES TO POST A SECOND BOND FOR EXPENSES INCURRED BY THE STATE IN A RECEIVERSHIP PROCEEDING INVOLVING THE COLLECTION AGENCY; TO MAKE TECHNICAL CORECTIONS; TO ALLOW BAIL BONDSMEN TO CREATE SHARED TRUST ACCOUNTS; TO CODIFY AN ADMINISTRATIVE RULE ON BONDSMEN AFFIDAVITS; AND TO AUTHORIZE THE COMMISSIONER TO DENY LICENSE RENEWALS TO PROFESSIONAL BONDSMEN UNTIL THEY CURE DEPOSIT DEFICIENCIES. Representative Hall recognized Bill Hale with the NC Department of Insurance to explain the bill (see attached handout presented). A proposed committee substitute was presented by Representative Dockham and adopted for committee discussion. This bill would limit collection agency statement filings and

increase the surety bond requirements for collection agencies. The bill also would amend the bail bondsmen law to clarify license and qualification requirements, allow the use of intra-office shared trust accounts, statutorily require the filing of affidavits, allow denial of license renewal if security deposits fall below legal requirements, and allow the Commissioner to examine licensees. The Vice-Chair, Representative Hall, moved to give the committee substitute a favorable report, unfavorable to the original bill. Representative Brubaker seconded the motion. The motion passed

.

The meeting was turned back over to Representative Dockham.

There being no further business, the Chair adjourned the meeting at 12:55 PM.

Respectfully submitted,

Representative Jerry C. Dockham
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Form
HB 350, HB 356, and HB 593
Handouts
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — March 28, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Retha Summers, LPC, NCC	Career & Family Consulting Private Practice POBox 207 Tarboro NC
Patricia Peyton, LPC, LMFT	Fountain Correctional Center for Women Rocky Mount, NC 27802
DEANNA MADISON MA, LPC	Cumberland Cnty Mental Health / So. Prof. Counseling P.O. 3069 Fayetteville NC 28304 / Elizabethtown NC
Suzanne L. Walker MS, LPC	Cumberland County Mental Health Center P.O. Box 3069 Fayetteville NC 28302
Doug Pfaff	Auto Glass by Pfaff's PO Box 5065 Winston Salem, N.C 27113
Beverley Ward	Ever-Ready Glass & Lock Service 500 Nowell Rd. Raleigh NC. 27607
John Webb	DEALS AUTO GLASS 1801 S. CANNON BLVD KANNAPOLIS N C 28083
William Williford	Ever-Ready Glass & Lock Ser. 500 Nowell Rd Raleigh NC. 27607
Dianne T. Dougherty, LPC	4096 Barrett Dr. Raleigh NC 27609
Julie Bean, LPC	Family Service of the Piedmont 315 E. Washington St Greensboro NC 27403
Richard Varela, LPC	KV Consultants & Associates 2606 Raeford Rd. Fayetteville, NC 28303
HEATHER LANGAN, LPC	(910) 223-7114 EXCHANGE CLUB - 286-9106 X229

VISITOR REGISTRATION SHEET

INSURANCE — March 28, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JoCarole Willsa MS LPC, CCAS, CSAC	Private Practice — 2000 Regency Parkway, Suite 204, Cary, N.C. 27511
Rob Young MA LPC	South Light Pathways Division 2809 Highwoods Blvd. Raleigh NC 27604
Louise Glenn, MA LPC	Private practice 17 Haycox Ct. Durham, 27713
Tom Lynge, MA, MS LPC, CRC-MAC, CCAS	Southeaster Regional MH/DD/SA 1224 Biggs St, Laurinburg, NC 28353
Vance Barbee, MS LPC	po Box 707, Private practice Richlands, NC 28574
Dale Sheffield Ph.D, LPC	Bent Tree office Park 7901 Strickland Rd., Ste 112 Raleigh NC 27615
Cynthia Dowdy MS, LPC	Raleigh, NC dowdy@intrex.net
Neha It Berkol MS, DMH LPC	867 Washington St Raleigh NC — Fax (919) 833-5869
Keith Montgomery MS, LPC, LMFT-A, CRC	122 Hanby Ave Carolina Beach NC (Southeastern MH/DD/SA) 458-5089
Beverly Hicks, MSA LPC, LMFT, CCS, CSAC	North Ridge Counseling 901-F Paverstone Dr, Raleigh, NC 27615 — 849-2197
Pat Yancey	APPCNC / Carolina Center for Hospice & End of Life Care

VISITOR REGISTRATION SHEET

INSURANCE — March 28, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Perkinson LPC	Wake Teen Medical Services 3349 Hillsborough St. Ste 300 Raleigh 27607
Trudy Burgess, LPC (VA+NC) NCC, NCP, Certified Imago Relationship Therapist	Tru Counseling & Consulting 751 West 2nd St. Washington, NC 27889
Gina Roberts PhD, LPC	Elon College Counseling Services, Elon College, NC. + private practice: 7000 Cheeseys Church Rd., Raleigh NC.
Grey Ralford	Dept. of Revenue
Emily Fulghum	NAII
ANN LORE	OUHS
Bill Eggborn	KENNEDY COVINGTON
Jan Ramsey	NCSOS
Susan Valauri	Nationwide
Frank Gray	N.C Collectors Assn.
PAUL STOCK	BANK LOBBY
John McMillan	MFT's PA

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

March 28, 2001 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cecile Broadhurst	SouthLight 2500 Blue Ridge Rd., Ste 400 Raleigh, NC 27511 787-6131 X102
Sherry Lindsley	Integrated Health Care 4505 Mill Village Rd Raleigh, NC 27612 919-510-4067
Patty Calhoun	Leesville Rd. High School 8409 Leesville Rd. Raleigh NC 27613
Jan Poinderter-Cameron	Formerly employed by Wake Co. Human Services. Home: 204 W. Church St., Benson NC 27504
Deborah S Smith	EAP Partnerships, 848 Country Club Sq Rocky Mount, NC 27804 Home: 603 Long Branch Dr. Nashville, NC 27856
Kerri Kutscheid	EAP Partnerships 848 Country Club Sq. Rocky Mount, NC 27804
ERIC DAVIS	PROGRAM RESOURCE INSTITUTE 404 W. MAIN ST. SANFORD, N.C 27330
Ernest Gore	PRI contract services P.O. Box 747 Lillington, NC 27546
Ted Fitzgerald	Addiction Professionals of NC PO Box 747 Lillington NC 27546
Pat Nystrom	Topsail Middle School 17385 Hwy 17 Hampstead NC 28443
Kathryn Brown Rourke	Psychological Health Services of Greensboro 603 E Bailey Madison Greensboro NC 27410
Judy Davis	A Place for Women to Gather 6512 Six Forks Rd Raleigh 27615 919/846-3601

VISITOR REGISTRATION SHEET

Insurance
Name of Committee

3-28-01
Date

VISITORS:. PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Colonial Life + Accident Ins
[illegible]	BMAC Insurance
[illegible]	NCAHP
Larry Lechner	Household Financial Group.
Amy Fulbright	Hunton & Williams
[illegible]	NCAHP
[illegible]	NCAHP
Warren Savage	Bailey & Dixon

reported out 3/28

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 593 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR DIRECT PAYMENT OF LICENSED PROFESSIONAL COUNSELORS UNDER HEALTH INSURANCE POLICIES AND PLANS.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

HOUSE BILL 593

Short Title:	Health Insurance: Licensed Prof'l. Counselor.	(Public)
Sponsors:	Representatives Alexander; Coates, Holliman, Insko, Luebke, Saunders, Underhill, and Wainwright.	
Referred to:	Insurance.	

March 14, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR DIRECT PAYMENT OF LICENSED PROFESSIONAL COUNSELORS 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, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, or physician assistant.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of 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 that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed

professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, 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.

(c3) For purposes of this section, a "duly licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1."

SECTION 2.(a) G.S. 58-65-1(a) reads as rewritten:

"(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term `hospital service plan' as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term `medical service plan' as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical ~~and/~~ or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term `medical services plan' also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes."

SECTION 2.(b) G.S. 58-65-1(c) reads as rewritten:

"(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.

For purposes of this section, a "duly licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 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 corporati n 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."

SECTION 3. This act becomes effective October 1, 2001, and applies to claims for payment or reimbursement for services rendered on or after that date.

HOUSE BILL 593:
Health Insurance: Licensed Prof'l. Counselor

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Alexander
Date:	March 28, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 593, if enacted, will prohibit most health benefit plans from denying payment or reimbursement for any covered service which is within the scope of practice of a licensed professional counselor. The bill does not apply to HMO plans. The act is effective October 1, 2001, and applies to claims for payment or reimbursement for services rendered on or after that date.***

CURRENT LAW: G.S. 58-50-30 together with G.S. 58-65-1, require insurers, with respect to a specified list of categories or classes of health care providers, to pay for a covered service regardless of the class of provider performing the service, as long as the service is within the scope of practice of the provider. Any limitations on the coverage (number of visits, preauthorization requirements, etc.) must be the same, regardless of provider class. In addition, the level of coverage (e.g. plan covers 80% of UCR, member copay amount, etc.) must be the same, regardless of provider. The current classes of providers covered by the statutes include: a licensed optometrist, podiatrist, dentist, chiropractor, psychologist, clinical social worker, certified substance abuse professional, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse (i.e., a nurse midwife, clinical specialist in psychiatric and mental health nursing or nurse practitioner), or physician assistant. The purpose of the laws is to ensure that covered persons have nondiscriminatory access to a variety of classes of providers when seeking covered services.

Theses provisions apply to most health benefit plans, including preferred provider networks, but do not apply to HMO health plans governed under Article 67 of Chapter 58.

Licensed Professional Counselors:

A "licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes. G.S. 90-330(a) (3) defines the scope of practice as follows:

> (3) The "practice of counseling" means holding oneself out to the public as a professional counselor offering counseling services that include, but are not limited to, the following:
>
> a. Counseling. - Assisting individuals, groups, and families through the counseling relationship by treating mental disorders and other conditions through the use of a combination of clinical mental health and human development principles, methods, diagnostic procedures, treatment plans, and other psychotherapeutic techniques, to develop an understanding of personal problems, to define goals, and to plan action reflecting the client's interests, abilities, aptitudes, and mental health needs as these are related to personal-social-emotional concerns, educational progress, and occupations and careers.
>
> b. Appraisal Activities. - Administering and interpreting tests for assessment of personal characteristics.

c. Consulting. - Interpreting scientific data and providing guidance and personnel services to individuals, groups, or organizations.

d. Referral Activities. - Identifying problems requiring referral to other specialists.

e. Research Activities. - Designing, conducting, and interpreting research with human subjects.

BILL ANALYSIS: **Section 1** adds "*licensed professional counselors*" to the list of professions that are designated in G.S. 58-50-30, which prohibits insurers governed by Articles 1 through 64 of Chapter 58 from denying payment or reimbursement (or otherwise discriminating against that profession), for any covered service performed by a licensed practitioner of that profession, as long as the covered service is within the practitioner's lawful scope of practice.

Section 2(a) and (b) make the same addition to G.S. 58-65-1 governing Hospital, Medical, and Dental Service Corporations (e.g., Blue Cross/Blue Shield of North Carolina).

Section 3 makes the act effective October 1, 2001, and applies to claims for payments or reimbursement for services rendered on or after that date.

BACKGROUND:
According to Dr. Lloyd Goodwin, a professor at UNC-Greenville, the scope of practice of a Licensed Professional Counselor includes, but is not limited to the following:

- Assessment and diagnosis of an individual's mental health and personal characteristics, assets, and limitations through clinical interviews and/or the administration and interpretation of tests.
- Clinical individual, group, marital and family counseling and psychotherapy services.
- Treatment of mental disorders and related personal, family, interpersonal, and vocational concerns.
- Development of counseling, psychotherapy, and treatment goals and plans.
- Case management and coordination of related health, mental health, and rehabilitation services.
- Career assessment and counseling services.
- Counselor supervision, training, and education.
- Administration of counseling and related mental health and rehabilitation programs.
- Research in counseling, psychotherapy, mental health, rehabilitation, addictions, and related health care areas.
- Consultations on mental health and counseling related issues to other health care providers, human service providers, school personnel, and community organizations.

According to Blue Cross Blue Shield of North Carolina (BCBSNC), effective July 1, 2001, Licensed Professional Counselors (LPCs) will become eligible providers for BCBSNC products. The following is a summary of the key issues related to this change:

- LPCs, with appropriate state licensure, are eligible to obtain a BCBSNC provider number (note: if a provider currently has a BCBSNC number for the State Health Plan, there is no need to request an additional number).
- Contracting with LPCs for in-network status will be determined based on ongoing assessments of BCBSNC provider network needs.
- Participation in BCBSNC managed care networks will require LPCs to be credentialed according to the standards set by BCBSNC.

Legislative History of G.S. 58-50-30
Chapter on Insurance

1913, c. 91 provides uniform standard provisions for accident and health policies.
1913, c.91, s. 11: Discriminations forbidden

Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by this act, 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.

1965, c.396, s.2:

This section amends G.S. 58-260 by giving the policyholder, insured, or beneficiary the right to choose providers of vision care. Furthermore, persons entitled to benefits under such a policy shall be entitled to payment of or reimbursement for such services, whether a duly licensed physician or a duly licensed optometrist performed them.

c. 1169, s.2:

This section amends c.396, s.2 by inserting the words "or a duly licensed dentist" after the words "a duly licensed optometrist" wherever the same appear.

Essentially, this section gives citizens the right to choose providers of oral surgery and includes dentists in the list of those eligible for payment or reimbursement of services.

1967, c. 690, s. 2:

This section amends C. 58, Art. 27, s. 260 by inserting the words "or a duly licensed podiatrist" after the word "optometrist" in line 3 of the second paragraph and in line 6 of the second paragraph. Therefore, this section grants individuals the right to choose services of podiatrists and includes podiatrists in the list of those eligible for payment or reimbursement of services.

1969, c. 679:

This section amends G.S. 58-260 by inserting immediately after the word "dentist," in lines 3 and 7 of the second paragraph, the words "or a duly licensed chiropractor," thus allowing individuals the right to obtain chiropractic services and adding licensed chiropractors to the list of those eligible for payment or reimbursement of services.

1973, c. 610:

This section amends G.S. 58-260 by inserting language that addresses disability payments under certain policies of insurance. Basically, the section provides that the insured or other persons entitled to benefits under any policy of insurance governed by this Chapter shall be entitled to payment of or reimbursement for such disability whether such disability be certified by a duly licensed physician, optometrist, podiatrist, dentist, or chiropractor.

1977, c. 601, ss2, 3 ½:

Section 2 amends G.S. 58-260 by inserting "duly licensed practicing psychologist" in appropriate places, thus providing patients the freedom to obtain psychological services. This section also adds psychologists to the list of those eligible for payment or reimbursement of services and adds psychologists to the list of those professionals who may certify a disability.

Section 3 ½ defines a "duly licensed practicing psychologist" as a psychologist who is duly licensed or certified in North Carolina, has a doctorate degree in psychology, and who has 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.

1991, c.720, s. 29:

This section simply makes technical corrections to the insurance laws (G.S. 58-50-5(c), 58-50-15, and 58-50-30) by substituting "Articles 50 through 55" for "Articles 47 and 49 through 53".

1993, c. 347, s. 2:

This section removes barriers in insurance policies and plans to provide for reimbursement to advanced practice registered nurses providing services within the scope of their practice. Patients have the right to choose services of an advanced practice registered nurse. An advanced practice registered nurse is added to the list of those eligible for payment or reimbursement of services and payment or reimbursement for certification of disability.

The section requires payment or reimbursement 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.

c. 375, s. 3:

This section amends G.S. 58-50-30 by changing "duly licensed practicing psychologist" to "duly licensed psychologist". 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. 464, s. 2:

This section amends G.S. 58-50-30 by inserting "certified clinical social worker" in appropriate sections. Thus, patients have the right to choose services of a certified clinical social worker and such social worker is included in the is added to the list of those eligible for payment or reimbursement of services and payment or reimbursement for certification of disability. 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.

c. 554, s. 1:

This section amends G.S. 58-50-30 to better fulfill the intent of the insurance equality statute by correcting omissions in that statute. Inserted language clarifies that the insured or other persons entitled to benefits shall be entitled to payment of or reimbursement for services rendered in connection with a condition or complaint. Further insertion broadens powers for chiropractic services.

> 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 the medically necessary treatment if performed or authorized by any other duly licensed physician.

1995 c. 193, s. 41:

This section provides technical and grammatical changes to G.S. 58-50-30(a). Most notably it changes language that was inserted by c. 554, s. 1 from "his practice" to "the chiropractor's practice".

c. 223, s. 1:

This section amends G.S. 58-50-30 by inserting language that enables individuals the right to obtain pharmaceutical services. Thus a duly licensed pharmacist is added to the list of those eligible for payment or reimbursement of services rendered in connection with a condition or complaint and payment or reimbursement for certification of disability.

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. 406, s. 3:

This section amends G.S. 58-50-30 by inserting "certified fee-based practicing pastoral counselor" to the list of professionals from which individuals have the right to obtain services. A certified fee-based practicing pastoral counselor is added to the list of those eligible for payment or reimbursement of services rendered in connection with a condition or complaint and payment or reimbursement for certification of disability. This section also limits a duly certified fee-based practicing pastoral counselor to only those 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.

1997, c. 197, ss. 1,2:

Chapter 197 removes the sunset on certain direct payments under health insurance policies and plans. Section 1 removes the sunset from Section 5 of Chapter 347 of the 1993 Session Laws, and Section 2 removes the sunset from Section 8 of Chapter 464 of the 1993 Session Laws.

1999, c. 186, s. 1:

This section removes the sunset from Section 6 of Chapter 406 of the 1995 Session Laws, thus removing the sunset from the act providing for reimbursement by health insurers for services provided by fee-based practicing pastoral counselors.

1999, c. 199, s.1:

This section amends G.S. 58-50-30 by inserting "certified substance abuse professional" to the list of professionals from which individuals have the right to obtain services. A certified substance abuse professional is added to the list of those eligible for payment or reimbursement of services rendered in connection with a condition or complaint and payment or reimbursement for certification of disability. A duly certified substance abuse professional is defined as a person certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

1999, c. 210, s. 2:

This section rewrites G.S. 58-50-30 by deleting "or advanced practice registered nurse" and by inserting "advanced practice nurse, or physician assistant." Thus individuals have the a right to choose services of a duly licensed physician assistant and such assistant is added to the list of those eligible for payment or reimbursement of services rendered in connection with a condition or complaint and payment or reimbursement for certification of disability.

Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1.

SAMUEL M. TAYLOR
ATTORNEY AT LAW

TALKING POINTS
H593/S480
HEALTH INSURANCE: LICENSED PROFESSIONAL COUNSELOR

- What this legislation does NOT do:
  - It does NOT mandate any new benefits. Insurers will not have to cover any types of health services that they are not already covering.
  - It does NOT prohibit insurers from imposing other limits health care benefits. It does NOT, for example, limit deductibles, copays, co-insurance. It does NOT prohibit benefit caps. Insurers will STILL be able to establish maximum dollar limits on mental health services or, if they desire, limit an enrollee's number of counseling sessions.
  - It does NOT require insurers to add LPCs to their preferred provider panels.
  - It does NOT require insurance companies to reimburse LPCs directly.
  - It does NOT affect the State Health Plan. LPCs are already covered by the State Health Plan.
- What this legislation DOES DO:
  - We believe it will REDUCE costs.
    - LPCs are among lowest cost mental health providers. Average session cost for LPCs is $60 per hour.
    - The bill will add more low cost providers to the provider pool, which will put downward pressure on provider prices.
    - As an example of the benefits the reimbursing LPC services, we note that BCBS recently advised the LPC Association that it will add LPCs as eligible providers for a number of its health benefit plans.
  - Finally, H593 will make mental health services more available in RURAL areas of our state. 20% of LPCs work in medically under-served counties.
- LPCs are among the last mental health groups to seek protection of the provider anti-discrimination statute.
  - We are here because the existing law has put LPCs at an economic disadvantage in the marketplace for mental health services
  - Please do not leave LPCs in this untenable position. Please pass H593 this year.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 350 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO SHARE WITH THE FEDERAL AND STATE FINANCIAL INSTITUTION REGULATORS INFORMATION ABOUT INSURANCE COMPANIES THAT ARE AFFILIATES OF DEPOSITORY INSTITUTIONS OR OF FINANCIAL HOLDING COMPANIES; TO AMEND THE INSURANCE HOLDING COMPANY ACT AND AN INSURANCE COMPANY INVESTMENT STATUTE TO COMPLY WITH FEDERAL LAW, IN ACCORDANCE WITH THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 350*

Short Title:	Gramm-Leach-Bliley Act Requirements-AB.	(Public)
Sponsors:	Representatives Hurley and Dockham (Primary Sponsors).	
Referred to:	Insurance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO SHARE WITH THE FEDERAL AND STATE FINANCIAL INSTITUTION REGULATORS INFORMATION ABOUT INSURANCE COMPANIES THAT ARE AFFILIATES OF DEPOSITORY INSTITUTIONS OR OF FINANCIAL HOLDING COMPANIES; TO AMEND THE INSURANCE HOLDING COMPANY ACT AND AN INSURANCE COMPANY INVESTMENT STATUTE TO COMPLY WITH FEDERAL LAW, IN ACCORDANCE WITH THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-2-128. Interagency consultation.**

(a) Purpose. -- It is the stated intention of the Congress in P.L. 106-102, the Gramm-Leach-Bliley Act, that the Board of Governors of the Federal Reserve System, as the umbrella supervisor for financial holding companies, and the Commissioner, as the functional regulator of persons engaged in insurance activities, coordinate efforts to supervise persons that control both a depository institution and a person engaged in insurance activities regulated under State law. In particular, Congress believes that the Board and the Commissioner should share, on a confidential basis, information relevant to the supervision of persons that control both a depository institution and a person engaged in insurance activities, including information regarding the financial health of the consolidated organization and information regarding transactions and relationships between persons engaged in insurance activities and affiliated depository institutions. The purpose of this section is to encourage this coordination and confidential sharing of information and to thereby improve both the efficiency and the quality of the supervision of financial holding companies and their affiliated depository institutions and persons engaged in insurance activities.

(b) Commissioner's Authority. -- Upon the request of the Board or the appropriate federal banking agency, the North Carolina Secretary of State, or the North Carolina Commissioner of Banks, the Commissioner may provide any examination or other reports, records, or other information to which the Commissioner has access with respect to a person that:

(1) Is engaged in insurance activities and regulated by the Commissioner.

(2) Is an affiliate of a depository institution or financial holding company.

Upon the request of the Board or the appropriate federal banking agency, the North Carolina Secretary of State, or the North Carolina Commissioner of Banks, the Commissioner may provide any examination or other reports, records, or other information to which the Commissioner has access with respect to any insurance producer.

(c) Privilege. -- The provision of information or material under this section by the Commissioner does not constitute a waiver of, or otherwise affect, any privilege to which the information or material is otherwise subject.

(d) Definitions. -- As used in this section, the terms:

(1) "Appropriate federal banking agency" and "depository institution" have the same meanings as in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813.

(2) "Board" and "financial holding company" have the same meanings as in section 2 of the Bank Holding Company Act of 1956, 12 U.S.C. § 1841, et seq.

(3) "Insurance producer" or "producer" means a person required to be licensed under this Article to sell, solicit, or negotiate insurance. "Insurance producer" or "producer" includes an agent, a broker, and a limited representative."

SECTION 2. Article 19 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-19-2. Compliance with federal law.**

(a) As used in this section, "depository institution" has the same meaning as in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813, and includes any foreign bank that maintains a branch, an agency, or a commercial lending company in the United States.

(b) With respect to affiliations between a depository institution or any affiliate of a depository institution and any insurer, the provisions of section 104(c) of the Gramm-Leach-Bliley Act, P.L. 106-102, shall apply to this Article."

SECTION 3. G.S.58-7-170(b)(1) reads as rewritten:

"(1) The cost of investments made by insurers in stock authorized by G.S. 58-7-173 shall not exceed twenty-five percent (25%) of the insurer's admitted assets, provided that no more than twenty percent (20%) of the insurer's admitted assets shall be invested in common stock; and the cost of an investment in stock of any one corporation shall not exceed three percent (3%) of the insurer's admitted assets. Notwithstanding any other provision in this Chapter, the financial

statement carrying value of all stock investments shall be used for the purpose of determining the asset value against which the percentage limitations are to be applied. Investments in the voting securities of a depository institution, or any company that controls a depository institution, shall not exceed five percent (5%) of the insurer's admitted assets. As used in this subdivision, "depository institution" has the same meaning as in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813; and includes any foreign bank that maintains a branch, an agency, or a commercial lending company in the United States."

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

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

March 28, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 350 – Gramm-Leach-Bliley Act Requirements

The following are the reasons for the provisions in this bill:

SECTION 1. *Confidentiality and information sharing.* Under P.L. 106-102, state law must allow state regulators to give assurances to federal regulators that they can maintain the confidentiality of information shared in confidence by federal banking regulators to facilitate interagency consultation, in accordance with Sections 111, 112, and 307 of the Gramm-Leach-Bliley Act.

SECTION 2. *North Carolina Holding Company Act.* The period for review and action by the Department of Insurance on proposed affiliations is limited to 60 days before the effective date of the transaction, for transactions falling under the Gramm-Leach-Bliley Act. Under Section 104(c)(2), states have only a 60-day period "preceding the effective date of the acquisition or change or continuation of control" in which to collect information and take action. With respect to required capital infusions related to change in control, Section104(c)(2) of the Gramm-Leach-Bliley Act also provides that states will have only 60 days before the effective date of the transaction to require "restoration of capital" in connection with a change in control.

SECTION 3. *Investments in affiliate banks and bank controlling affiliates.* Section 306 of the Gramm-Leach-Bliley Act provides that state law cannot restrict investment by insurers in the voting securities of a depository institution or companies controlling the bank, except that the insurer's state of domicile may limit those investments to five percent (5%) of the insurer's admitted assets.

HOUSE BILL 350:
Gramm-Leach Bliley Act Requirements-AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Reps. Hurley and Dockham
Date:	March 28, 2001	**Summary by:**	Trina Griffin
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 350 does three things, as required by the Gramm-Leach-Bliley Act:

- ***It provides for interagency consultation and confidential sharing of information between the Federal Reserve Board and the Commissioner of Insurance.***
- ***It conforms the state law applicable to affiliations between depository institutions and insurers to Section 104(c) of the Gramm-Leach-Bliley Act.***
- ***It limits the investment by insurers in the voting securities of depository institutions to 5% of the insurer's assets.***

BACKGROUND:

On November 12, 1999, President Clinton signed the Gramm-Leach-Bliley Act of 1999, also known as the Financial Services Modernization Act ("Act"). This legislation eliminates many Federal and State law barriers to affiliation among banks and securities firms, insurers and other financial service providers. Furthermore, the legislation provides financial organizations with flexibility in structuring these new financial affiliations through a holding company structure or a financial subsidiary, with certain limitations on activities and appropriate safeguards. Several provisions of the Act either preempt the States in certain areas or require the States to enact compliance legislation.

BILL ANALYSIS:

Interagency Consultation

Section 1 authorizes the Commissioner of Insurance to share information with the federal and state financial institution regulators about insurance companies that are affiliates of depository institutions or of financial holding companies.

Compliance with federal law

Section 2 adds a new section to Article 19 of Chapter 58 (Insurance Holding Company System Regulatory Act) to conform to the requirements of the Gramm-Leach-Bliley Act. Under the federal law, State regulation is expressly subject to the following limitations and exceptions in Section 104(c), which are intended to preempt state insurance law and regulation that would frustrate the Act's intent to permit affiliations between insurance and other financial services entities:

- *Interfering With FHC Affiliations.* The Act prohibits any state from preventing or restricting a depository institution, or an affiliate thereof, from being associated directly or indirectly with any person authorized or permitted by the Act or other federal law. This includes the affiliation with insurers and other financial activities. However, a state is not prohibited from reviewing or taking action (including approval or disapproval) with regard to the acquisition or change of control of an insurer. This grant of authority is qualified by some potentially important conditions: (1) State review and action must occur within the 60 days preceding the acquisition; and (2) the review or

action cannot have the effect of discriminating, intentionally or unintentionally, against the bank or affiliate. (Note: "effect," not "intent," is the test.)

- *Restoration of Capital.* The State may require an insurer to maintain or restore capital to the level required under the capital regulations of general applicability, but this action must take place within 60 days preceding the acquisition.
- *Restricting Change of Stock Ownership.* The State may restrict a change in stock ownership in an insurer after the conversion of the insurer from mutual to stock form so long as the restriction does not have the effect of discriminating against a depository institution or an affiliate thereof.

Limitation on Insurer Investments in Depository Institutions

Section 3 of the bill limits the extent to which insurers may invest in the voting securities of a depository institution. The investments may not exceed 5% of the insurer's assets. This limitation is permissive, not required, by Section 306 of the Gramm-Leach-Bliley Act.

EFFECTIVE DATE: This act is effective when it becomes law.

PUBLIC LAW 106-102 (GRAMM-LEACH-BLILEY ACT)

SEC. 104. OPERATION OF STATE LAW.

(c) AFFILIATIONS-

(1) IN GENERAL- Except as provided in paragraph (2), no State may, by statute, regulation, order, interpretation, or other action, prevent or restrict a depository institution, or an affiliate thereof, from being affiliated directly or indirectly or associated with any person, as authorized or permitted by this Act or any other provision of Federal law.

(2) INSURANCE- With respect to affiliations between depository institutions, or any affiliate thereof, and any insurer, paragraph (1) does not prohibit--

(A) any State from--

(i) collecting, reviewing, and taking actions (including approval and disapproval) on applications and other documents or reports concerning any proposed acquisition of, or a change or continuation of control of, an insurer domiciled in that State; and

(ii) exercising authority granted under applicable State law to collect information concerning any proposed acquisition of, or a change or continuation of control of, an insurer engaged in the business of insurance in, and regulated as an insurer by, such State;

during the 60-day period preceding the effective date of the acquisition or change or continuation of control, so long as the collecting, reviewing, taking actions, or exercising authority by the State does not have the effect of discriminating, intentionally or unintentionally, against a depository institution or an affiliate thereof, or against any other person based upon an association of such person with a depository institution;

(B) any State from requiring any person that is acquiring control of an insurer domiciled in that State to maintain or restore the capital requirements of that insurer to the level required under the capital regulations of general applicability in that State to avoid the requirement of preparing and filing with the insurance regulatory authority of that State a plan to increase the capital of the insurer, except that any determination by the State insurance regulatory authority with respect to such requirement shall be made not later than 60 days after the date of notification under subparagraph (A); or

(C) any State from restricting a change in the ownership of stock in an insurer, or a company formed for the purpose of controlling such insurer, after the conversion of the insurer from mutual to stock form so long as such restriction does not have the effect of discriminating, intentionally or unintentionally, against a depository institution or an affiliate thereof, or against any other person based upon an association of such person with a depository institution.

PUBLIC LAW 106-102 (GRAMM-LEACH-BLILEY ACT)
SEC. 306. CERTAIN STATE AFFILIATION LAWS PREEMPTED FOR INSURANCE COMPANIES AND AFFILIATES.

Except as provided in section 104(c)(2), no State may, by law, regulation, order, interpretation, or otherwise--

(1) prevent or significantly interfere with the ability of any insurer, or any affiliate of an insurer (whether such affiliate is organized as a stock company, mutual holding company, or otherwise), to become a financial holding company or to acquire control of a depository institution;

(2) limit the amount of an insurer's assets that may be invested in the voting securities of a depository institution (or any company which controls such institution), except that the laws of an insurer's State of domicile may limit the amount of such investment to an amount that is not less than 5 percent of the insurer's admitted assets; or

(3) prevent, significantly interfere with, or have the authority to review, approve, or disapprove a plan of reorganization by which an insurer proposes to reorganize from mutual form to become a stock insurer (whether as a direct or indirect subsidiary of a mutual holding company or otherwise) unless such State is the State of domicile of the insurer.

PUBLIC LAW 106-102 (GRAMM-LEACH-BLILEY ACT)

SEC. 307. INTERAGENCY CONSULTATION.

(a) PURPOSE- It is the intention of the Congress that the Board of Governors of the Federal Reserve System, as the umbrella supervisor for financial holding companies, and the State insurance regulators, as the functional regulators of companies engaged in insurance activities, coordinate efforts to supervise companies that control both a depository institution and a company engaged in insurance activities regulated under State law. In particular, Congress believes that the Board and the State insurance regulators should share, on a confidential basis, information relevant to the supervision of companies that control both a depository institution and a company engaged in insurance activities, including information regarding the financial health of the consolidated organization and information regarding transactions and relationships between insurance companies and affiliated depository institutions. The appropriate Federal banking agencies for depository institutions should also share, on a confidential basis, information with the relevant State insurance regulators regarding transactions and relationships between depository institutions and affiliated companies engaged in insurance activities. The purpose of this section is to encourage this coordination and confidential sharing of information, and to thereby improve both the efficiency and the quality of the supervision of financial holding companies and their affiliated depository institutions and companies engaged in insurance activities.

(b) EXAMINATION RESULTS AND OTHER INFORMATION-

(1) INFORMATION OF THE BOARD- Upon the request of the appropriate insurance regulator of any State, the Board may provide any information of the Board regarding the financial condition, risk management policies, and operations of any financial holding company that controls a company that is engaged in insurance activities and is regulated by such State insurance regulator, and regarding any transaction or relationship between such an insurance company and any affiliated depository institution. The Board may provide any other information to the appropriate State insurance regulator that the Board believes is necessary or appropriate to permit the State insurance regulator to administer and enforce applicable State insurance laws.

(2) BANKING AGENCY INFORMATION- Upon the request of the appropriate insurance regulator of any State, the appropriate Federal banking agency may provide any information of the agency regarding any transaction or relationship between a depository institution supervised by such Federal banking agency and any affiliated company that is engaged in insurance activities regulated by such State insurance regulator. The appropriate Federal banking agency may provide any other information to the appropriate State insurance regulator that the agency believes is necessary or appropriate to permit the State insurance regulator to administer and enforce applicable State insurance laws.

(3) STATE INSURANCE REGULATOR INFORMATION- Upon the request of the Board or the appropriate Federal banking agency, a State insurance regulator may provide any examination or other reports, records, or other

information to which such insurance regulator may have access with respect to a company which--

(A) is engaged in insurance activities and regulated by such insurance regulator; and

(B) is an affiliate of a depository institution or financial holding company.

(c) CONSULTATION- Before making any determination relating to the initial affiliation of, or the continuing affiliation of, a depository institution or financial holding company with a company engaged in insurance activities, the appropriate Federal banking agency shall consult with the appropriate State insurance regulator of such company and take the views of such insurance regulator into account in making such determination.

(d) EFFECT ON OTHER AUTHORITY- Nothing in this section shall limit in any respect the authority of the appropriate Federal banking agency with respect to a depository institution or bank holding company or any affiliate thereof under any provision of law.

(e) CONFIDENTIALITY AND PRIVILEGE-

(1) CONFIDENTIALITY- The appropriate Federal banking agency shall not provide any information or material that is entitled to confidential treatment under applicable Federal banking agency regulations, or other applicable law, to a State insurance regulator unless such regulator agrees to maintain the information or material in confidence and to take all reasonable steps to oppose any effort to secure disclosure of the information or material by the regulator. The appropriate Federal banking agency shall treat as confidential any information or material obtained from a State insurance regulator that is entitled to confidential treatment under applicable State regulations, or other applicable law, and take all reasonable steps to oppose any effort to secure disclosure of the information or material by the Federal banking agency.

(2) PRIVILEGE- The provision pursuant to this section of information or material by a Federal banking agency or State insurance regulator shall not constitute a waiver of, or otherwise affect, any privilege to which the information or material is otherwise subject.

(f) DEFINITIONS- For purposes of this section, the following definitions shall apply:

(1) APPROPRIATE FEDERAL BANKING AGENCY; DEPOSITORY INSTITUTION- The terms `appropriate Federal banking agency' and `depository institution' have the same meanings as in section 3 of the Federal Deposit Insurance Act.

(2) BOARD AND FINANCIAL HOLDING COMPANY- The terms `Board' and `financial holding company' have the same meanings as in section 2 of the Bank Holding Company Act of 1956.

US Code, Title 12, Section 1813

- (c) Definitions Relating to Depository Institutions. -
  - (1) Depository institution. - The term "depository institution" means any bank or savings association.
  - (2) Insured depository institution. - The term "insured depository institution" means any bank or savings association the deposits of which are insured by the Corporation pursuant to this chapter.
  - (3) Institutions included for certain purposes. - The term "insured depository institution" includes any uninsured branch or agency of a foreign bank or a commercial lending company owned or controlled by a foreign bank for purposes of section 1818 of this title.
  - (4) Federal depository institution. - The term "Federal depository institution" means any national bank, any Federal savings association, and any Federal branch.
  - (5) State depository institution. - The term "State depository institution" means any State bank, any State savings association, and any insured branch which is not a Federal branch.

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Memorandum

DATE: April 2, 2001
TO: Representatives Hurley and Dockham
FROM: Trina Griffin, Staff Attorney, Research Division
Fax: 715-5460; Trinag@ncleg.net

Marilyn Chism, Fiscal Analyst, Fiscal Research Division
Fax: 715-3589; Marilync@ncleg.net

RE: H350 - Certification of Legislation Required by Federal Law

BACKGROUND

G.S. 120-36.8 requires that every introduced bill proposing any change in the law which purports to implement federal law or purports to be required or necessary for compliance with federal law, or on which is conditioned the receipt of federal funds, shall have attached a certification identifying the federal law. The certification is to be provided by the Fiscal Research Division in consultation with Bill Drafting and General Research.

House Bill 350 proposes to implement several requirements of the Gramm-Leach-Bliley Act, P.L. 106-102 (November 12, 1999). This memorandum provides a summary of and citations to the federal requirements of P.L. 106-102 and corresponding parts of H350. The Fiscal Research Division's certification with respect to fiscal impact is included as the last section of this memorandum.

I. Interagency Consultation

Title III, Subtitle A, Section 307 of the Gramm-Leach-Bliley Act relates to the consultation and sharing of confidential information between the Board of Governors of the Federal Reserve System and State insurance regulators. The purpose of this section is to encourage interagency coordination and confidential sharing of information in order to improve both the efficiency and the quality of the supervision of financial holding companies and their affiliated depository institutions and companies engaged in insurance activities. The requirements of this section are not mandatory, but rather it states that the Board and the States ***should*** share information and that upon a request by the Board, a State insurance regulator ***may*** provide information regarding insurers or affiliates of depository institutions.

HOUSE BILL 350

SECTION 1. INTERAGENCY CONSULTATION

Section 1 of the bill authorizes the Commissioner of Insurance to share information with federal and state financial institution regulators about insurance companies that are affiliates of depository institutions or of financial holding companies. This provision complies with Section 307 of the Gramm-Leach-Bliley Act.

II. Affiliations between Depository Institutions and Insurers

Title I, Subtitle A, Section 104 of the Gramm-Leach-Bliley Act relates to the operation of state law with regard to regulating the affiliation among banks, securities firms, and insurance companies. Specifically, Section 104 prohibits states from preventing or restricting a depository institution, or an affiliate thereof, from being affiliated directly or indirectly or associated with any person. There are three exceptions to this restriction. First, a state may review or take action on applications or other documents concerning any proposed acquisition of, or a change or continuation of control of, an insurer. However, any action taken by a state in this regard must occur within the 60 days preceding the acquisition and the action cannot have the effect of discriminating, intentionally or unintentionally, against the bank or affiliate. Second, states are permitted to require insurers to maintain or restore capital to the level required under the capital regulations of general applicability, but this action must also take place within 60 days preceding the acquisition. Third, states are permitted to restrict a change in stock ownership in an insurer after the conversion of the insurer from mutual to stock form so long as the restriction does not have the effect of discriminating against a depository institution or an affiliate thereof.

HOUSE BILL 350

SECTION 2. COMPLIANCE WITH FEDERAL LAW

Section 2 of the bill adds a new section to Article 19 of Chapter 58, the Holding Company System Regulatory Act, which states that the provisions contained in this Article are subject to section 104(c) of the Gramm-Leach-Bliley Act and, therefore, it conforms to federal requirements.

III. Limitation on Insurer Investments in Depository Institutions

Title III, Subtitle A, Section 306 of the Gramm-Leach-Bliley Act preempts state affiliation laws for insurance companies. Specifically, it prohibits a state from preventing or significantly interfering with the ability of any insurer to become a financial holding company or to acquire control of a depository institution. It also prohibits a state from limiting the amount of an insurer's assets that may be invested in the voting securities of a depository institution, except that a state may limit the amount of investment to no more than 5% of the insurer's admitted assets. This 5% limitation is permissive and, therefore, is not mandated by the Act.

HOUSE BILL 350

SECTION 3. LIMITATION ON INSURER INVESTMENTS IN DEPOSITORY INSTITUTIONS.

Section 3 of the bill limits the extent to which insurers may invest in the voting securities of a depository institution. The investments may not exceed 5% of the insurer's admitted assets. Since the 5% limitation is permissive for states, this provision is neither inconsistent nor required by the Gramm-Leach-Bliley Act.

CERTIFICATION OF FISCAL IMPACT

The Fiscal Research Division certifies that House Bill 350 has no impact on the Department of Insurance. Section 1 of House Bill 350 authorizes the Department to share information with Federal and State financial institution regulators. Sections 2 and 3 implement requirement of Gramm-Leach-Bliley Act as discussed above, but such implementation requires no additional resources.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 356 A BILL TO BE ENTITLED AN ACT TO UPDATE THE BOND REQUIREMENTS FOR COLLECTION AGENCIES; TO REQUIRE NONRESIDENT COLLECTION AGENCIES TO POST A SECOND BOND FOR EXPENSES INCURRED BY THE STATE IN A RECEIVERSHIP PROCEEDING INVOLVING THE COLLECTION AGENCY; TO MAKE TECHNICAL CORECTIONS; TO ALLOW BAIL BONDSMEN TO CREATE SHARED TRUST ACCOUNTS; TO CODIFY AN ADMINISTRATIVE RULE ON BONDSMEN AFFIDAVITS; AND TO AUTHORIZE THE COMMISSIONER TO DENY LICENSE RENEWALS TO PROFESSIONAL BONDSMEN UNTIL THEY CURE DEPOSIT DEFICIENCIES.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, unfavorable as to (original bill)

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 356*
PROPOSED COMMITTEE SUBSTITUTE H356*-PCS4100-SO-5

Short Title: Collection Agency/Bail Bond Amendments-AB. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE BOND REQUIREMENTS FOR COLLECTION AGENCIES; TO REQUIRE NONRESIDENT COLLECTION AGENCIES TO POST A SECOND BOND FOR EXPENSES INCURRED BY THE STATE IN A RECEIVERSHIP PROCEEDING INVOLVING THE COLLECTION AGENCY; TO MAKE TECHNICAL CORRECTIONS; TO ALLOW BAIL BONDSMEN TO CREATE SHARED TRUST ACCOUNTS; TO CODIFY AN ADMINISTRATIVE RULE ON BONDSMEN AFFIDAVITS; AND TO AUTHORIZE THE COMMISSIONER TO DENY LICENSE RENEWALS TO PROFESSIONAL BONDSMEN UNTIL THEY CURE DEPOSIT DEFICIENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-70-5(f) reads as rewritten:

"(f) A completed statement by each stockholder owning ten percent (10%) or more of the applicant's outstanding voting stock and each partner, director, ~~officer, office manager, sales representative or other collector~~ and officer actively engaged in the collection agency business, containing: the name of the collection agency, the name and address of the individual completing the form, the positions held by ~~such~~ the individual, each conviction of any criminal offense and any criminal charges pending other than minor traffic violations of ~~such~~ the individual, and the name and address of three people not related to the individual who can attest to the individual's reputation for honesty and fair dealings;".

SECTION 2. G.S. 58-70-20 reads as rewritten:

"**§ 58-70-20. Bond requirement.**

(a) As a condition precedent to the issuance of any permit under ~~G.S. 58-70-1, any~~ this Article, every applicant for ~~such~~ a permit shall file with the Commissioner ~~of Insurance and shall thereafter maintain in force while licensed~~ a bond in favor of the State of North Carolina ~~and~~ that is executed by a surety company ~~duly authorized~~ licensed to transact surety business in this State. The bond shall be maintained in force during the permit period, continuous in ~~form~~ form, and ~~shall~~ remain in ~~full force and~~

effect until all moneys collected have been accounted ~~for, and it shall be expressly stated in the~~ for. The bond shall expressly provide that ~~it~~ the bond is for the benefit of any person, firm or corporation for whom ~~such~~ the collection agency engages in the collection of accounts. ~~Such~~ The bond shall be in the amount of ~~five thousand dollars ($5,000)~~ ten thousand dollars ($10,000) for the initial permit. The amount of ~~such~~ the bond for any renewal permit shall be no less than ~~five thousand dollars ($5,000)~~ ten thousand dollars ($10,000), nor more than ~~fifty thousand dollars ($50,000),~~ seventy-five thousand dollars ($75,000), and shall be computed as follows: The total collections paid directly to the collection agency less commissions earned by the collection agency on those collections for the calendar year ending immediately prior to the date of application, multiplied by one-sixth.

(b) A person required by this section to maintain a bond may, in lieu of that bond, deposit with the Commissioner the equivalent amount in cash, in certificates of deposit issued by banks organized under the laws of the State of North Carolina, or any national bank having its principal office in North Carolina, or securities, which shall be held in accordance with Article 5 of this Chapter. Securities may only be obligations of the United States or of federal agencies listed in G.S. 147-69.1(c)(2) guaranteed by the United States, obligations of the State of North Carolina, or obligations of a city or county of this State. Any proposed deposit of an obligation of a city or county of this State is subject to the prior approval of the Commissioner.

(c) In addition to the requirements of subsections (a) and (b) of this section, as a condition precedent to the issuance of any permit under this Article, every nonresident applicant for a permit shall file with the Commissioner a bond in the amount of ten thousand dollars ($10,000) in favor of the Department that is executed by a surety company licensed to transact surety business in this State. The bond shall be maintained in force during the permit period, be continuous in form, and remain in effect until terminated by the Commissioner. The bond shall expressly provide that the bond is for the purpose of reimbursing the Department for expenses incurred in visiting and examining a nonresident collection agency in connection with a federal bankruptcy or State receivership proceeding in which the collection agency is the subject of the proceeding."

SECTION 3. G.S. 58-71-40(a) reads as rewritten:

"(a) No person shall act in the capacity of ~~a bail bondsman~~ professional bondsmen, surety bondsmen, or ~~runner~~ runners or perform any of the functions, duties, or powers prescribed for ~~bail bondsmen~~ professional bondsmen, surety bondsmen, or runners under ~~the provisions of~~ this Article unless that person ~~shall be~~ is qualified and ~~(except as regards an accommodation bondsman)~~ licensed ~~in accordance with the provisions of~~ under this Article. No license shall be issued ~~to a professional bondsman or runner~~ under this Article except to an individual natural person."

SECTION 4. G.S. 58-71-100 reads as rewritten:

"**§ 58-71-100. Receipts for collateral; trust accounts.**

(a) When a bail bondsman accepts collateral he shall give a written receipt for the collateral. The receipt shall give in detail a full description of the collateral received.

Collateral security shall be held and maintained in trust. When collateral security is received in the form of cash or check or other negotiable instrument, the licensee shall deposit the cash or instrument within two banking days after receipt, in an established, separate noninterest-bearing trust account in any bank located in North Carolina. The trust account funds under this section shall not be commingled with other operating funds.

(b) With the approval of the Commissioner, bail bondsmen operating out of the same business office or location may establish a shared trust account for collateral security received by them. The Commissioner may require the bondsmen desiring to establish the shared trust account to furnish the Commissioner information about their business that the Commissioner considers necessary to administer this Article effectively."

SECTION 5. G.S. 58-71-140 reads as rewritten:

"**§ 58-71-140. Registration of licenses and power of appointments by insurers.**

(a) No professional bail bondsman shall become a surety on an undertaking unless he or she has registered his or her current license in the office of the clerk of superior court in the county in which he or she resides and a certified copy of the same with the clerk of superior court in any other county in which he or she shall write bail bonds.

(b) A surety bondsman shall register his or her current surety bondsman's license and a certified copy of his or her power of appointment with the clerk of superior court in the county in which the surety bondsman resides and with the clerk of superior court in any other county in which the surety bondsman writes bail bonds on behalf of an insurer.

(c) No runner shall become surety on an undertaking on behalf of a professional bondsman unless that runner has registered his or her current license and a certified copy of his or her power of attorney in the office of the clerk of superior court in the county in which the runner resides and with the clerk of superior court in any other county in which the runner writes bail bonds on behalf of the professional bondsman.

(d) Professional bail bondsmen, surety bondsmen, and runners shall file with the clerk of court having jurisdiction over the principal, an affidavit on a form furnished by the Administrative Office of the Courts. The affidavit shall include, but not be limited to:

(1) A statement that the bondsman has not, nor has anyone for the bondsman's use, been promised or received any collateral, security, or premium for executing this appearance bond.

(2) If promised a premium, the amount of the premium promised and the due date.

(3) If the bondsman has received a premium, the amount of premium received.

(4) If given collateral security, the name of the person from whom it is received, and the nature and amount of the collateral security, listed in detail."

SECTION 6. G.S. 58-71-160 reads as rewritten:

"**§ 58-71-160. Security deposit to be maintained.**

(a) Any professional bondsman, whose security deposits with the Commissioner are, for any reason, reduced in value below the requirements of this Article, shall immediately upon receipt of a notice of deficiency from the Commissioner ~~of Insurance~~ deposit such additional securities as are necessary to comply with the law. No professional bondsman shall sign, endorse, ~~execute~~ execute, or become surety on any additional bail bonds, or pledge or deposit any cash, check, or other security of any nature in lieu of a bail bond in any county in North Carolina until ~~such time as he~~ the professional bondsman has made such additional deposit of securities as ~~shall be~~ required by the notice of deficiency.

(b) The Commissioner may deny the renewal of any license held by a professional bondsman under this Chapter or may deny the issuance of any license applied for by a professional bondsman under this Chapter if, at the time of the renewal application or license application, the professional bondsman has not complied with a notice of deficiency under subsection (a) of this section. The Commissioner may issue the renewal license or the new license upon compliance by the professional bondsman with the notice of deficiency."

SECTION 7. G.S. 58-71-170(a) reads as rewritten:

"(a) Whenever the Commissioner ~~deems~~ considers it prudent, the Commissioner shall visit and examine or cause to be visited and examined by a competent person appointed by the Commissioner for that purpose any professional bail ~~bondsman~~ bondsman, surety bondsman, or runner subject to ~~the provisions of~~ this Article. For this purpose the Commissioner or person making the examination shall have free access to all ~~books and papers~~ records of the ~~bondsman~~ licensee that relate to the ~~bondsman's~~ licensee's business and to the ~~books and papers~~ records kept by any of the ~~bondsman's agents or runners.~~licensee's agents."

SECTION 8. This act becomes effective October 1, 2001, and applies to permits or licenses issued or renewed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 356*
PROPOSED COMMITTEE SUBSTITUTE H356-CSSO-5 [v.2]

3/28/2001 10:15:12 AM

Short Title: Collection Agency/Bail Bond Amendments-AB. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE BOND REQUIREMENTS FOR COLLECTION AGENCIES; TO REQUIRE NONRESIDENT COLLECTION AGENCIES TO POST A SECOND BOND FOR EXPENSES INCURRED BY THE STATE IN A RECEIVERSHIP PROCEEDING INVOLVING THE COLLECTION AGENCY; TO MAKE TECHNICAL CORRECTIONS; TO ALLOW BAIL BONDSMEN TO CREATE SHARED TRUST ACCOUNTS; TO CODIFY AN ADMINISTRATIVE RULE ON BONDSMEN AFFIDAVITS; AND TO AUTHORIZE THE COMMISSIONER TO DENY LICENSE RENEWALS TO PROFESSIONAL BONDSMEN UNTIL THEY CURE DEPOSIT DEFICIENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-70-5(f) reads as rewritten:

"(f) A completed statement by each stockholder owning ten percent (10%) or more of the applicant's outstanding voting stock and each partner, director, ~~officer, office manager, sales representative or other collector~~ and officer actively engaged in the collection agency business, containing: the name of the collection agency, the name and address of the individual completing the form, the positions held by ~~such~~ the individual, each conviction of any criminal offense and any criminal charges pending other than minor traffic violations of ~~such~~ the individual, and the name and address of three people not related to the individual who can attest to the individual's reputation for honesty and fair dealings;"

SECTION 2. G.S. 58-70-20 reads as rewritten:

"**§ 58-70-20. Bond requirement.**

(a) As a condition precedent to the issuance of any permit under ~~G.S. 58-70-1, any~~ this Article, every applicant for ~~such~~ a permit shall file with the Commissioner ~~of Insurance and shall thereafter maintain in force while licensed~~ a bond in favor of the State of North Carolina ~~and~~ that is executed by a surety company ~~duly authorized~~ licensed to transact surety business in this State. The bond shall be maintained in force during the permit period, continuous in ~~form~~ form, and ~~shall~~ remain in ~~full force and~~

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(b) A person required by this section to maintain a bond may, in lieu of that bond, deposit with the Commissioner the equivalent amount in cash, in certificates of deposit issued by banks organized under the laws of the State of North Carolina, or any national bank having its principal office in North Carolina, or securities, which shall be held in accordance with Article 5 of this Chapter. Securities may only be obligations of the United States or of federal agencies listed in G.S. 147-69.1(c)(2) guaranteed by the United States, obligations of the State of North Carolina, or obligations of a city or county of this State. Any proposed deposit of an obligation of a city or county of this State is subject to the prior approval of the Commissioner.

(c) In addition to the requirements of subsections (a) and (b) of this section, as a condition precedent to the issuance of any permit under this Article, every nonresident applicant for a permit shall file with the Commissioner a bond in the amount of ten thousand dollars ($10,000) in favor of the Department that is executed by a surety company licensed to transact surety business in this State. The bond shall be maintained in force during the permit period, be continuous in form, and remain in effect until terminated by the Commissioner. The bond shall expressly provide that the bond is for the purpose of reimbursing the Department for expenses incurred in visiting and examining a nonresident collection agency in connection with a federal bankruptcy or State receivership proceeding in which the collection agency is the subject of the proceeding."

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"(a) No person shall act in the capacity of ~~a bail bondsman~~ professional bondsmen, surety bondsmen, or ~~runner~~ runners or perform any of the functions, duties, or powers prescribed for ~~bail bondsmen~~ professional bondsmen, surety bondsmen, or runners under ~~the provisions of~~ this Article unless that person ~~shall be~~ is qualified and ~~(except as regards an accommodation bondsman)~~ licensed ~~in accordance with the provisions of~~ under this Article. No license shall be issued ~~to a professional bondsman or runner~~ under this Article except to an individual natural person."

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(b) With the approval of the Commissioner, bail bondsmen operating out of the same business office or location may establish a shared trust account for collateral security received by them. The Commissioner may require the bondsmen desiring to establish the shared trust account to furnish the Commissioner information about their business that the Commissioner considers necessary to administer this Article effectively."

SECTION 5. G.S. 58-71-140 reads as rewritten:

"**§ 58-71-140. Registration of licenses and power of appointments by insurers.**

(a) No professional bail bondsman shall become a surety on an undertaking unless he or she has registered his or her current license in the office of the clerk of superior court in the county in which he or she resides and a certified copy of the same with the clerk of superior court in any other county in which he or she shall write bail bonds.

(b) A surety bondsman shall register his or her current surety bondsman's license and a certified copy of his or her power of appointment with the clerk of superior court in the county in which the surety bondsman resides and with the clerk of superior court in any other county in which the surety bondsman writes bail bonds on behalf of an insurer.

(c) No runner shall become surety on an undertaking on behalf of a professional bondsman unless that runner has registered his or her current license and a certified copy of his or her power of attorney in the office of the clerk of superior court in the county in which the runner resides and with the clerk of superior court in any other county in which the runner writes bail bonds on behalf of the professional bondsman.

(d) Professional bail bondsmen, surety bondsmen, and runners shall file with the clerk of court having jurisdiction over the principal, an affidavit on a form furnished by the Administrative Office of the Courts. The affidavit shall include, but not be limited to:

(1) A statement that the bondsman has not, nor has anyone for the bondsman's use, been promised or received any collateral, security, or premium for executing this appearance bond.

(2) If promised a premium, the amount of the premium promised and the due date.

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SECTION 6. G.S. 58-71-160 reads as rewritten:

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(a) Any professional bondsman, whose security deposits with the Commissioner are, for any reason, reduced in value below the requirements of this Article, shall immediately upon receipt of a notice of deficiency from the Commissioner ~~of Insurance~~ deposit such additional securities as are necessary to comply with the law. No professional bondsman shall sign, endorse, ~~execute~~ execute, or become surety on any additional bail bonds, or pledge or deposit any cash, check, or other security of any nature in lieu of a bail bond in any county in North Carolina until ~~such time as he~~ the professional bondsman has made such additional deposit of securities as ~~shall be~~ required by the notice of deficiency.

(b) The Commissioner may deny the renewal of any license held by a professional bondsman under this Chapter or may deny the issuance of any license applied for by a professional bondsman under this Chapter if, at the time of the renewal application or license application, the professional bondsman has not complied with a notice of deficiency under subsection (a) of this section. The Commissioner may issue the renewal license or the new license upon compliance by the professional bondsman with the notice of deficiency."

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SECTION 8. This act becomes effective October 1, 2001, and applies to permits or licenses issued or renewed on or after that date.

HOUSE BILL 356*

Short Title:	Collection Agency/Bail Bond Amendments-AB.	(Public)
Sponsors:	Representatives Dockham and Hurley (Primary Sponsors).	
Referred to:	Insurance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE BOND REQUIREMENTS FOR COLLECTION AGENCIES; TO REQUIRE NONRESIDENT COLLECTION AGENCIES TO POST A SECOND BOND FOR EXPENSES INCURRED BY THE STATE IN A RECEIVERSHIP PROCEEDING INVOLVING THE COLLECTION AGENCY; TO MAKE TECHNICAL CORRECTIONS; TO ALLOW BAIL BONDSMEN TO CREATE SHARED TRUST ACCOUNTS; TO CODIFY AN ADMINISTRATIVE RULE ON BONDSMEN AFFIDAVITS; AND TO AUTHORIZE THE COMMISSIONER TO DENY LICENSE RENEWALS TO PROFESSIONAL BONDSMEN UNTIL THEY CURE DEPOSIT DEFICIENCIES.

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(c) In addition to the requirements of subsections (a) and (b) of this section, as a condition precedent to the issuance of any permit under this Article, every nonresident applicant for a permit shall file with the Commissioner a bond in the amount of ten thousand dollars ($10,000) in favor of the Department that is executed by a surety company licensed to transact surety business in this State. The bond shall be maintained in force during the permit period, be continuous in form, and remain in effect until terminated by the Commissioner. The bond shall expressly provide that the bond is for the purpose of reimbursing the Department for expenses incurred in visiting and examining a nonresident collection agency in connection with a federal bankruptcy or State receivership proceeding in which the collection agency is the subject of the proceeding."

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(b) A surety bondsman shall register his or her current surety bondsman's license and a certified copy of his or her power of appointment with the clerk of superior court in the county in which the surety bondsman resides and with the clerk of superior court in any other county in which the surety bondsman writes bail bonds on behalf of an insurer.

(c) No runner shall become surety on an undertaking on behalf of a professional bondsman unless that runner has registered his or her current license and a certified copy of his or her power of attorney in the office of the clerk of superior court in the county in which the runner resides and with the clerk of superior court in any other county in which the runner writes bail bonds on behalf of the professional bondsman.

(d) Professional bail bondsmen, surety bondsmen, and runners shall file with the clerk of court having jurisdiction over the principal, an affidavit on a form furnished by the Administrative Office of the Courts (number AOC-L Form 277 or its successor) entitled "Affidavit of Surety (Bondsmen)". The affidavit shall include, but not be limited to:

(1) A statement that the bondsman has not, nor has anyone for the bondsman's use, been promised or received any collateral, security, or premium for executing this appearance bond.

(2) If promised a premium, the amount of the premium promised and the due date.

(3) If the bondsman has received a premium, the amount of premium received.

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(b) The Commissioner may deny the renewal of any license held by a professional bondsman under this Chapter or may deny the issuance of any license applied for by a professional bondsman under this Chapter if, at the time of the renewal application or license application, the professional bondsman has not complied with a notice of deficiency under subsection (a) of this section. The Commissioner may issue the renewal license or the new license upon compliance by the professional bondsman with the notice of deficiency."

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SECTION 8. This act becomes effective October 1, 2001, and applies to permits issued or renewed on or after that date.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

March 28, 2001

TO: House Insurance Committee

FROM: William K. Hale

SUBJECT: House Bill 356 -- Collection Agencies and Bail Bondsmen

The following definitions should help the reader of this memorandum:

A "professional bondsman" is someone who pledges cash or approved securities with the Commissioner as security for bail bonds written in a criminal proceeding and who receives or is promised money or other things of value for writing bail bonds.

A "surety bondsman" is someone who is appointed by an insurance company to execute or countersign bail bonds for the insurer in criminal proceedings and who receives or is promised money or other things of value for doing so.

A "runner" is someone employed by a bondsman to keep track of defendants and make sure they appear in court, by apprehension or otherwise.

SECTION 1. Deletes the requirement for sales representatives, office managers, and collectors to provide the Department of Insurance a statement containing specified information. The reason for deleting this requirement is the Department holds the licensee responsible for any violations of the law. At one point in the past it was thought that each collector and salesman might need to be licensed separately. That has never happened. The Department receives approximately 20,000 statements per year from collectors, office managers, and sales representatives. It is rare that they are ever reviewed. They serve no purpose. They are a waste of money, time, and filing space for both the Department and the industry.

SECTION 2. Increases the surety bond requirement at the initial time of licensing from $5,000 to $10,000. It also changes the maximum bond amount a collection agency must have on renewal from $50,000 to $75,000. The initial $5,000 surety bond has never been increased. This amount is not adequate protection of businesses for which the agency collects. Requires all nonresident collection agencies to file a $10,000 bond with the Commissioner. This is in addition to other surety bond requirements. The reason for this additional bond for nonresident agencies is to reimburse the State for expenses incurred when Department employees must exam a bankrupt collection agency. The Department

has had several cases that required out-of-state travel in order to protect consumers and North Carolina businesses interests in bankruptcy proceedings.

SECTION 3. This statute is convoluted. The current language only refers to a bail bondsman and runner in the first sentence and only refers to a professional bondsman or runner in the last sentence. The statute needs to include surety bondsman as well.

SECTION 4. Current law requires that each bail bondsman deposit collateral security in a trust account. This change would allow bail bondsmen operating out of the same business office to share a trust account for security collateral received, with the approval of the Commissioner. This will alleviate an enforcement problem with the current law. Now you have one bail bond office with four bondsmen and four separate trust accounts. One account for that office would be more practical and consistent with the intent of the law.

SECTION 5. This incorporates a provision from the Department's rules (11 NCAC 13.0511), with changes, into this statute. The rule requires professional bail bondsmen to file affidavits with the clerk of court for each bail bond written by the bondsman. The proposed changes will require surety bondsmen and bail bond runners to file the affidavit also.

SECTION 6. Bondsmen must maintain a deposit with the Commissioner as a reserve to cover any bail obligations they incur. The deposit is commensurate with the volume of bail business written by a bondsman. If the deposit falls below the legally required floor for the amount of business a bondsman has written, the Commissioner issues a deficiency notice to the bondsman and orders the bondsman to deposit additional money. The bondsman may not underwrite any new bonds until the additional funds are deposited. However, while a deficiency exists, it is possible under current law for the bondsman to have his license renewed. This section would allow the Commissioner to deny renewal of a license and deny the issuance of any other kind of license to the bondsman as long as the deficiency exists.

SECTION 7. The current law that allows the Commissioner to examine the books and records of a bondsman only refers to professional bondsmen. This change would add surety bondsmen and runners for the purpose of examination of books and records.

HOUSE BILL 356:
Collection Agency/Bail Bonds Amendments

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representatives Dockham and Hurley
Date:	March 28, 2001		
Version:	First Edition	**Summary by:**	Frank W. Folger Committee Counsel

SUMMARY: ***This bill would limit collection agency statement filings and increase the surety bond requirements for collection agencies. The bill also would amend bail bondsmen law to clarify license and qualification requirements, allow the use of intra-office shared trust accounts, statutorily require the filing of affidavits, allow denial of license renewal if security deposits fall below legal requirements, and allow the Commissioner to examine licensees.***

BILL ANALYSIS: **Collection Agency Law Changes**

Section 1. would eliminate the requirement that office managers, sales representatives and other collectors file annual statements with the Department of Insurance. Currently, these individuals in addition to 10% stockholders of collection agencies and partners, directors and officers of collection agencies are required to make these filings. The Departments deems filings by office managers, sales representatives and other collectors unnecessary and wasteful.

Section 2. would increase the surety bond requirement at initial licensing from $5000 to $10,000. For renewal permits, it would increase the minimum bond requirement from $5000 to $10,000 and the maximum from $50,000 to $70,000. It would also require an additional $10,000 bond from non-resident applicants for a permit to cover the potential costs of the agency going bankrupt or into receivership.

Bail Bondsmen Law Changes

Section 3. would clarify that each of the following must be qualified and licensed to perform those functions in this State: professional bail bondsmen, surety bondsmen, and runners. Currently, the statute contains inconsistent language.

Section 4. would allow, with Commissioner approval, bail bondsmen in the same office or location to maintain a shared trust account for its collateral security. Currently, each bail bondsman is required to keep a separate trust account for collateral security received in the course of business.

Section 5. would require professional bail bondsmen, surety bondsmen, and runner to file with the appropriate clerk of court an affidavit furnished by AOC that includes statements regarding whether the bondsman has been promised or has received a premium for executing the appearance bond, the amount promised or received, the date of receipt, and if collateral security was pledged, the pledger's name and the nature and amount of the collateral security. Currently, Departmental rules require affidavits by professional bail bondsmen only.

Section 6. would allow the Commissioner to deny renewal or issuance of a license of a professional bail bondsman if that bondsman has a deficiency in the security deposits the bondsman is required to maintain for the amount of business written by that bondsman.

Section. 7. would allow the Commissioner to examine a professional bail bondsman, surety bondsman, or runner, and to have access to that licensee's business records.

Section 8. The act would become effective October 1, 2001 and would apply to permits issued or renewed after that date.

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 29, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 29, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the page, Ron Jailall (Johnston County – Rep. Daughtry). The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Blue, Brubaker, Dedmon, Grady, Hall, Johnson, Justus, Redwine, Saunders, Setzer, Smith, Warner, and C. Wilson. Linda Attarian and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 109, entitled, AN ACT TO AUTHORIZE REIMBURSEMENT FOR LICENSED MARRIAGE AND FAMILY THERAPISTS UNDER THE STATE HEALTH PLAN FOR THE TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY. The Chair recognized Representative Martha Alexander to explain the bill. This bill would add licensed marriage and family therapists to the list of providers that may be reimbursed under the State Health Plan for the necessary care and treatment of mental health and chemical dependency. This legislation would provide teachers and state employees with distinct, cost-effective services that are not presently available under the plan, and the cost would be negligible. Family therapy is the most successful form of outpatient therapy for keeping chemically dependent youths in treatment, thus avoiding hospitalization. John Carr, NC Association for Marriage and Family Therapists, was recognized to speak in favor of the bill. Mr. Sam Byrd, Fiscal Services, was recognized and indicated the costs were negligible and, in fact, could provide a savings to the State health plan. After some discussion, Representative Justus moved to give the bill a favorable report. Representative Warner seconded the motion. The motion passed.

HB 462, entitled, AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT. The Chair recognized Representative Bill Owens to explain the bill. A proposed committee substitute was presented by Representative Owens. Representative Dockham moved to adopt the proposed committee substitute for consideration. The motion passed. This bill would provide workers' compensation coverage for public school and charter school students participating in school-approved unpaid internships and job shadowing experiences off school grounds. Frank Folger, Staff Counsel, was recognized to explain the differences in the Proposed Committee Substitute and the original bill. Page 4, line 27, the weekly compensation for a student injured is clarified which at this point is $30 per week. Leanne Winner, NC School Boards Association, was recognized and explained the Work

Based Learning Experience Program. She indicated if employers were forced to obtain this type of coverage for students, the program would no longer be in existence. Ben Matthews, NC Department of Public Instruction, was recognized and indicated the language in the bill should be changed to reflect grades 9 through 12. Due to time constraints the committee tabled this bill until the next INSURANCE Committee meeting scheduled for April 4, 2001.

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

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
HB 109, HB 462
Handouts
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — March 29, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathy Kaplan	NCAHP
P.G. "Pete" Roberts	NC AMFT
Susan Brooks	NCAMFT
Pam Ricney	NCAMFT
Jon Carr	Jordan Price
Ben Matthews	NCDPI
Charlene Stubbs	OSP
Jesse Davis	NC AMFT
Cynthia Hughes	NC AMFT
Sissy Klarman	SHP
Anne Winn	NC-New

VISITOR REGISTRATION SHEET

INSURANCE — March 29, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Wingfield	BCBSNC
Leanne Winner	NCSBA
[illegible]	NCAHIP
[illegible]	Moore & Van Allen
Buck Lattimore	NC Industrial Commission
Scarlette Gardner	NC Industrial Commission
Emily Fulghum	Smith Anderson
Bob Price	Jordan Price
Barbara Wood	CFRS
Boyd Cauble	City of Charlotte
Sam Taylor	LPCANC

VISITOR REGISTRATION SHEET

INSURANCE — March 29, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
NANCY REES	LPCA NC
Ron [illegible]	NCASA
Betty Gurry	NC AMFT
Bill Hale	NCDOI
Larry Beckner	Household Financial Group

Reported CSHB 3-29-01

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 109 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE REIMBURSEMENT FOR LICENSED MARRIAGE AND FAMILY THERAPISTS UNDER THE STATE HEALTH PLAN FOR THE TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 109

Short Title:	Reimbursement for Marriage/Family Therapists.	(Public)
Sponsors:	Representatives Alexander; Earle, Easterling, Fox, Goodwin, Hackney, Hall, Hill, Insko, Jarrell, Luebke, Preston, Underhill, Wainwright, Weiss, Wright, and Yongue.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 14, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE REIMBURSEMENT FOR LICENSED MARRIAGE AND FAMILY THERAPISTS UNDER THE STATE HEALTH PLAN FOR THE TREATMENT OF MENTAL HEALTH AND CHEMICAL DEPENDENCY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-40.7B reads as rewritten:

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

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

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered under this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
   a. Licensed psychiatric hospitals;
   b. Licensed psychiatric beds in licensed general hospitals;
   c. Licensed residential treatment facilities;
   d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
   e. Licensed intensive outpatient treatment programs; and
   f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:

a. Licensed chemical dependency units in licensed psychiatric hospitals;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units.

(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed or certified doctors of psychology;
(3) Certified clinical social workers;
(3a) Licensed professional counselors;
(4) Certified clinical specialists in psychiatric and mental health nursing;
(4a) Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
(5) Repealed by Session Laws 1997-512, s. 14.
(6) Psychological associates with a masters degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology;
(7), (8) Repealed by Session Laws 1997-512, s. 14.
(9) Certified fee-based practicing pastoral counselors; ~~and~~
(10) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or ~~certified.~~certified; and
(11) Licensed marriage and family therapists.

(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;
j. Certified fee-based practicing pastoral counselors; ~~and~~
k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General ~~Statutes.~~Statutes; and
l. Licensed marriage and family therapists.

(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. Certified fee-based practicing pastoral counselors;
1. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; ~~and~~
j1. Licensed marriage and family therapists; and

k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:

1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

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

(d) Benefits provided under this section shall be subject to a case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, and intensive outpatient programs, (iv) length-of-stay certification of emergency inpatient admissions, and (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency treatment. Care which is not both medically necessary and medically appropriate will be noncertified, and benefits will be denied. Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6.

(e) For the purpose of this section, 'emergency' is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others."

SECTION 2. This act becomes effective October 1, 2001, and applies to claims for payment or reimbursement for services rendered on or after that date.

HOUSE BILL 109:
Reimbursement for Marriage/Family Therapists

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Alexander
Date:	March 20, 2001	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 109 adds licensed marriage and family therapists to the list of providers that may be reimbursed under the State Health Plan for the necessary care and treatment of mental health and chemical dependency.***

CURRENT LAW: North Carolina has made available a Comprehensive Major Medical Plan (the "State Health Plan" or the "Plan") for the benefit of its employees, retired employees, and their dependents. State law specifies who is eligible to be covered and what services are covered. Necessary care and treatment of mental illness and chemical dependency is covered by the Plan, subject to limitations concerning which providers may provide the care and treatment and be reimbursed. Some of the providers who are currently reimbursed for treating mental illness and chemical dependency include psychiatrists, psychologists, psychologist associates, certified clinical social workers, licensed professional counselors, and certified fee-based practicing pastoral counselors.

"Marriage and family therapy" is defined by statute to mean the clinical practice, within the context of marriage and family systems, of the diagnosis and treatment of psychosocial aspects of mental and emotional disorders. Under current law, generally it is unlawful for a person not licensed as a marriage and family therapist by the North Carolina Marriage and Family Therapy Licensure Board to practice marriage or family therapy. In order to become licensed, an applicant must possess a minimum of a master's degree in marriage and family therapy or a degree in an allied health field, have at least 1,500 hours of clinical experience in marriage and family therapy, and pass an examination administered by the Board.

BILL ANALYSIS: House Bill 109 would permit a licensed marriage and family therapist to be reimbursed by the State Health Plan under three circumstances:

- When providing necessary care and treatment for mental health;
- When providing necessary care and treatment for chemical dependency; and
- When providing treatment for chemical dependency in outpatient practice settings, if the therapist has appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager.

According to the North Carolina Association for Marriage and Family Therapy, there are 548 licensed marriage and family therapists. Of these therapists, 166 hold a license as a pastoral counselor, professional counselor, or clinical social worker; 28 are licensed psychologists; and 13 are licensed psychologist associates.

The act would become effective October 1, 2001 and apply to claims for payment or reimbursement for services rendered on or after that date.

H109 – SMSW- 001

its current premium rates or a reduction in existing benefits or payments to health care providers or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from formularies, and fraud detection) are maintained and improved where possible. Of particular note in these cost containment strategies is that the program's contract with its pharmacy benefit manager, AdvancePCS, calls for a further reduction in claim payments for outpatient prescription drugs for the 2001-03 biennium. Effective July 1, 2001, dispensing fee benchmarks for pharmacies will be reduced from $4.00 to $1.50 per prescription. In addition, ingredient prices for pharmacies will be reduced from 90% to 85% of average wholesale price (AWP) for branded drugs and from maximum allowable charges (MAC) by the federal Health Care Financing Administration (HCFA) or 80% of AWP to 45% of AWP for generic drugs. Current non-contributory premium rates are $143.10 monthly for employees whose primary payer of health benefits is Medicare and $187.98 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $89.06 monthly for children whose primary payer of health benefits is Medicare and $117.16 monthly for other covered children, and $213.60 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $281.04 per month for other family contract dependents. Claim cost trends are expected to increase 12% annually. Total enrollment in the program is expected to increase about 3% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 3% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 5% per year. The program is expected to have an increase in the number of active employee dependents and retiree dependents of 2% per year. Investment earnings are based upon a 6% return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for Indemnity Plan's Mental Health and Chemical Dependency: For the fiscal year ending June 30, 1999, the Plan's self-insured indemnity program paid $19,995,800 in mental health claims plus another $2,047,800 in substance abuse claims. Approximately 72%, or $14,451,900, of the mental health claims was outpatient claims and some 28% of the substance abuse claims were outpatient claims. Mental health and substance abuse claims accounted for a little more than 3% of the program's total claim payments for the 1998-99 fiscal year.

Based upon information supplied by the North Carolina Marriage and Family Therapy Licensure Board, there were 444 licensed therapists residing in 64 of the State's 100 counties as of February 15, 2001. Another 59 licensed therapists reside out of the State. Of the number of licensed therapists residing in the State, approximately 70% reside in the counties of Buncombe, Cumberland, Durham, Forsyth, Guilford, Mecklenburg, Orange, Pitt, and Wake. Also according to the Licensure Board's staff, therapists practice using the same procedure codes and charges as certified clinical social workers, fee-based pastoral counselors, and licensed professional counselors. A comparison of charges for most procedures billed by these professional providers to the Plan's self-insured indemnity program for calendar year 2000 reveals:

	Cert. Clin. Soc. Work.		Fee-Bas. Past. Counsel.		Lic. Profess. Counsel.	
Procedure	No. Visits	Average Charge	No. Visits	Average Charge	No. Visits	Average Charge
Outpatient Psych.						
45-50 Min. (90806)	23,119	$87	2,300	$87	11,487	$88
75-80 Min. (90808)	292	$110	179	$105	261	$109

Individ. Psychother. 45-50 Min. (90844)	2,221	$86		434	$85	704	$88
Group Psychother. (90853)	505	$58		36	$49	108	$51

Charges by other providers for these same procedure codes averaged 10-15% more than the charges by the certified clinical social workers, fee-based pastoral counselors, and licensed professional counselors.

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, House Bill 109, March 4, 2001, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 109, March 6, 2001, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

-Calendar Year 2000 Report on Claims, Visits, Charges, and Claim Payments by Provider under the self-insured indemnity program of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan prepared by the program's claims processor, Blue Cross and Blue Shield of North Carolina.

-Fiscal Years 1995-1999 Report on Mental Health and Substance Abuse for the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan prepared by the self-insured indemnity program's claims processor, Blue Cross and Blue Shield of North Carolina.

-Membership data from the North Carolina Marriage and Family Therapy Licensure Board, February 15, 2001.

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION 733-4910

PREPARED BY: Sam Byrd

APPROVED BY: James D. Johnson



DATE: March 12, 2001

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 109

SHORT TITLE: Reimbursement for Marriage/Family Therapists

SPONSOR(S): Rep. Alexander

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts, premium payments for dependents by active and retired teachers and State employees, and premium payments for coverages selected by eligible former teachers and State employees.

BILL SUMMARY: The bill allows licensed marriage and family therapists to be paid directly for their services in the treatment of mental illness and chemical dependency under the Teachers' and State Employees' Comprehensive major Medical Plan.

EFFECTIVE DATE: October 1, 2001.

ESTIMATED IMPACT ON STATE: The consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, Aon Consulting, and the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, both concur that the bill will not measurably increase the costs to the Plan. Any increases in costs through expanded utilization of services would be expected to be offset through lower professional and institutional unit costs.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan only had a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Beginning in July, 2000, firefighters, rescue squad workers, and members of the National Guard and their eligible dependents were allowed to voluntarily participate in the Plan on a fully contributory basis, provided they were ineligible for any other type of group health benefits and had been without such benefits for at least six months. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. All other types of premium in the indemnity program are fully contributory. The Plan's Executive Administrator has set the premium rates for firefighters, rescue squad workers, and members of the National Guard and their families at 47% more than the comparable rates charged for employees, retired employees, and their families. Premiums paid by employers to HMOs are

limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with three HMOs currently covering about 9% of the Plan's total population in 24 of th[redacted] State's 100 counties. The Plan's employees and retired employees select the type of program that they wis[redacted] for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 2000, include:

	Self-Insured Indemnity Program	**Alternative HMOs**	**Plan Total**
Number of Participants			
Active Employees	248,518	28,822	277,340
Active Employee Dependents	134,795	17,376	152,171
Retired Employees	104,305	3,185	107,490
Retired Employee Dependents	17,936	594	18,530
Former Employees & Dependents with Continued Coverage	2,865	381	3,246
Firefighters, Rescue Squad Workers, National Guard Members & Dependents	3	-	3
Total Enrollments	508,422	50,358	558,780
Number of Contracts			
Employee Only	270,322	23,223	293,545
Employee & Child(ren)	38,775	6,006	44,781
Employee & Family	45,764	3,026	48,79[redacted]
Total Contracts	354,861	32,255	387,[redacted]
Percentage of Enrollment by Age			
29 & Under	28.0%	41.6%	29.2%
30-44	20.9	26.6	21.4
45-54	21.3	19.2	21.1
55-64	14.5	9.2	14.0
65 & Over	15.4	3.4	14.3
Percentage of Enrollment by Sex			
Male	39.1%	36.9%	38.9%
Female	60.9	63.1	61.1

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2000, the self-insured program started its operations with a beginning cash balance of $188 million. Receipts for the year are estimated to be $930 million from premium collections, $10 million from investment earnings, and $10 million in risk adjustment and administrative fees from HMOs, for a total of $950 million in receipts for the year. Disbursements from the self-insured program are expected to be $1.070 billion in claim payments and $31 million in administration and claims processing expenses for a total of $1.101 billion for the year beginning July 1, 2000. For the fiscal year beginning July 1, 2001, the self-insured indemnity program i[redacted] expected to have an operating cash balance of only $37 million. The self-insured indemnity program i[redacted] consequently assumed to be unable to carry out its operations for the 2001-2003 biennium without increases in

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 462

Short Title:	Workers' Comp/Certain Public School Students.	(Public)
Sponsors:	Representative Owens.	
Referred to:	Insurance.	

March 5, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-2(2) reads as rewritten:

"(2) Employee. – The term 'employee' means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term 'employee' shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term 'employee' shall include all officers and employees thereof, including such as are elected by the people. The term 'employee' shall include members of the North Carolina national guard while on State active duty under orders of the Governor and members of the North Carolina State Defense Militia while on State active duty under orders of the Governor. The term 'employee' shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving

on a fee basis or on a salary basis, or whether deputy sheriffs serving upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment, and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been injured shall, when the employee is dead, include also his legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee as herein defined of a municipality, county, or of the State of North Carolina while engaged in the discharge of his official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of his employer.

Every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation specifically excluding such executive officer in such contract of insurance and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term employee shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-491(a) when

performing duties in the course and scope of a State approved mission pursuant to Article 11 of Chapter 143B.

Employee shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

Any sole proprietor or partner of a business or any member of a limited liability company may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article.

The term employee shall include any public school student enrolled in kindergarten through twelfth grade who is participating in an unpaid, school-approved, work-based learning experience that is located off the public school grounds on the premises of a business or other entity that employs individuals. The local board of education or the charter school is the employer within the meaning of this Article during the time that the student is participating in this unpaid, school-approved, work-based learning experience. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 2. G.S. 97-2(5) reads as rewritten:

"(5) Average Weekly Wages. – 'Average weekly wages' shall mean the earnings of the injured employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury, including the subsistence allowance paid to veteran trainees by the United States government, provided the amount of said allowance shall be reported monthly by said trainee to his employer, divided by 52; but if the injured employee lost more than seven consecutive calendar days at one or more times during such period, although not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed; provided, results fair and just to both parties will be thereby obtained. Where, by reason of a shortness of time during which the employee has been in the employment of his employer or the casual nature or terms of his employment, it is impractical to compute the average weekly wages as above defined,

regard shall be had to the average weekly amount which during the 52 weeks previous to the injury was being earned by a person of the same grade and character employed in the same class of employment in the same locality or community.

But where for exceptional reasons the foregoing would be unfair, either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.

Wherever allowances of any character made to an employee in lieu of wages are specified part of the wage contract they shall be deemed a part of his earnings.

Where a minor employee, under the age of 18 years, sustains a permanent disability or dies leaving dependents surviving, the compensation payable for permanent disability or death shall be calculated, first, upon the average weekly wage paid to adult employees employed by the same employer at the time of the accident in a similar or like class of work which the injured minor employee would probably have been promoted to if not injured, or, second, upon a wage sufficient to yield the maximum weekly compensation benefit. Compensation for temporary total disability or for the death of a minor without dependents shall be computed upon the average weekly wage at the time of the accident, unless the total disability extends more than 52 weeks and then the compensation may be increased in proportion to his expected earnings. <u>The minimum average weekly wage required under this subdivision shall be used to compute compensation for an employee who is a public school student enrolled in kindergarten through twelfth grade and who is participating in an unpaid, school-approved, work-based learning experience located off the public school grounds on the premises of a business or other entity that employs individuals.</u>

In case of disabling injury or death to a volunteer fireman or member of an organized rescue squad or duly appointed and sworn member of an auxiliary police department organized pursuant to G.S. 160A-282 or senior members of the State Civil Air Patrol functioning under Article 11, Chapter 143B, under compensable circumstances, compensation payable shall be calculated upon the average weekly wage the volunteer fireman or member of an organized rescue squad or member of an auxiliary police department or senior member of the State Civil Air Patrol was earning in the employment wherein he principally earned his livelihood as of the date of injury. Provided, however, that the minimum compensation payable to a volunteer fireman, member of an organized rescue squad or sworn member of an auxiliary police department organized pursuant to G.S. 160A-282, or

senior members of the State Civil Air Patrol shall be sixty-six and two thirds percent (66 2/3%) of the maximum weekly benefit established in G.S. 97-29."

SECTION 3. G.S. 97-10.1 reads as rewritten:

"**§ 97-10.1. Other rights and remedies against employer excluded.**

(a) If the employee and the employer are subject to and have complied with the provisions of this Article, then the rights and remedies herein granted to the employee, his dependents, next of kin, or personal representative shall exclude all other rights and remedies of the employee, his dependents, next of kin, or representative as against the employer at common law or otherwise on account of such injury or death.

(b) The rights and remedies under this Article shall be the sole remedies against the local board of education, the charter school, or against the business or other entity, for a compensable injury of a public school student enrolled in grades K-12 who is participating in an unpaid, school-approved, work-based learning experience that is located off public school grounds on the premises of a business or other entity that employs individuals. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 4. This act becomes effective July 1, 2001, and applies to injuries that occur on or after that date.

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION

"PUBLIC EDUCATION: NORTH CAROLINA'S BEST INVESTMENT"

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Director of Governmental Relations

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February 19, 2001

Representative Bill Owens
Legislative Office Building
Raleigh, North Carolina 27602

Dear Bill:

Thank you for your willingness to introduce the bill that would provide workers' compensation coverage for students participating in unpaid internships and job shadowing experiences through the Job Ready Program.

As we discussed many of the businesses that participate in the program were reluctant at first, due to the potential liability if the student-worker was hurt on the business premise. In order to make the program work, school systems across North Carolina have had to purchase separate insurance to cover the potential liability.

The bill grew out of the Employer Issues Committee of the Job Ready Partnership, on which our attorney Allison Schafer serves. This proposed bill was approved by the full statewide Job Ready Council. Representatives of a number of groups participated in the drafting of this bill, including the Department of Public Instruction, local school systems and business groups. This bill would automatically add to the unpaid student-workers to their local workers' compensation coverage, which they already have and are required by law to maintain. We believe that this will be a cost savings to the school districts across North Carolina.

Thank you for your support.

Sincerely,

Leanne E. Winner

P.O. Box 97877 • Raleigh, NC 27624-7877 • Phone: (919)841-4040 • Fax: (919)841-4020

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 4, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 4, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the page, Belvin Sherrill (Iredell County – Rep. Setzer). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Blue, Brubaker, Dedmon, Grady, Hall, Justus, Redwine, Saunders, Setzer, Wainwright, Warner, and C. Wilson. Linda Attarian, Frank Folger, and Trina Griffin, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 462, entitled, AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT. The Chair recognized Representative Bill Owens to explain the bill, and he presented a proposed committee substitute. Representative Justus moved to adopt the proposed committee substitute for consideration. The motion passed. This bill would provide workers' compensation coverage for public school and charter school students participating in school-approved unpaid internships and job shadowing experiences off school grounds. Frank Folger, Staff Counsel, was recognized to explain the differences in the Proposed Committee Substitute and the original bill. Scarlett Gardner with the Industrial Commission was recognized to speak on questions raised and the purpose of Workers' Compensation. Due to the amount of questions being raised, this bill was displaced to allow another bill to be heard in this committee meeting.

HB 191, entitled, AN ACT TO ALLOW AN ADDITIONAL INCOME TAX DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS. Representative Bill Hurley was recognized to explain the bill, and he presented a proposed committee substitute. Representative Saunders moved to adopt the proposed committee substitute for consideration. The motion passed. This bill would allow self-employed tax payers to deduct100% of their health insurance premiums from their taxable income for purposes of North Carolina income tax. The act is effective for taxable years beginning on or after January 1, 2001. Frank Folger, Staff Counsel, was recognized to provide further explanation. Perri Morgan, National Federation of Independent Business, was recognized to speak in favor of the bill. Representative Warner moved to give the committee substitute a favorable report, unfavorable to the original bill, and be re-referred to the Committee on FINANCE. Motion passed.

The proposed committee substitute for **HB 462** was again taken up for consideration. Several questions were raised regarding liability and coverage issues, and staff was asked to address these questions before the next INSURANCE Committee meeting on April 11, 2001.

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

Respectfully submitted,

Representative Jerry Dockham
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
HB 191, HB 462
Handouts
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — April 4, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
W Savage	Bailey & Dixon
[signature]	VC AHP
PERRI MORGAN	NFIB
[signature]	NCHA
[signature]	McClees Consulting, Inc.
NANCY POMERANZ	NC DOR
Joe Johnson	Ragsdale Liggett
Ken McHan	Alley Associates
Cissy Baker	Pam & Associates
Brad Adcock	BCBSNC
[signature]	Jordan Price

VISITOR REGISTRATION SHEET

INSURANCE — April 4, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Hoffman	NCSBA
Leanne Winner	NCSBA
Susan Valauri	Nationwide
Tim Minton	NC Home Builders Assn
Ben Matthews	NCPPI
Chuck Townsend	NC DPI
JB Buxton	SBE
Anna Bridgers	Randolph Cloud & Ass.
Randolph E. Cloud	Randolph E. Cloud & Assoc.
Scarlette Gardner	NCLC
Charlene Shabazz	NCASP
Bill Scogin	Kennedy Covington

VISITOR REGISTRATION SHEET

INSURANCE — April 4, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert PASchall	Young, Moore
Susan Hanna	WCPSS
Fred Allen	NC Aggregates Assn.
[illegible]	Moore & Van Allen
[illegible]	NCAIA
[illegible]	NCGA.
Sheila Williams	NCDOT
D Gschwendner	NCDOT
[illegible]	[illegible]
Pam Silberman	UNC-SPH
Ann Marshall	"
Aisling Ward	UNC-SPH
[illegible]	AP

Reported out 4-5-01

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 191 A BILL TO BE ENTITLED AN ACT TO ALLOW AN ADDITIONAL INCOME TAX DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, unfavorable as to (original bill), (and recommendation that the committee substitute bill be re-referred to the Committee on Finance.)

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 191*
PROPOSED COMMITTEE SUBSTITUTE H191*-PCS9084-LY-6

Short Title: Self-Employed Health Insurance Deduction. (Public)

Sponsors:

Referred to:

February 21, 2001

A BILL TO BE ENTITLED

AN ACT TO ALLOW AN ADDITIONAL INCOME TAX DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-134.6(d) is amended by adding a new subdivision to read:

"...

(4) The taxpayer may deduct the amount by which the taxpayer's deductions under section 162(l) of the Code for health insurance costs of self-employed individuals would have increased if the applicable percentage in section 162(l)(1)(B) of the Code for the taxable year were one hundred percent (100%). A taxpayer may not take this deduction if any of the following apply:

a. The taxpayer claims a deduction for medical care expenses under section 213(a) of the Code for the taxable year.

b. The taxpayer claims a tax credit under G.S. 105-151.27 for the taxable year.

c. The taxpayer claims a tax credit under G.S. 105-151.28 for the taxable year."

SECTION 2. This act is effective for taxable years beginning on or after January 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

HOUSE BILL 191*

Short Title:	Self-Employed Health Insurance Deduction.	(Public)
Sponsors:	Representatives Hurley, Goodwin (Primary Sponsors); Alexander, Barbee, Barefoot, Barnhart, Blue, Brubaker, Carpenter, Coates, Crawford, Culp, Davis, Dedmon, Edwards, Esposito, Fox, Gray, Harrington, Insko, Lucas, Luebke, McAllister, McComas, Miner, Mitchell, Morris, Preston, Redwine, Rogers, Saunders, Shubert, Smith, Teague, Tolson, Underhill, Wainwright, Walker, Warner, West, C. Wilson, and G. Wilson.	
Referred to:	Finance.	

February 21, 2001

A BILL TO BE ENTITLED

AN ACT TO ALLOW AN ADDITIONAL INCOME TAX DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-134.6(d) is amended by adding a new subdivision to read:

"...

(4) The taxpayer may deduct the amount by which the taxpayer's deductions under section 162(l) of the Code for health insurance costs of self-employed individuals would have increased if the applicable percentage in section 162(l)(1)(B) of the Code for the taxable year were one hundred percent (100%)."

SECTION 2. This act is effective for taxable years beginning on or after January 1, 2001.

HOUSE BILL 191:
Self-Employed Health Insurance Deduction

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Hurley
Date:	March 28, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 191, if enacted, would allow self-employed tax payers to deduct 100% of their health insurance premiums from their taxable income for purposes of North Carolina income tax. The act is effective for taxable years beginning on or after January 1, 2001.***

CURRENT LAW: Under North Carolina law, taxable income is defined as "taxable income as determined under the federal Internal Revenue Code (Code), adjusted pursuant to G.S. 105-134.6 and G.S. 105-143.7". Thus, the starting point for determining North Carolina taxable income is federal taxable income. From that, a taxpayer may, if allowable, make certain deductions and additions to arrive at their North Carolina taxable income.

Under section 162(l) of the Code, a self-employed individual may deduct a certain percentage of premiums for health insurance when calculating federal taxable income. Pursuant to this section, for taxable years beginning with 1999 through 2001, a deduction of 60% of the premiums is allowable. For taxable year 2002, the percentage increases to 70% and in years 2003 and thereafter it is 100%. (USCS Sec. 162(1)(B)).

Since the deduction is made in calculating federal taxable income, and federal taxable income is the starting point for determining North Carolina taxable income, the deduction also is made to North Carolina taxable income. House Bill 191 would allow the taxpayer to deduct the remaining percentage (up to 100%) not allowable under the Code from North Carolina taxable income. Thus, for taxable year 2001, the deduction would be an additional 40%. As a result of this additional deduction, for NC income tax purposes, the full amount of the health insurance premium paid by a self-employed individual would be tax deductible.

BILL ANALYSIS: Section 1 amends G.S. 105-134.6(d) to allow the deduction of a certain additional percentage of health insurance premiums paid by tax payers who are self employed, from taxable income when calculating North Carolina taxable income.

Section 2 makes the act effective for taxable years beginning on or after January 1, 2001.

Bill Analysis
House Bill 191: Self-Employed Health Insurance Deduction

To: Finance Committee Chairs and Bill Sponsor
From: E. Norris Tolson, Secretary of Revenue
Date: March 19, 2001

Bill Summary

This bill adds a new subdivision (4) to G. S. 105-134.6(d). The new subdivision allows self-employed individuals a deduction from federal taxable income. The deduction is for the amount by which the individual's deduction under section 162(l) of the Internal Revenue Code for health insurance costs would have increased if the applicable percentage in Code section 162(l)(1)(B) for the taxable year were one hundred percent (100%).

Medical expenses, including health insurance premiums, are generally deductible for federal income tax purposes only if the taxpayer claims itemized deductions in lieu of the standard deduction. Deductible health insurance premiums include premiums paid for qualified long-term care insurance. Code section 162(l) provides a special rule whereby self-employed persons are allowed to deduct a percentage of their health insurance premiums in arriving at adjusted gross income (AGI). If the taxpayer itemizes deductions, the remaining portion of the premiums is included with other medical expenses.

Under section 162(l)(1)(B) of the Code, the applicable percentage to be used in determining the allowable deduction for health insurance premiums paid by a self-employed taxpayer is sixty percent (60%) for tax years 1999 through 2001; seventy percent (70%) for tax year 2002; and one hundred percent (100%) for tax year 2003 and later years.

Department Comments and Concerns

Allowing a self-employed individual an additional deduction under this new subdivision may result in a double benefit for the same expenses. For example, a self-employed taxpayer who pays $3,600 during the taxable year for long term care insurance premiums is allowed to deduct sixty percent (60%) of these costs as an adjustment to income on the federal return under section 162(l)(1)(B) of the Code. The remaining forty percent (40%) of the costs, $1,440, can be claimed as a deductible medical expense on the federal return if the taxpayer itemizes deductions.

Deductions claimed on the federal return flow through to the State return because federal taxable income is the starting point for calculating State taxable income. As currently written, subdivision (4) allows the self-employed taxpayer to take the $1,440 deduction once for State purposes through the mechanism of

claiming the deduction on the federal return and to take this $1,440 deduction a second time on the State return under the deduction added by the new subdivision.

In addition, G.S. 105-151.27(d) and G.S. 105-151.28(b) provide that self-employed taxpayers are entitled to claim a tax credit for the amount of premiums that are paid for child health insurance and long term care insurance, respectively, and are not deducted under section 162(l) of the Code. The new deduction in this bill could result in the taxpayer claiming both a deduction and a tax credit on the North Carolina income tax return for the same expenses.

To prevent a double deduction on the State return for the same expenses as well as the allowance of both a deduction and a credit for the same expenses, the Department recommends that the following be added to new subdivision (4).

"A taxpayer may not take this deduction if any of the following applies:

(1) The taxpayer claims a deduction for medical care expenses under section 213(a) of the Code for the taxable year.
(2) The taxpayer claims a tax credit under G. S. 105-151.27(d) for the taxable year.
(3) The taxpayer claims a tax credit under G. S. 105-151.28(b) for the taxable year."

Distribution:
Representative Gordon P. Allen
Representative Charles F. Buchanan
Representative Paul Luebke
Representative William L. Wainwright
Representative John W. Hurley

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 462
PROPOSED COMMITTEE SUBSTITUTE H462-CSSO-7 [v.3]

4/4/2001 10:25:25 AM

Short Title: Workers' Comp/Certain Public School Students. (Public)

Sponsors:

Referred to:

March 5, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-2(2) reads as rewritten:

"(2) Employee. – The term 'employee' means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term 'employee' shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term 'employee' shall include all officers and employees thereof, including such as are elected by the people. The term 'employee' shall include members of the North Carolina national guard while on State active duty under orders of the Governor and members of the North Carolina State Defense Militia while on State active duty under orders of the Governor. The term 'employee' shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving on a fee basis or on a salary basis, or whether deputy sheriffs serving

upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment, and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been injured shall, when the employee is dead, include also his legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee as herein defined of a municipality, county, or of the State of North Carolina while engaged in the discharge of his official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of his employer.

Every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation specifically excluding such executive officer in such contract of insurance and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term employee shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-491(a) when

performing duties in the course and scope of a State approved mission pursuant to Article 11 of Chapter 143B.

Employee shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

Any sole proprietor or partner of a business or any member of a limited liability company may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article.

The term employee shall include any public school student enrolled in sixth through twelfth grade who is enrolled in an unpaid, school-approved, work-based learning experience that is located off the public school grounds on the premises of a business or other entity that employs individuals. The local board of education or the charter school is the employer within the meaning of this Article during the time that the student is enrolled in this unpaid, school-approved, work-based learning experience. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 2. G.S. 97-2(5) reads as rewritten:

"(5) Average Weekly Wages. – 'Average weekly wages' shall mean the earnings of the injured employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury, including the subsistence allowance paid to veteran trainees by the United States government, provided the amount of said allowance shall be reported monthly by said trainee to his employer, divided by 52; but if the injured employee lost more than seven consecutive calendar days at one or more times during such period, although not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed; provided, results fair and just to both parties will be thereby obtained. Where, by reason of a shortness of time during which the employee has been in the employment of his employer or the casual nature or terms of his employment, it is

impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury was being earned by a person of the same grade and character employed in the same class of employment in the same locality or community.

But where for exceptional reasons the foregoing would be unfair, either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.

Wherever allowances of any character made to an employee in lieu of wages are specified part of the wage contract they shall be deemed a part of his earnings.

Where a minor employee, under the age of 18 years, sustains a permanent disability or dies leaving dependents surviving, the compensation payable for permanent disability or death shall be calculated, first, upon the average weekly wage paid to adult employees employed by the same employer at the time of the accident in a similar or like class of work which the injured minor employee would probably have been promoted to if not injured, or, second, upon a wage sufficient to yield the maximum weekly compensation benefit. Compensation for temporary total disability or for the death of a minor without dependents shall be computed upon the average weekly wage at the time of the accident, unless the total disability extends more than 52 weeks and then the compensation may be increased in proportion to his expected earnings.

The minimum weekly compensation as provided in G.S. 97-29 shall be the weekly compensation paid for total incapacity pursuant to G.S. 27-29, partial incapacity pursuant to G.S. 97-30, disability in the schedule of injuries for which average weekly wages are used in determining compensation pursuant to G.S. 97-31, or death pursuant to G.S. 97-38, from a compensable injury under this Chapter of an employee who is a public school student enrolled in sixth through twelfth grade and who is enrolled in an unpaid, school-approved, work-based learning experience located off the public school grounds on the premises of a business or other entity that employs individuals. Except as otherwise provided, the provisions of this Article apply to an injury to an employee who is a public school student enrolled in sixth through twelfth grade and who is enrolled in an unpaid, school-approved, work-based learning experience located off the public school grounds on the premises of a business or other entity that employs individuals.

In case of disabling injury or death to a volunteer fireman or member of an organized rescue squad or duly appointed and sworn member of an auxiliary police department organized pursuant to G.S. 160A-282 or senior members of the State Civil Air Patrol functioning under Article 11, Chapter 143B, under compensable circumstances, compensation payable shall be calculated upon the average weekly wage the volunteer fireman or member of an organized rescue squad or member of an auxiliary police department or senior member of the State Civil Air Patrol was earning in the employment wherein he principally earned his livelihood as of the date of injury. Provided, however, that the minimum compensation payable to a volunteer fireman, member of an organized rescue squad or sworn member of an auxiliary police department organized pursuant to G.S. 160A-282, or senior members of the State Civil Air Patrol shall be sixty-six and two thirds percent (66 2/3%) of the maximum weekly benefit established in G.S. 97-29."

SECTION 3. G.S. 97-10.1 reads as rewritten:

"**§ 97-10.1. Other rights and remedies against employer excluded.**

(a) If the employee and the employer are subject to and have complied with the provisions of this Article, then the rights and remedies herein granted to the employee, his dependents, next of kin, or personal representative shall exclude all other rights and remedies of the employee, his dependents, next of kin, or representative as against the employer at common law or otherwise on account of such injury or death.

(b) Notwithstanding G.S. 97-10.2 or any other provision of this Article, the rights and remedies under this Article shall be the sole remedies against the local board of education, the charter school, or against the business or other entity, for a compensable injury of a public school student enrolled in grades 6-12 who is enrolled in an unpaid, school-approved, work-based learning experience that is located off public school grounds on the premises of a business or other entity that employs individuals. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 4. This act becomes effective July 1, 2002, and applies to injuries that occur on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 462

Short Title:	Workers' Comp/Certain Public School Students.	(Public)
Sponsors:	Representative Owens.	
Referred to:	Insurance.	

March 5, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-2(2) reads as rewritten:

"(2) Employee. – The term 'employee' means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term 'employee' shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term 'employee' shall include all officers and employees thereof, including such as are elected by the people. The term 'employee' shall include members of the North Carolina national guard while on State active duty under orders of the Governor and members of the North Carolina State Defense Militia while on State active duty under orders of the Governor. The term 'employee' shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving

on a fee basis or on a salary basis, or whether deputy sheriffs serving upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment, and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been injured shall, when the employee is dead, include also his legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee as herein defined of a municipality, county, or of the State of North Carolina while engaged in the discharge of his official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of his employer.

Every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation specifically excluding such executive officer in such contract of insurance and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term employee shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-491(a) when

performing duties in the course and scope of a State approved mission pursuant to Article 11 of Chapter 143B.

Employee shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

Any sole proprietor or partner of a business or any member of a limited liability company may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article.

The term employee shall include any public school student enrolled in kindergarten through twelfth grade who is participating in an unpaid, school-approved, work-based learning experience that is located off the public school grounds on the premises of a business or other entity that employs individuals. The local board of education or the charter school is the employer within the meaning of this Article during the time that the student is participating in this unpaid, school-approved, work-based learning experience. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 2. G.S. 97-2(5) reads as rewritten:

"(5) Average Weekly Wages. – 'Average weekly wages' shall mean the earnings of the injured employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury, including the subsistence allowance paid to veteran trainees by the United States government, provided the amount of said allowance shall be reported monthly by said trainee to his employer, divided by 52; but if the injured employee lost more than seven consecutive calendar days at one or more times during such period, although not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed; provided, results fair and just to both parties will be thereby obtained. Where, by reason of a shortness of time during which the employee has been in the employment of his employer or the casual nature or terms of his employment, it is impractical to compute the average weekly wages as above defined,

regard shall be had to the average weekly amount which during the 52 weeks previous to the injury was being earned by a person of the same grade and character employed in the same class of employment in the same locality or community.

But where for exceptional reasons the foregoing would be unfair, either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.

Wherever allowances of any character made to an employee in lieu of wages are specified part of the wage contract they shall be deemed a part of his earnings.

Where a minor employee, under the age of 18 years, sustains a permanent disability or dies leaving dependents surviving, the compensation payable for permanent disability or death shall be calculated, first, upon the average weekly wage paid to adult employees employed by the same employer at the time of the accident in a similar or like class of work which the injured minor employee would probably have been promoted to if not injured, or, second, upon a wage sufficient to yield the maximum weekly compensation benefit. Compensation for temporary total disability or for the death of a minor without dependents shall be computed upon the average weekly wage at the time of the accident, unless the total disability extends more than 52 weeks and then the compensation may be increased in proportion to his expected earnings. The minimum average weekly wage required under this subdivision shall be used to compute compensation for an employee who is a public school student enrolled in kindergarten through twelfth grade and who is participating in an unpaid, school-approved, work-based learning experience located off the public school grounds on the premises of a business or other entity that employs individuals.

In case of disabling injury or death to a volunteer fireman or member of an organized rescue squad or duly appointed and sworn member of an auxiliary police department organized pursuant to G.S. 160A-282 or senior members of the State Civil Air Patrol functioning under Article 11, Chapter 143B, under compensable circumstances, compensation payable shall be calculated upon the average weekly wage the volunteer fireman or member of an organized rescue squad or member of an auxiliary police department or senior member of the State Civil Air Patrol was earning in the employment wherein he principally earned his livelihood as of the date of injury. Provided, however, that the minimum compensation payable to a volunteer fireman, member of an organized rescue squad or sworn member of an auxiliary police department organized pursuant to G.S. 160A-282, or

senior members of the State Civil Air Patrol shall be sixty-six and two thirds percent (66 2/3%) of the maximum weekly benefit established in G.S. 97-29."

SECTION 3. G.S. 97-10.1 reads as rewritten:

"**§ 97-10.1. Other rights and remedies against employer excluded.**

(a) If the employee and the employer are subject to and have complied with the provisions of this Article, then the rights and remedies herein granted to the employee, his dependents, next of kin, or personal representative shall exclude all other rights and remedies of the employee, his dependents, next of kin, or representative as against the employer at common law or otherwise on account of such injury or death.

(b) The rights and remedies under this Article shall be the sole remedies against the local board of education, the charter school, or against the business or other entity, for a compensable injury of a public school student enrolled in grades K-12 who is participating in an unpaid, school-approved, work-based learning experience that is located off public school grounds on the premises of a business or other entity that employs individuals. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 4. This act becomes effective July 1, 2001, and applies to injuries that occur on or after that date.

HOUSE BILL 462:
Workers' Comp/Certain Public School Students

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Owens
Date:	March 29, 2001	**Summary by:**	Frank W. Folger
Version:	First Edition		Committee Counsel

SUMMARY: ***This bill would provide workers' compensation coverage for public school and charter school students participating in school-approved unpaid internships and job shadowing experiences off school grounds.***

CURRENT LAW: Neither workers' compensation nor any other special statutory provisions cover student participants in the Job Ready Program or any other school-approved unpaid work-based learning experiences off school grounds. Injuries to student participants would be resolved as any other civil action, with the local board of education, partnering business and other entities being subject to suit by the injured party or the party's representative.

BILL ANALYSIS: Section 1. would include in the Act's definition of "employee" public school and charter school students in grades K-12 participating in unpaid, school-approved, work-based learning experiences located off school grounds and on the premises of a business or other entity employing individuals. It would make the local board of education or the charter school the "employer" for purposes of the Act and thus responsible for covering the students compensable claims under the Act.

Section 2. would establish that students with compensable claims under this bill be compensated based on the minimum average weekly wage as provided in G.S. 97-2(5).

Section 3. would provide that the rights and remedies under the Workers' Compensation Act are exclusive for compensable injuries arising from these student work-based learning experiences.

BACKGROUND: This bill arose from the Employer Issues Committee of the Job Ready Partnership, was approved by the full statewide Job Ready Council, and was drafted by the Department of Public Instruction, local school systems and business groups, among others. According to the N.C. School Board Association, school systems across the State have already had to purchase insurance to cover the potential liability from operating Job Ready programs; thus the bill could produce cost savings to local school administrative units by limiting liability to workers' compensation coverage which they are already required to maintain under G.S. 115C-337(a).

EFFECTIVE DATE: Effective July 1, 2001 and applicable to injuries occurring on or after that date.

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION

"PUBLIC EDUCATION: NORTH CAROLINA'S BEST INVESTMENT"

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February 19, 2001

Representative Bill Owens
Legislative Office Building
Raleigh, North Carolina 27602

Dear Bill:

Thank you for your willingness to introduce the bill that would provide workers' compensation coverage for students participating in unpaid internships and job shadowing experiences through the Job Ready Program.

As we discussed many of the businesses that participate in the program were reluctant at first, due to the potential liability if the student-worker was hurt on the business premise. In order to make the program work, school systems across North Carolina have had to purchase separate insurance to cover the potential liability.

The bill grew out of the Employer Issues Committee of the Job Ready Partnership, on which our attorney Allison Schafer serves. This proposed bill was approved by the full statewide Job Ready Council. Representatives of a number of groups participated in the drafting of this bill, including the Department of Public Instruction, local school systems and business groups. This bill would automatically add to the unpaid student-workers to their local workers' compensation coverage, which they already have and are required by law to maintain. We believe that this will be a cost savings to the school districts across North Carolina.

Thank you for your support.

Sincerely,

Leanne E. Winner

P.O. Box 97877 • Raleigh, NC 27624-7877 • Phone: (919)841-4040 • Fax: (919)841-4020

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 11, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 11, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Nikki Brooks and Sharice Dowe (Cumberland County – Rep. Lucas). The following Committee members were present: Representatives Blue, Brubaker, Dedmon, Grady, Hall, Justus, Redwine, Saunders, Smith, Warner, and C. Wilson. Linda Attarian, Frank Folger, and Trina Griffin, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 462, entitled, AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT. The Chair recognized Representative Bill Owens to explain the proposed committee substitute adopted for discussion during the April 4, 2001, committee meeting. This bill would provide workers' compensation coverage for public school and charter school students participating in school-approved unpaid internships and job shadowing experiences off school grounds. Representative Warner moved to give the committee substitute a favorable report, unfavorable to the original bill. Motion passed.

HB 13, entitled, AN ACT TO PROHIBIT INSURANCE COMPANIES FROM ENCOURAGING INSURANCE CLAIMANTS TO OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES. Representative Wilma Sherrill was recognized to explain the bill, and she presented a proposed committee substitute. Representative Saunders moved to adopt the proposed committee substitute for consideration. The motion passed. This bill does not change the current law, especially as it relates to steering. It would require an insurance company to inform a policyholder in writing once a year of that person's legal rights under current law when an insurance company recommends a repair shop. This bill would prohibit an insurer or insurer's representatives from recommending a claimant use a particular motor vehicle repair service without certain disclosures and from penalizing a claimant for not using the recommended repair service of the insurer or the insurer's representative. It would also direct the LRC to study the practices of the insurance industry in recommending repair services or sources to claimants and the enforcement of this provision by the Department of Insurance. Frank Folger, Staff Counsel, was recognized to explain the differences in the Proposed Committee Substitute and the original bill.

Susan Valauri, Lobbyist with Nationwide Insurance Company, was recognized to explain the repair (body shop) referral process. Mike Causey, NC Glass Association and Independent Auto Body Association, was recognized to speak in favor of HB 13. He

indicated this was a pro-consumer, pro-business bill. Gary Logan, Logan's Body Shop, was recognized to speak in favor of the bill. Peter Stewart, Stewart Body Shop, was recognized to speak in opposition to the bill. Marvin Martin, Martin's Auto Rebuilders, Inc., was recognized to speak in favor of the bill.

Commissioner Jim Long, NC Department of Insurance, was recognized to provide comments. He indicated the Department of Insurance does not have any complaints on file from consumers pertaining to this issue, but he does have several complaints from body shops, particularly in the western part of the State. The Department of Insurance supports HB 13 and feels it is good to keep consumers/customers informed of their rights in a situation when their vehicle has been damaged. Due to time constraints the committee tabled this bill until the next INSURANCE Committee meeting scheduled for April 18, 2001.

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

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
HB 462, HB 13
Handouts
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

April 11, 2001 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lamont Thomas	Heavy's Body Shop
Vernell C Thomas	Heavys Body Shop
William R. Cannon	Suburban Paint + Body Shop
Jovita Mask	Independent Insurance Agents of North Carolina
BILL SCOGGIN	KENNEDY WINGOOD
Bob Price	Jordan Price
GARY LOGAN	LOGAN'S Body Shop FAYETTEVILLE, NC.
DON Talbot	Fayetteville City Council 433 HAY St. FAY, NC 28301
Doug Pfaff	Auto Glass by Pfaff's 3125 Peters Creek Pkwy Winston Salem, N.C 27127
Beverley Ward	Ever Ready Glass + Lock Service 500 Nowell Rd. Raleigh NC.
William Will Ford	Ever Ready GLASS & Lock 500 Nowell Rd Raleigh NC

VISITOR REGISTRATION SHEET

INSURANCE — April 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Harold Webb	Lobbyist
Sam Johnson	Atty
Robert Glazer	NC Auto Dealers Assn.
Archie Bright	Nationwide Insurance Co.
Rick Thomoson	Nationwide Insurance
C.W. Ballard	Nationwide Insurance
John Webb	N.C. Glass Assoc.
Mary Rivers	Diamond's Body Shop
Jay Rivers	Diamond's Body Shop
Steve Brown	Nationwide Ins Co
Ed Yahnker	Nationwide Ins. Co.

VISITOR REGISTRATION SHEET

INSURANCE — April 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bryanna Cianfrani	Nationwide Insurance
Donnie Hogg	Nationwide Ins.
Richard Haddock	Haddock Auto Body Inc.
Douglas Baker	Nationwide Ins. Co.
STEVE LAWRENCE	RICK HENDRICK COLLISION CENTER
Jimmy Tutor	Nationwide Insurance
RAEFORD LOCKAMY	Nationwide Insurance
Pete Stewart	Stewart Body Shop, Fayetteville NC
Lori DeBeus	True 2 Form Collision Garner
George Hislip	True 2 Form Collision Garner
Mark Barnes	BARNES COLLISION REPAIR CENTER

VISITOR REGISTRATION SHEET

INSURANCE — April 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marvin C. Mashburn	Martin - Auto Rebuilders Inc
Mike Causey	NC Glass Assn, Independent Auto Body Assn
Warren Savage	Bailey + Dixon
Larry Ault	Auto Body Shop & Repair Inc.
DAVID HUSKINS	RIDGETOP ASSOCIATES
Mona Mumbert	Poyner + Spruill
Larry [illegible]	Auto Body Supply
Randy Bennett	Hendrick Automotive Group
Rhea Daniel	NATIONWIDE INS CO.
C Valauri	NC Beer & Wine
D Plunkett	NC Beer & Wine.
Paula Hopper	Moore & Van Allen

VISITOR REGISTRATION SHEET

INSURANCE — April 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NCSA
Steve Brewer	Nationwide Ins
PETE RAMAGLIA	PETE'S AUTO BODY INC./WILSON, NC
Lynn Collar	Nationwide Ins. – Raleigh
Mark Burgess	Nationwide Ins - Nash Co.
Mike Garris	Nationwide Ins - Pitt Co.
Richard Hill	Nationwide Ins., Wake Co.
Kenneth R. Moore	NATIONWIDE INS. CO., WAKE CO.
Doug Bethwick	Nationwide Ins. Co., Wake Co.
Robert Paschal	Young, Moore
Brenda Dunn	USA CUSTOM PAINT & BODY, INC
Barbara Carsten	Manning, Fulton & Skinner

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VISITOR REGISTRATION SHEET

INSURANCE — April 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jimmy Taylor	Johnson Automotive 3737 Chapel Hill Blvd Durham NC 27707
[signature]	GMAC Insurance.
Charles Wilkins	AFLAC
[signature]	Rudolph & Clay & Assoc.
[signature]	Precision Collision 9912 B Capital Blvd Wake Forest NC 27587
Richard Barbour	Harmant Body Mart 325 Cumberland St FAY N.C.
[signature]	MGM
[signature]	Capitol Group
Ryan Bonner	NFO
Sherry Blayne	Town & Country Body Shop
ED Byrd	Town & Country Body Shop

VISITOR REGISTRATION SHEET

INSURANCE — April 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Ferrell	Hofe, Caldwell & Fendt PA
[signature]	NCRMA
Steve Woodson	NC Farm Bureau Federation
Reglester	IGONC
[signature]	NCAHP

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 13
PROPOSED COMMITTEE SUBSTITUTE H13-CSLT-27 [v.2]

4/11/2001 11:29:03 AM

Short Title: Motor Vehicle Repairs. (Public)

Sponsors:

Referred to:

January 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT INSURANCE COMPANIES FROM RECOMMENDING THAT INSURANCE CLAIMANTS OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES WITHOUT BEING INFORMED THAT CLAIMANTS DO NOT HAVE TO USE THOSE RECOMMENDED REPAIR SERVICES OR SOURCES AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE INSURANCE INDUSTRY PRACTICE OF RECOMMENDING REPAIR SERVICES TO CLAIMANTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-180 reads as rewritten:

"**§ 58-3-180. Motor vehicle repairs; selection by claimant.**

(a) A policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage.

(b) The amount determined by the insurer to be payable under a policy covering damage to a motor vehicle shall be paid regardless of the repair service or source selected by the claimant.

(b1) No insurer or insurer representative shall recommend the use of a particular motor vehicle repair service without clearly informing the claimant that (i) the claimant is under no obligation to use the recommended repair service, (ii) the claimant may use the repair service of the claimant's choice, and (iii) the amount determined by the insurer to be payable under the policy will be paid regardless of whether or not the claimant uses the recommended repair service. Each insurer shall disclose the information required be this subsection in writing to each policyholder at least annually. The disclosure form is subject to the prior approval of the Commissioner.

(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and G.S. 58-33-45, provided that the maximum civil penalty that can be assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars ($2,000).

(d) As used in this section, 'insurer representative' includes an insurance agent, limited representative, broker, adjuster, and appraiser.

(e) The Commissioner may adopt rules to carry out the provisions of this section."

SECTION 2. The Legislative Research Commission may conduct a comprehensive study of the practices of the insurance industry in recommending repair services or sources to claimants and the policies and procedures of the Department of Insurance in enforcing G.S. 58-3-180 to determine if State law should be amended to better protect and promote the public's right to select a repair service or source.

If the Legislative Research Commission undertakes the study, it shall report its findings and recommendations to the 2002 Regular Session of the 2001 General Assembly.

SECTION 3. Section 1 of this act becomes effective October 1, 2001. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 13

Short Title:	Motor Vehicle Repairs.	(Public)
Sponsors:	Representatives Sherrill; Cansler, Walend, and Carpenter.	
Referred to:	Rules, Calendar, and Operations of the House.	

January 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT INSURANCE COMPANIES FROM ENCOURAGING INSURANCE CLAIMANTS TO OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-180 reads as rewritten:

"**§ 58-3-180. Motor vehicle repairs; selection by claimant.**

(a) A policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage.

(a1) No insurer or insurer representative shall recommend, or in any way encourage, a claimant use a particular motor vehicle repair service or source for the purpose of obtaining (i) an estimate of the cost of repairs to a damaged motor vehicle, or (ii) repair services to a damaged motor vehicle. No insurer or insurer representative shall inform the claimant that the insurer will guarantee repairs performed by one or more particular repair services or sources but not by other repair services or sources.

(b) The amount determined by the insurer to be payable under a policy covering damage to a motor vehicle shall be paid regardless of the repair service or source selected by the claimant.

(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and G.S. 58-33-45, provided that the maximum civil penalty that can be assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars ($2,000).

(d) As used in this section, 'insurer representative' includes an insurance agent, limited representative, broker, adjuster, and appraiser."

SECTION 2. This act becomes effective October 1, 2001.

HOUSE BILL 13:
Motor Vehicle Repairs

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Sherrill
Date:	April 11, 2001	**Summary by:**	Frank W. Folger
Version:	PCS H13-CSLT-19		Committee Counsel

SUMMARY: ***This bill would prohibit an insurer or insurer's representative from recommending a claimant use a particular motor vehicle repair service without certain disclosures and from penalizing a claimant for not using the recommended repair service of the insurer or the insurer's representative. It would also direct the LRC to study the practices of the insurance industry in recommending repair services or sources to claimants and the enforcement of this provision by the Department of Insurance.***

CURRENT LAW: Insurance policies covering damage to a motor vehicle has to allow the claimant to select that claimant's repair service or source for the repair. The amount determined to be payable by the insurer is to be paid regardless of the repair service or source selected by the claimant. Violators of this provision are subject to civil penalties of up to $2000, licensure or certification suspension or revocation or refusal of renewal, payment of restitution to any harmed person, and payment of restitution to any State agency for extraordinary administrative expenses incurred in the investigation and hearing of the violation. N.C.G.S. §58-3-180

BILL ANALYSIS: Section 1. would prohibit, in addition to the existing prohibition, an insurer or insurer representative from recommending a claimant use a particular motor vehicle repair service or source of repairs without clearly informing the claimant that:

1. the claimant does not have to use the recommended repair service;
2. the claimant can use the repair service chosen by the claimant; and
3. the amount the insurer determines is payable under the policy will be paid whether or not the recommended repair service is used.

The insurer would have to disclose this information in writing, at least annually, to each policyholder; and the disclosure form would have to receive the Commissioner's prior approval. The section would also define "insurance representative" to include an agent, limited representative, broker, adjuster, or appraiser; and it would grant the Commissioner authority to adopt rules to carry out these statutory provisions.

Section 2. would require the Legislative Research Commission to study the practices of the insurance industry in recommending repair services or sources to claimants and the Department of Insurance's policies and procedures for enforcing N.C.G.S. §58-3-180 to assess the need for consumer protection legislation in this area. The LRC's study may include but is not limited to a review of the following:

1. Insurance industry practices of recommending, using, and guaranteeing the work of preferred repair services;
2. Insurer-provide info given to claimants or policyholders calling to report a claim;
3. Insurer's nonproprietary criteria for determining whether a particular repair service is "preferred" and thus recommended to claimants or policyholders;

4. The Department of Insurance's policies and procedures for investigating complaints of violations by insurers of N.C.G.S. §58-3-180 to the extent disclosure is legally permitted; and
5. Data on investigation and enforcement (sanctions, warnings, etc.) of N.C.G.S. §58-3-180 to the extent Departmental disclosure is legally permitted.

It would require the LRC to report to the 2002 Regular Session of the 2001 General Assembly.

Section 3. would make Section 1. effective Oct. 1, 2001 and the remainder of the act effective when it becomes law.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 462 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, unfavorable as to (original bill).

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 462
PROPOSED COMMITTEE SUBSTITUTE H462-CSSO-7 [v.3]

4/4/2001 10:25:25 AM

Short Title: Workers' Comp/Certain Public School Students. (Public)

Sponsors:

Referred to:

March 5, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-2(2) reads as rewritten:

"(2) Employee. – The term 'employee' means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term 'employee' shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term 'employee' shall include all officers and employees thereof, including such as are elected by the people. The term 'employee' shall include members of the North Carolina national guard while on State active duty under orders of the Governor and members of the North Carolina State Defense Militia while on State active duty under orders of the Governor. The term 'employee' shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving on a fee basis or on a salary basis, or whether deputy sheriffs serving

upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment, and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been injured shall, when the employee is dead, include also his legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee as herein defined of a municipality, county, or of the State of North Carolina while engaged in the discharge of his official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of his employer.

Every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation specifically excluding such executive officer in such contract of insurance and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term employee shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-491(a) when

performing duties in the course and scope of a State approved mission pursuant to Article 11 of Chapter 143B.

Employee shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

Any sole proprietor or partner of a business or any member of a limited liability company may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article.

The term employee shall include any public school student enrolled in sixth through twelfth grade who is enrolled in an unpaid, school-approved, work-based learning experience that is located off the public school grounds on the premises of a business or other entity that employs individuals. The local board of education or the charter school is the employer within the meaning of this Article during the time that the student is enrolled in this unpaid, school-approved, work-based learning experience. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 2. G.S. 97-2(5) reads as rewritten:

"(5) Average Weekly Wages. – 'Average weekly wages' shall mean the earnings of the injured employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury, including the subsistence allowance paid to veteran trainees by the United States government, provided the amount of said allowance shall be reported monthly by said trainee to his employer, divided by 52; but if the injured employee lost more than seven consecutive calendar days at one or more times during such period, although not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed; provided, results fair and just to both parties will be thereby obtained. Where, by reason of a shortness of time during which the employee has been in the employment of his employer or the casual nature or terms of his employment, it is

impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury was being earned by a person of the same grade and character employed in the same class of employment in the same locality or community.

But where for exceptional reasons the foregoing would be unfair, either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.

Wherever allowances of any character made to an employee in lieu of wages are specified part of the wage contract they shall be deemed a part of his earnings.

Where a minor employee, under the age of 18 years, sustains a permanent disability or dies leaving dependents surviving, the compensation payable for permanent disability or death shall be calculated, first, upon the average weekly wage paid to adult employees employed by the same employer at the time of the accident in a similar or like class of work which the injured minor employee would probably have been promoted to if not injured, or, second, upon a wage sufficient to yield the maximum weekly compensation benefit. Compensation for temporary total disability or for the death of a minor without dependents shall be computed upon the average weekly wage at the time of the accident, unless the total disability extends more than 52 weeks and then the compensation may be increased in proportion to his expected earnings.

The minimum weekly compensation as provided in G.S. 97-29 shall be the weekly compensation paid for total incapacity pursuant to G.S. 27-29, partial incapacity pursuant to G.S. 97-30, disability in the schedule of injuries for which average weekly wages are used in determining compensation pursuant to G.S. 97-31, or death pursuant to G.S. 97-38, from a compensable injury under this Chapter of an employee who is a public school student enrolled in sixth through twelfth grade and who is enrolled in an unpaid, school-approved, work-based learning experience located off the public school grounds on the premises of a business or other entity that employs individuals. Except as otherwise provided, the provisions of this Article apply to an injury to an employee who is a public school student enrolled in sixth through twelfth grade and who is enrolled in an unpaid, school-approved, work-based learning experience located off the public school grounds on the premises of a business or other entity that employs individuals.

In case of disabling injury or death to a volunteer fireman or member of an organized rescue squad or duly appointed and sworn member of an auxiliary police department organized pursuant to G.S. 160A-282 or senior members of the State Civil Air Patrol functioning under Article 11, Chapter 143B, under compensable circumstances, compensation payable shall be calculated upon the average weekly wage the volunteer fireman or member of an organized rescue squad or member of an auxiliary police department or senior member of the State Civil Air Patrol was earning in the employment wherein he principally earned his livelihood as of the date of injury. Provided, however, that the minimum compensation payable to a volunteer fireman, member of an organized rescue squad or sworn member of an auxiliary police department organized pursuant to G.S. 160A-282, or senior members of the State Civil Air Patrol shall be sixty-six and two thirds percent (66 2/3%) of the maximum weekly benefit established in G.S. 97-29."

SECTION 3. G.S. 97-10.1 reads as rewritten:

"**§ 97-10.1. Other rights and remedies against employer excluded.**

(a) If the employee and the employer are subject to and have complied with the provisions of this Article, then the rights and remedies herein granted to the employee, his dependents, next of kin, or personal representative shall exclude all other rights and remedies of the employee, his dependents, next of kin, or representative as against the employer at common law or otherwise on account of such injury or death.

(b) Notwithstanding G.S. 97-10.2 or any other provision of this Article, the rights and remedies under this Article shall be the sole remedies against the local board of education, the charter school, or against the business or other entity, for a compensable injury of a public school student enrolled in grades 6-12 who is enrolled in an unpaid, school-approved, work-based learning experience that is located off public school grounds on the premises of a business or other entity that employs individuals. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 4. This act becomes effective July 1, 2002, and applies to injuries that occur on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 462

Short Title:	Workers' Comp/Certain Public School Students.	(Public)
Sponsors:	Representative Owens.	
Referred to:	Insurance.	

March 5, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT PUBLIC AND CHARTER SCHOOL STUDENTS WHO PARTICIPATE IN UNPAID, SCHOOL-APPROVED, WORK-BASED LEARNING EXPERIENCES LOCATED OFF SCHOOL GROUNDS ARE ELIGIBLE FOR COMPENSATION UNDER THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-2(2) reads as rewritten:

"(2) Employee. – The term 'employee' means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term 'employee' shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term 'employee' shall include all officers and employees thereof, including such as are elected by the people. The term 'employee' shall include members of the North Carolina national guard while on State active duty under orders of the Governor and members of the North Carolina State Defense Militia while on State active duty under orders of the Governor. The term 'employee' shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving

on a fee basis or on a salary basis, or whether deputy sheriffs serving upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment, and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been injured shall, when the employee is dead, include also his legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee as herein defined of a municipality, county, or of the State of North Carolina while engaged in the discharge of his official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of his employer.

Every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation specifically excluding such executive officer in such contract of insurance and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term employee shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-491(a) when

performing duties in the course and scope of a State approved mission pursuant to Article 11 of Chapter 143B.

Employee shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

Any sole proprietor or partner of a business or any member of a limited liability company may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article.

The term employee shall include any public school student enrolled in kindergarten through twelfth grade who is participating in an unpaid, school-approved, work-based learning experience that is located off the public school grounds on the premises of a business or other entity that employs individuals. The local board of education or the charter school is the employer within the meaning of this Article during the time that the student is participating in this unpaid, school-approved, work-based learning experience. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 2. G.S. 97-2(5) reads as rewritten:

"(5) Average Weekly Wages. – 'Average weekly wages' shall mean the earnings of the injured employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury, including the subsistence allowance paid to veteran trainees by the United States government, provided the amount of said allowance shall be reported monthly by said trainee to his employer, divided by 52; but if the injured employee lost more than seven consecutive calendar days at one or more times during such period, although not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed; provided, results fair and just to both parties will be thereby obtained. Where, by reason of a shortness of time during which the employee has been in the employment of his employer or the casual nature or terms of his employment, it is impractical to compute the average weekly wages as above defined,

regard shall be had to the average weekly amount which during the 52 weeks previous to the injury was being earned by a person of the same grade and character employed in the same class of employment in the same locality or community.

But where for exceptional reasons the foregoing would be unfair, either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.

Wherever allowances of any character made to an employee in lieu of wages are specified part of the wage contract they shall be deemed a part of his earnings.

Where a minor employee, under the age of 18 years, sustains a permanent disability or dies leaving dependents surviving, the compensation payable for permanent disability or death shall be calculated, first, upon the average weekly wage paid to adult employees employed by the same employer at the time of the accident in a similar or like class of work which the injured minor employee would probably have been promoted to if not injured, or, second, upon a wage sufficient to yield the maximum weekly compensation benefit. Compensation for temporary total disability or for the death of a minor without dependents shall be computed upon the average weekly wage at the time of the accident, unless the total disability extends more than 52 weeks and then the compensation may be increased in proportion to his expected earnings. The minimum average weekly wage required under this subdivision shall be used to compute compensation for an employee who is a public school student enrolled in kindergarten through twelfth grade and who is participating in an unpaid, school-approved, work-based learning experience located off the public school grounds on the premises of a business or other entity that employs individuals.

In case of disabling injury or death to a volunteer fireman or member of an organized rescue squad or duly appointed and sworn member of an auxiliary police department organized pursuant to G.S. 160A-282 or senior members of the State Civil Air Patrol functioning under Article 11, Chapter 143B, under compensable circumstances, compensation payable shall be calculated upon the average weekly wage the volunteer fireman or member of an organized rescue squad or member of an auxiliary police department or senior member of the State Civil Air Patrol was earning in the employment wherein he principally earned his livelihood as of the date of injury. Provided, however, that the minimum compensation payable to a volunteer fireman, member of an organized rescue squad or sworn member of an auxiliary police department organized pursuant to G.S. 160A-282, or

senior members of the State Civil Air Patrol shall be sixty-six and two thirds percent (66 2/3%) of the maximum weekly benefit established in G.S. 97-29."

SECTION 3. G.S. 97-10.1 reads as rewritten:

"**§ 97-10.1. Other rights and remedies against employer excluded.**

(a) If the employee and the employer are subject to and have complied with the provisions of this Article, then the rights and remedies herein granted to the employee, his dependents, next of kin, or personal representative shall exclude all other rights and remedies of the employee, his dependents, next of kin, or representative as against the employer at common law or otherwise on account of such injury or death.

(b) The rights and remedies under this Article shall be the sole remedies against the local board of education, the charter school, or against the business or other entity, for a compensable injury of a public school student enrolled in grades K-12 who is participating in an unpaid, school-approved, work-based learning experience that is located off public school grounds on the premises of a business or other entity that employs individuals. For purposes of this section, 'public school' includes a charter school established under Part 6A of Article 16 of Chapter 115C of the General Statutes."

SECTION 4. This act becomes effective July 1, 2001, and applies to injuries that occur on or after that date.

HOUSE BILL 462:
Workers' Comp/Certain Public School Students

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Owens
Date:	March 29, 2001	**Summary by:**	Frank W. Folger
Version:	First Edition		Committee Counsel

SUMMARY: ***This bill would provide workers' compensation coverage for public school and charter school students participating in school-approved unpaid internships and job shadowing experiences off school grounds.***

CURRENT LAW: Neither workers' compensation nor any other special statutory provisions cover student participants in the Job Ready Program or any other school-approved unpaid work-based learning experiences off school grounds. Injuries to student participants would be resolved as any other civil action, with the local board of education, partnering business and other entities being subject to suit by the injured party or the party's representative.

BILL ANALYSIS: Section 1. would include in the Act's definition of "employee" public school and charter school students in grades K-12 participating in unpaid, school-approved, work-based learning experiences located off school grounds and on the premises of a business or other entity employing individuals. It would make the local board of education or the charter school the "employer" for purposes of the Act and thus responsible for covering the students compensable claims under the Act.

Section 2. would establish that students with compensable claims under this bill be compensated based on the minimum average weekly wage as provided in G.S. 97-2(5).

Section 3. would provide that the rights and remedies under the Workers' Compensation Act are exclusive for compensable injuries arising from these student work-based learning experiences.

BACKGROUND: This bill arose from the Employer Issues Committee of the Job Ready Partnership, was approved by the full statewide Job Ready Council, and was drafted by the Department of Public Instruction, local school systems and business groups, among others. According to the N.C. School Board Association, school systems across the State have already had to purchase insurance to cover the potential liability from operating Job Ready programs; thus the bill could produce cost savings to local school administrative units by limiting liability to workers' compensation coverage which they are already required to maintain under G.S. 115C-337(a).

EFFECTIVE DATE: Effective July 1, 2001 and applicable to injuries occurring on or after that date.

HB 462: Workers' Compensation/Certain Public School Students

HB462 grew out of concerns in establishing the Job Ready Partnership. Many businesses that were asked to participate were concerned about workplace injuries that the student might incur. At that time a specialized policy was established in the DPI to cover these incidents. A subcommittee of the Partnership has recommended that these students be added to the workers' compensation policies.

Current Coverage

- Currently, 70% of the local school districts purchase a specialized liability policy through DPI.
- Under the specialized policy, which is a no fault policy, a student could recovery a maximum of $10,000.
- For the past two years that the specialized policy has been in place there have been no claims.
- The other 30% could potentially be sued under their general liability policy.
- Under a general liability policy, the injured student would need to show that the school district or business was negligent. There are many workplace injuries that neither would be negligent. Even if the school district or the business were negligent, if the student was contributorily negligent then there would be no legitimate claim.
- Not every child that was injured while in the program would be eligible to have his/her medical costs covered.

HB 462 Proposal

- HB 462 would put students who participate in these types of programs under the school district's local workers' compensation policy.
- This would guarantee that if a child was hurt while enrolled in the program that his/her medical costs would be covered.
- The claimant's weekly wage is set at the minimum weekly wage, which is currently $30.
- G.S. 97-2(5) allows that if a minor is permanently injured or dies the Industrial Commission can award additional compensation.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 12, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 12, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the page Sharice Dowe (Cumberland County-Rep. Lucas). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Barbee, Grady, Hall, Johnson, Redwine, Setzer, and Wilson. Frank Folger and Linda Attarian, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes (Attachment). The following bills were considered.

SB 132, entitled, A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH INSURANCE PLANS TO PROVIDE COVERAGE FOR COLORECTAL CANCER SCREENING. The Chair recognized Senator Carpenter, the bill sponsor, to explain the bill. The NC Advisory Committee on Cancer Coordination and Control is a very active, astute committee. Several physicians and six Legislators are members of this committee; Representatives Edwards, Alexander, and Wright, and Senators Martin, Odom, and Carpenter. This committee recommended SB 132. Colorectal cancer is the second leading cancer killer in North Carolina and the United States (Lung cancer is the leading killer). According to a White House press release last October, an estimated 130,000 new cases and 56,000 deaths from colorectal cancer were expected in 2000. In 1999, according to Division of Public Health, 1,511 North Carolinians died of colorectal cancer. (See bill summary) The purpose of this bill is to increase the number of colon cancer screening procedures and thereby reducing death from colon cancer. Early colorectal cancer is a curable disease. Because colorectal cancers grow slowly, early detection significantly increases survival. When detected early, the five-year survival rate is 90%. However, less than 40% of colorectal cancers are discovered at that stage. At least 18 states are considering legislation to mandate colorectal screening. Virginia recently enacted such legislation. The General Assembly enacted legislation in 1991 to require the State Employees Comprehensive Health Plan to pay one hundred percent (100%) of routine colorectal diagnostic examinations and tests once every three years for individuals to age 40 years, once every two years for individuals to age 50 years, and once a year for individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Harry Kaplan, NC Association of Health Plans, Inc., was recognized to speak in favor of the bill. Duke University Professor July Dowe and Robert Paschal, NC Association of Health Underwriters, were recognized to give personal testimony in favor of the bill. Bill Hale, Legislative Counsel with the Dept. of Insurance, was recognized to respond to the question asked by Representative Redwine; what is the difference in this mandated bill and all the other mandated bills before this committee, aside from not having any fiscal impact? Mr. Hale's response was that this bill is similar to the mammogram bill introduced in 1991 and the PSA bill introduced in 1993. It saves lives and money in the long run through early detection. After additional discussion by the committee members, Representative Setzer moved to give the committee substitute a favorable report. The motion passed.

HB 760, entitled, A BILL TO BE ENTITLED AN ACT TO TO REQUIRE CANCER INSURANCE POLICIES TO OFFER A WELLNES BENEFIT RIDER. The presiding Chair recognized Representative Bill Hurley to explain the bill. This bill will allow a private policy holders to purchase a "wellness rider"that will pay the subscriber an annual cash payment of at least $50.00 if the subscriber can show proof of having undergone annual cancer screening. It is an inducement to have annual checkups for early detection of cancer, which in turn will save money for the insurance companies in the long run. The act is effective January 1, 2002 and does not apply to policies issued before that date. After additional discussion by the committee members, Representative Hall moved to give the bill a favorable report. The motion passed.

There being no further business, the Chair adjourned the meeting at 12:40 PM.

Respectfully submitted,

Representative Jerry C. Dockham
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Form
SB 132, HB 760
Bill Summaries
Handouts

VISITOR REGISTRATION SHEET

INSURANCE — April 12, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Johnson	Ratsdale Liggett
B. Stone-Wiggins	DHHS Cancer Control Program
Bobbie Matthews	DHHS Cancer Control Program
Cathy Daniels	DHHS/Public Health (ACCCC)
Deborah Chesshutt	RN / Advisory Committee on Cancer Coordination + Control
Ken Wright	BCBSNC
Joyce Peters	JP Assoc/ MANAGT
Peg O'Connell	Medicine Review of NC
John Thompson	American Cancer Society
Lisa Povey Green	
Susan Odell	Colon Cancer Alliance

VISITOR REGISTRATION SHEET

INSURANCE — April 12, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dudley E. Cha	American Council Services
[illegible]	NCDOI
Michelle McClure	Atty Gen
Mike Causey	NC Grocers Assn
Bob Price	Jordan Price
Lori Ann Harris	LA Harris & Assoc
Harry Kaplan	NCAHP
Robert Pasahal	Young, Moore
Anna Bridges	Randolph Cloud & Ass.
[illegible]	Moore & Van Allen
[illegible]	Delta Dental

VISITOR REGISTRATION SHEET

INSURANCE — April 12, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valaur	Nationwide
Daschel Propes	NC DOI
Criss Porter	Bone and Associates
Sheila McKenney	NC DOI

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 132 A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH INSURANCE PLANS TO PROVIDE COVERAGE FOR COLORECTAL CANCER SCREENING.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 132

Insurance and Consumer Protection Committee Substitute Adopted 3/14/01

Short Title: Health Insurance/Colorectal Cancer Screening. (Public)

Sponsors:

Referred to:

February 13, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH INSURANCE PLANS TO PROVIDE COVERAGE FOR COLORECTAL CANCER SCREENING.

The General Assembly of North Carolina enacts:

SECTION 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-179. Coverage for colorectal cancer screening.**

(a) Every health benefit plan, as defined in G.S. 58-3-167, shall provide coverage for colorectal cancer examinations and laboratory tests for cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control for colorectal cancer screening, for any nonsymptomatic covered individual who is:

(1) At least 50 years of age, or

(2) Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan apply to coverage for colorectal examinations and laboratory tests required to be covered under this section."

SECTION 2. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers."

SECTION 3. This act becomes effective January 1, 2002, and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the 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.

SENATE BILL 132:
Health Insurance/Colorectal Cancer Screening

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Carpenter
Date:	April 12, 2001	**Summary by:**	Linda Attarian
Version:	2nd		Committee Counsel

SUMMARY: ***Senate Bill 132 will require health plans regulated under Chapter 58 to provide reimbursement for colorectal cancer screenings. The mandated benefit covers nonsymptomatic individuals age 50 or older and individuals less than 50 years old who are at high risk for colorectal cancer in accordance with guidelines published by the American Cancer Society and by the North Carolina Advisory Committee on Cancer Coordination and Control. If an appropriate participating provider is unavailable to perform the screening, the health plan must provide a referral to an appropriate out of network provider at no additional cost to the individual. Otherwise, the same deductibles, coinsurance and other limitations in the individual's policy or plan that apply to similar benefits will apply to the colorectal screening. The act, if enacted, becomes effective January 1, 2002, and applies to all health benefit plans that are delivered, issued for delivery, or renewed on or after that date.***

CURRENT LAW:

Currently, North Carolina law does not require insurers regulated under Chapter 58 to provide coverage for colorectal cancer screening.

Medicare and *Medicaid* covers colorectal screening.

State Health Plan: The General Assembly enacted legislation in 1991 to require the State Employees Comprehensive Health Plan to pay one hundred percent (100%) of routine colorectal diagnostic examinations and tests once every three years for individuals to age 40 years, once every two years for individuals to age 50 years, and once a year for individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. The maximum amount payable is one hundred fifty dollars ($150.00) per fiscal year.

BILL ANALYSIS:

Section 1 adds a new section to Article 3 of Chapter 58 to require health plans to provide coverage for colorectal cancer examinations and laboratory tests for cancer. Health plans may apply the same deductibles, coinsurance, and other limitations to this benefit as it does to similar benefits covered under the plan.

Health plans are defined to include an accident and health insurance policy, a nonprofit hospital or medical service corporation contract, an HMO subscriber contract, a plan provided by a MEWA, or a plan provided by any other health benefit arrangement to the extent permitted by ERISA.

Section 2. Standard Health Plans developed by the Small Employer and Carrier Committee and recommended to the Commissioner of Insurance under G.S. 58-50-125 to improve the availability and affordability of health benefits coverage for small employers are generally not required to provide mandated benefit coverage that other health plans regulated under Chapter 58 are subject. G.S. 58-50-155 lists exceptions to the general rule. Section 2 of SB 132 amends G.S. 58-50-155 by adding colorectal examinations and tests to the list of exceptions.

TABLE 5
1999 NORTH CAROLINA RESIDENT MORTALITY STATISTICS:
Cancer – Colon, Rectum, and Anus

GEOGRAPHIC AREA	1999 DEATHS Number	Rate*	GEOGRAPHIC AREA	1999 DEATHS Number	Rate*
North Carolina	**1,511**	**19.7**			
1 Alamance	35	28.2	51 Johnston	16	14.3
2 Alexander	5	15.4	52 Jones	5	53.7
3 Alleghany	2	20.1	53 Lee	9	18.3
4 Anson	7	29.4	54 Lenoir	12	20.6
5 Ashe	9	37.6	55 Lincoln	18	30.0
6 Avery	2	12.5	56 McDowell	10	24.6
7 Beaufort	18	40.8	57 Macon	7	24.4
8 Bertie	10	50.4	58 Madison	6	31.6
9 Bladen	7	22.6	59 Martin	4	15.6
10 Brunswick	9	12.9	60 Mecklenburg	92	14.3
11 Buncombe	43	22.1	61 Mitchell	5	34.0
12 Burke	19	22.5	62 Montgomery	3	12.0
13 Cabarrus	27	21.6	63 Moore	14	19.4
14 Caldwell	14	18.4	64 Nash	21	23.6
15 Camden	5	74.1	65 New Hanover	16	10.8
16 Carteret	18	30.4	66 Northampton	6	28.6
17 Caswell	1	4.5	67 Onslow	28	18.9
18 Catawba	24	17.9	68 Orange	16	14.6
19 Chatham	14	29.6	69 Pamlico	1	7.9
20 Cherokee	8	34.7	70 Pasquotank	6	17.3
21 Chowan	6	42.7	71 Pender	7	18.0
22 Clay	4	47.6	72 Perquimans	3	27.6
23 Cleveland	18	19.4	73 Person	8	23.8
24 Columbus	13	24.8	74 Pitt	25	19.5
25 Craven	16	17.8	75 Polk	5	29.5
26 Cumberland	37	12.7	76 Randolph	16	12.7
27 Currituck	2	11.4	77 Richmond	12	26.6
28 Dare	2	6.9	78 Robeson	24	20.8
29 Davidson	23	16.1	79 Rockingham	20	22.3
30 Davie	13	39.4	80 Rowan	32	25.4
31 Duplin	10	22.5	81 Rutherford	22	36.4
32 Durham	39	19.2	82 Sampson	16	29.5
33 Edgecombe	9	16.7	83 Scotland	12	34.5
34 Forsyth	59	20.2	84 Stanly	14	25.0
35 Franklin	6	13.2	85 Stokes	8	18.3
36 Gaston	44	24.3	86 Surry	17	24.7
37 Gates	3	29.7	87 Swain	2	16.2
38 Graham	3	39.9	88 Transylvania	10	35.3
39 Granville	8	17.6	89 Tyrrell	2	49.7
40 Greene	9	49.2	90 Union	11	9.5
41 Guilford	65	16.5	91 Vance	18	42.6
42 Halifax	9	16.4	92 Wake	67	11.3
43 Harnett	15	17.6	93 Warren	4	21.1
44 Haywood	18	34.6	94 Washington	2	15.6
45 Henderson	24	29.1	95 Watauga	5	12.3
46 Hertford	8	37.6	96 Wayne	30	26.6
47 Hoke	7	22.5	97 Wilkes	16	25.1
48 Hyde	5	89.1	98 Wilson	16	22.9
49 Iredell	23	19.5	99 Yadkin	6	16.6
50 Jackson	7	23.5	100 Yancey	4	23.8

*Death rates with a small number of deaths in the numerator should be interpreted with caution. SEE TECHNICAL NOTES.
Note: Death rates in this table are per 100,000 population.

Cost-Effectiveness of Colorectal Cancer Screening

David Lieberman, MD
Professor of Medicine, Oregon Health Sciences University
Chief, Gastroenterology, Portland Medical Center

Colorectal cancer is the second leading cause of cancer death in North America and Western Europe. There is now clear evidence that screening of average risk asymptomatic individuals, beginning at age 50, can reduce mortality from colorectal cancer. It is likely that a substantial fraction of the reduction in deaths is due to early cancer detection. The biology of colorectal cancer also provides a unique opportunity for cancer prevention since most cancers evolve from polyps. Therefore, additional benefit from screening is derived from identification and removal of premalignant polyps. Health care policy makers recognize the benefits of screening, but ask if society can afford it. This question can be turned around to ask: can society afford not to screen? A review of data regarding the cost of screening reveals two important insights:

- screening is cost-effective relative to other common medical interventions
- there is a substantial cost in not screening.

When analyzing the cost of colon screening, it is important to consider colon screening as a program. The program begins with the initial screening test. If negative, the test may need to be repeated at intervals to be effective. Current recommendations are that the fecal occult blood test (FOBT) be repeated every one or two years, and sigmoidoscopy repeated every five years if negative. Since the screening test is being used to identify patients with a higher risk of colorectal cancer, a positive test warrants an evaluation of the colon. If the colon evaluation is normal, the patient may not need further screening for five to 10 years, but eventually would be recycled back into a screening program. If neoplasia is found during the colon evaluation, polypectomy or surgery is appropriate. Such patients are known to have a 30-40% risk of recurrent polyps within three years, and are generally entered into colonoscopic surveillance programs with exams every three to five years. If cancer is discovered, the cost of cancer care becomes an additional cost to the program.

If screening is not performed at all, or compliance with screening is poor, there are predictable rates of cancer development and death. The average-risk 50-year-old has a 6% chance of developing colon cancer during his/her lifetime, and a 3% risk of dying from it. To calculate the cost-benefit of screening, the costs of no screening must be considered. 10 to 20% of patients who are not screened will develop symptoms (rectal bleeding, abdominal pain, constipation, diarrhea) after age 50 that will result in some form of colon evaluation (flexible sigmoidoscopy, barium enema or colonoscopy). Most of these patients will not have cancer. Patients with cancer will eventually undergo diagnostic test to detect it and incur the cost of cancer care, and in some cases end-of-life care. They may also experience complications of surgery, and reduced quality of life because of the late discovery of cancer.

Models (Eddy, 1991: Lieberman, 1995; Wagner, 1996) have been developed to analyze the cost of screening but few have analyzed the cost of no screening. We have used available studies to calculate and compare the likely benefit derived from screening. Trials with FOBT and sigmoidoscopy suggest that screening can prevent 20-40% of potential cancers and up to 30-50% of cancer deaths. Cancer prevention not only saves lives, but has an enormous impact on cost estimates by eliminating the cost of cancer care for those who would have developed cancer.

Application of market costs for each element of the screening program in a model permits an estimate of per screenee costs. There are two key points from this analysis. First, the cost of screening when calculated as the cost per quality adjusted life-year saved is $10,000 to $20,000. These costs are lower than other well-accepted forms of medical management such as treatment of hypertension and breast cancer screening. The 10-year cost of no screening exceeds $1,100 per screenee if the cost of cancer care averages $40,000 per cancer patient. This cost is similar to the 10-year cost of screening with FOBT or sigmoidoscopy, which will prevent cancers and save lives. These results suggest that as the cost of cancer care increases, it will be more expensive not to screen than to screen the population.

A key element of the cost estimates is the rate of compliance with screening. Screening programs are less effective if health care providers do not provide the tests and if patients fail to see the value. It is important to consider the potential obstacles to screening. Until recently, health care providers have been uncertain about the benefits of screening and rarely discussed screening with patients. Several studies have shown that when health care providers discuss screening with patients, compliance is enhanced. Efforts to educate health care providers about the efficacy of screening will have a large impact on compliance and effectiveness of screening in practice settings. The second element of screening is the patient. The idea of providing a stool sample or undergoing what may be perceived as an uncomfortable exam of the colon are significant barriers to screening efforts. Nevertheless, when patients understand the benefits, these obstacles can be overcome. More than 50% of women comply with recommendations for cervical cancer and breast cancer screening, which may be considered unappealing and uncomfortable, because they are aware of the benefits.

The benefits of colon screening are now clear based on studies published in the past few years. The cost of screening is comparable or less than other forms of accepted medical therapy. Finally, there is a substantial cost to society of not screening – there is the emotional impact on patients and families dealing with a preventable cancer, and there is the economic impact of caring for these patients. The message is now very clear – population screening makes sense, it work, and it is cost-effective.

References:

1. Eddy D. Screening for colorectal cancer. Ann Intern Med 1990; 113: 373-384.
2. Lieberman D.A. Cost-effectiveness model for colon cancer screening. Gastroenterology 1995; 109: 1781-1790.
3. Wagner JL, Tunis S, Brown M, Ching A, Almeida R. Cost-effectiveness of coloretal cancer screening in average-risk adults. In: Young GP, Rozen P. Levin B, editors, Prevention and early detection of colorectal cancer. London: WB Saunders. 1996; 3321-356.

The American Digestive Health Foundation (ADHF is a cooperative effort of the American Gastroenterological Association, The American Society for Gastrointestinal Endoscopyand the American Association for the Study of Liver Diseases, promotes digestive health for all Americans by supporting educational initiatives and research into the causes, prevention, diagnosis, treatment and cure of digestive and liver diseases.

AMERICAN CANCER SOCIETY

Colorectal Cancer

What is Colorectal Cancer (cancer of the colon and rectum)?

Most cancers are named after the part of the body where the cancer first starts. Colorectal cancer begins in either the colon or the rectum. Both are part of the digestive tract, sometimes called the GI (gastrointestinal) tract. This is where food is processed to absorb nutrients and rid the body of waste matter. The colon has four sections. Cancer can start in any of the four sections or in the rectum. Since colon cancer and rectal cancer have many features in common, they are usually discussed together

How many people get Colorectal Cancer?

Colorectal cancer is the third most common cancer in men and women. The American Cancer Society estimates that 130,200 cases of colorectal cancer will be diagnosed in 2000 and about 56,300 people will die of colorectal cancer. Colon and rectal cancers account for about 9% of new cases of cancer each year. They result in about 11% of all deaths from cancer.

During 1990-1995, the number of new cases of colorectal cancer has gone down significantly for whites, African Americans, and Hispanics. Although not significant, new colorectal cancer rates among Asian/Pacific Islanders also appear to be declining. Unfortunately, the number of new cases of colorectal cancer for Native Americans is unclear [1]. The overall decline may be the result of greater use of screening methods and the removal of polyps before they become cancerous. The death rate from colorectal cancer has also been going down for the past 20 years. Our progress may be because more cases are found early and treatments have improved.

It is important to note that social and economic barriers remain an issue for medically underserved populations. Research indicates that African Americans are 14% more likely to be diagnosed with colorectal cancer and 34% more likely to die from it than white Americans. Further, African Americans and Hispanics are more likely to be diagnosed with colorectal cancer in advanced stages[2]. Other research has indicated that rates for underserved populations may be higher in certain geographical regions or subgroups.

What are the current strategies for controlling colorectal cancer?

Colorectal cancer is second only to lung cancer in our ability to prevent cancer from ever occurring. While we do not know the exact cause of most colorectal cancers, there are certain known risk factors. Age, family history, personal history of intestinal polyps, personal history of chronic inflammatory bowel disease, poor diet, and not getting enough exercise are some of the risk factors for this disease. A large fraction of colorectal cancers could be prevented by appropriate modifications in diet and the adoption of regular physical activity.

Furthermore, existing screening tests have been shown to reduce death rates from colorectal cancer, either by detecting polyps before they become cancerous, or by detecting and removing early stage colorectal cancers when the disease is still highly curable. The American Cancer Society recommends colorectal screening (described below) which has been determined to be effective in reducing the risk of death from this disease.

WHAT ARE THE AMERICAN CANCER SOCIETY RECOMMENDED COLORECTAL CANCER SCREENING GUIDELINES?

ACS Guidelines - Beginning at age 50, both men and women should follow one of the three screening options along with a Digital rectal examination (DRE):

- ✓ Annual fecal occult blood test plus flexible sigmoidoscopy every 5 years, or
- ✓ Colonoscopy every 10 years, or
- ✓ Double contrast barium enema every 5-10 years.

People should begin screening earlier if they have any symptoms of the disease (rectal bleeding, blood in the stool, a change in bowel habits) or any of these risk factors: strong family history of colon or rectal cancer or polyps; personal history of colon or rectal cancer, or chronic inflammatory bowel disease (having already had colorectal cancer).

WHAT IS NEEDED TO INCREASE THE UTILIZATION OF COLORECTAL CANCER SCREENING?

Despite the availability of effective screening tests, colorectal cancer screening is dramatically underutilized. Some factors affecting utilization could include lack of public and provider awareness of screening tools, financial barriers, and inadequate health insurance coverage and/or benefits.

The American Cancer Society believes that all individuals should benefit from cancer screenings, irrespective of their health insurance coverage. Health insurance, covered items and services, deductibles, coinsurance and other co-pays affect care seeking behavior. Limitations on covered benefits should not impede one's ability to benefit from early detection of cancer. To that end, the Society supports policies that provide all individuals access to and coverage of early detection screening for cancer. These benefits should be risk and age appropriate and based on current scientific evidence as outlined by the American Cancer Society.

Furthermore, the American Cancer Society believes that the Centers for Disease Control and Prevention (CDC) should be empowered with additional resources to lay the foundation for a nationwide program to support colorectal cancer screening, including: public and provider education, prevention and health services research on how best to promote screening, tracking colorectal cancer rates and stages of diagnosis, and if necessary, support for screening in the uninsured. In addition, there are several other programs that could play a role in providing access to cancer screenings, such as Community Health Centers.

NOTES:

[1] Cancer mortality among Native Americans has not been well described. Studies have shown that, while total cancer mortality for all Native Americans appears to be lower than the cancer mortality for the total U.S. white population, there are regional differences and differences in mortality from specific types of cancer that must not be overlooked.

[2] National Center for Health Statistics: Vital Statistics for the United States, 1993. Washington, DC, Public Health Service, 1998. American Cancer Society, Surveillance Research 1996.

National Government Relations Department
October 2000

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 760 A BILL TO BE ENTITLED AN ACT TO REQUIRE CANCER INSURANCE POLICIES TO OFFER A WELLNESS BENEFIT RIDER.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 760

Short Title:	Cancer Insurance/Wellness Benefit Rider.	(Public)
Sponsors:	Representatives Hurley; Alexander, Barefoot, Cox, Lucas, Smith, Wainwright, Warner, and Womble.	
Referred to:	Insurance.	

March 26, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE CANCER INSURANCE POLICIES TO OFFER A WELLNESS BENEFIT RIDER.

The General Assembly of North Carolina enacts:

SECTION 1. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-135. Cancer policy wellness benefit rider required.**

Every insurance company offering an individual health insurance policy that is a specified disease policy covering cancer shall offer as part of the policy's cancer coverage a wellness benefit rider. The wellness benefit rider shall provide an annual cash payment of not less than fifty dollars ($50.00) to each insured adult who shows proof of having undergone annual cancer screening."

SECTION 2. This act becomes effective January 1, 2002, and applies to specified disease policies issued or renewed on and after that date.

HOUSE BILL 760:
Cancer Insurance/Wellness Benefit Rider

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Hurley
Date:	April 4, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 760, if enacted, will require insurers that offer specified disease policies, to include with those policies a "wellness rider" that will pay the subscriber an annual cash payment of at least $50.00 if the subscriber show proof of having undergone annual cancer screening. The act is effective January 1, 2002 and applies to policies issued on or after that date.***

CURRENT LAW: A "rider" is an attachment to an insurance policy that modifies the conditions of the policy by expanding or restricting its benefits or excluding certain conditions from coverage. No such riders as proposed in this legislation are currently provided for under NC law.

A "specified disease policy" is a type of health benefit plan available from insurers.

BILL ANALYSIS: **Section 1** amends Article 51 of Chapter 58 to require every insurance company that offers "cancer" policies to individual subscribers to offer as an additional benefit to that policy a annual cash payment to the subscriber of not less than $50.00 if the subscriber can show proof of having undergone annual cancer screening.

Section 2 makes the bill effective January 1, 2002 and applies to specified disease policies issued or renewed on and after that date.

BACKGROUND: The Department of Insurance estimates that more than 300,000 NC residents currently have this type of cancer policy.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 18, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 18, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Rachel Thomas and Joell Marlowe (Cumberland County – Rep. Hurley). The following Committee members were present: Representatives Baddour, Barbee, Blue, Brubaker, Dedmon, Grady, Hall, Johnson, Justus, Redwine, Smith, Wainwright, Warner, and C. Wilson. Linda Attarian, Frank Folger, and Trina Griffin, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 13, entitled, AN ACT TO PROHIBIT INSURANCE COMPANIES FROM ENCOURAGING INSURANCE CLAIMANTS TO OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES. Representative Wilma Sherrill was recognized to explain the proposed committee substitute, which had been adopted for discussion during the April 11, 2001, Insurance Committee meeting. This bill does not change the existing law, especially as it relates to steering. It would require an insurance company with the approval of the Commissioner of Insurance to inform a policyholder in writing once a year of that person's legal rights under current law when an insurance company recommends a repair shop. This bill would prohibit an insurer or insurer's representatives from recommending a claimant use a particular motor vehicle repair service without certain disclosures and from penalizing a claimant for not using the recommended repair service of the insurer or the insurer's representative. It would also direct the LRC to study the practices of the insurance industry in recommending repair services or sources to claimants and the enforcement of this provision by the Department of Insurance. Representative Sherrill indicated she had several letters of complaint from consumers pertaining to this issue to present to the Commissioner.

William Williford, Eveready Glass and Lock Service, was recognized to speak in favor of HB 13. Susan Valauri, Lobbyist with Nationwide Insurance Company, was recognized to speak in opposition to the bill. She explained Nationwide's direct repair system (body shop) – the Blue Ribbon Service with preferred companies. Benefits of the program are direct billing to the insurer, the turnaround time for the repair work is shorter, and the consumer receives a lifetime warranty on the vehicle for as long as someone owns the vehicle. Ronnie Pack, Pack Brothers Body Shop, was recognized and spoke in favor of the bill.

Representative Redwine presented two amendments to the proposed committee substitute. One would amend section B.1. that talks about steering and indicate the policy shall provide the disclosure. The second amendment would do the same thing but would leave it up to the Commissioner to adopt rules or the type of disclosure to be used.

It would give the Commissioner of Insurance the flexibility to decide. Representative Redwine sent forth an amendment. Trina Griffin, Staff Counsel, was recognized to explain the amendment. Dascheil Propes, Chief, Deputy Commissioner, NC Department of Insurance, was recognized to provide comments. Representative Hurley moved to accept the amendment for discussion. The motion passed. Representative Justus moved to roll the amendment into a committee substitute, with a favorable report to the committee substitute, which changes the title, unfavorable to the original bill. The motion passed.

HB 1045, entitled, A BILL TO BE ENTITLED AN ACT TO RESTORE STABILITY UNDER THE WORKERS' COMPENSATION ACT BY OVERTURNING THE CASE DECIDED BY THE 2000 COURT OF APPEALS OF NORTH CAROLINA ENTITLED HANSEN V. CRYSTAL FORD-MERCURY, INC., BY PROVIDING THAT INSURERS THAT PROVIDE HEALTH BENEFIT PLANS, DISABILITY INCOME PLANS, OR ANY OTHER HEALTH INSURANCE ARE NOT REAL PARTIES IN INTEREST IN ANY PROCEEDING OR SETTLEMENT UNDER THE WORKERS' COMPENSATION ACT AND PROHIBITING INSURERS THAT PROVIDE HEALTH BENEFIT PLANS FROM OFFSETTING AGAINST PROVIDER REIMBURSEMENT ANY CHARGE FOR MEDICAL SERVICES UNLESS THE SPECIFIC MEDICAL CHARGES WERE FOUND TO BE COMPENSABLE ACCORDING TO A FINAL ADJUDICATION UNDER THE WORKERS' COMPENSATION ACT OR A SETTLEMENT AGREEMENT UNDER THE ACT APPROVED BY THE NORTH CAROLINA INDUSTRIAL COMMISSION. Representative Baddour was recognized, and he presented a proposed committee substitute. Representative Wainwright moved to adopt the proposed committee substitute for consideration. The motion passed. This bill would establish that an insurer covering an employee under a health benefit plan, disability income plan, and any other health insurance plan is not a real party in interest and cannot intervene or participate in workers' compensation proceedings or settlement agreements to determine the compensability of a claim or seek reimbursement for medical payments, statutorily overturning the ruling in Hansen v. Crystal Ford-Mercury, Inc. It would provide conditions precedent to Industrial Commission approval of a settlement agreement and make Commission approval of a settlement agreement final, non-reviewable, and immune from collateral attack. It would also prohibit insurance policies from excluding workers' compensation claims coverage generally and prevent offset except in situations where liability or responsibility has been determined by adjudication or by Commission order.

Mike Carpenter, Executive Vice-President, Home Builders Association; Dick Taylor, NC Academy of Trial Lawyers; and Paul Cranfield, NC Academy of Defense Attorneys (Trial Lawyers) were recognized to speak in favor of the bill. Randolph Ward, Blue Cross / Blue Shield of North Carolina was recognized to comment on the bill. Representative Grady moved to give a favorable report to the committee substitute, unfavorable to the original bill. The motion passed.

There being no further business, the meeting was adjourned at 12:58 p.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
HB 13, HB 1045
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — April 18, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Wilson	NC ATL
Dick Taylor	NC ATL
Susan Valauri	Nationwide
Dria Cannata	NCIRB
Ronnie Pack	Pack Bros. Body Shop
[illegible]	MHA
Richard Daughtry	Interstate Glass, Inc.
Doug Pfaff	Pfaff's auto Glass
Beverly Ward	Ever Glass + Lock Service
Lee-Ann Lee	NC Agribusiness Council
Jay & Mary Rivers	Rivers Body Shop Cumb. County

VISITOR REGISTRATION SHEET

INSURANCE — April 18, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
GARY LOGAN	LOGAN'S Body Shop
Richard Barbour	Harnett Body Works
MARK BARNES	BARNES COLLISION REPAIR CENTER
James J Taylor	Johnson Automotive Group
Steve Nuce	Precision Collision Repair Center
Shane Register	True2Form Collision Centers
Lori DeBeus	True2Form Collision - Garner
GEORGE HARSLIP	True2Form Collision -
Linwood Jones	NCHA
Jim LORE	LORE & McCLEARY
ANN LORE	OUNS
Harry Hayden	NCAHP

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

April 18, 2001 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dave Simpson	CAROLINAS AGC
Mike Causey	NC Glass Assn, Inside Auto Body Ass.
R. Paul Wilms	NCHBA
Jack McMillan	MFDS PA.
Laura Mavretic	Commissioner, NC Industrial Comm.
Buck Lattimore	NC INDUSTRIAL COMMISSION
VICTOR FARAH	JERNIGAN LAW FIRM
Melissa Searcy	
Barbara Candler	Manning, Fulton & Skinner
[illegible]	NCAHP
Lillian Beard	NCAHP
R W Kaylor	Kaylor Law Firm
Ted Mooney	AP

VISITOR REGISTRATION SHEET

INSURANCE — April 18, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
BERNADETTE DEMASI	NSA CUSTOM PLAN BOOK, INC 3711 YARRELL DR. RALEIGH, NC 27609
Robin Huffman	NC Psychiatric Assoc.
Ken Shivar	Builders Mutual - Raleigh
STEPHANIE GAY	BUILDERS MUTUAL - RALEIGH
Amy Jo Bain	NC Medical Society
Steve Keene	" "
David Ferrell	Hafer, Caldwell & Ferrell PA
Bill Scoggin	RCLH
[illegible]	MVA
PERRI MORGAN	NFIB
Robert PASchal	Young, Moore
[illegible]	NCHAC
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

INSURANCE — April 18, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nancy Thompson	MCIC
John Peterson	NCBAIC
[illegible]	APAC
[illegible]	NC ATL
RANDY WARD	Atty.
Andy Ellen	NC RAIH
[illegible]	[illegible]
[illegible]	SKB
Butch Gunnells	NCSDA
M. Mouse	interested citizen
[illegible]	NCDOT

VISITOR REGISTRATION SHEET

INSURANCE — April 18, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sherry Blaylock	Town & Country Body Shop
Tim Minton	NC Home Builders Assn
Charlene Shabay	NC OSP
Mike Okun	NCStateAFL-CIO
Keith Biggs	Forestry Mutual Ins. Co
Jimmie Lockleare	FMIC
Charles W DeBrito	Forestry Mutual
MARVIN C. MARTIN	MARTIN'S AUTO REBUILDERS
Cheri Michaelson	Carolina Collision
[illegible]	Carolina Collision Center Inc.
[illegible]	Logan Body Shop

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 13 A BILL TO BE ENTITLED AN ACT TO PROHIBIT INSURANCE COMPANIES FROM ENCOURAGING INSURANCE CLAIMANTS TO OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, ☒ which changes the title, unfavorable as to (original bill).

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 13
PROPOSED COMMITTEE SUBSTITUTE H13-PCS8192-LT-27

Short Title: Motor Vehicle Repairs. (Public)

Sponsors:

Referred to:

January 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT INSURANCE COMPANIES FROM RECOMMENDING THAT INSURANCE CLAIMANTS OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES WITHOUT BEING INFORMED THAT CLAIMANTS DO NOT HAVE TO USE THOSE RECOMMENDED REPAIR SERVICES OR SOURCES AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE INSURANCE INDUSTRY PRACTICE OF RECOMMENDING REPAIR SERVICES TO CLAIMANTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-180 reads as rewritten:

"**§ 58-3-180. Motor vehicle repairs; selection by claimant.**

(a) A policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage.

(b) The amount determined by the insurer to be payable under a policy covering damage to a motor vehicle shall be paid regardless of the repair service or source selected by the claimant.

(b1) No insurer or insurer representative shall recommend the use of a particular motor vehicle repair service without clearly informing the claimant that (i) the claimant is under no obligation to use the recommended repair service, (ii) the claimant may use the repair service of the claimant's choice, and (iii) the amount determined by the insurer to be payable under the policy will be paid regardless of whether or not the claimant uses the recommended repair service. Each insurer shall disclose the information in a manner to be determined by the Commissioner.

(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and G.S. 58-33-45, provided that the maximum civil penalty that can be assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars ($2,000).

(d) As used in this section, 'insurer representative' includes an insurance agent, limited representative, broker, adjuster, and appraiser.

(e) The Commissioner may adopt rules to carry out the provisions of this section."

SECTION 2. The Legislative Research Commission may conduct a comprehensive study of the practices of the insurance industry in recommending repair services or sources to claimants and the policies and procedures of the Department of Insurance in enforcing G.S. 58-3-180 to determine if State law should be amended to better protect and promote the public's right to select a repair service or source.

If the Legislative Research Commission undertakes the study, it shall report its findings and recommendations to the 2002 Regular Session of the 2001 General Assembly.

SECTION 3. Section 1 of this act becomes effective October 1, 2001. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 13
PROPOSED COMMITTEE SUBSTITUTE H13-CSLT-27 [v.2]

4/11/2001 11:29:03 AM

Short Title: Motor Vehicle Repairs. (Public)

Sponsors:

Referred to:

January 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT INSURANCE COMPANIES FROM RECOMMENDING THAT INSURANCE CLAIMANTS OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES WITHOUT BEING INFORMED THAT CLAIMANTS DO NOT HAVE TO USE THOSE RECOMMENDED REPAIR SERVICES OR SOURCES AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE INSURANCE INDUSTRY PRACTICE OF RECOMMENDING REPAIR SERVICES TO CLAIMANTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-180 reads as rewritten:

"**§ 58-3-180. Motor vehicle repairs; selection by claimant.**

(a) A policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage.

(b) The amount determined by the insurer to be payable under a policy covering damage to a motor vehicle shall be paid regardless of the repair service or source selected by the claimant.

(b1) No insurer or insurer representative shall recommend the use of a particular motor vehicle repair service without clearly informing the claimant that (i) the claimant is under no obligation to use the recommended repair service, (ii) the claimant may use the repair service of the claimant's choice, and (iii) the amount determined by the insurer to be payable under the policy will be paid regardless of whether or not the claimant uses the recommended repair service. Each insurer shall disclose the information required be this subsection in writing to each policyholder at least annually. The disclosure form is subject to the prior approval of the Commissioner.

(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and G.S. 58-33-45, provided that the maximum civil penalty that can be assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars ($2,000).

(d) As used in this section, 'insurer representative' includes an insurance agent, limited representative, broker, adjuster, and appraiser.

(e) The Commissioner may adopt rules to carry out the provisions of this section."

SECTION 2. The Legislative Research Commission may conduct a comprehensive study of the practices of the insurance industry in recommending repair services or sources to claimants and the policies and procedures of the Department of Insurance in enforcing G.S. 58-3-180 to determine if State law should be amended to better protect and promote the public's right to select a repair service or source.

If the Legislative Research Commission undertakes the study, it shall report its findings and recommendations to the 2002 Regular Session of the 2001 General Assembly.

SECTION 3. Section 1 of this act becomes effective October 1, 2001. The remainder of this act is effective when it becomes law.

HOUSE BILL 13

Short Title:	Motor Vehicle Repairs.	(Public)
Sponsors:	Representatives Sherrill; Cansler, Walend, and Carpenter.	
Referred to:	Rules, Calendar, and Operations of the House.	

January 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT INSURANCE COMPANIES FROM ENCOURAGING INSURANCE CLAIMANTS TO OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-180 reads as rewritten:

"**§ 58-3-180. Motor vehicle repairs; selection by claimant.**

(a) A policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage.

(a1) No insurer or insurer representative shall recommend, or in any way encourage, a claimant use a particular motor vehicle repair service or source for the purpose of obtaining (i) an estimate of the cost of repairs to a damaged motor vehicle, or (ii) repair services to a damaged motor vehicle. No insurer or insurer representative shall inform the claimant that the insurer will guarantee repairs performed by one or more particular repair services or sources but not by other repair services or sources.

(b) The amount determined by the insurer to be payable under a policy covering damage to a motor vehicle shall be paid regardless of the repair service or source selected by the claimant.

(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and G.S. 58-33-45, provided that the maximum civil penalty that can be assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars ($2,000).

(d) As used in this section, 'insurer representative' includes an insurance agent, limited representative, broker, adjuster, and appraiser."

SECTION 2. This act becomes effective October 1, 2001.

HOUSE BILL 13:
Motor Vehicle Repairs

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Sherrill
Date:	April 11, 2001	**Summary by:**	Frank W. Folger
Version:	PCS H13-CSLT-19		Committee Counsel

SUMMARY: ***This bill would prohibit an insurer or insurer's representative from recommending a claimant use a particular motor vehicle repair service without certain disclosures and from penalizing a claimant for not using the recommended repair service of the insurer or the insurer's representative. It would also direct the LRC to study the practices of the insurance industry in recommending repair services or sources to claimants and the enforcement of this provision by the Department of Insurance.***

CURRENT LAW: Insurance policies covering damage to a motor vehicle has to allow the claimant to select that claimant's repair service or source for the repair. The amount determined to be payable by the insurer is to be paid regardless of the repair service or source selected by the claimant. Violators of this provision are subject to civil penalties of up to $2000, licensure or certification suspension or revocation or refusal of renewal, payment of restitution to any harmed person, and payment of restitution to any State agency for extraordinary administrative expenses incurred in the investigation and hearing of the violation. N.C.G.S. §58-3-180

BILL ANALYSIS: Section 1. would prohibit, in addition to the existing prohibition, an insurer or insurer representative from recommending a claimant use a particular motor vehicle repair service or source of repairs without clearly informing the claimant that:

1. the claimant does not have to use the recommended repair service;
2. the claimant can use the repair service chosen by the claimant; and
3. the amount the insurer determines is payable under the policy will be paid whether or not the recommended repair service is used.

The insurer would have to disclose this information in writing, at least annually, to each policyholder; and the disclosure form would have to receive the Commissioner's prior approval. The section would also define "insurance representative" to include an agent, limited representative, broker, adjuster, or appraiser; and it would grant the Commissioner authority to adopt rules to carry out these statutory provisions.

Section 2. would require the Legislative Research Commission to study the practices of the insurance industry in recommending repair services or sources to claimants and the Department of Insurance's policies and procedures for enforcing N.C.G.S. §58-3-180 to assess the need for consumer protection legislation in this area. The LRC's study may include but is not limited to a review of the following:

1. Insurance industry practices of recommending, using, and guaranteeing the work of preferred repair services;
2. Insurer-provide info given to claimants or policyholders calling to report a claim;
3. Insurer's nonproprietary criteria for determining whether a particular repair service is "preferred" and thus recommended to claimants or policyholders;

4. The Department of Insurance's policies and procedures for investigating complaints of violations by insurers of N.C.G.S. §58-3-180 to the extent disclosure is legally permitted; and
5. Data on investigation and enforcement (sanctions, warnings, etc.) of N.C.G.S. §58-3-180 to the extent Departmental disclosure is legally permitted.

It would require the LRC to report to the 2002 Regular Session of the 2001 General Assembly.

Section 3. would make Section 1. effective Oct. 1, 2001 and the remainder of the act effective when it becomes law.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 1045 A BILL TO BE ENTITLED AN ACT TO RESTORE STABILITY UNDER THE WORKERS' COMPENSATION ACT BY OVERTURNING THE CASE DECIDED BY THE 2000 COURT OF APPEALS OF NORTH CAROLINA ENTITLED HANSEN V. CRYSTAL FORD-MERCURY, INC., BY PROVIDING THAT INSURERS THAT PROVIDE HEALTH BENEFIT PLANS, DISABILITY INCOME PLANS, OR ANY OTHER HEALTH INSURANCE ARE NOT REAL PARTIES IN INTEREST IN ANY PROCEEDING OR SETTLEMENT UNDER THE WORKERS' COMPENSATION ACT AND PROHIBITING INSURERS THAT PROVIDE HEALTH BENEFIT PLANS FROM OFFSETTING AGAINST PROVIDER REIMBURSEMENT ANY CHARGE FOR MEDICAL SERVICES UNLESS THE SPECIFIC MEDICAL CHARGES WERE FOUND TO BE COMPENSABLE ACCORDING TO A FINAL ADJUDICATION UNDER THE WORKERS' COMPENSATION ACT OR A SETTLEMENT AGREEMENT UNDER THE ACT APPROVED BY THE NORTH CAROLINA INDUSTRIAL COMMISSION.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, unfavorable as to (original bill).

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1045
PROPOSED COMMITTEE SUBSTITUTE H1045-CSLD-10 [v.1]

4/18/2001 9:35:47 AM

Short Title: Restore Worker's Comp. Stability. (Public)

Sponsors:

Referred to:

April 10, 2001

A BILL TO BE ENTITLED

AN ACT TO RESTORE STABILITY UNDER THE WORKERS' COMPENSATION ACT BY OVERTURNING THE CASE DECIDED BY THE 2000 COURT OF APPEALS OF NORTH CAROLINA ENTITLED HANSEN V. CRYSTAL FORD-MERCURY, INC., BY PROVIDING THAT INSURERS THAT PROVIDE HEALTH BENEFIT PLANS, DISABILITY INCOME PLANS, OR ANY OTHER HEALTH INSURANCE ARE NOT REAL PARTIES IN INTEREST IN ANY PROCEEDING OR SETTLEMENT UNDER THE WORKERS' COMPENSATION ACT AND PROHIBITING INSURERS THAT PROVIDE HEALTH BENEFIT PLANS FROM OFFSETTING AGAINST PROVIDER REIMBURSEMENT ANY CHARGE FOR MEDICAL SERVICES UNLESS THE SPECIFIC MEDICAL CHARGES WERE FOUND TO BE COMPENSABLE ACCORDING TO A FINAL ADJUDICATION UNDER THE WORKERS' COMPENSATION ACT OR A SETTLEMENT AGREEMENT UNDER THE ACT APPROVED BY THE NORTH CAROLINA INDUSTRIAL COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 97 of the General Statutes is amended by adding a new section to read:

"**§ 97-90.1. Insurers that provide employee's health benefit plans, disability income plans, or any other health insurance plans.**

An insurer that covers an employee under a health benefit plan as defined in G.S. 58-3-167, a disability income plan, or any other health insurance plan is not a real party in interest and shall not intervene or participate in any proceeding or settlement agreement under this Article to determine whether a claim is compensable under this Article or to seek reimbursement for medical payments under its plan. The insurer that covers an employee under a health benefit plan as defined in G.S. 58-3-167 or any other health insurance plan may seek reimbursement from the employee, employer, or carrier that is liable or responsible for the specific medical charge according to a final adjudication of the claim under this Article or an order of the Commission approving a

settlement agreement entered into under this Article for health plan payments for that specific medical charge."

SECTION 2. G.S. 97-17 reads as rewritten:

"§ 97-17. Settlements allowed in accordance with Article.

(a) ~~Nothing herein contained shall be construed so as to~~ This Article does not prevent settlements made by and between the employee and employer so long as the amount of compensation and the time and manner of payment are in accordance with the provisions of this Article. A copy of ~~such~~ a settlement agreement shall be filed by the employer with and approved by the ~~Industrial Commission: Provided, however, that no~~Commission. No party to any agreement for compensation approved by the ~~Industrial~~ Commission shall ~~thereafter be heard to~~ deny the truth of the matters ~~therein set forth,~~contained in the settlement agreement, unless ~~it shall be made to appear~~the party is able to show to the satisfaction of the Commission that there has been error due to fraud, misrepresentation, undue influence or mutual mistake, in which event the Industrial Commission may set aside ~~such~~the agreement. Except as provided in this subsection, the decision of the Commission to approve a settlement agreement is final, and is not subject to review or collateral attack.

(b) The Commission shall not approve a settlement agreement under this section, unless all of the following conditions are satisfied:

(1) The settlement agreement is deemed by the Commission to be fair, just, and in the best interest of all of the parties.

(2) The settlement agreement contains a list of all of the known medical expenses of the employee related to the injury to the date of the settlement agreement, including medical expenses that the employer or carrier disputes, and a list of medical expenses, if any, that will be paid by the employer under the settlement agreement.

(3) The settlement agreement contains a finding that the positions of all of the parties to the agreement are reasonable as to the payment of medical expenses.

(c) In determining whether the positions of all of the parties to the agreement are reasonable as to the payment of medical expenses under subdivision (3) of subsection (b) of this section, the Commission shall consider all of the following:

(1) Whether the employer admitted or denied the employee's claim for compensation.

(2) The amount of all of the known medical expenses of the employee related to the injury to the date of the settlement agreement, including medical expenses that the employer or carrier disputes.

(3) The need for finality in the litigation."

SECTION 3. G.S. 97-92 reads as rewritten:

"(b) The records of the ~~Commission,~~Commission that are not awards under G.S. 97-84 and that are not reviews of awards under G.S. 97-85, insofar as they refer to accidents, injuries, and settlements are not public records under G.S. 132-1 and shall not

be open to the public, but only to the parties satisfying the Commission of their interest in such records and the right to inspect them, and to State and federal agencies pursuant to G.S. 97-81."

SECTION 4. G.S. 58-51-5(a) is amended by adding a new subdivision to read:

"(8) It contains no provision excluding from coverage claims that are subject to the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes, unless the exclusion extends to only specific medical charges for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under that Article or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article."

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

"**§ 58-50-57. Offsets against provider reimbursement for workers' compensation payments forbidden.**

(a) An insurer that provides a health benefit plan as defined in G.S. 58-3-167 shall not offset or reverse a health plan payment against a provider reimbursement for other medical charges unless the health plan payment was for a specific medical charge for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.

(b) No contract between an insurer that provides a health benefit plan as defined in G.S. 58-3-167 and a medical provider shall contain a provision that authorizes the insurer to offset or reverse a health plan payment against a provider reimbursement for other medical charges unless the health plan payment was for a specific medical charge for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article."

SECTION 6. The North Carolina Industrial Commission shall adopt any rules needed to implement this act.

SECTION 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1045

Short Title:	Restore Worker's Comp. Stability.	(Public)
Sponsors:	Representatives Baddour; Alexander, Blue, Daughtry, Dedmon, Dockham, Fitch, Gibson, Goodwin, Hackney, McComas, Michaux, Mitchell, Pope, Smith, Thompson, Wainwright, and Weiss.	
Referred to:	Insurance.	

April 10, 2001

A BILL TO BE ENTITLED

AN ACT TO RESTORE STABILITY UNDER THE WORKERS' COMPENSATION ACT BY OVERTURNING THE CASE DECIDED BY THE 2000 COURT OF APPEALS OF NORTH CAROLINA ENTITLED HANSEN V. CRYSTAL FORD-MERCURY, INC., BY PROVIDING THAT INSURERS THAT PROVIDE HEALTH BENEFIT PLANS, DISABILITY INCOME PLANS, OR ANY OTHER HEALTH INSURANCE ARE NOT REAL PARTIES IN INTEREST IN ANY PROCEEDING OR SETTLEMENT UNDER THE WORKERS' COMPENSATION ACT AND PROHIBITING INSURERS THAT PROVIDE HEALTH BENEFIT PLANS FROM OFFSETTING AGAINST PROVIDER REIMBURSEMENT ANY CHARGE FOR MEDICAL SERVICES UNLESS THE SPECIFIC MEDICAL CHARGES WERE FOUND TO BE COMPENSABLE ACCORDING TO A FINAL ADJUDICATION UNDER THE WORKERS' COMPENSATION ACT OR A SETTLEMENT AGREEMENT UNDER THE ACT APPROVED BY THE NORTH CAROLINA INDUSTRIAL COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 97 of the General Statutes is amended by adding a new section to read:

"**§ 97-90.1. Insurers that provide employee's health benefit plans, disability income plans, or any other health insurance plans.**

An insurer that covers an employee under a health benefit plan as defined in G.S. 58-3-167, a disability income plan, or any other health insurance plan is not a real party in interest and shall not intervene or participate in any proceeding or settlement agreement under this Article to determine whether a claim is compensable under this Article or to seek reimbursement for medical payments under its plan. The insurer that covers an employee under a health benefit plan as defined in G.S. 58-3-167, a disability

income plan, or any other health insurance plan may seek reimbursement from an employee, employer, or carrier for only health plan payments for specific medical charges that have been finally adjudicated to be compensable under this Article or have been found to be compensable according to an order of the Commission approving a settlement agreement entered into under this Article."

SECTION 2. G.S. 97-92 reads as rewritten:

"(b) The records of the Commission, insofar as they refer to accidents, injuries, and settlements are not public records under G.S. 132-1 and shall not be open to the public, but only to the parties satisfying the Commission of their interest in such records and the right to inspect them, and to State and federal agencies pursuant to G.S. 97-81."

SECTION 3. G.S. 58-51-5(a) is amended by adding a new subdivision to read:

"(8) It contains no provision excluding from coverage claims that are subject to the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes, unless the exclusion extends to only specific medical charges that have been finally adjudicated to be compensable under that Article or have been found to be compensable according to an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article."

SECTION 4. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-57. Offsets against provider reimbursement for workers' compensation payments forbidden.**

(a) An insurer that provides a health benefit plan as defined in G.S. 58-3-167 shall not offset or reverse a health plan payment against a provider reimbursement for other medical charges unless the health plan payment was for a specific medical charge that had been finally adjudicated to be compensable under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes, or had been found to be compensable according to an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.

(b) No contract between an insurer that provides a health benefit plan as defined in G.S. 58-3-167 and a medical provider shall contain a provision that authorizes the insurer to offset or reverse a health plan payment against a provider reimbursement for other medical charges unless the health plan payment was for a specific medical charge that had been finally adjudicated to be compensable under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes, or had been found to be compensable according to an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 1045:
Restore Workers' Comp Stability

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Baddour
Date:	April 18, 2001	**Summary by:**	Frank W. Folger
Version:	H1045-CSLD-9		Committee Counsel

SUMMARY: ***This bill would establish that an insurer covering an employee under a health benefit plan, disability income plan, and any other health insurance plan is not a real party in interest and cannot intervene or participate in workers' compensation proceedings or settlement agreements to determine the compensability of a claim or seek reimbursement for medical payments, statutorily overturning the ruling in Hansen v. Crystal Ford-Mercury, Inc. It would provide conditions precedent to Industrial Commission approval of a settlement agreement and make Commission approval of a settlement agreement final, non-reviewable, and immune from collateral attack. It would also prohibit insurance policies from excluding workers' compensation claims coverage generally and prevent offset except in situations where liability or responsibility has been determined by adjudication or by Commission order.***

CURRENT LAW: Pursuant to the Courts of Appeals holding in Hansen v. Crystal Ford-Mercury, Inc., 138 N.C.App. 369, an insurer may intervene as a real party in interest in a workers' compensation proceeding when it alleges it has paid medical expenses due to an employee's compensable injury and is entitled to reimbursement and liability is disputed by the employer.

BILL ANALYSIS: Section 1 would create a new section, N.C.G.S. §97-90.1, that:

1. declares an insurer covering an employee under a health benefit plan, disability income plan, or any other health insurance plan is not a real party in interest in a workers compensation proceeding or settlement agreement and has no standing to intervene or participate in either to determine a claim's compensability or seek reimbursement for medical payments under its plan.
2. allows an insurer covering an employee under a health benefit plan or other health insurance plan to seek reimbursement from the party that is liable or responsible for specific medical charges according to a final adjudication of a claim under the Workers' Compensation Act (the Act) or order of the Commission approving a settlement agreement entered into under the Act.

Section 1.1 would amend N.C.G.S. §97-17, the section governing settlement agreements under the Act, to:

1. make technical corrections to the existing language of the section.
2. mandate that Commission approval of a settlement agreement is final and not subject to review or collateral attack.
3. establish that for Commission approval of a settlement agreement:
    a. it must be deemed by the Commission to be fair, just, and in the best interest of all parties;
    b. it must list all known medical expenses of the employee related to the injury as of its date, including disputed expenses and list, if any, expenses to be paid by the employer under the agreement; and

c. it must contain findings that the positions of all parties to the agreement are reasonable as to the payment of medical expenses, upon the Commission considering:

i. Whether the employer admitted or denied the employee's claim;

ii. The amount of all related medical expenses of the employee, including those in dispute; and

iii. The need for finality in the litigation.

Section 2 would clarify that Commission records, other than awards, to the extent the records reference accidents, injuries and settlements, are not public records under the public records statute, N.C.G.S. §132-1.

Section 3 would prohibit an accident or health insurer from excluding from coverage claims subject to the Act, unless the exclusion is only for specific medical charges for which the employee, employer or carrier is liable or responsible according to a final adjudication of a claim or Commission order approving a settlement agreement.

Section 4 would prohibit an insurer that provides a health benefit plan from:

1. offsetting or reversing a health plan payment against a provider reimbursement for other medical charges unless payment was for a specific medical charge for which the employee, employer or carrier is liable or responsible according to a final adjudication of a claim or Commission order approving a settlement agreement.
2. contracting with a medical provider to authorizes the insurer to offset or reverse a health plan payment against a provider reimbursement for other medical charges unless payment was for a specific medical charge for which the employee, employer or carrier is liable or responsible according to a final adjudication of a claim or Commission order approving a settlement agreement.

The act would be effective upon becoming law.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 19, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 19, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the page Rachel Thomas (Cumberland County-Rep. Hurley). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Baddour, Barbee, Blue, Brubaker, Cunningham, Dedmon, Earle, Grady, Hall, Redwine, Saunders, Smith, Wainwright, Warner, and Wilson. Linda Attarian, Frank Folger and Trina Griffin, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes (Attachment). The following bills were considered:

HB 351, entitled, AN ACT TO MAKE TECHNICAL AND SUBSTANTIVE CHANGES IN THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES. A proposed committee substitute was presented and adopted for committee discussion. Representative Brubaker moved to amend the committee substitute, to delete section 4 from the PCS. Bill Hale was recognized to explain the amendment. "In the proposed committee substitute only the underlined language at the end of Section 4 of the original bill was deleted, however the intention of the Department of Insurance was to remove all of Section 4." The amendment was adopted. Representative Barbee moved to roll the amendment into the committee substitute and give a favorable report to the committee substitute, unfavorable to the original bill. The motion passed.

HB 1048, entitled, AN ACT TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL NOT MANDATE ADDITIONAL COVERAGE BEYOND WHAT IS REQUIRED AS OF DECEMBER 31, 2001, WITH CERTAIN EXCEPTIONS; AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE ISSUE OF HEALTH INSURANCE MANDATES. Representative Redwine, the bill sponsor, was recognized to explain the bill. The bill is to provide that health benefit plans shall not mandate additional coverage beyond what is required as of December 31, 2001, with certain exceptions, and to authorize the legislative research commission to study the issue of health insurance mandates. The moratorium on health insurance mandates would expire on January 1, 2004. Representative Redwine moved to amend the bill, to delete lines 19 – 22, and lines 25 – 26, on page 1. The amendment was adopted. It adds a provision specifying that the bill does not prohibit an expansion of coverage in an individual or group health benefit plan or policy if the expansion of coverage is deemed to be cost-efficient based upon a cost-benefit analysis performed by the Department of Insurance. After much discussion Representative Redwine made a motion to roll the amendment into a committee substitute and give favorable report as to committee substitute, which changes the title, unfavorable to the original bill. The motion passed.

HB 808, entitled, AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY. Representative Alexander was recognized to explain the bill, and she presented a proposed committee substitute. Representative Hurley moved to adopt the proposed committee substitute. The motion passed. The proposed bill requires all insurers to cover chemical dependency benefits and mental illness benefits. Group plans are required to be in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual and lifetime dollar limits, different deductibles, co-payments, or coinsurance factors, lower maximum out-of-pocket limits, or for more restrictive day and visit limits for mental illness and chemical dependency benefits than it provides for physical benefits generally under the policy. Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use

common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case. Plans will meet the parity requirements in the bill if at least one of the patient's choices of treatment options within the patient's policy meets the parity requirement. According to a study conducted by Medstat Group for the Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD, 56% of the funding for mental health and substance abuse treatment in 1997 was paid by the public sector, up from 53% in 1987. According to the same study, spending for mental health and substance abuse treatment nationwide reached $85.3 billion in 1997. There has been a decline in private insurers' real spending for substance abuse services between 1987 and 1997 of 0.6%. The act is effective on January 1, 2002. John Tote, Executive Director of the Mental Health Assn., Al Adams, former Legislator, NC Retired Governmental Assn., and Amy Jo Bain, NC Medical Society, were recognized to speak in favor of the bill. Mr. Tote stated that chemical dependency and substance abuse is treatable and is cost effective. Mental parity has been part of the State Health Plan for the last decade. He also stated that in the committee substituted the mandate issue has been addressed. Mr. Al Adams stated that he has been involved in discussion, when this issue was first brought before the Legislature in 1981, to evaluate the coverage of parity in the State Health Plan. Since complete parity has been part of the State Health Plan, the plan covers 400,000 state employees and dependents; the cost for mental care and substance abuse has been reduced from 6 % to 2.8 % of the total cost of the State Health Plan. Ms. Bain stated that this bill represents a compromise and treating these illnesses would be cost effective in treating employees before he/she become ineffective in their job performance due to mental illness or substance abuse. The Chair recognized Dr. Knoop, Senior Medical Director of BC/BS, Peri Morgan, National Federation of Independent Businesses, Leslie Bavokya, NC Citizens for Business and Industry, and Paul Mahoney, NC Assoc. of Health Plans, who spoke in opposition to the bill. With medical care cost rising dramatically already, businesses, particularly smaller businesses, are struggling with health care cost. By adding this type of care the price of the insurance will go up and this increase of health care cost could potentially reduce the number of North Carolinians receiving health care coverage. Representative Wainwright moved to amend the committee substitute on page 12, line 38, to change the effective date from January 1, 2002 to December 1, 2001. The amendment failed. Due to the amount of questions being raised by the Committee members and the time constraints, Representative Redwine made a motion to adjourn. The motion passed and the committee tabled this bill until the next INSURANCE Committee meeting scheduled for April 25, 2001.

There being no further business, the Chair adjourned the meeting at 1:05 PM.

Respectfully submitted,

Representative Jerry C. Dockham
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Form
HB 351, HB 1048, and HB 808
Bill Summaries
Handouts

ATTENDANCE

INSURANCE

(Name of Committee)

DATES	02-28-01	03-07-01	03-14-01	03-21-01	03-28-01	03-29-01	04-04-01	04-11-01	04-12-01	04-18-01	04-19-01	04-24-01			
HURLEY, Bill CHAIR	X	X	X	X	X	X	X	X	X	X	X				
DOCKHAM, Jerry CHAIR	X	X	X	X	X	X	X		X		X				
BARBEE, Bobby VICE-CHAIR	X	X	X	X					X	X	X				
BLUE, Daniel	X	X	X	X	X	X	X	X		X	X				
BRUBAKER, Harold			X	X	X	X	X	X		X	X				
DEDMON, Andrew	X	X	X		X	X	X	X		X	X				
GRADY, Robert	X	X	X	X	X	X	X	X	X	X	X				
HALL, John VICE-CHAIR	X	X	X	X	X	X	X	X	X	X	X				
HUNTER, Howard															
JOHNSON, Linda	X	X	X	X	X	X			X	X					
JUSTUS, Larry T.			X	X	X	X	X	X		X					
REDWINE, David		X	X	X	X	X	X	X	X	X	X				
SAUNDERS, Drew					X	X	X	X			X				
SETZER, Mitchell	X	X	X	X	X	X	X		X						
SMITH, Ronald	X	X	X	X	X	X		X		X	X				
WAINWRIGHT, William, VICE-CHAIR				X	X		X			X	X				
WARNER, Alex	X	X	X	X	X	X	X	X		X	X				
WILSON, Connie	X	X		X	X	X	X	X	X	X	X				
Ex-Officio Members															
BADDOUR, Phil					X					X	X				
CUNNINGHAM, W. Pete											X				
EARLE, Beverly											X				
HACKNEY, Joe					X										

VISITOR REGISTRATION SHEET

INSURANCE — April 19, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Perri McKeon	NFIB
William Williford	Ever-Ready Glass & Lock - Raleigh
Lela Barham	Ever-Ready Glass & Lock - Raleigh
Martha Lowrance	WAIC
Anne Wimmer	NC-WAM
Jackie Brown	NCCBI
Marge Foreman	NCAE
Robert Paschal	Young, Moore
LANA FRAME	NC PSYCHIATRIC ASSOC.
Warren Pendergast MD	NC Medical Society NC Psychiatric Assn NC Physicians Health Pgm
Robin Huffman	NC Psychiatric Assoc.

VISITOR REGISTRATION SHEET

INSURANCE — April 19, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Price	Jordan Price
Ellen Holliman	
Susan Ormond	NCAJ
Joseph Ley	Key Woman Education
Kitty Oden	NCNA
SUE KEITH	ALCOHOL/DRUG COUNCIL OF NC
Tony Rabil	Alcohol/Drug Council of NC
Jesse J. See	addiction Professionals, NC
Jan Taylor	Licensed Professional Counselors Assoc
Ernest Cone	PRI / Concord, Inc
Adam Li	NCHFC
Ken Wright	BCBSNC
Harry Taylor	NCAHP

VISITOR REGISTRATION SHEET

INSURANCE — April 19, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bryant Jones	TROSA 1820 James St Durham
Marvin T. Carter	TROSA 1820 James St. Durham, N.C.
Albert Burnette	TROSA 1820 James St Durham, NC
Jerry Sawyer	TROSA 1820 James St Durham, NC.
Terrance Gause	TROSA 1820 James ST. Durham, N.C.
Jeffery Purnell	TROSA 1820 James St. Durham, N.C
Reginald Johnson	TROSA 1820 James St. Durham, NC 27701
Roderick Whitfield	TROSA 1820 James ST. Durham NC.
Robert Gordon	TROSA 1820 James Durham, N.C.
Darlene Lawrence	Trosa 1820 James st Durham, NC.
Dineen Jennings	TROSA 1820 James St. Durham, NC

VISITOR REGISTRATION SHEET

INSURANCE — April 19, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan M.H. Todd	NCNA-Council of Nurse Practitioners - Raleigh
Anthony T. Davis	TROSA 1820 James St Durham, N.C. 27707
Beko Sharper	TROSA 1820 James St Durham N.C. 27707
Sonya Morgan	NCNA Council of Nurse Practitioners - Durham
Paula Jones	NCNA Council of Nurse Practitioners - Ral.
Trish Hussey	NC SA Advisory Council on Women; NFR Commission ED-Freedom House Recovery Center, Chapel Hill
Bill Hussey	N.C. Mental Health Planning & Advisory Council
Joe Donovan	NAMI - North Carolina
Margaret Westbrook	Kennedy Commission
Linwood Jones	NCHA
Stacy Smith	SDC - Carrboro

VISITOR REGISTRATION SHEET

INSURANCE — April 19, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gregory Debnam	TROSA 1820 James St Durham, N.C. 27707
Kathy Johnson	APRN's 202 S. Pineview Ave Goldsboro, NC 27530
STEVE ROBERTS	AARP
Lan Duncan	NCAHP
Joyce Peters	JP Assoc/ MAMSI
Cathy Wright	PO BOX 874 Nurse Practitioner Carthage 28327
Sherrye Sumpter	TROSA 1820 James St. Durham N.C 27707
Tanya Frazier	TROSA 1820 James St. Durham, NC 27707
Barbara Tucker	Trosa 1820 James St. Durham NC 27707
Janice Rogers	TROSA 1820 James St, Durham NC 27707
Elizabeth Watkins	Trosa 1820 James St. Durham, N.C. 277

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

April 19, 2001 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
W. Ann Forbes	Board of Nursing.
J. Michael Staggs	Nat'l Assoc. of Social Workers - NC
Jennifer Sullivan	"
[illegible] Melcher	NAMI NC
Ted Fitzgerald	Addiction Professionals of NC National Association of Drug & Alcohol Counselors
[illegible]	MHA/NC
[illegible]	MHA/NC
Nancy Covey	MHA & NAMI
PAUL MAHONEY	NCAHP
Julianne Beaudet	NCAHP
Virginia Lemmond	personal -

VISITOR REGISTRATION SHEET

INSURANCE — April 19, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	SAP
Robert Bock	APNC
Patti Stapleton Bock	APNC
Anna Roberts	CSI
Mary Hartsell	NCNA A-PRN
Margaret Kaveny Werner	NCNA APRN
DAVID BARNES	Poyner + Spruill
Deborah Cannon	NCNA APN - Ayden NC
Ann A. Peterson	Sampson Medical Svcs, PA Clinton NC
Ann Faust	Rep. Alexandria LA
Crissy Porter	Bone & Associates

VISITOR REGISTRATION SHEET

INSURANCE — April 19, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
SAUNDRA OBIE BEST	NC Board of Nursing Raleigh, N.C.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 351 A BILL TO BE ENTITLED AN ACT TO MAKE TECHNICAL AND SUBSTANTIVE CHANGES IN THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, unfavorable as to original bill.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 351*
PROPOSED COMMITTEE SUBSTITUTE H351-CSRM-20 [v.1]

4/17/2001 6:42:35 PM

Short Title: Utilization Review and Grievance Changes. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND SUBSTANTIVE CHANGES IN THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-61(a)(6) reads as rewritten:

"(6) 'Grievance' means a written complaint submitted by a covered person about any of the following:

a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

b. Claims payment or handling; or reimbursement for services.

c. The contractual relationship between a covered person and an insurer.

d. The outcome of an appeal of a noncertification under this section."

SECTION 2. G.S. 58-50-61(a)(13) reads as rewritten:

"(13) 'Noncertification' means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or

terminated. A 'noncertification' is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A 'noncertification' includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision."

SECTION 3. G.S. 58-50-61(a)(17) reads as rewritten:

"(17) 'Utilization review' means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

a. Ambulatory review. – Utilization review of services performed or provided in an outpatient setting.

b. Case management. – A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

c. Certification. – A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.

d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of treatment.

e. Discharge planning. – The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.

f. Prospective review. – Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.

g. Retrospective review. – Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.

h. Second opinion. – An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service."

SECTION 4. G.S. 58-50-61(f) reads as rewritten:

"(f) Prospective and Concurrent Reviews. – As used in this subsection, 'necessary information' includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send a written ~~or electronic confirmation~~ notice of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification."

SECTION 5. G.S. 58-50-61(i) reads as rewritten:

"(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of ~~noncertifications.~~ noncertifications and, if established, the procedures shall be in writing. ~~The~~ After a written notice of noncertification has been issued in accordance with subsection (h) of this section, 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. If, after informal reconsideration, the insurer upholds the noncertification decision, the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, it shall treat the request for informal reconsideration as a request for an appeal; provided that the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration."

SECTION 6. G.S. 58-50-61(k) reads as rewritten:

"(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the ~~decision~~ decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, ~~The~~ the written decision shall contain:

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.
(2) A statement of the reviewers' understanding of the reason for the covered person's appeal.
(3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
(4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
(5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62."

SECTION 7. G.S. 58-50-62(b) reads as rewritten:

"(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. A decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question is not subject to the insurer's grievance procedures, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. The grievance process may provide for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first- and second-level reviews of ~~grievances; except that an appeal~~ grievances. Appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section."

SECTION 8. G.S. 58-50-62 is amended by adding the following new subsection to read:

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

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

shall issue a written decision that includes the information set forth in subsection (c) of this section.

(3) If the insurer is unable to render an informal consideration decision within 10 business days after receipt of the grievance, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply beginning on the day the insurer determines an informal consideration decision cannot be made before the tenth business day after receipt of the grievance."

SECTION 9. G.S. 58-50-62(e) reads as rewritten:

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

(1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Except as provided in subdivision (3) of this subsection, ~~Within~~ within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.

(2) An insurer shall issue a written ~~decision~~ decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. ~~The~~ Except as provided in subdivision (3) of this subsection, the written decision issued in a first-level grievance review shall contain:

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

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

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

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

e. ~~A~~ If the decision is not in favor of the covered person, a statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.

(3) For grievances concerning the quality of clinical care delivered by the covered person's provider, the insurer shall acknowledge the grievance within 10 business days. The acknowledgement shall advise the covered person that (i) the insurer will refer the grievance to its quality assurance committee for review and consideration or any appropriate action against the provider and (ii) State law does not allow for a second-level grievance review for grievances concerning quality of care.'

SECTION 10. G.S. 58-50-62(f) reads as rewritten:

"(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance.

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

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

b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.

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

same matter if the second-level grievance review panel comprises three or more persons."

SECTION 11. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 12. This act becomes effective October 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 351*

Short Title:	Utilization Review and Grievance Changes.	(Public)
Sponsors:	Representatives Hurley and Dockham (Primary Sponsors).	
Referred to:	Insurance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND SUBSTANTIVE CHANGES IN THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-61(a)(6) reads as rewritten:

"(6) 'Grievance' means a written complaint submitted by a covered person about any of the following:

a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

b. Claims payment or handling; or reimbursement for services.

c. The contractual relationship between a covered person and an insurer.

d. The outcome of an appeal of a noncertification under this section."

SECTION 2. G.S. 58-50-61(a)(13) reads as rewritten:

"(13) 'Noncertification' means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-

190, and the requested service is therefore denied, reduced, or terminated. A 'noncertification' is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A 'noncertification' includes any situation in which an insurer or its designated agent makes an evaluation or review of medical information about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision."

SECTION 3. G.S. 58-50-61(a)(17) reads as rewritten:

"(17) 'Utilization review' means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

a. Ambulatory review. – Utilization review of services performed or provided in an outpatient setting.

b. Case management. – A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

c. Certification. – A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.

d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of treatment.

e. Discharge planning. – The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.

f. Prospective review. – Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.

g. Retrospective review. – Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.

h. Second opinion. – An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service."

SECTION 4. G.S. 58-50-61(f) reads as rewritten:

"(f) Prospective and Concurrent Reviews. – As used in this subsection, 'necessary information' includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification. When the covered person is institutionalized, a written notice of noncertification shall be provided to the covered person, however, the noncertification is deemed to have been communicated to the covered person upon notification of the covered person's provider."

SECTION 5. G.S. 58-50-61(i) reads as rewritten:

"(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of ~~noncertifications.~~ noncertifications and, if established, the procedures shall be in writing. ~~The~~ After a written notice of noncertification has been issued in accordance with subsection (h) of this section, 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. If, after informal reconsideration, the insurer upholds the noncertification decision, the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, it shall treat the request for informal reconsideration as a request for an appeal; provided that the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration."

SECTION 6. G.S. 58-50-61(k) reads as rewritten:

"(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision to the covered person and the covered person's

provider within 30 days after the insurer receives the request for an appeal. The written decision shall contain:

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.

(2) A statement of the reviewers' understanding of the reason for the covered person's appeal.

(3) The reviewers' decision in clear terms ~~and~~ and, if the decision is not in favor of the covered person, the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

(4) ~~A~~ If the decision is not in favor of the covered person, a reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.

(5) ~~A~~ If the decision is not in favor of the covered person, a statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62."

SECTION 7. 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 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. When the covered person is institutionalized, a written notice of noncertification shall be provided to the covered person; provided, however, the noncertification is deemed to have been communicated to the covered person upon notification of the covered person's provider. An insurer is not required to provide an expedited review for retrospective noncertifications."

SECTION 8. G.S. 58-50-62(b) reads as rewritten:

"(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. A decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question is not subject to the insurer's grievance procedures, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. The grievance process may provide for an immediate informal consideration by the

insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first- and second-level reviews of ~~grievances; except that an appeal~~ grievances. Appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section."

SECTION 8.1. G.S. 58-50-62 is amended by adding the following new subsection to read:

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

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

(2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall issue a written decision that includes the information set forth in subsection (c) of this section.

(3) If the insurer is unable to render an informal consideration decision within 10 business days after receipt of the grievance, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply beginning on the day the insurer determines an informal consideration decision cannot be made before the tenth business day after receipt of the grievance."

SECTION 9. G.S. 58-50-62(e) reads as rewritten:

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

(1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.

(2) An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical

one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. ~~The~~ Except as provided in subdivision (3) of this subsection, the written decision issued in a first-level grievance review shall contain:

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

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

c. The reviewers' decision in clear terms ~~and~~ and, if the decision is not in favor of the covered person, the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

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

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

(3) Grievances concerning the quality of clinical care delivered by the covered person's provider are subject to peer review confidentiality, and therefore the written decision shall contain:

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

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

c. A statement that information regarding the matter is subject to confidential peer review and that specific details of the review, and the outcome of the review cannot be provided to the covered person.

d. A statement advising the covered person that a second-level grievance review is not available."

SECTION 10. G.S. 58-50-62(f) reads as rewritten:

"(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance.

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

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

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

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

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

SECTION 11. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 12. This act becomes effective October 1, 2001.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

April 18, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 351 (PCS) – Managed Care
Utilization Review and Grievance Changes

Utilization Review (GS 58-50-61)

SECTION 1. Amends the definition of "grievance," to make it clear that a complaint from a covered person that a plan does not cover a health care service or supply is not considered a grievance and is not subject to grievance handling procedures.

SECTION 2. Amends the definition of "noncertification", to clarify that a noncertification includes cases where coverage for a service is denied, reduced, or terminated because the service does not meet the prudent layperson standard set out in the emergency room law. Noncertification also includes cases where coverage is denied, reduced, or terminated because services are experimental, investigational, or cosmetic.

SECTION 3. Amends the definition of "retrospective review", to clarify that retrospective review includes cases where coverage for a service is denied, reduced, or terminated because the service does not meet the prudent layperson standard set out in the emergency room law.

SECTION 4. For prospective and concurrent reviews, the notice of noncertification to the member must be in writing.

SECTION 5. Requires that insurer procedures for offering informal reconsiderations be in writing. Provides that informal reconsiderations begin only after notice of noncertification has been provided. Requires an insurer to communicate a decision on informal reconsideration within ten business days after receiving the request for reconsideration, and that a reconsideration decision upholding the original noncertification be communicated in accordance with the standards that apply to issuing original noncertification decisions. If a decision on informal reconsideration cannot be

issued within ten business days after receipt of the request, the request shall automatically be treated as an appeal, except that the requirement to acknowledge the request shall not apply until the date that the insurer determines it cannot issue the decision within the time frame prescribed for informal reconsiderations or ten days after receipt of the request for informal reconsideration, whichever is sooner.

SECTION 6. Clarifies the items that must be in a plan's written decision on a nonexpedited appeal if the decision upholds the original noncertification.

Insurer Grievance Procedures (GS 58-50-62)

SECTION 7. This ties in with the amendment in SECTION 1 of the bill and makes it clear that a complaint from a covered person that a plan does not cover a health care service or supply is not considered a grievance and is not subject to grievance handling procedures if the exclusion is clearly stated in the certificate of coverage.

SECTION 8. Requires that insurer procedures for voluntary offering of informal considerations of grievances be in writing. Provides that when an insurer issues a decision on informal consideration concerning clinical issues, the insurer shall automatically consider the request to be a first-level grievance and shall, within ten days after making the decision on informal consideration, issue an acknowledgment of request for a grievance. Provides that when an insurer issues a decision on informal consideration concerning non-clinical issues, it shall, within ten days after receiving the request, send a notice of its decision, including information about the insured's right to file a the formal grievance process. Requires that insurers automatically treat a request for informal consideration as a formal grievance request if it cannot issue a decision on the informal review within ten days after receiving the request.

SECTION 9. Makes it clear that detailed information about the basis for an insurer's decision for any type of first-level grievance must be provided only in those cases where the decision is not in favor of the insured, and that notice of the insured's right to a second-level grievance review also need only be sent in these cases. For grievances about quality of clinical care, the person filing the grievance is informed that these cases cannot go to a second-level grievance review and that the insurer will refer the grievance to its quality assurance committee.

SECTION 10. Makes it clear that a covered person may authorize his or her provider to file a second-level grievance on his or her behalf.

HOUSE BILL 351:
Utilization Review and Grievance Changes

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Reps. Hurley and Dockham
Date:	April 18, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 351 would make several changes to the current law regarding utilization review and grievance procedures to provide clarity to the definitions of terms and rights of covered persons. The bill is effective October 1, 2001.***

CURRENT LAW/BILL ANALYSIS:

Section 1 amends the definition of "grievance" within the context of grievance reviews. As amended, the definition clarifies that complaints submitted by a covered person for a second-level grievance review concerning a health benefit plan's policy of not covering a particular health care service shall not reviewed if the coverage exclusion is specifically stated in the plan's certificate of coverage.

Section 2 amends the definition of "noncertification" in the context of utilization reviews that are conducted by a health benefit plan to evaluate the clinical necessity, appropriateness, efficacy or efficiency of heath care services. The amendment claifies that determinations pursuant to a utilization review that a health care service provided in an emergency setting does not meet the prudent layperson standard for coverage under G.S. 58-3-190; or decisions concerning whether a requested treatment is experimental, investigational, or cosmetic affecting the extent of coverage under the health benefit plan are noncertifications for the purposes of utilization review and grievance procedures.

Section 3 amends the definition of "utilization review" by changing what constitutes a retrospective review. A retrospective review is a utilization review conducted after the requested health care services have been provided. The review looks at whether the services were medically necessary at the time they were provided. Section 3 provides that utilization reviews of claims concerning whether a health care service provided in an emergency setting meets the prudent layperson standard for coverage as set forth in G.S. 583-190 are also retrospective reviews for the purposes of the utilization review provisions and grievance procedures.

Section 4 amends G.S. 58-50-61(f), regarding communication between the health plan, the patient, and the patient's health care provider after a decision has been made concerning a prospective or concurrent utilization review. A concurrent utilization review is a review of whether the requested health care services are medically necessary and appropriate, that is conducted during a patient's hospital stay or course of treatment. A prospective utilization review is pre-authorization or precertification, in other words, a review of whether the requested health care services are medically necessary and appropriate, conducted before admission or before a course of treatment.

G.S. 58-50-61(f) provides that the insurer must notify the patient's provider of the utilization review decision within three days of receiving the necessary information about the requested health care services, and must send written notice of any denial to the patient. If the patient is currently receiving the requested treatment, the insurer will be liable for the coverage until the patient is notified of the denial. Section 4 amends the subsection to provide that when the patient is institutionalized, the insurer still must send written notice to the patient, but the denial is "deemed" to be communicated to the patient once the patient's provider is notified.

Section 5 amends G.S. 58-50-61(i) that requires insurers to provide procedures for an informal review of noncertifications. Section 5 requires the procedure to be in writing, clarifies when the reconsideration would commence, and provides that if the insurer fails to render a reconsideration decision within 10 days, the internal appeal procedures shall commence.

Section 6 makes technical changes to G.S. 58-50-61(k) to provide that only in instances where an appeal decision of a noncertification is NOT in favor of the covered person will the insured be required to provide certain information supporting that decision.

Section 7 amends G.S. 58-50-61(l), regarding communication between the health plan, the patient, and the patient's health care provider after a decision has been made concerning an expedited appeal of a utilization review decision. The subsection provides that the insurer must send written notice of its decision to the patient within 4 days. If the patient is currently receiving the requested treatment, the insurer will be liable for the coverage until the patient is notified of the denial. Section 7 amends the subsection to provide that when the patient is institutionalized, the insurer still must send written notice to the patient, but the decision is "deemed" to be communicated to the patient once the patient's provider is notified.

Section 8 amends G.S. 59-50-62 (Insurer Grievance Procedures) to conform to Section 1 of the bill that amends the definition of "grievance".

Section 8.1 adds a new subsection to G.S. 58-50-62 to provide clarity to the informal process of review of grievances, to the proceedings of formal first- and second-level reviews of grievances, and to provide for what the covered person can expect depending on the outcome of the informal process.

Section 9 amends G.S. 59-50-62 to provide that a when a covered person submits a complaint about the quality of care that was provided by the covered person's health care provider, the covered person is to receive a statement informing them that the outcome of the review will confidential since the complaint is a matter of peer review. The statement must also include information about the qualifications of the person or persons that will be conducting the review, the reviewer's understanding of the grievance, and that a second-level grievance review will not be conducted.

Section 10 amends G.S. 59-59-62(f) to provide that a covered person's provider, acting on behalf of the covered person, may seek a formal second-level review of a decision upholding a first-level grievance review decision that was not in favor of the covered person.

Section 11 is a severability clause.

Section 12 makes the act effective October 1, 2001.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1048 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL NOT MANDATE ADDITIONAL COVERAGE BEYOND WHAT IS REQUIRED AS OF DECEMBER 31, 2001, WITH CERTAIN EXCEPTIONS; AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE ISSUE OF HEALTH INSURANCE MANDATES.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, ☒ which changes the title, unfavorable as to original bill.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1048*
PROPOSED COMMITTEE SUBSTITUTE H1048*-PCS3406-RM-24

Short Title: Moratorium on Health Ins. Mandates. (Public)

Sponsors:

Referred to:

April 10, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL NOT MANDATE ADDITIONAL COVERAGE BEYOND WHAT IS REQUIRED AS OF DECEMBER 31, 2001, WITH CERTAIN EXCEPTION; AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE ISSUE OF HEALTH INSURANCE MANDATES.

The General Assembly of North Carolina enacts:

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

"**§ 58-50-63. Additional coverage mandates prohibited; exception.**

(a) Notwithstanding any other provision of law to the contrary, except as otherwise provided in this section, an insurer shall not deliver, issue, or renew a health benefit plan after January 1, 2002, that includes any additional coverage requirements beyond those requirements in effect for health benefit plans on December 31, 2001.

(b) Nothing in this section shall be construed to prohibit an employer from electing to expand coverage on any group or individual health benefit plan or policy covering the employer and the employees of the employer.

(c) As used in this section, the terms 'insurer' and 'health benefit plan' have the meaning applied in G.S. 58-3-167."

SECTION 2. The Legislative Research Commission may study the issue of health insurance mandated benefits and the cost to employers and individuals of unfunded health insurance mandates. In conducting the study, the Commission shall consider cost-benefit analysis to determine the cost-efficiency of mandated benefits, including cost-benefit analyses performed by the Department of Insurance pursuant to G.S. 58-50-63. The Commission shall make a progress report to the 2001 General Assembly upon its reconvening in 2002, and shall make its final report to the 2003 General Assembly. Progress and final reports of the Commission may include recommended legislation.

SECTION 3. This act is effective when it becomes law. Section 1 of this act expires January 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 1048*

Short Title:	Moratorium on Health Ins. Mandates.	(Public)
Sponsors:	Representatives Redwine; Hensley, Owens, and Shubert.	
Referred to:	Insurance.	

April 10, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL NOT MANDATE ADDITIONAL COVERAGE BEYOND WHAT IS REQUIRED AS OF DECEMBER 31, 2001, WITH CERTAIN EXCEPTIONS; AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE ISSUE OF HEALTH INSURANCE MANDATES.

The General Assembly of North Carolina enacts:

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

"**§ 58-50-63. Additional coverage mandates prohibited; exceptions.**

(a) Notwithstanding any other provision of law to the contrary, except as otherwise provided in this section, an insurer shall not deliver, issue, or renew a health benefit plan after January 1, 2002, that includes any additional coverage requirements beyond those requirements in effect for health benefit plans on December 31, 2001.

(b) Nothing in this section shall be construed to prohibit:

(1) An employer from electing to expand coverage on any group or individual health benefit plan or policy covering the employer and the employees of the employer.

(2) An expansion of coverage in an individual or group health benefit plan or policy if the expansion of coverage is deemed to be cost-efficient based upon a cost-benefit analysis performed by the Department of Insurance.

(c) As used in this section, the terms 'insurer' and 'health benefit plan' have the meaning applied in G.S. 58-3-167."

SECTION 1.(b) The Commissioner of Insurance may adopt temporary rules in accordance with Chapter 150B of the General Statutes to implement this section.

SECTION 2. The Legislative Research Commission may study the issue of health insurance mandated benefits and the cost to employers and individuals of

unfunded health insurance mandates. In conducting the study, the Commission shall consider cost-benefit analysis to determine the cost efficiency of mandated benefits, including cost-benefit analyses performed by the Department of Insurance pursuant to G.S. 58-50-63. The Commission shall make a progress report to the 2001 General Assembly upon its reconvening in 2002, and shall make its final report to the 2003 General Assembly. Progress and final reports of the Commission may include recommended legislation.

SECTION 3. This act is effective when it becomes law. Section 1 of this act expires January 1, 2004.

HOUSE BILL 1048:
Moratorium on Health Ins. Mandates

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Redwine
Date:	April 19, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 1048 provides that insurers shall not be required to include coverage for health care services that were otherwise mandated by an act of the General Assembly effective on or after January 1, 2002, unless the coverage is deemed to be cost-efficient based on a cost-benefit analysis performed by the Department of Insurance. Mandated coverage in effect as of December 31, 2001 would still be required. The bill would not prohibit insurers from voluntarily expanding coverage benefits for group or individual policies or plans. The bill authorizes the Legislative Services Commission to study the issue of the cost of mandated benefits. The bill is effective when it becomes law and expires in January 1, 2004.***

CURRENT LAW: A partial list of current mandates: (See list provided by the Department of Insurance).

- Mammograms and pap smears (G.S. 58-51-57, 1991)
- Prostrate-specific antigen (PSA) tests (G.S. 58-51-58, 1993)
- Maternity coverage parity to physical illness coverage (58-3-170, 1993).
- Certain types of FDA approved cancer drugs (if policy covers prescription drugs). (G.S. 58-51-59, 1993)
- Treatment for diabetes (58-51-61, 1997)
- Reconstructive breast surgery following mastectomy (58-51-62, 1997)
- Minimum hospital stay following birth (G.S. 58-3-169, 1997)
- Postmastectomy inpatient care (G.S. 58-3-168, 1997)
- Emergency care (58-3-190, 1997)
- Anesthesia and hospital care for dental procedures for young children or others with special conditions. (G.S. 58-3-122, 1999)
- Bone mass measurement for diagnosis of osteoporosis (58-3-174, 1999)
- Contraceptive drugs or devices (58-3-178, 1999)

BILL ANALYSIS: **Section 1(a)** adds a new section to Article 50 of Chapter 58 that would prohibit insurers from issuing or renewing a health benefit plan that included any *mandated* coverage benefits that would otherwise go into effect on or after January 1, 2002 that were not deemed to be cost-efficient based on a cost-benefit analysis conducted by the Department of Insurance. This section would only be effective until January 1, 2004. Coverage mandates in effect currently and those becoming effective on or before December 31, 2001 may not be excluded. This section does not prohibit insurers from voluntarily expanding benefits.

Section 1(b) authorizes the Commissioner of Insurance to adopt temporary rules.

Section 2 authorizes the Legislative Services Commission to study the issue of mandated coverage. The study shall include a determination of the cost efficiency of mandated benefits.

FROM: NCSL ISSUE BRIEF ON MANDATED BENEFITS:

THE DEBATE

Proponents contend that mandates are necessary to ensure adequate health care for consumers. Supporters of state mandated health benefits argue that these laws are necessary to protect consumers by providing needed coverage for a particular disease, treatment or service, especially in those markets where there are minimal incidents of a particular disease. In addition, advocates feel that state health benefit mandates protect individuals employed by smaller business for the following reasons.

- Competition for employees: Larger businesses use comprehensive health benefits packages to compete for employees (leverage small employers do not have). Many self-insured businesses, which tend to be larger firms, already provide benefits that states are mandating.
- Inexperienced benefits specialist: Many small businesses do not have an employee benefits specialist with experience in negotiating health benefits plans. As a result, employees may be left with an undesirable health benefits package.
- Smaller size: Because smaller business have fewer employees, they are actually less attractive to health plans in the negotiation process.

In addition, advocates of mandated benefit laws contend that legislation may be the only way to ensure coverage for those purchasing individual policies or individuals covered under small business policies.

Opponents of mandated benefit laws contend that these laws:

- Offset any consumer gains by raising costs: A study completed by the General Accounting Office (GAO) concluded that mandates contribute to a rise in health care costs, which subsequently are passed to consumers through higher premiums. As addressed in various studies, some mandates--such as those for obstetrics and mental health--may substantially increase the cost of a policy, whereas others, such as those for mammography screening and provider mandates, add very little cost.[1]
- Increases the number of uninsured: The National Center for Policy Analysis (NCPA) estimates that 25 percent of the uninsured are priced out of the market by state mandates.[2]

In addition, a study commissioned by the Health Insurance Association of America (HIAA), released in January 1999, reported that "...a fifth to a quarter of the uninsured have no coverage because of state mandates, and federal mandates are likely to have larger effects."[3] Furthermore, the report stipulates that state mandates may affect only up to one-half of the state's population due to the Employment Retirement Income Security Act (ERISA) of 1974, which permits large employers to self-insure. In other words, these companies are permitted to directly pay claims rather than going through an insurance company. Since these companies are regulated by the federal government, rather than the state, large employers are able to avoid state mandates.[4]

MANDATED BENEFIT STUDIES

Over the past five years, many studies have been conducted to determine the financial and social effects of mandating specific benefits. Some state legislatures have considered or are considering legislation to require that mandated benefits bills be approved by a special study commission. Although these studies are beneficial, some problems do exist. Although more companies and state legislatures have studied the financial effects of mandated benefits, a few issues do complicate the results of these studies. Some of these issues are listed below.

- Most studies calculate the cost of claims for each mandated benefit instead of the incremental cost of adding a benefit. For example, many health plans already offer the same or a similar benefit and therefore the cost of this mandate would be minimal.
- The total cost of some mandates is not limited to the particular procedure. A prime example is mandated coverage for infertility treatments. If the treatment is successful, then the ensuing maternity costs often are higher than normal due to high-risk pregnancies or multiple childbirths.
- Mandated coverage for nonphysician provider services has the potential to raise or lower costs. There may be increased expenses if beneficiaries use providers for services they previously were paying for out-of-pocket (i.e., chiropractors). Conversely, costs may decrease if a less costly provider is used for particular services (for example, nurse midwives in the case of women's health care services).

So far during the 2001 legislative session, **Arkansas, New Jersey, North Dakota** and **Tennessee** mandated benefit study bills have passed the chamber of origin.

North Carolina Department of Insurance

Life and Health Division

Mandated Benefits for Health Benefit Plans

The following are some North Carolina General Statute (NCGS) which either mandate benefits, level of benefits, or offering of benefits for health benefit plans subject to regulation by North Carolina Department of Insurance. Some of the statutes listed below are duplicated in Articles 65 and 67 of Chapter 58 that are the Medical Service Corporations and Health Maintenance Organizations articles respectively. Refer to statutes directly for effective dates, applicability, limitations or exceptions.

NOTE: This is not an exhaustive list and does in no way represent all statutes and/or regulations with which an insurance policy form must comply.

You may access the statutes and bills via the Internet by visiting the North Carolina General Assembly's Web page at *www.ncga.state.nc.us.*

- NCGS 58-3-121 - Discrimination against coverage for certain bones and joints prohibited (coverage for certain treatments of TMJ, etc.)
- NCGS 58-3-122 (1999 House Bill 1119 – effective January 1, 2000) – Anesthesia and hospital charges necessary for safe and effective administration of dental procedures for young children, persons with serious mental or physical conditions, and person with significant behavioral problems; coverage in health benefit plans.
- NCGS 58-3-169 - Required coverage for minimum hospital stay following birth.
- NCGS 58-3-170 - Requirements for maternity coverage (does not mandate maternity coverage, but mandates how the coverage is provided WHEN it is provided.)
- NCGS 58-3-174 (1999 House Bill 314 - effective January 1, 2000) – Coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone density.
- NCGS 58-3-176 (1999 Senate Bill 90 – effective January 1, 2000) – Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services; exemption for religious employers.
- NCGS 58-3-190 - Requirements for coverage of emergency care.

- NCGS 58-3-221 (1999 Senate Bill 347 – Effective January 1, 2000) – Access to nonformulary prescription drugs.
- 58-3-223 (1999 Senate Bill 344 – effective January 1, 2000) – Managed care access to specialist care.
- NCGS 58-51-15(a)(2)b - Guidelines for limitations of coverage for preexisting conditions.
- NCGS 58-51-25 - Policy coverage to continue as to mentally retarded or physically handicapped children.
- NCGS 58-51-30 - Policies to cover newborn infants and foster children.
- NCGS 58-51-38 - Direct access to obstetrician-gynecologists.
- NCGS 58-51-50 - Coverage for chemical dependency treatment (mandated offering).
- NCGS 58-51-55(b1) - Coverage for mental illness.
- NCGS 58-51-57 - Coverage for mammograms and pap smears.
- NCGS 58-51-58 - Coverage for prostate-specific antigen (PSA) tests.
- NCGS 58-51-59 - Coverage for certain prescribed drugs for cancer treatment.
- NCGS 58-51-61 - Coverage for certain treatment for diabetes.
- NCGS 58-51-62 - Coverage for reconstructive breast surgery resulting from a mastectomy.
- NCGS 58-51-110 - Renewal, discontinuation, or replacement of group health insurance.
- NCGS 58-51-120 - Coverage of children.
- NCGS 58-51-125 - Adopted child coverage.
- NCGS 58-53-5 - Continuation of group hospital, surgical and major medical coverage after termination of employment or membership (group continuation).
- NCGS 58-53-45 - Right to obtain individual policy upon termination of group hospital, surgical or major medical coverage (group conversion).

- NCGS 58-68-30 - Increase portability through limitations on preexisting condition exclusions (group health plans).
- NCGS 58-68-35 - Prohibiting discrimination against individual participants and beneficiaries based on health status (group health plans).
- NCGS 58-68-40 - Guaranteed availability of coverage for employers in the small group market.
- NCGS 58-68-45 - Guaranteed renewability of coverage for employers in the group market.
- NCGS 58-68-60 - Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.
- NCGS 58-68-65 - Guaranteed renewability of individual health insurance coverage.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 808*
PROPOSED COMMITTEE SUBSTITUTE H808*-PCS3385-LN-12

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

Sponsors:

Referred to:

March 26, 2001

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-50 reads as rewritten:

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

(a) Definitions. – As used in this section, the ~~term "chemical~~ term:

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

(2) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(3) 'Insurer' has the same meaning as in G.S. 58-3-167.

(b) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance ~~that is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds~~ that includes coverage for the necessary care and treatment of chemical dependency shall ensure that benefits under the chemical dependency coverage ~~benefits for the necessary care and treatment of chemical dependency that~~ are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for treatment of chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may

impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

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

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

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

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

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

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

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

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

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

SECTION 2. G.S. 58-51-55 reads as rewritten:

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

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

(b) Coverage of Physical Illness. – No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

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

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

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

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

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

~~(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected~~

~~physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires an insurer to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-51-50.~~

~~(d) Applicability. Subsection (b1) of this section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).~~"

SECTION 3. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

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

(a) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that includes coverage for the necessary care and treatment of mental illness shall ensure that benefits under the mental illness coverage are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Average. – If a health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Definitions. – As used in this section:

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(2) 'Insurer' has the same meaning as in G.S. 58-3-167.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes."

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

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

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

(b) Chemical Dependency Parity Requirement. – Every group insurance certificate or group subscriber contract under any hospital or medical plan governed by this Article and Article 66 of this Chapter that includes coverage for the necessary care and treatment of chemical dependency shall ensure that benefits under the chemical dependency coverage ~~is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds benefits for the necessary care and treatment of chemical dependency that~~ are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a hospital or medical plan governed by this Article contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, then the group insurance certificate or group subscriber contract may impose limits on the chemical

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

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires a service corporation to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-65-75.~~

~~(d) Applicability. Subsection (b1) of this section applies only to subscriber contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

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

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

(a) Definition. – As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that

produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Chemical Dependency Requirement. – ~~On and after January 1, 1985, every~~Every health maintenance organization that writes a health care plan on a group basis ~~and that is subject to this Article shall offer~~ that provides benefits for the necessary care and treatment of chemical dependency shall ensure that benefits under the chemical dependency coverage ~~that~~ are not less favorable than benefits under the health care plan generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a group health plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, then the health maintenance organization may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in ~~G.S. 58-67-70~~G.S. 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Disorders, DSM-IV, or subsequent editions of this manual.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires an HMO to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-67-70.~~

~~(d) Applicability. Subsection (b1) of this section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

SECTION 8. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Treatment of chemical dependency and mental illness, if provided under the standard health plan, that is at least equal to the coverage required by G.S. 58-51-50 and G.S. 58-3-220, respectively. The Plan may use a case management program in accordance with G.S. 58-51-50 and G.S. 58-3-220, respectively.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers."

SECTION 9. This act becomes effective January 1, 2002, and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after that date. 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 2001

HOUSE BILL 808*

Short Title:	Mental Health/Chemical Dep. Parity.	(Public)
Sponsors:	Representatives Alexander, Baddour, Hackney, Wainwright; Adams, Barefoot, Bell, Blue, Boyd-McIntyre, Buchanan, Church, Cole, Cox, Crawford, Cunningham, Davis, Earle, Easterling, Fitch, Fox, Goodwin, Haire, Hall, Hill, Holliman, Insko, Jarrell, Jeffus, Lucas, Luebke, McAllister, Michaux, Nesbitt, Oldham, Russell, Saunders, Tolson, Warner, Weiss, G. Wilson, Womble, and Yongue.	
Referred to:	Rules, Calendar, and Operations of the House.	

March 26, 2001

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-50 reads as rewritten:

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

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

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

(2) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(3) 'Insurer' has the same meaning as in G.S. 58-3-167.

(b) Every insurer ~~that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds~~ shall provide in each group health benefit plan benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for treatment of chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles,

coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. – An insurer may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. – Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

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

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

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

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

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

a. Chemical dependency units in licensed facilities; ~~facilities licensed after October 1, 1984;~~

b. Medical units;

c. Psychiatric units; and

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

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

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

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

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

SECTION 2. G.S. 58-51-55 reads as rewritten:

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

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

(b) Coverage of Physical Illness. – No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

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

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

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

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

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

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

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires an insurer to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-51-50.~~

~~(d) Applicability. Subsection (b1) of this section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).~~"

SECTION 3. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

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

(a) Mental Health Parity Requirement. – An insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Average. – If a health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Case Management. – An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules may ensure only that case management programs are not designed to avoid the requirement of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Medical Necessity. – Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary.

(e) Definitions. – As used in this section:

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(2) 'Insurer' has the same meaning as in G.S. 58-3-167.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes."

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

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

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

(b) Chemical Dependency Parity Requirement. – Every group insurance certificate or group subscriber contract under any hospital or medical plan governed by this Article and Article 66 of this Chapter ~~that is issued, renewed, or amended on or after January 1, 1985, shall offer~~ shall provide to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a hospital or medical plan governed by this Article contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, then the group insurance certificate or group subscriber contract may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. – A group insurance certificate or group subscriber contract may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. – Nothing in this section prohibits a hospital or medical plan governed by this Article from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

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

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

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

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

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

a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~licensed facilities;

b. Medical units;

c. Psychiatric units; and

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

a. Chemical dependency units in psychiatric hospitals;

b. Chemical dependency hospitals;

c. Residential chemical dependency treatment facilities;

d. Social setting detoxification facilities or programs;

e. Medical detoxification facilities or programs; and

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

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

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

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

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-65-75~~58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

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

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

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

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

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

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

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

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

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

~~(4) Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the subscriber contract,~~

~~including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.~~

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires a service corporation to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-65-75.~~

~~(d) Applicability. Subsection (b1) of this section applies only to subscriber contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

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

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

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

(b) Chemical Dependency Requirement. – ~~On and after January 1, 1985, every~~Every health maintenance organization that writes a health care plan on a group basis and that is subject to this Article shall ~~offer~~ provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits under the health care plan generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a group health plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, then the health maintenance organization may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. – A health maintenance organization may use a case management program for chemical dependency treatment benefits to evaluate and

determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules shall only ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. – Nothing in this section prohibits a health maintenance organization from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

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

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

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

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

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

a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~licensed facilities;

b. Medical units;

c. Psychiatric units; and

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

a. Chemical dependency units in psychiatric hospitals;

b. Chemical dependency hospitals;

c. Residential chemical dependency treatment facilities;

d. Social setting detoxification facilities or programs;

e. Medical detoxification facilities or programs; and

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

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

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

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

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

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in ~~G.S. 58-67-70~~G.S. 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Disorders, DSM-IV, or subsequent editions of this manual.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires an HMO to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-67-70.~~

~~(d) Applicability. Subsection (b1) of this section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

SECTION 8. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Treatment of chemical dependency and mental illness that is at least equal to the coverage required by G.S. 58-51-50 and G.S. 58-3-220, respectively. The Plan may use a case management program in accordance with G.S. 58-51-50 and G.S. 58-3-220, respectively.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers."

SECTION 9. This act becomes effective January 1, 2002, and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after that date. 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.

HOUSE BILL 808:
Mental Health/Chemical Dependency Parity

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Alexander
Date:	April 19, 2001	**Summary by:**	Linda Attarian
Version:	First Edition		Committee Counsel

SUMMARY: ***House bill 808 would mandate coverage of mental illness and chemical dependency for and require that the coverage would be at full parity with covered benefits for physical illness. Thus the plan must provide the same day and visit limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits and nay other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. The act is effective on January 1, 2002.***

CURRENT LAW: *Chemical Dependency:* Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. If the group policyholder accepts the coverage, the benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than $8,000 in total annual benefits for all illnesses under the policy, it must also provide chemical dependency coverage of at least $8,000 *per year* and at least $16,000 over the *lifetime* of the policy.

Mental illness: Insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans. However, if the plan does provide mental health benefits, it must ensure that any lifetime and annual limits on that coverage is no less favorable than the benefits provided for physical benefits generally under the plan. Any plan that can show a 1% increase in costs as a result of this requirement can opt out of the requirement, and any plan that has 50 or fewer employees is exempt. This law expires October 1, 2001.

Self-funded plans: Plans governed by ERISA are subject to the federal Mental Health Parity Act of 1996. The Act prohibits these plans from imposing annual or lifetime dollar limits on reimbursement ceilings for mental health benefits that are more restrictive than those applied to care for physical illness. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement

BILL ANALYSIS:

Coverage and Parity Requirements:

The proposed bill requires all insurers to cover chemical dependency benefits and mental illness benefits. Group plans are required to be in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual and lifetime dollar limits, different deductibles, co-payments, or coinsurance factors, lower maximum out-of-pocket limits, or for more restrictive day and visit limits for mental illness and chemical dependency benefits than it provides for physical benefits generally under the policy

Cost Control Provisions:

Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case. Plans will meet the parity requirements in the bill if at least one of the patient's choices of treatment options within the patient's policy meets the parity requirement.

Utilization Review for Chemical Dependency Treatment:

The bill requires the use of ASAM (American Society of Addiction Medicine Patient Placement) criteria or other criteria adopted by the insurer or its utilization review organization in the utilization review of placement decisions relating to the treatment of chemical dependency.

Definitions of Mental Illness and Chemical Dependency:

- *Chemical Dependency:*
  Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as the *"pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal."* Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines "chemically dependent" in the same manner, but the bill adds a requirement that the dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions).

- *Mental Illness:*
  Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MH/DD/SA Act defines "mental illness" as follows: *"(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment."(GS 122C-3(21)).*

- *Exclusions:* The bill specifically excludes from the mental illness coverage requirement the following disorders:
  - Mental disorders coded in the DSM-IV as substance abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders,

phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.

- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

Effective Date: January 1, 2002.

BACKGROUND: According to a study conducted by Medstat Group for the Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD, 56% of the funding for mental health and substance abuse treatment in 1997 was paid by the public sector, up from 53% in 1987. According to the same study, spending for mental health and substance abuse treatment nationwide reached $85.3 billion in 1997. There has been a decline in private insurers' real spending for substance abuse services between 1987 and 1997 of 0.6%.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 24, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 24, 2001, at 8:00 a.m. Representative Hurley called the meeting to order and introduced the page, Elizabeth Brock (Davie County – Tar Heel Challenge). The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Baddour, Barbee, Blue, Dedmon, Grady, Hall, Johnson, Justus, Redwine, Saunders, and C. Wilson. Linda Attarian, Frank Folger, and Trina Griffin, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 1088, entitled, AN ACT TO PROVIDE THAT THE COMMON LAW DETERMINES WHETHER A DRIVER OF A TRUCK OR TRACTOR TRAILER OF AN INTERSTATE MOTOR CARRIER IS AN EMPLOYEE SUBJECT TO THE WORKERS' COMPENSATION ACT. Representative Drew Saunders was recognized to explain the bill. Section 1 of this bill would amend the definitional section of the Workers' Compensation Act on "employee" to declare that whether a truck driver or tractor trailer driver for a motor carrier licensed by the Interstate Commerce Commission is an employee of the carrier or an independent contractor would be determined by common law. Section 2 would make the act effective upon becoming law and applicable to all claims for workers' compensation finally determined on or after that date. Representative Saunders indicated the Trucker's Association supports HB 1088. Frank Folger, Staff Counsel, was recognized to further explain the bill. Jim Lore and Victor Farah, attorneys in Raleigh, were recognized to speak in opposition to the bill. George Teague, representing the Interstate Commerce Exemption Coalition of Independent Truck Companies, was recognized to speak in favor of the bill. After some discussion, Representative Dedmon moved for a favorable report. The motion passed.

HB 360, entitled, AN ACT TO EXPRESSLY ALLOW NONBINDING ARBITRATION IN HEALTH INSURANCE POLICIES; CLARIFY THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS;

AND TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS. Bill Hale, NC Department of Insurance, was recognized to explain the bill, and presented a proposed committee substitute. Representative Dockham moved to adopt the proposed committee substitute for consideration. The motion passed. Bill Hale presented a technical amendment, and explained same (page 6, line 14 between the word holder and the 45 days – add the phrase "upon receipt of the group's finalized benefits or". A second amendment was presented which states, "whichever is earlier". Representative Barbee moved for approval of the two amendments. The motion passed. Representative Dockham moved the two amendments be rolled into a committee substitute with a favorable report to the committee substitute, unfavorable to the original bill. The motion passed.

HB 790, entitled, AN ACT TO INCREASE THE DAMAGE AMOUNTS ON DEFINED MOTOR VEHICLE ACCIDENTS. Representative Starnes was recognized and presented a clarifying amendment. Representative Saunders moved for adoption of the amendment for consideration. Representative Johnson seconded the motion. The motion passed. This bill increases the damage amounts on defined motor vehicle accidents for purposes of determining the surcharges to be assessed under the Safe Driver Incentive Plan. Susan Valauri, Nationwide Insurance Company, was recognized to speak in opposition to the bill. Dascheil Propes, Chief Deputy Commissioner, NC Department of Insurance, was recognized and indicated there is currently a possible automobile insurance rate increase approaching 20%. Representative Saunders moved to roll the amendment into a committee substitute, with a favorable report to the committee substitute, unfavorable to the original bill. The motion failed.

HB 1120, entitled, AN ACT TO REQUIRE INEXPERIENCED DRIVERS TO MAINTAIN FINANCIAL RESPONSIBILITY CONTINUOUSLY AND INSURANCE COMPANIES TO TRANSMIT INFORMATION REGARDING FINANCIAL RESPONSIBILITY OF DRIVERS TO THE DIVISION OF MOTOR VEHICLES IN AN ELECTRONIC FORM. Representative Nye was recognized to explain the bill. HB 1120 would require the Division of Motor Vehicles to track insurance coverage of inexperienced drivers, defined as drivers whose drivers license has been in effect for three years or less. Current law requires DMV only to track continuous coverage of motor vehicles and lapses in coverage for vehicles. Representative Saunders moved for a favorable report. The motion passed.

HB 164, entitled, AN ACT TO PROVIDE FOR AUTOMOBILE INSURANCE PREMIUM DISCOUNTS FOR CERTAIN PERSONS WHO COMPLETE ACCIDENT PREVENTION COURSES. Representative Baker was recognized to explain the bill. This bill would allow insurance companies to provide a discount for certain people who pass safe driving classes. Bill Hale, Department of Insurance, was recognized to speak on current law. Representative Redwine moved for a favorable report. The motion passed.

HB 1105, entitled, AN ACT TO MAKE TECHNICAL CORRECTIONS TO INSURANCE LAWS. Bill Hale, Department of Insurance, was recognized to explain the bill. Representative Saunders moved for a favorable report. The motion passed.

There being no further business, the meeting was adjourned at 9:30 a.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
House Bills 1088, 360, 790, 1120, 164, and 1105
Bill Summaries
Handouts

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

April 24, 2001 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Wilson	NCATL
Mike Okun	NC State AFL-CIO
James Andrews	NC State AFL-CIO
John McMillan	MF+S PA.
Amy Jo Bain	NCMS
Robert Pasquale	Young, Moore
John M May	NC CWA political council
Victor Farah	Atty
Jim Lore	Lore & McClean
VL McBride	NATA
Jamie Dean	MGM
Bill Scoggin	KCAT
[illegible]	NC-AM

VISITOR REGISTRATION SHEET

INSURANCE — April 24, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Canales	Manning Fulton & Skinner
ANN LOVE	OUHS
Steve Woodson	NCFB
John Phelps	NCLM
Kimwood Jones	NCHA
Joyce Peters	NC Assoc/Nurses
Starla McKenney	NCDOT
Crissy Porter	Bone & Associates
D. Duke	[illegible]
Jenny Fullbright	Hunton & Williams
Susan Valauri	Nationwide

VISITOR REGISTRATION SHEET

INSURANCE — April 24, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
PAUL MAHONEY	NCANP
Don Imus	NY
[illegible]	NHA
BRUCE THOMPSON	PARKER POE ADAMS & BERNSTEIN, LLP
Charles McCord	MSNBC
[illegible]	RCBSNC
John Thompson	ACS
Beth Bigelow	Alley Associates
[illegible]	NCSAS
Chris Fitzsimon	Common Sense Fdtn
Lou C Numbers	BCBS

VISITOR REGISTRATION SHEET

INSURANCE — April 24, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Frank Lewis	OSBPM
Ann Duncan	NCAHP

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley and Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 1088 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THE COMMON LAW DETERMINES WHETHER A DRIVER OF A TRUCK OR TRACTOR TRAILER OF AN INTERSTATE MOTOR CARRIER IS AN EMPLOYEE SUBJECT TO THE WORKERS' COMPENSATION ACT.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1088

Short Title:	Workers Comp./Drivers of Interstate Carriers.	(Public)
Sponsors:	Representative Saunders.	
Referred to:	Insurance.	

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE COMMON LAW DETERMINES WHETHER A DRIVER OF A TRUCK OR TRACTOR TRAILER OF AN INTERSTATE MOTOR CARRIER IS AN EMPLOYEE SUBJECT TO THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-2(2) reads as rewritten:

"(2) Employee. – The term "employee" means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term "employee" shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term "employee" shall include all officers and employees thereof, including such as are elected by the people. The term "employee" shall include members of the North Carolina national guard while on State active duty under orders of the Governor and members of the North Carolina State Defense Militia while on State active duty under orders of the Governor. The term "employee" shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving on a fee basis or on a salary basis, or whether deputy sheriffs serving

HOUSE BILL 1088:
Wokers' Comp./Drivers of Interstate Carriers

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Saunders
Date:	April 24, 2001	**Summary by:**	Frank W. Folger
Version:	First Edition		Committee Counsel

SUMMARY: ***This bill would provide that the common law determines whether a driver of a truck or tractor-trailer of an interstate motor carrier is an employee subject to the workers' compensation act.***

CURRENT LAW: N.C.G.S. §97-19 provides an exception to the general "employer" and "employee" requirement for compensability under the Workers' Compensation Act. It is referred to as the "statutory employer" provision and imposes liability under the Act, under specified circumstances, on the principal contractor for injuries and death to subcontractors. In Cook v. Norvell-Mackorell Real Estate Co., the Court of Appeals determined that this provision did not apply between a principal and an independent contractor but only between two independent contractors.

North Carolina case law (common law) has stated that the vital test to be answered in determining whether an individual is an employee or independent contractor is whether "the employer has or has not retained the right of control or superintendence over the contractor or employee as to details." The Supreme Court has also established a set of criteria for determining whether. An independent contractor relationship is indicated if the person employed: 1. is engaged in an independent business, calling or occupation; 2.is to have the independent use of his special skill, knowledge, or training in the execution of the work; 3. is doing a specified piece of work at a fixed price or for a lump sum or upon a quantitative basis; 4. is not subject to discharge because he adopts one method of doing the work rather than another; 5. is not in the regular employ of the other contracting party; 6. is free to use such assistants as he may think proper; 7. has full control over such assistants; and 8. selects his own time.

BILL ANALYSIS: Section 1 would amend the definitional section of the Workers' Compensation Act on "employee" to declare that whether a truck diver or tractor trailer driver for a motor carrier licensed by the Interstate Commerce Commission is an employee of the carrier or an independent contractor would be determined by common law.

Section 2 would make the act effective upon becoming law and applicable to all claims for workers' compensation finally determined on or after that date.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley and Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 360 A BILL TO BE ENTITLED AN ACT TO EXPRESSLY ALLOW NONBINDING ARBITRATION IN HEALTH INSURANCE POLICIES; CLARIFY THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS; AND TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, ☒ which changes the title, unfavorable as to original bill.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 360*
PROPOSED COMMITTEE SUBSTITUTE H360-CSSV-17 [v.1]

4/18/2001 7:44:55 PM

Short Title: Health Insurance Omnibus Changes. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAW ON STIPULATIONS AS TO JURISDICTION AND LIMITATIONS OF ACTION AND THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; CLARIFY THE HMO POINT-OF-SERVICE LAW; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS; TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS; TO CLARIFY THE LAWS ON RECONSTRUCTIVE SURGERY NOTICES; AND TO CLARIFY THE LAW ON DEEMER PROVISIONS.

The General Assembly of North Carolina enacts:

PART I. JURISDICTION AND LIMITATION OF ACTIONS IN HEALTH INSURANCE POLICIES

SECTION 1. G.S. 58-3-35 reads as rewritten:

"**§ 58-3-35. Stipulations as to jurisdiction and limitation of actions.**

(a) ~~No company or order, domestic or foreign, authorized to do business in this State under Articles 1 through 64 of~~ No insurer, self-insurer, service corporation, HMO,

or MEWA licensed under this ~~Chapter, may~~ Chapter shall make any condition or stipulation in its insurance contracts or policies concerning the court or jurisdiction ~~wherein~~ in which any suit or action ~~thereon~~ on the contract may be brought.

(b) ~~may be brought, nor may it~~ No insurer, self-insurer, service corporation, HMO, or MEWA licensed under this Chapter shall limit the time within which ~~such~~ any suit or action referred to in subsection (a) of this section may be commenced to less than one year after the cause of action accrues or to less than six months from any time at which a plaintiff takes a nonsuit to an action begun within the legal time. ~~All conditions and stipulations forbidden by this section are void.~~

(c) All conditions and stipulations forbidden by this section are void."

PART II. PREFERRED PROVIDER PLAN CLARIFICATION

SECTION 2.1 G.S. 58-50-56(a)(3) reads as rewritten:

"(3) "Preferred provider benefit plan" means a health benefit plan offered by an insurer in which covered services are available from health care providers who under a contract with the insurer in accordance with this section and in which enrollees are given incentives through differentials in deductibles, coinsurance, or copayments to obtain covered health care services from contracted health care providers. ~~both of the following features are present:~~

~~a. Utilization review or quality management programs are used to manage the provision of covered health care services; andservices.~~

~~b. Enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those furnished by participating providers, and health care services are provided by preferred providers under a contract pursuant to this section.~~"

SECTION 2.2. G.S. 58-3-191(c) reads as rewritten:

"(c) For purposes of this section, "health benefit plan" or "plan" means (i) health maintenance organization (HMO) subscriber contracts and (ii) insurance company or hospital and medical service corporation preferred provider benefit plans ~~in which utilization review or quality management programs are used to manage the provision of covered health care services, and enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those provided by participating providers.~~as defined in G.S. 58-50-56."

PART III. SMALL EMPLOYER RATE GUARANTEES

SECTION 3. G.S. 58-50-130(b)(3) reads as rewritten:

"(3) ~~Small employer carriers~~ A small employer carrier shall not modify the premium rate ~~for~~ charged to a small employer or a small employer

group member, including changes in rates related to the increasing age of a group member, for 12 months from the initial issue date or renewal date, unless the group is composite rated and composition of the group changed by twenty percent (20%) or more or benefits are changed. The percentage increase in the premium rate charged to a small employer for a new rating period ~~may~~ shall not exceed the sum of the following:

a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period, and

b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer, and

c. Any adjustment because of change in coverage or change in case characteristics of the small employer group."

PART IV. PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION

SECTION 4. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-16. Promotion of alcohol and narcotic screening and intervention.**

G.S. 58-51-15(b)(11) does not apply to an accident or health insurance policy that provides hospital, medical, or surgical expense coverage."

PART V. NEWBORN AND FOSTER CHILD COVERAGE

SECTION 5. G.S. 58-31-30(b) reads as rewritten:

"(b) Every health benefit plan, as defined in G.S. 58-51-115(a)(1), 58-3-167, that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home. Every health benefit plan shall extend coverage to a foster child without requirements for prior notification unless an additional premium charge to add the foster child is due. If an additional premium charge is due to cover the foster child, the health benefit plan shall cover the foster child upon placement in the

foster home if the foster child is enrolled within 30 days after the placement in the foster home."

PART VI. SUCCESSOR PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY

SECTION 6. G.S. 58-51-110(b) reads as rewritten:

"(b) Whenever a contract described in subsection (a) of this section is replaced by another group contract within 15 days of termination of coverage of the previous group contract, the liability of the succeeding insurer for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding insurer's plan of ~~benefits with respect to classes eligible and activity at work and nonconfinement rules must~~ benefits, regardless of any other provisions of the new group contract relating to active employment or hospital confinement or pregnancy, shall be covered by the succeeding insurer's plan of benefits; and

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

PART VII. CONTINUATION ELECTION PERIOD

SECTION 7.1. G.S. 58-53-10 reads as rewritten:

"**§ 58-53-10. Eligibility.**

Continuation shall only be available to an employee or member who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately ~~prior to~~ before the date of termination. The employee or member may elect continuation for a period of not fewer than 60 days after the date of termination or loss of eligibility. The employee or member shall make the first contribution upon the election to continue coverage; and the coverage shall be retroactive to the date of termination or loss of eligibility."

SECTION 7.2. 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.~~policyholder or by the insurer."

PART VIII. HMO GROUP COVERAGE PREMIUM CHANGE NOTICE

SECTION 8.1 G.S. 58-67-50(b) reads as rewritten:

"(b) (1) Premium Approval.-- No schedule of premiums for ~~enrollee~~ coverage for health care services, or any amendment ~~thereto, may~~ to the schedule, shall be used in conjunction with any health care plan until a copy of ~~such schedule, or amendment thereto,~~ the schedule or amendment has been filed with and approved by the Commissioner.

(2) Individual coverage.—Premiums shall ~~Such premiums may~~ be established in accordance with actuarial principles for various categories of ~~enrollees, provided that premiums~~ enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of ~~his~~ the enrollee's health. ~~However, the premiums~~ Premiums shall not be excessive, inadequate, or unfairly discriminatory; and ~~must~~ shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. ~~Such~~ The premiums or any revisions ~~thereto~~ to the premiums with respect to nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 ~~months; or as an~~ months. As an alternative to giving ~~such~~ this guarantee ~~with respect only to~~ for nongroup enrollee coverage, ~~such~~ the premium or premium revisions may be made applicable to all similar category of enrollee coverage at one time if the health maintenance organization chooses to apply for ~~such~~ the premium revision with respect to such categories of coverages no more frequently than once in any 12-month period. ~~Such~~ The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the ~~corporation~~ HMO has given written notice of the premium revision to the enrollee 45 days ~~prior to~~ before the effective date of ~~such~~ the revision. The enrollee thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may ~~promulgate~~ adopt reasonable rules, after notice and hearing, to require the ~~submission~~ submittal of supporting data and such information ~~as is deemed~~ as the Commissioner considers necessary to determine

whether ~~such~~ the rate revisions meet ~~these standards.~~ the standards in this subdivision.

(3) Group Coverage. – Employer group premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate, or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any revisions to the premiums for employer group coverage shall be guaranteed for a period of not less than 12 months. No premium revision shall become effective for any category of group coverage unless the HMO has given written notice of the premium revision to the master group contract holder 45 days before the effective date of the revision. The master group contract holder thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision."

SECTION 8.2. G.S. 58-67-35(a)(6) reads as rewritten:

"(6) The offering and contracting for the provision or arranging of, in addition to health care services, of:

a. Additional health care services;

b. Indemnity benefits, covering out-of-area or emergency services;

c. Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or hospital or medical service corporations; and

d. Point-of-service products, for which an HMO may pre-certify out-of-plan covered services on the same basis as it pre-certifies in-plan covered services, and for which the Commissioner shall adopt rules governing:

1. The percentage of an HMO's total health care expenditures for out-of-plan covered services for all of its members that may be spent on those services, which may not exceed twenty percent (20%);

2. Product limitations, which may provide for payment differentials for services rendered by providers who are not in an HMO network, subject to G.S. 58-3-200(d).

3. Deposit and other financial requirements; and

4. Other requirements for marketing and administering those products."

PART IX. HIPAA COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE

SECTION 9. G.S. 58-68-30(d) reads as rewritten:

"(d) Exceptions. –

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. – A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5) Condition first diagnosed under previous coverage. – A group health insurer shall not impose any preexisting condition exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and the condition was covered under the qualifying previous coverage or prior creditable coverage; provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than 63 days before the enrollment date for the new coverage."

PART X. MEDICARE SUPPLEMENT GUARANTEED ISSUANCE

SECTION 10.1 G.S. 58-54-45 reads as rewritten:

"**§ 58-54-45. By reason of disability.**

(a) In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement ~~Plan A~~ Plans A, C, and J available to persons eligible for Medicare by reason of disability before age 65. This action shall be taken without regard to medical

condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B.

(b) Persons eligible for Medicare by reason of disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment, have the guaranteed right to purchase Medicare Supplement Plans A and C from any insurer within 63 days after the date of termination or disenrollment.

(c) An insurer may develop premium rates specific to the disabled population. No insurer shall discriminate in the pricing of the Medicare supplement plans referred to in this section because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the plan is submitted during an open enrollment or is submitted within 63 days after the managed care plan is terminated. The rates and any applicable rating factors for the Medicare supplement plans referred to in this section shall be filed with and approved by the Commissioner."

SECTION 10.2. Section 39 of S.L. 1998-211 reads as rewritten:

"Section 39. Except as otherwise provided herein, this act is effective as follows: this section and Sections 1, 2, 3, 4, 5, 6, 7, 9.1, 10, 11, 14, 15, 17, 18, 22, 27, 29, 32, 33, 34, 37.1, and 38 of this act are effective when they become law. Sections 9, 12, 13, 19, 20, 21, 23, 24, 25, 28, 30, 31, 35, 36, and 37 of this act become effective November 1, 1998. Sections 8, 16, and 26 of this act become effective January 1, 1999. ~~G.S. 58-54-45, as enacted by Section 13 of this act, expires November 1, 2001.~~"

PART XI. MEDICARE SUPPLEMENT AND LONG-TERM CARE RULES

SECTION 11.1. G.S. 58-54-50 reads as rewritten:

"**§ 58-54-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements.

(2) Establishing a uniform methodology for calculating and reporting loss ratios.

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.

(4) Establishing standards for Medicare Select policies and certificates.

(5) Any other changes required by Congress or the U.S. Department of Health and Human Services, or any successor agency."

SECTION 11.2. Article 55 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-55-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies."

PART XII. SHPPA REPEAL TECHNICAL CORRECTIONS

SECTION 12.1. G.S. 58-50-110(1) is repealed.

SECTION 12.2. G.S. 58-50-110(14) reads as rewritten:

"(14) 'Late enrollee' has the same meaning as defined in G.S. 58-68-30(b)(2); provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. In addition to the special enrollment provisions in G.S. 58-68-30(f), an eligible employee or dependent shall not be considered a late enrollee under a small employer health benefit plan if:

a. Repealed by Session Laws 1998-211, s. 9.

1, 2. Repealed by Session Laws 1998-211, s. 9.

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

b. The individual elects a different health benefit plan offered ~~through the Alliance or~~ by the small employer during an open enrollment period;

c. Repealed by Session Laws 1998-211, s. 9.

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

e. Repealed by Session Laws 1998-211, s. 9."

SECTION 12.3. G.S. 58-50-130(a)(4a) reads as rewritten:

"(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. ~~An accountable health carrier shall~~

~~not enforce participation or contribution requirements on member small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.~~"

PART XIII. RECONSTRUCTIVE SURGERY NOTICES

SECTION 13.1 G.S. 58-51-62(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ policyholder under ~~the~~ an individual policy, contract, or plan and to every certificate holder under a group policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the policyholder or certificate holder."

SECTION 13.2. G.S. 58-65-96(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ subscriber under ~~the~~ an individual certificate, contract, or plan and to every certificate holder under a group policy, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the subscriber or certificate holder."

SECTION 13.3. G.S. 58-67-79(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ subscriber under the plan upon enrollment and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the subscriber."

PART XIV. DEEMER PROVISIONS

SECTION 14. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-151. Deemer provisions.**

No entity subject to the Commissioner's jurisdiction and regulation shall be fined or penalized by the Commissioner for using forms, contracts, schedules of premiums, or other documents required to be filed and approved under this Chapter or for executing contracts required to be filed and approved under this Chapter if those forms, contracts, scheduled of premiums or other documents have been by law deemed to have been approved, and the entity has notified the Commissioner before using the filing or executing the contract that the law has deemed the filing to be approved."

PART XV. SEVERABILITY

SECTION 15. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

PART XVI. EFFECT OF HEADINGS

SECTION 16. 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 XVII. EFFECTIVE DATES

SECTION 17. Parts I through X of this act become effective October 1, 2001. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 360*

Short Title:	Health Insurance Omnibus Changes-AB.	(Public)
Sponsors:	Representatives Dockham and Hurley (Primary Sponsors).	
Referred to:	Insurance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO EXPRESSLY ALLOW NONBINDING ARBITRATION IN HEALTH INSURANCE POLICIES; CLARIFY THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS; AND TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS.

The General Assembly of North Carolina enacts:

PART I. NONBINDING ARBITRATION IN HEALTH INSURANCE POLICIES

SECTION 1. G.S. 58-3-35 reads as rewritten:

"**§ 58-3-35. Stipulations as to jurisdiction and limitation of actions.**

(a) ~~No company or order, domestic or foreign, authorized to do business in this State under Articles 1 through 64 of~~ No insurer, self-insurer, service corporation, HMO, or MEWA licensed under this ~~Chapter, may~~ Chapter shall make any condition or stipulation in its insurance contracts or policies concerning the court or jurisdiction ~~wherein~~ in which any suit or action ~~thereon~~ on the contract may be brought.

(b) ~~may be brought, nor may it~~ No insurer, self-insurer, service corporation, HMO, or MEWA licensed under this Chapter shall limit the time within which ~~such~~ any suit or action referred to in subsection (a) of this section may be commenced to less than one year after the cause of action accrues or to less than six months from any time at which a plaintiff takes a nonsuit to an action begun within the legal time. ~~All conditions and stipulations forbidden by this section are void.~~

(c) No health or life insurance policy or annuity contract shall contain any condition, provision, stipulation, or agreement that directly or indirectly deprives an insured or beneficiary of the right to a trial by jury or any question of fact arising under the policy or contract. An insurance policy or contract may contain an arbitration clause. The arbitration procedure and rights of the parties to the arbitration shall be substantially similar to those contained in Rules of the Supreme Court adopted under G.S. 7A-37.1 which give either party the option and right to proceed in the courts after an arbitration award.

(d) All conditions and stipulations forbidden by this section are void."

PART II. PREFERRED PROVIDER PLAN CLARIFICATION

SECTION 2. G.S. 58-50-56(a)(3) reads as rewritten:

"(3) "Preferred provider benefit plan" means a ~~health~~benefit plan offered by an insurer in which health care services are furnished by preferred health care providers under a contract in accordance with this section and in which either or both of the following features are present:

a. Utilization review or quality management programs are used to manage the provision of covered health care ~~services; and~~services.

b. Enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those furnished by participating providers.~~providers, and health care services are provided by preferred providers under a contract pursuant to this section.~~"

PART III. SMALL EMPLOYER RATE GUARANTEES

SECTION 3. G.S. 58-50-130(b)(3) reads as rewritten:

"(3) ~~Small employer carriers~~ A small employer carrier shall not modify the premium rate ~~for~~ charged to a small employer or a small employer group member, including changes in rates related to the increasing age of a group member, for 12 months from the initial issue date or renewal date, unless the group is composite rated and composition of the group changed by twenty percent (20%) or more or benefits are changed. The percentage increase in the premium rate charged to a small employer for a new rating period ~~may~~ shall not exceed the sum of the following:

a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period, and
b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer, and
c. Any adjustment because of change in coverage or change in case characteristics of the small employer group."

PART IV. PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION

SECTION 4.1. G.S. 58-51-15(b)(11) is repealed.

SECTION 4.2. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-16. Promotion of alcohol and narcotic screening and intervention.**

No insurer licensed under this Chapter shall make any condition or stipulation in its accident or health insurance contracts that would defeat or avoid coverage as a result of loss sustained or contracted in consequence of the insured's being under the influence of alcohol or a narcotic."

PART V. NEWBORN AND FOSTER CHILD COVERAGE

SECTION 5. G.S. 58-31-30(b) reads as rewritten:

"(b) Every health benefit plan, as defined in G.S. 58-51-115(a)(1), 58-3-167, that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home."

PART VI. SUCCESSOR PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY

SECTION 6. G.S. 58-51-110(b) reads as rewritten:

"(b) Whenever a contract described in subsection (a) of this section is replaced by another group contract within 15 days of termination of coverage of the previous group

contract, the liability of the succeeding insurer for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding insurer's plan of ~~benefits with respect to classes eligible and activity at work and nonconfinement rules must~~ benefits, regardless of any other provisions of the new group contract relating to active employment or hospital confinement or pregnancy, shall be covered by the succeeding insurer's plan of benefits; and

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

PART VII. CONTINUATION ELECTION PERIOD

SECTION 7.1. G.S. 58-53-10 reads as rewritten:

"**§ 58-53-10. Eligibility.**

Continuation shall only be available to an employee or member who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately ~~prior to~~ before the date of termination. The employee or member may elect continuation for a period of not fewer than 60 days after the date of termination or loss of eligibility. The employee or member shall make the first contribution upon the election to continue coverage; and the coverage shall be retroactive to the date of termination or loss of eligibility."

SECTION 7.2. 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.~~policyholder or by the insurer."

PART VIII. HMO GROUP COVERAGE PREMIUM CHANGE NOTICE

SECTION 8. G.S. 58-67-50(b) reads as rewritten:

"(b) (1) Premium Approval.-- No schedule of premiums for ~~enrollee~~ coverage for health care services, or any amendment ~~thereto, may~~ to the schedule, shall be used in conjunction with any health care plan until a copy of ~~such schedule, or amendment thereto,~~ the schedule or amendment has been filed with and approved by the Commissioner.

(2) Individual coverage.—Premiums shall ~~Such premiums may~~ be established in accordance with actuarial principles for various categories of ~~enrollees, provided that premiums~~ enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of ~~his~~ the enrollee's health. ~~However, the premiums~~ Premiums shall not be excessive, inadequate, or unfairly discriminatory; and ~~must~~ shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. ~~Such~~ The premiums or any revisions ~~thereto~~ to the premiums with respect to nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 ~~months; or as an~~ months. As an alternative to giving ~~such~~ this guarantee ~~with respect only to~~ for nongroup enrollee coverage, ~~such~~ the premium or premium revisions may be made applicable to all similar category of enrollee coverage at one time if the health maintenance organization chooses to apply for ~~such~~ the premium revision with respect to such categories of coverages no more frequently than once in any 12-month period. ~~Such~~ The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the ~~corporation~~ HMO has given written notice of the premium revision to the enrollee 45 days ~~prior to~~ before the effective date of ~~such~~ the revision. The enrollee thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may ~~promulgate~~ adopt reasonable rules, after notice and hearing, to require the ~~submission~~ submittal of supporting data and such information ~~as is deemed~~ as the Commissioner considers necessary to determine whether ~~such~~ the rate revisions meet ~~these standards.~~ the standards in this subdivision.

(3) Group Coverage. – Employer group premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate, or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any revisions to the premiums for employer group coverage shall be guaranteed for a period of not less than 12 months. No premium

revision shall become effective for any category of group coverage unless the HMO has given written notice of the premium revision to the master group contract holder 45 days before the effective date of the revision. The master group contract holder thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision."

PART IX. HIPAA COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE

SECTION 9. G.S. 58-38-30(d) reads as rewritten:

"(d) Exceptions. –

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. – A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5) Condition first diagnosed under previous coverage. – A group health insurer shall not impose any preexisting condition exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and the condition was covered under the qualifying previous coverage or prior creditable coverage; provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than 63 days before the enrollment date for the new coverage."

PART X. MEDICARE SUPPLEMENT GUARANTEED ISSUANCE

SECTION 10. G.S. 58-54-45 reads as rewritten:

"**§ 58-54-45. By reason of disability.**

(a) In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement ~~Plan A~~ Plans A, C, and J available to persons eligible for Medicare by reason of disability before age 65. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B.

(b) Persons eligible for Medicare by reason of disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment, have the guaranteed right to purchase Medicare Supplement Plans A and C from any insurer within 63 days after the date of termination or disenrollment.

(c) An insurer may develop premium rates specific to the disabled population. No insurer shall discriminate in the pricing of the Medicare supplement plans referred to in this section because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the plan is submitted during an open enrollment or is submitted within 63 days after the managed care plan is terminated. The rates and any applicable rating factors for the Medicare supplement plans referred to in this section shall be filed with and approved by the Commissioner."

PART XI. MEDICARE SUPPLEMENT AND LONG-TERM CARE RULES

SECTION 11.1. G.S. 58-54-50 reads as rewritten:

"**§ 58-54-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements.

(2) Establishing a uniform methodology for calculating and reporting loss ratios.

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.

(4) Establishing standards for Medicare Select policies and certificates.

(5) Any other changes required by Congress or the U.S. Department of Health and Human Services, or any successor agency."

SECTION 11.2. Article 55 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-55-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies."

PART XII. SHPPA REPEAL TECHNICAL CORRECTIONS

SECTION 12.1. G.S. 58-50-110(1) is repealed.

SECTION 12.2. G.S. 58-50-110(14) reads as rewritten:

"(14) 'Late enrollee' has the same meaning as defined in G.S. 58-68-30(b)(2); provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. In addition to the special enrollment provisions in G.S. 58-68-30(f), an eligible employee or dependent shall not be considered a late enrollee under a small employer health benefit plan if:

a. Repealed by Session Laws 1998-211, s. 9.

1, 2. Repealed by Session Laws 1998-211, s. 9.

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

b. The individual elects a different health benefit plan offered ~~through the Alliance or~~ by the small employer during an open enrollment period;

c. Repealed by Session Laws 1998-211, s. 9.

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

e. Repealed by Session Laws 1998-211, s. 9."

SECTION 12.3. G.S. 58-50-130(a)(4a) reads as rewritten:

"(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. ~~An accountable health carrier shall not enforce participation or contribution requirements on member~~

~~small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.~~"

PART XIII. THIRD PARTY ADMINISTRATOR

SECTION 13.(a) G.S. 58-56-51(b) reads as rewritten:

"(b) Each application for the issuance or renewal of a license shall be made upon a form prescribed by the Commissioner and shall be accompanied by a nonrefundable filing fee of one hundred dollars ($100.00) and evidence of maintenance of a fidelity bond, errors and omissions liability insurance, or other security, of a type and in an amount to be determined by rules of the Commissioner. Applications for issuance of licenses shall include or be accompanied by the following information and documents:

(1) All organizational documents of the TPA, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, or trust agreement, any other applicable documents, and all amendments to these documents.

(2) The bylaws, rules, regulations, or similar documents regulating the internal affairs of the TPA.

(3) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of affairs of the TPA, including all (i) members of the board of directors, board of trustees, executive committee, or other governing board or committee, (ii) the principal officers in the case of a corporation or the partners or members in the case of a partnership or association, (iii) all shareholders holding directly or indirectly ten percent (10%) or more of the voting securities of the TPA, and (iv) any other person who exercises control or influence over the affairs of the TPA.

(4) Annual financial statements or reports for the two most recent years that prove that the applicant is solvent and any other information the Commissioner may require in order to review the current financial condition of the applicant.

(5) A general description of the business operations, including information on staffing levels and activities proposed in this State and nationwide. The description must provide details setting forth the TPA's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping, and underwriting.

(6) If the applicant will be managing the solicitation of new or renewal business, evidence that it employs or has contracted with an agent licensed by this State for soliciting and taking applications. Any applicant that intends to directly solicit insurance contracts or to otherwise act as an insurance agent must provide proof of having a license as an insurance agent in this State.

(7) Any other pertinent information required by rules of the Commissioner.

The information required by subdivisions (1) through (7) of this subsection, including any ~~trade secrets, shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding instituted against the TPA. Applications for renewals of licenses shall include or be accompanied by any changes in the information required by subdivisions (1) through (7) of this subsection.~~documents, materials, or other information in the possession or control of the Department that are furnished by a third-party administrator, insurer, producer, or any employee or agent acting on behalf of the third-party administrator, insurer or producer, or obtained by the Commissioner, shall be kept confidential. However, the Commissioner may use those documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties."

SECTION 13.(b) Article 56 of Chapter 58 of the General Statutes is amended by adding the following new subdivisions to read:

"(b1) In order to assist in the performance of the Commissioner's duties, the Commissioner may:

(1) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (b) of this section, with other state, federal, and international regulatory agencies, with the NAIC and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information.

(2) Receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(3) Enter into agreements governing sharing and use of information consistent with this section.

(b2) No waiver of an existing privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (g) of this section.

(b3) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this State.

(b4) In this section, 'department', 'insurance regulator', 'law enforcement official or authority', 'NAIC', and 'regulatory official or agency' include employees, agents, consultants, and contractors of those entities.

(b5) Applications for renewals of licenses shall include or be accompanied by any changes in the information required by subdivisions (1) through (7) of subsection (b) of this section."

SECTION 14. This act becomes effective October 1, 2001.

HOUSE BILL 360:
Health Insurance Omnibus Changes-AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Reps. Hurley and Dockham
Date:	April 19, 2001	**Summary by:**	Trina Griffin
Version:	Proposed Committee Substitute **H360-CSSV-17[v.2]**		Committee Counsel

SUMMARY: ***This bill makes several changes and clarifications in the law regarding health insurance.***

BILL ANALYSIS BY PART:

I. JURISDICTION AND LIMITATION OF ACTIONS IN HEALTH INSURANCE POLICIES

This section of the bill clarifies that insurers, self-insurers, service corporations, HMOs, and MEWAs may not make any condition in their insurance contracts concerning the court or jurisdiction in which a suit on the contract may be brought.

II. PREFERRED PROVIDER PLAN CLARIFICATION.

This section deletes references to the use of utilization review or quality management programs as part of the definition of "preferred provider benefit plan" and "health benefit plan".

III. SMALL EMPLOYER RATE GUARANTEES.

This section amends the small employer rate guarantee law by prohibiting a small employer carrier from modifying the premium rate charged to a small employer group member during a 12-month period as a result of the increasing age of a group member.

IV. PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION

Currently, insurance policies that address intoxicants and narcotics must contain the following provision: "Except for the payment of benefits for the necessary care and treatment of chemical dependency as provided by law, the insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician." House Bill 360 provides that this provision does not apply to an accident or health insurance policy that provides hospital, medical, or surgical expense coverage.

V. NEWBORN AND FOSTER CHILD COVERAGE

This section of the bill amends the law on newborn and foster care coverage to require health benefit plans to provide coverage to a newborn or foster child without requirements for prior notification unless an additional premium is due.

VI. SUCCESSOR PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY

This section amends the law for commercial insurers to conform to the HMO law regarding replacement coverage. The bill would prohibit an insurer implementing replacement rules that would allow a delay in the effective date of coverage for an insured with regard to active employment, confinement to a hospital, or pregnancy.

VII. CONTINUATION ELECTION PERIOD

This section provides that a person who elects continuation coverage must do so for a period of not fewer than 60 days after the date of termination or eligibility from the prior plan. This provision is identical to that provided by COBRA.

VIII. HMO GROUP COVERAGE PREMIUM CHANGE NOTICE

This section requires HMOs that provide group coverage to provide 45 days' notice for premium changes.

IX. HIPAA COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE.

This section prohibits a group health insurer from imposing a preexisting condition exclusion under successor health care coverage for a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person was previously covered, provided that the previous coverage was continuous to a date not more than 63 days before the enrollment date for new coverage.

X. MEDICARE SUPPLEMENT GUARANTEED ISSUANCE

This section expands open enrollment to include Plan C and J for all Medicare eligibles below age 65 due to disability if they enroll during the open enrollment period. This would also guarantee issuance of replacement coverage from Plans A and C to Medicare eligibles below age 65 due to disability who have been terminated by a Medicare managed care plan.

XI. MEDICARE SUPPLEMENT AND LONG-TERM CARE RULES

This section allows the Commissioner to adopt temporary rules for Medicare supplement and long-term care insurance to implement federal requirements.

XII. SHPPA REPEAL TECHNICAL CORRECTIONS

This section makes several technical corrections to reflect the repeal of the State Health Plan Purchasing Alliance law.

XIII. RECONSTRUCTIVE SURGERY NOTICES

This section amends the law on notice to policyholders about the benefit concerning reconstructive surgery after a mastectomy. Currently, North Carolina law requires an annual notice to every person insured under the policy. The bill would amend this to only require annual notice only to the individual whose name is on the policy or certificate if it is a group policy.

XIV. DEEMER PROVISIONS

This section provides that if the Commissioner does not approve a document required to be filed with the Department within a given period of time, the document is deemed to be approved and no insurer will be fined or penalized for using such forms, contracts, schedules of premiums, or other documents.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

April 19, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale

SUBJECT: House Bill 360 (PCS) – Health Insurance Omnibus Changes

SECTION 1. This amends the law prohibiting insurers from limiting the jurisdiction or time within which a suit may be brought by a policyholder by extending the prohibition to HMOs, service corporations, and multiple employer welfare arrangements.

SECTION 2.1. This removes the inappropriate requirement that a preferred provider benefit plan must include utilization review. This also makes the statutory definition consistent with the definition found in administrative rules.

SECTION 2.2. This makes a parallel amendment to a definition in one of the managed care statutes.

SECTION 3. This amends the 12-month rate guarantee law to assure that a small employer pays the same premium for 12, with a few exceptions.

SECTION 4. There is a provision of North Carolina law, which was adopted more than four decades ago, that is outdated because it predates the development of trauma centers, as well as the general availability of effective treatment for alcohol problems. Thirty-eight states (including NC) and the District of Columbia adopted this law as part of their insurance codes, and four more states have restrictions on coverage for drug and alcohol-related injuries. The North Carolina law contains a provision that states, "The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician." As a result, emergency departments and trauma centers generally do not screen for intoxicants and instead spend valuable time running other expensive tests, so insurers end up paying more than they would for alcohol screening and treatment.

SECTION 5. This provides that every health benefit plan shall extend coverage to a newborn (including adoptees and foster children) without requirements for notification to the plan unless an additional premium charge is required to add the dependent. The

proposed language will also clarify that when additional premiums are due the plan shall provide a period of not less than 30 days for payment of the premiums and the coverage will be effective back to the qualifying date.

SECTION 6. This amends a law for commercial insurers to conform to the HMO law regarding replacement coverage. A recent HCFA bulletin stated that group replacement coverage must comply with the HIPAA prohibition on access tied to factors related to health status. An insurer cannot use replacement rules that allow a delay in the effective date of coverage for an individual when the insured is confined in a health care setting or a period of disability when coverage is effective for the group. This is needed in order to make sure the group replacement laws are all consistent and that the intent of HCFA bulletin and HIPPA is reflected in our laws.

SECTIONS 7.1 and 7.2. These provide employees under the health insurance continuation law (similar to COBRA, but for small groups) with 60 days from their loss of insurance eligibility to elect group continuation and to pay the first premium, which is identical to that provided by COBRA.

SECTION 8.1. This provides that HMOs must give 45 days' notice of rate increases to group policyholders. It tracks the law for individual policyholders.

SECTION 8.2. This clarifies the HMO point-of-service law, which allows for services provided by non-network providers, to allow HMOs to pre-certify those services as they do network provider services.

SECTION 9. This provides that a pre-existing condition does not include a condition for which medical advice, diagnosis, or care or treatment was recommended or received for the first time while a person was covered under a previous plan that covered that condition, as long as coverage under the previous plan was in effect not more than 63 days before the person's enrollment under the new coverage.

SECTIONS 10.1 and 10.2. These expand guaranteed open enrollment to include Plan C and J for all Medicare eligibles below age 65 (due to disability) if they enroll during the open enrollment period. These would also guarantee issuance of replacement coverage from Plans A and C to Medicare eligibles below age 65 (due to disability) who have been terminated by a Medicare managed care plan.

SECTIONS 11.1 and 11.2. More and more, the Congress and the U.S. Department of Health and Human Services are requiring the states to change their laws on Medicare supplement and long-term care insurance, usually by requiring amendments to model regulations that have been adopted by the National Association of Insurance Commissioners (NAIC) and in turn have been adopted by the states. The federal government requires these changes to be implemented within timeframes that, under North Carolina's rulemaking laws, make it impossible for the Department to adopt rules in time to comply. This lack of compliance can cause a state to lose its control over companies that write these important coverages. Fortunately, the Department's statutory authority to make these rule changes has sufficed. However, now the Department needs the ability to more quickly react to federal changes, and these sections will provide for that ability.

SECTIONS 12.1, 12.2, and 12.3. The State Health Plan Purchasing Alliance law was repealed by the 1999 General Assembly. These make technical corrections to reflect that repeal.

SECTIONS 13.1, 13.2, and 13.3. These amend the laws on reconstructive surgery after a mastectomy to make North Carolina laws follow federal requirements on notice to policyholders about the benefit. Present North Carolina law requires an annual notice to every person insured under the policy, which is impractical. These take a sensible approach and amend the law to require an annual notice to the individual whose name is on the policy or certificate (if it is a group policy).

SECTION 14. In the insurance laws on rate and policy form filings, there are what are known as "deemer provisions." These laws provide that if the Department does not approve a filing within a given period of time, the law "deems" the filing to be approved. The mechanics of handling deemer provisions in the day-to-day world of many filings can get complicated. This section takes a sensible approach and gives the filing insurance company the opportunity to point out to the Department that it can use a filing that the law has itself approved without having to go through the initial stages of answering questions from the Department about whether the filing has been approved or disaproved.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 790

Short Title:	Increase Damage Limits for MV Accidents.	(Public)
Sponsors:	Representative Starnes.	
Referred to:	Insurance.	

March 26, 2001

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE DAMAGE AMOUNTS ON DEFINED MOTOR VEHICLE ACCIDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-75(a) reads as rewritten:

"(a) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) may provide for separate surcharges for major, intermediate, and minor accidents. A "major accident" is an at-fault accident that results in either (i) bodily injury or death or (ii) only property damage of ~~two thousand five hundred dollars ($2,500)~~ four thousand dollars ($4,000) or more. An "intermediate accident" is an at-fault accident that results in only property damage of more than ~~one thousand five hundred dollars ($1,500)~~ three thousand five hundred dollars ($3,500) but less than ~~two thousand five hundred dollars ($2,500).~~ four thousand dollars ($4,000). A "minor accident" is an at-fault accident that results in only property damage of ~~one thousand five hundred dollars ($1,500)~~ three thousand dollars ($3,000) or less. The subclassification plan may also exempt certain minor accidents from the Facility recoupment surcharge. The Bureau shall assign varying Safe Driver Incentive Plan point values and surcharges for bodily injury in at-fault accidents that are commensurate with the severity of the injury, provided that the point value and surcharge assigned for the most severe bodily injury shall not exceed the point value and surcharge assigned to a major accident involving only property damage."

SECTION 2. This act becomes effective October 1, 2001.

HOUSE BILL 790:
Increase Damage Limits for MV Accidents

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Starnes
Date:	April 23, 2001	**Summary by:**	Trina Griffin
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 790 increases the damage amounts on defined motor vehicle accidents for purposes of determining the surcharges to be assessed under the Safe Driver Incentive Plan. The act would become effective October 1, 2001.***

CURRENT LAW: The North Carolina Rate Bureau has developed, subject to review and modification by the Commissioner of Insurance, a Safe Driver Incentive Plan ("Plan") to adequately and factually distinguish among various classes of drivers that have safe driving records and various classes of drivers that have a record of at-fault accidents, a record of convictions for major or minor moving traffic violations, or a combination. The Plan also provides for premium differentials among these classes of drivers.

The Plan may provide for separate surcharges for major, intermediate, and minor accidents. Each of these types of accidents is defined based on the value of property damage caused by the accident. Under current law, the following property damage limits apply:

Major accident = Results in either bodily injury or death **or** only property damage of $2,500 or more.

Intermediate accident = Property damage of more than $1,500 but less than $2,500.

Minor accident = Property damage of $1,500 or less.

BILL ANALYSIS: House Bill 790 increases the damage limits for purposes of classifying at-fault automobile accidents under the Plan as follows:

Major accident = Results in either bodily injury or death **or** only property damage of $4,000 or more.

Intermediate accident = Property damage of more than $3,500 but less than $4,000.

Minor accident = Property damage of $3,000 or less.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley and Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1120 A BILL TO BE ENTITLED AN ACT TO REQUIRE INEXPERIENCED DRIVERS TO MAINTAIN FINANCIAL RESPONSIBILITY CONTINUOUSLY AND INSURANCE COMPANIES TO TRANSMIT INFORMATION REGARDING FINANCIAL RESPONSIBILITY OF DRIVERS TO THE DIVISION OF MOTOR VEHICLES IN AN ELECTRONIC FORM.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 1120

Short Title:	Financial Resp. of Inexperienced Drivers.	(Public)
Sponsors:	Representative Nye.	
Referred to:	Insurance.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INEXPERIENCED DRIVERS TO MAINTAIN FINANCIAL RESPONSIBILITY CONTINUOUSLY AND INSURANCE COMPANIES TO TRANSMIT INFORMATION REGARDING FINANCIAL RESPONSIBILITY OF DRIVERS TO THE DIVISION OF MOTOR VEHICLES IN AN ELECTRONIC FORM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-7(c1) reads as rewritten:

"(c1) Insurance. – The Division ~~may~~ shall not issue a drivers license to a person until the person has furnished proof of financial responsibility. Proof of financial responsibility shall be in one of the following forms:

(1) A written certificate or electronically-transmitted facsimile thereof from any insurance carrier duly authorized to do business in this State certifying that there is in effect a nonfleet private passenger motor vehicle liability policy for the benefit of the person required to furnish proof of financial responsibility. The certificate or facsimile shall state the effective date and expiration date of the nonfleet private passenger motor vehicle liability policy and shall state the date that the certificate or facsimile is issued. The certificate or facsimile shall remain effective proof of financial responsibility for a period of 30 consecutive days following the date the certificate or facsimile is issued but shall not in and of itself constitute a binder or policy of insurance.

(2) A binder for or policy of nonfleet private passenger motor vehicle liability insurance under which the applicant is insured, provided that the binder or policy states the effective date and expiration date of the nonfleet private passenger motor vehicle liability policy.

The preceding provisions of this subsection do not apply to applicants who do not own currently registered motor vehicles and who do not operate nonfleet private passenger motor vehicles that are owned by other persons and that are not insured under commercial motor vehicle liability insurance policies. In such cases, the applicant shall sign a written certificate to that effect. Such certificate shall be furnished by the Division and may be incorporated into the license application form. Any material misrepresentation made by such person on such certificate shall be grounds for suspension of that person's license for a period of 90 days.

For the purpose of this subsection, the term 'nonfleet private passenger motor vehicle' has the definition ascribed to it in Article 40 of General Statute Chapter 58.

The Commissioner may require that certificates required by this subsection be on a form approved by the Commissioner.

The requirement of furnishing proof of financial responsibility does not apply to a person who applies for a renewal of his or her drivers license.

Nothing in this subsection precludes any person from showing proof of financial responsibility in any other manner authorized by Articles 9A and 13 of this Chapter.

This subsection does not apply to inexperienced drivers, as that term is defined in subsection (c2) of this section."

SECTION 2. G.S. 20-7 is amended by adding a new subsection to read:

"(c2) Insurance. – The Division shall not issue a drivers license to an inexperienced driver until the Division confirms that there is in effect a nonfleet private passenger motor vehicle liability policy covering that person from an insurance carrier duly authorized to do business in this State. Every person applying for a drivers license for the first time shall state the motor vehicle liability policy number on the application. Every person licensed to operate a motor vehicle in this State shall maintain financial responsibility continuously for the period of time that person is an inexperienced driver. As used in this section, "inexperienced driver" is a person who has been issued a drivers license in this State and the license has been in effect for a period of three years or less."

SECTION 3. Article 2 of Chapter 20 of the General Statutes is amended by adding a new section to read:

"**§ 20-7.3. Insurance carriers transmit policy information electronically.**

On a monthly basis, every insurance carrier authorized to do business in this State shall transmit to the Division of Motor Vehicles, in electronic form, information about every nonfleet private passenger motor vehicle liability policy in effect, including the vehicle identification number associated with the policy, the effective date and expiration date of each policy, and the names and drivers license numbers of all persons authorized to drive the motor vehicle covered under each policy."

SECTION 4. G.S. 20-309(e) reads as rewritten:

"(e) Upon termination by cancellation or otherwise of an insurance policy provided in subsection (b) of this section, the insurer shall notify the Division of the termination within 20 business days; provided, no cancellation notice is required if the same insurer issues a replacement insurance policy complying with this Article at the

same time the insurer cancels or otherwise terminates the old policy, no lapse in coverage results, and the insurer sends the certificate of insurance form for the new policy to the Division. The insurer shall notify the Division of any new policy for insurance within 20 working days of its issuance unless the new coverage is a replacement insurance policy for a policy terminated by the same insurer. ~~Any insurance company with twenty-five million dollars ($25,000,000) or more in annual vehicle insurance premium volume must~~ Insurers shall submit the notices required under this section by electronic means. ~~All other insurance companies may submit the notices required under this section by either paper or electronic means.~~ The names of insureds and the beginning date and termination date of insurance coverage provided to the Division by the insurer pursuant to this paragraph shall constitute a designated trade secret under G.S. 132-1.2.

The Division, upon receiving notice of a lapse in insurance coverage, shall notify the owner of the lapse in coverage, and the owner shall, to retain the registration plate for the vehicle registered or required to be registered, within 10 days from date of notice given by the Division either:

(1) Certify to the Division that he had financial responsibility effective on or prior to the date of such termination; or

(2) In the case of a lapse in financial responsibility, pay a fifty dollar ($50.00) civil penalty; and certify to the Division that he now has financial responsibility effective on the date of certification, that he did not operate the vehicle in question during the period of no financial responsibility with the knowledge that there was no financial responsibility, and that the vehicle in question was not involved in a motor vehicle crash during the period of no financial responsibility.

Failure of the owner to certify that he has financial responsibility as herein required shall be prima facie evidence that no financial responsibility exists with regard to the vehicle concerned and unless the owner's registration plate has on or prior to the date of termination of insurance been surrendered to the Division by surrender to an agent or representative of the Division designated by the Commissioner, or depositing the same in the United States mail, addressed to the Division of Motor Vehicles, Raleigh, North Carolina, the Division shall revoke the vehicle's registration for 30 days.

In no case shall any vehicle, the registration of which has been revoked for failure to have financial responsibility, be reregistered in the name of the registered owner, spouse, or any child of the spouse, or any child of such owner within less than 30 days after the date of receipt of the registration plate by the Division of Motor Vehicles, except that a spouse living separate and apart from the registered owner may register such vehicle immediately in such spouse's name. Additionally, as a condition precedent to the reregistration of the vehicle by the registered owner, spouse, or any child of the spouse, or any child of such owner, except a spouse living separate and apart from the registered owner, the payment of a restoration fee of fifty dollars ($50.00) and the appropriate fee for a new registration plate is required. Any person, firm or corporation

failing to give notice of termination shall be subject to a civil penalty of two hundred dollars ($200.00) to be assessed by the Commissioner of Insurance upon a finding by the Commissioner of Insurance that good cause is not shown for such failure to give notice of termination to the Division."

SECTION 5. This act becomes effective October 1, 2001, except that this act shall not become effective until funds are appropriated to implement the provisions of this act.

HOUSE BILL 1120:
Financial Resp. of Inexperienced Drivers

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Nye
Date:	April 24, 2001	**Summary by:**	Linda Attarian
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 1120 would require the Division of Motor Vehicles (DMV) to track insurance coverage of inexperienced drivers, defined as drivers whose driver license has been in effect for three years or less. Current law requires DMV only to track continuous coverage of motor vehicles and lapses in coverage for vehicles. The act is effective on October 1, 2001, but will not become effective until funds are appropriated to implement the act.

CURRENT LAW: *Collecting proof of financial responsibility:* Under G.S. 20-7, the only persons required to show proof of financial responsibility (i.e., covered under a motor vehicle liability policy) are those receiving a North Carolina driver license for the first time, which may be an inexperienced driver, a person moving here from another state, a person getting a license after a period of license suspension or revocation, or a person getting their license after a voluntary surrender.

Maintaining proof of financial responsibility: Nothing in the General Statutes requires a licensed driver to maintain proof of financial responsibility. G.S. 20-309(a) requires an owner of a motor vehicle to maintain financial responsibility continuously throughout the period of registration.

BILL ANALYSIS: **Section 1** makes a conforming change to subsection (c1) of G.S. 20-7 by stating that the subsection does not apply to inexperienced drivers, as defined in a new subsection (c2) provided for in **Section 2** of the bill.

G.S. 20-7(c1) currently states that the Division of Motor Vehicles may not issue a driver's license to a person unless the driver shows proof of financial responsibility (liability insurance).

Section 2 adds a new subsection (c2) to G.S. 20-7 to define an inexperienced driver as a person whose drivers license has been in effect for three years or less, and to require the DMV:

- To collect proof that the inexperienced driver is covered under a motor vehicle liability; and
- To ensure that every person applying for a driver's license for the first time states on the application the policy number of the liability insurance the driver is covered under.

Section 2 also specifies that all inexperienced drivers (a driver with a license that has been in effect for three years or less) must continue to be financially responsible for the full three years.

Section 3 adds a new subsection to Article 2 of Chapter 20 to require the DMV to collect information to track proof of financial responsibility of inexperienced drivers and for insurers to provide it. The insurer must submit monthly and electronically the following information to the DMV:

- The vehicle identification number associated with the policy;
- The effective date and expiration date of the policy; and
- The names and diver's license numbers of all persons authorized to drive the motor vehicle covered under each policy.

Section 4 amends G.S. 20-309(e) to require all insurers to submit notices of cancellation or issuance of motor vehicle insurance policies to the DMV electronically. Currently, the system is essentially a paper process, however, effective October 1, 2000 insurers with $25,000,000 or more in annual vehicle incurrence premium volume must send such notices to the DMV electronically.

Section 5 makes this act effective October 1, 2002, except that this act shall not become effective until funds are appropriated to implement the act.

BACKGROUND:

In 1999, the General Assembly directed the DMV to develop a plan to improve the system of collecting and maintaining proof of financial responsibility for newly licensed drivers classified as inexperienced operators. The Division submitted its report to the Joint Legislative Transportation Oversight Committee. House Bill 1120 reflects their proposal. The legislation does not include an appropriation to the DMV to purchase and implement the necessary computer system.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley and Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 164 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR AUTOMOBILE INSURANCE PREMIUM DISCOUNTS FOR CERTAIN PERSONS WHO COMPLETE ACCIDENT PREVENTION COURSES.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 164

Short Title:	Accident Prevention Course Reduction.	(Public)
Sponsors:	Representative Baker.	
Referred to:	Insurance.	

February 19, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR AUTOMOBILE INSURANCE PREMIUM DISCOUNTS FOR CERTAIN PERSONS WHO COMPLETE ACCIDENT PREVENTION COURSES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-66. Private passenger motor vehicle insurance premium rate reduction for completion of accident prevention course.**

(a) The classification plan promulgated pursuant to G.S. 58-36-65 may provide for an appropriate reduction in premium rates for liability and physical damage coverages to those insureds 55 years of age or older who successfully complete motor vehicle accident prevention courses approved by the Commissioner of Motor Vehicles. Those insureds shall qualify for the reduction for a three-year period after the policy issuance or renewal that follows the completion of the course. Each insured shall successfully complete an approved course every three years to be eligible for the reduction. Any reduction used by an insurer shall be presumed appropriate unless credible data demonstrate otherwise.

(b) Upon successfully completing an approved course, each insured shall be issued a completion certificate by the course's sponsor, on a form approved by the Commissioner of Motor Vehicles, which shall be the only acceptable evidence of qualification for the reduction in rates.

No reduction in rates shall be allowed for:

(1) Self-instructed courses;

(2) Courses that do not provide actual classroom instruction for the minimum number of hours prescribed by the Commissioner of Motor Vehicles; or

(3) Any course required to be taken by:

a. A court order;
b. A Division of Motor Vehicles order or regulation; or
c. A statutory mandate.

(c) An insured who has more than two Safe Driver Incentive Plan points assessed against him or her is not eligible for the reduction in premium rates provided for in this section. The insured's ineligibility shall continue until the insured no longer has more than two Safe Driver Incentive Plan, points and the insured successfully completes an approved course.

(d) Insurers that write nonfleet private passenger motor vehicle insurance may deviate from the reduction promulgated by the North Carolina Rate Bureau and approved by the Commissioner to provide a greater discount as approved by the Commissioner.

(e) The provisions of this section shall not apply to rates used on motor vehicle insurance policies reinsured by the North Carolina Motor Vehicle Reinsurance Facility under Article 37 of this Chapter."

SECTION 2. The North Carolina Rate Bureau shall promulgate a revision to the classification plan to reflect the provisions of this act. The Bureau shall file the revision with the Commissioner no later than September 1, 2001, and the revision shall become effective January 1, 2002.

SECTION 3. Sections 2 and 3 of this act are effective when it becomes law. The remainder of this act becomes effective January 1, 2002, and applies only to nonfleet private passenger motor vehicle insurance policies that are issued or renewed on and after January 1, 2002.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley and Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 1105 A BILL TO BE ENTITLED AN ACT TO MAKE TECHNICAL CORRECTIONS TO INSURANCE LAWS.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

HOUSE BILL 1105

Short Title:	Insurance Technical Corrections.	(Public)
Sponsors:	Representative Hurley.	
Referred to:	Insurance.	

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CORRECTIONS TO THE INSURANCE LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-1-1 reads as rewritten:

"**§ 58-1-1. Title of the Chapter.**

~~Articles 1 through 64 of this~~ This Chapter may be cited and shall be known as the Insurance Law."

SECTION 2. G.S. 58-1-15(b) reads as rewritten:

"(b) Any warranty made solely by a manufacturer, distributor, or seller of goods or services without charge, or an extended warranty offered as an option and made solely by a manufacturer, distributor, or seller of goods or services for charge, that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor, or any other remedial measure, including replacement of goods or repetition of services, shall not be a contract of insurance under ~~Articles 1 through 64 of~~ this Chapter; however, service agreements on motor vehicles are governed by G.S. 58-1-25, 58-1-35, and 58-1-36. Service agreements on home appliances are governed by G.S. 58-1-30, 58-1-35, and 58-1-36."

SECTION 3. G.S. 58-2-40(3) reads as rewritten:

"(3) Prescribe to the companies, associations, orders, or bureaus required by ~~Articles 1 through 64 of~~ this Chapter to report to the Commissioner, the necessary forms for the statements required. The Commissioner may change those forms from time to time when necessary to secure full information as to the standing, condition, and such other information desired of companies, associations, orders, or bureaus under the jurisdiction of the Department."

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

"(4) Receive and thoroughly examine each financial statement required by ~~Articles 1 through 64 of~~ this Chapter."

SECTION 5. G.S. 58-2-40(5) reads as rewritten:

"(5) Report in detail to the Attorney General any violations of the laws relative to insurance companies, associations, orders and bureaus or the business of insurance; and the Commissioner may institute civil actions or criminal prosecutions either by the Attorney General or another attorney whom the Attorney General may select, for any violation of the provisions of ~~Articles 1 through 64 of~~ this Chapter."

SECTION 6. G.S. 58-2-60(a) reads as rewritten:

"(a) Whenever it appears to the Commissioner that any person has violated, is violating, or threatens to violate any provision of ~~Articles 1 through 64, 65 and 66, 67, 69, 70, or 71 of~~ this Chapter, or Article 9A of Chapter 143 of the General Statutes, he may apply to the superior court of any county in which the violation has occurred, is occurring, or may occur for a restraining order and injunction to restrain such violation. If upon application the court finds that any provision of ~~said~~ those statutes has been violated, is being violated, or a violation thereof is threatened, the court shall issue an order restraining and enjoining ~~such~~ the violations; and ~~such~~ that relief may be granted regardless of whether criminal prosecution is instituted under any provision of law."

SECTION 7. G.S. 58-2-65 reads as rewritten:

"**§ 58-2-65. License surrenders.**

This section applies to persons or entities licensed under ~~Articles 1 through 64, 65 and 66, 67, 69, 70, or 71 of~~ this Chapter, or Article 9A of Chapter 143 of the General Statutes. When a licensee is accused of any act, omission, or misconduct that would subject the license to suspension or revocation, the licensee, with the consent and approval of the Commissioner, may surrender the license for a period of time established by the Commissioner. A person or entity who surrenders a license shall not thereafter be eligible for or submit any application for licensure during the period of license surrender."

SECTION 8. G.S. 58-2-90(e) reads as rewritten:

"(e) Upon any appeal, the rates fixed or any rule, regulation, finding, determination, or order made by the Commissioner under the provisions of ~~Articles 1 through 64 of~~ this Chapter shall be prima facie correct."

SECTION 9. G.S. 58-2-150 reads as rewritten:

"**§ 58-2-150. Oath required for compliance with law.**

Before issuing license to any insurance company to transact the business of insurance in this State, the Commissioner shall require, in every case, in addition to the other requirements provided for by law, that the company file with him the affidavit of its president or other chief officer that it has not violated any of the provisions of ~~Articles 1 through 64~~ of this Chapter for the space of 12 months last past, and that it accepts the terms and obligations of ~~Articles 1 through 64 of~~ this Chapter as a part of the consideration of the license."

SECTION 10. G.S. 58-2-155 reads as rewritten:

"**§ 58-2-155. Investigation of charges.**

Upon ~~his~~ the Commissioner's 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~~ any other officer or agents of ~~such~~ the 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~~ the company with a statement of ~~such~~ the expenses. If the company refuses or neglects to pay, the Commissioner ~~is authorized to~~ may bring a civil action for the collection of these expenses."

SECTION 11. G.S. 58-3-5 reads as rewritten:

"**§ 58-3-5. No insurance contracts except under Articles 1 through 64 of this Chapter.**

Except as provided in G.S. 58-3-6, it is unlawful for any company to make any contract of insurance upon or concerning any property or interest or lives in this State, or with any resident ~~thereof,~~ of this State, or for any person as insurance agent or insurance broker to make, negotiate, solicit, or in any manner aid in the transaction of such insurance, unless and except as authorized under the provisions of ~~Articles 1 though 64 of~~ this Chapter."

SECTION 12. G.S. 58-3-30(a) reads as rewritten:

"(a) This section applies to the provisions of all group life, group accident, group health, and group accident and health insurance policies and group annuities under ~~Articles 1 through 64 of~~ this Chapter that are issued on or after October 1, 1989, and preferred provider arrangements under ~~Articles 1 through 64 of~~ this Chapter that are entered into on or after October 1, 1989."

SECTION 13. G.S. 58-3-130 reads as rewritten:

"**§ 58-3-130. Agent, adjuster, etc., acting without a license or violating insurance law.**

If any person shall assume to act either as principal, agent, broker, limited representative, adjuster or motor vehicle damage appraiser without license as is required by law or, pretending to be a principal, agent, broker, limited representative, adjuster or licensed motor vehicle damage appraiser, shall solicit, examine or inspect any risk, or shall examine into, adjust, or aid in adjusting any loss, investigate or advise relative to the nature and amount of damages to motor vehicles or the amount necessary to effect repairs thereto, or shall receive, collect, or transmit any premium of insurance, or shall do any other act in the soliciting, making or executing any contract of insurance of any kind otherwise than the law permits, or as principal or agent shall violate any provision of law contained in ~~Articles 1 through 64 of~~ this Chapter, the punishment for which is not elsewhere provided for, ~~he~~ that person shall be deemed guilty of a Class 1 misdemeanor."

SECTION 14. G.S. 58-7-1 reads as rewritten:

"**§ 58-7-1. Application of ~~Articles 1 through 64 of~~ this Chapter and general laws.**

The general provisions of law relative to the powers, duties, and liabilities of corporations apply to all incorporated domestic insurance companies where pertinent and not in conflict with other provisions of law relative to ~~such~~ those companies or with their charters. All insurance companies of this State shall be governed by ~~Articles 1 through 64 of~~ this Chapter, notwithstanding anything in their special charters to the contrary, provided notice of the acceptance of ~~Articles 1 through 64 of~~ this Chapter is filed with the Commissioner."

SECTION 15. G.S. 58-15-15(a) reads as rewritten:

"(a) Except for Article 11 of this Chapter and as otherwise specifically provided, all the provisions of ~~Articles 1 through 64 of~~ this Chapter relating to insurers generally, and those relating to insurers writing the same kinds of insurance that reciprocals are permitted to write, are applicable to reciprocals."

SECTION 16. G.S. 58-16-1 reads as rewritten:

"**§ 58-16-1. Admitted to do business.**

Foreign or alien insurance companies, upon complying with the conditions of ~~Articles 1 through 64 of~~ this Chapter applicable to them, may be admitted to transact in this State any class of insurance authorized by the laws in force relative to the duties, obligations, prohibitions, and penalties of insurance companies, and subject to all laws applicable to the transaction of such business by foreign or alien insurance companies and their agents."

SECTION 17. G.S. 58-16-15 reads as rewritten:

"**§ 58-16-15. Foreign companies; requirements for admission.**

A company organized under the laws of any other of these United States for the transaction of life insurance may be admitted to do business in this State if it complies with the other provisions of ~~Articles 1 through 64 of~~ this Chapter regulating the terms and conditions upon which foreign life insurance companies may be admitted and authorized to do business in this State, and, in the opinion of the Commissioner, is in sound financial condition and has policies in force upon not less than 500 lives for an aggregate amount of not less than five hundred thousand dollars ($500,000). Any life company organized under the laws of any other country than the United States, in addition to the above requirements, must make and maintain the deposit required of ~~such~~ those companies by Article 5 of this Chapter."

SECTION 18. G.S. 58-16-50 reads as rewritten:

"**§ 58-16-50. Action to enforce compliance with this Chapter.**

Compliance with the provisions of ~~Articles 1 through 64 of~~ this Chapter as to deposits, obligations, and prohibitions, and the payment of taxes, fines, fees, and penalties by foreign or alien insurance companies, may be enforced in the ordinary course of legal procedure by action brought in the Superior Court of Wake County by the Attorney General in the name of the State upon the relation of the Commissioner of Insurance."

SECTION 19. G.S. 58-22-30 reads as rewritten:

"**§ 58-22-30. Countersignature not required.**

A policy of insurance issued to a risk retention group or any member of that group is not required to be countersigned as otherwise provided in ~~Articles 1 through 64 of~~ this Chapter."

SECTION 20. G.S. 58-22-50 reads as rewritten:

"**§ 58-22-50. Administrative and procedural authority regarding risk retention groups and purchasing groups.**

The Commissioner ~~is authorized to~~ may make use of any of the powers established under ~~Articles 1 through 64 of~~ this Chapter to enforce the laws of this State as long as those powers are not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Act of 1986. This includes, but is not limited to, the Commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, and seek or impose penalties. With regard to any investigation, administrative proceeding, or litigation, the Commissioner ~~can~~ may rely on the procedural law and regulations of the State. The injunctive authority of the Commissioner in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction."

SECTION 21. G.S. 58-33-120 reads as rewritten:

"**§ 58-33-120. Agent, adjuster, etc., acting without a license or violating insurance law.**

If any person shall assume to act either as principal, agent, broker, limited representative, adjuster or motor vehicle damage appraiser without license as is required by law or pretending to be a principal, agent, broker, limited representative, adjuster or licensed motor vehicle damage appraiser, shall solicit, examine or inspect any risk, or shall examine into, adjust, or aid in adjusting any loss, investigate or advise relative to the nature and amount of damages to motor vehicles or the amount necessary to effect repairs thereto, or shall receive, collect, or transmit any premium of insurance, or shall do any other act in the soliciting, making or executing any contract of insurance of any kind otherwise than the law permits, or as principal or agent shall violate any provision of law contained in ~~Articles 1 through 64 of~~ this Chapter, the punishment for which is not elsewhere provided for, he shall be deemed guilty of a Class 1 misdemeanor."

SECTION 22. G.S. 58-34-5(a) reads as rewritten:

"(a) Retrospective compensation agreements for business written under ~~Articles 1 through 64 of~~ this Chapter must be filed with the Commissioner for ~~his~~ the Commissioner's approval."

SECTION 23. G.S. 58-50-25(a) reads as rewritten:

"(a) No agency, institution or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 or 68 of this Chapter shall be denied such payment or reimbursement on account of the fact that such services were rendered through a registered nurse acting under authority of rules and regulations adopted by the North Carolina Medical Board and the Board of Nursing pursuant to G.S. 90-6 and G.S. 90-171.23."

SECTION 24. G.S. 58-50-26 reads as rewritten:

"**§ 58-50-26. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 or 68 of this Chapter shall be denied the payment or reimbursement on account of the fact that the services were rendered through a physician assistant acting under the authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

SECTION 25. G.S. 58-50-30(a) reads as rewritten:

"(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 or 68 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 or 68 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly 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 or 68 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly 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 physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly 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."

SECTION 26. G.S. 58-51-40(a) reads as rewritten:

"(a) Whenever any policy of insurance governed by Articles 1 through 64 or 68 of this Chapter provides for benefits for charges of hospitals or physicians, the policy shall provide for payments of benefits for charges made for medical care rendered in or by duly licensed State tax-supported institutions, including charges for medical care of cerebral palsy, other orthopedic and crippling disabilities, mental and nervous diseases or disorders, mental retardation, alcoholism and drug or chemical dependency, and respiratory illness, on a basis no less favorable than the basis which would apply had the medical care been rendered in or by any other public or private institution or provider. The term "State tax-supported institutions" shall include community mental health centers and other health clinics which are certified as Medicaid providers."

SECTION 27. G.S. 58-19-5(4) reads as rewritten:

"(4) "Insurer" includes a person subject to ~~Articles~~ Article 65 ~~and 66~~ or 67 of this Chapter. "Insurer" does not include (1) an agency, authority, or instrumentality of the United States; any of its possessions and territories; the Commonwealth of Puerto Rico; the District of Columbia; nor a state or political subdivision of a state; nor (2) fraternal benefit societies or fraternal orders."

SECTION 28. G.S. 58-38-35(a)(2) reads as rewritten:

"(2) To all policies of life insurance as described in Article 58 of this Chapter, to all benefit certificates issued by fraternal orders and societies as described in Articles 24 and 25 of this Chapter, to all policies of accident and health insurance as described in Articles 50 through 55 and 68 of this Chapter, to all subscribers' contracts of hospital, medical, and dental service corporations as described in ~~Articles 65 and 66~~ Article 65 of this Chapter, and to all health maintenance organization evidences of coverage as described in Article 67 of this Chapter, that are made, issued, amended, or renewed after July 1, 1983."

SECTION 29. G.S. 58-51-35(c) reads as rewritten:

"(c) The provisions of this section shall apply to corporations governed by the provisions of ~~Articles 65 and 66~~ Article 65 of this Chapter."

SECTION 30. G.S. 58-54-1(5) reads as rewritten:

"(5) "Policy" means a Medicare supplement policy, which is a group or individual policy of accident and health insurance under ~~Articles 1 through 64 of~~ this Chapter, a subscriber contract under ~~Articles 65 and 66~~ Article 65 of this Chapter, or an evidence of coverage under Article 67 of this Chapter, other than a policy issued pursuant to a contract under section 1876 or section 1833 of the federal Social Security Act (42 U.S.C. § 1395 et seq.), or an issued policy under a demonstration

project authorized pursuant to amendments to the federal Social Security Act, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare."

SECTION 31. G.S. 58-48-35(a)(3) reads as rewritten:

"(3) Allocate claims paid and expenses incurred among the ~~two~~ three accounts separately, and assess member insurers separately for each account amounts necessary to pay the obligation of the Association under subsection (a) above subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations under G.S. 58-48-60 and other expenses authorized by this Article. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance in the account; provided, for purposes of assessment only, premiums otherwise reportable by a servicing insurer under any plan of operation approved by the Commissioner of Insurance under Articles 45 or 46 of this Chapter shall not be deemed to be the net direct written premiums of such servicing insurer or association, but shall be deemed to be the net direct written premiums of the individual insurers to the extent provided for in any such plan of operation. Each member insurer shall be notified of the assessment not later than 30 days before it is due. No member insurer may be assessed in any year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a license by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made."

SECTION 32. G.S. 58-31-40(b) reads as rewritten:

"(b) No agency or other person authorized or directed by law to select a plan and erect a building for the use of the State or any State institution shall receive and approve

of the plan until it is submitted to and approved by the Commissioner as to the safety of the proposed building from fire, including the property's occupants or contents. No agency or person authorized or directed by law to select a plan or erect a building comprising 10,000 square feet or ~~or~~ more for the use of any county, city, or school district shall receive and approve of the plan until it is submitted to and approved by the Commissioner as to the safety of the proposed building from fire, including the property's occupants or contents."

SECTION 33. G.S. 58-21-65(b) reads as rewritten:

"(b) The Commissioner shall issue a surplus lines license to any qualified holder of a current ~~fire and casualty~~ property and liability broker's or agent's license, but only when the broker or agent has:

(1) Remitted the fifty dollars ($50.00) annual fee to the Commissioner;

(2) Submitted a completed license application on a form supplied by the Commissioner, and the application has been approved by the Commissioner;

(3) Passed a qualifying examination approved by the Commissioner; except that all holders of a license ~~prior to~~ before July 11, 1985 shall be deemed to have passed such an examination; and

(4) Filed with the Commissioner, and maintains during the term of the license, in force and unimpaired a bond in favor of this State in the sum of ten thousand dollars ($10,000), aggregate liability, with corporate sureties approved by the Commissioner. The bond shall be conditioned that the surplus lines licensee will conduct business in accordance with the provisions of this Article and will promptly remit the taxes as provided by law. No bond shall be terminated unless at least 30 days prior written notice is given to the licensee and Commissioner. A person required by this subdivision to maintain a bond may, in lieu of that bond, deposit with the Commissioner the equivalent amount in cash, in certificates of deposit issued by banks organized under the laws of the State of North Carolina, or any national bank having its principal office in North Carolina, or securities, which shall be held in accordance with Article 5 of this Chapter. Securities may only be obligations of the United States or of federal agencies listed in G.S. 147-69.1(c)(2) guaranteed by the United States, obligations of the State of North Carolina, or obligations of a city or county of this State. Any proposed deposit of an obligation of a city or county of this State is subject to the prior approval of the Commissioner."

SECTION 34. G.S. 58-33-135(a) reads as rewritten:

"(a) The Commissioner shall appoint, in accordance with G.S. 58-2-30, one advisory committee for ~~fire and casualty~~ property and liability insurance licensees and one advisory committee for life and health insurance licensees. The advisory committees shall recommend reasonable rules to the Commissioner for ~~promulgation~~ adoption under G.S. 58-33-130. The Commissioner may adopt, reject, or modify ~~such~~

the recommendations. After the ~~promulgation~~ adoption of rules under G.S. 58-33-130, the committees may from time to time make further recommendations to the Commissioner for additional rules or changes in existing rules."

SECTION 35. G.S. 58-35-10(c) reads as rewritten:

"(c) A ~~fire and casualty~~ property and liability insurance agent or an insurance broker duly licensed in this State who extends credit to and only to ~~his~~ the agent's or broker's own policyholders may charge and collect finance charges or other fees at a periodic (monthly) rate as provided in G.S. 24-11(a), after ~~said~~ that amount has been outstanding for 30 days, and is ~~hereby~~ exempt from the provisions of this Article. Notwithstanding the exceptions set forth in subsections (a), (b) and (c) of this section, when any ~~person, firm, or corporation shall exercise~~ person exercises a power of attorney taken in connection with the financing of an insurance premium, ~~such person, firm or corporation~~ that person shall comply with ~~the requirements of~~ G.S. 58-35-85, as if ~~it were~~ that person were an insurance premium financing company."

SECTION 36. G.S. 58-36-1(5)a. reads as rewritten:

"(5) a. It is the duty of every insurer that writes workers' compensation insurance in this State and is a member of the Bureau, as defined in this section and G.S. 58-36-5 to insure and accept any workers' compensation insurance risk that has been certified to be "difficult to place" by any ~~fire and casualty~~ property and liability insurance agent who is licensed in this State. When any such risk is called to the attention of the Bureau by receipt of an application with an estimated or deposit premium payment and it appears that the risk is in good faith entitled to such coverage, the Bureau will bind coverage for 30 days and will designate a member who must issue a standard workers' compensation policy of insurance that contains the usual and customary provisions found in those policies. Multiple coordinated policies, as defined by the Bureau and approved by the Commissioner, may be used for the issuance of coverage under this subdivision for risks involved in employee leasing arrangements. Coverage will be bound at 12:01 A.M. on the first day following the postmark time and date on the envelope in which the application is mailed including the estimated annual or deposit premium, or the expiration of existing coverage, whichever is later. If there should be no postmark, coverage will be effective 12:01 A.M. on the date of receipt by the Bureau unless a later date is requested. Those applications hand delivered to the Bureau will be effective as of 12:01 A.M. of the date following receipt by the Bureau unless a later date is requested. The Bureau will make and adopt such rules as are necessary to carry this section into effect, subject to final approval of the Commissioner. As a prerequisite to the transaction of workers' compensation insurance in this State,

every member of the Bureau that writes ~~such~~ workers' compensation insurance ~~must~~ shall file with the Bureau written authority permitting the Bureau to act in its behalf, as provided in this section, and an agreement to accept risks that are assigned to the member by the Bureau, as provided in this section."

SECTION 37. 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 in this subsection 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~~ property and liability insurance agents licensed in this State and actively engaged in writing motor vehicle insurance in this State. The Commissioner shall select two agents from among a list of four nominees submitted by the Independent Insurance Agents of North Carolina, 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 the Governor's pleasure."

SECTION 38. G.S. 58-37-35(g)(6) reads as rewritten:

"(6) Upon the request of any licensed ~~fire and casualty~~ property and liability agent meeting any two of the standards set forth below as determined by the Commissioner within 10 days of the receipt of the application, the Facility shall contract with one or more members within 20 days of receipt of the determination to appoint ~~such~~ the licensed ~~fire and casualty~~ property and liability agent as designated

agents in accordance with reasonable rules as are established by the plan of operation. The standards shall be:

a. Whether the agent's evidence establishes that he has been conducting his business in a community for a period of at least one year;

b. Whether the agent's evidence establishes that he had a gross premium volume during the 13 months next preceding the date of his application of at least twenty thousand dollars ($20,000) from motor vehicle insurance;

c. Whether the agent's evidence establishes that the number of eligible risks served by him during the 13 months next preceding the date of application was 200 or more;

d. Whether the agent's evidence establishes a growth in eligible risks served and premium volume during his years of service as an agent;

e. Whether the agent's evidence establishes that he made available to eligible risks premium financing or any other plan for deferred payment of premiums.

With respect to business produced by designated agents, adequate provision shall be made by the Facility to assure that such business is rated using Facility rates. All business produced by designated agents may be ceded to the Facility, except designated agents appointed before September 1, 1987, may place liability insurance policies with a voluntary carrier, provided that all policies written by the voluntary carrier are retained by the voluntary carrier unless ceded to the Facility using Facility rates. Designated agents must provide the Facility with a list of such policies written by the voluntary carrier at least annually, or as requested by the Facility, on a form approved by the Facility. If no insurer is willing to contract with any such agent on terms acceptable to the Board, the Facility shall license such agent to write directly on behalf of the Facility. However, for this purpose the Facility does not act as an insurer, but acts only as the statutory agent of all of the members of the Facility, which shall be bound on risks written by the Facility's appointed agent. The Facility may contract with one or more servicing carriers and shall promulgate fair and reasonable underwriting procedures to require that business produced by Facility agents and written through those servicing carriers shall be rated using Facility rates. All business produced by Facility agents may be ceded to the Facility. Any designated agent who is disabled or retiring or the estate of any deceased designated agent may transfer the designation and the book of business to some other licensed fire and casualty agent meeting the requirements of this section and under rules established by the Facility, and a transfer from a designated agent appointed before September 1, 1987, shall entitle the transferee

designated agent to place liability insurance policies with a voluntary carrier.

The Commissioner shall require, as a condition precedent to the issuance, renewal, or continuation of a resident agent's license to any designated agent to act for the company appointing such designated agent under contract with the Facility, that the designated agent file and thereafter maintain in force while so licensed a bond in favor of the State of North Carolina executed by an authorized corporate surety approved by the Commissioner, cash, mortgage on real property, or other securities approved by the Commissioner, in the amount of ten thousand dollars ($10,000) for the use of aggrieved persons. Such bond, cash, mortgage, or other securities shall be conditioned on the accounting by the designated agent (i) to any person requesting the designated agent to obtain motor vehicle insurance for moneys or premiums collected in connection therewith, and (ii) to the company providing coverage with respect to any such moneys or premiums under contract with the Facility. Any such bond shall remain in force until the surety is released from liability by the Commissioner, or until the bond is cancelled by the surety. Without prejudice to any liability accrued prior to such cancellation, the surety may cancel the bond upon 30 days' advance notice in writing filed with the Commissioner.

No agent may be designated under this subdivision to any insurer that does not actively write voluntary market business."

SECTION 39. G.S. 58-48-30(a) reads as rewritten:

"(a) The board of directors of the Association shall consist of not less than five nor more than nine persons serving terms as established in the plan of operation. One non-voting member of the board shall be a property and ~~casualty~~ liability insurance agent authorized to write insurance for a member insurer, and appointed by the Commissioner; and the remaining members shall be selected by member insurers subject to the approval of the Commissioner. Vacancies of the board shall be filled for the remaining period of the term in the same manner as initial appointments. If no members are selected within 60 days after June 25, 1971, the Commissioner may appoint the initial members of the board of directors."

SECTION 40. G.S. 58-36-15(e) reads as rewritten:

"(e) The Commissioner may require the filing of supporting data including:

(1) The Bureau's interpretation of any statistical data relied upon;

(2) Descriptions of the methods employed in setting the rates;

(3) Analysis of the incurred losses submitted on an accident year or policy year basis into their component parts; to wit, paid losses, reserves for losses and loss expenses, and reserves for losses incurred but not reported;

(4) The total number and dollar amount of paid claims;

(5) The total number and dollar amount of case basis reserve claims;

(6) Earned and written premiums at current rates by rating territory;

(7) Earned premiums and incurred losses according to classification plan categories; and

(8) Income from investment of unearned premiums and loss and loss expense reserves generated by business within this State.

~~Provided, however, that with respect to business written prior to January 1, 1980, the Commissioner shall not require the filing of such supporting data which has not been required to be recorded under statistical plans approved by the Commissioner.~~"

SECTION 41. G.S. 153A-435(a) reads as rewritten:

"(a) A county may contract to insure itself and any of its officers, agents, or employees against liability for wrongful death or negligent or intentional damage to person or property or against absolute liability for damage to person or property caused by an act or omission of the county or of any of its officers, agents, or employees when acting within the scope of their authority and the course of their employment. The board of commissioners shall determine what liabilities and what officers, agents, and employees shall be covered by any insurance purchased pursuant to this subsection.

Purchase of insurance pursuant to this subsection waives the county's governmental immunity, to the extent of insurance coverage, for an act or omission occurring in the exercise of a governmental function. Participation in a local government risk pool pursuant to Article ~~39~~ 23 of ~~General Statute Chapter 58~~Chapter 58 of the General Statutes shall be deemed to be the purchase of insurance for the purposes of this section. By entering into an insurance contract with the county, an insurer waives any defense based upon the governmental immunity of the county.

SECTION 42. This act is effective when it becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

April 24, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 1105 – Insurance Technical Corrections

Most of this bill comprises amendments that simplify internal cross-references to other provisions in Chapter 58 of the General Statutes.

Sections 1 through 22 change awkward references to "Articles 1 through 64 of this Chapter" to "this Chapter." When Chapter 58 was recodified in 1989, other General Statute chapters were consolidated into Chapter 58. For example, the laws on service corporations (e.g., Blue Cross) and HMOs were in Chapters 57 and 57B of the General Statutes. What had been Chapter 58 was turned into Articles 1 through 64 of recodified Chapter 58, Chapter 57 became Articles 65 and 66, and Chapter 57B became Article 67. In 1997 Article 68 was used to enact North Carolina's version of the federal Health Insurance Portability and Accountability Act of 1996. The intent of Sections 1 through 22 is to simplify language without making any substantive change in the law.

Sections 23 through 26 and 28 add a reference to Article 68 so that those laws apply to health insurance policies that are governed by Article 68 (Health Insurance Portability and Accountability Act).

Sections 27 through 30 delete unnecessary references to Article 66. The reference to Article 65 is sufficient.

Section 31 recognizes that there are three accounts in the Insurance Guaranty Association.

Section 32 deletes a repeated word.

Sections 33 through 39 update terminology from "fire and casualty insurance" to "property and liability insurance."

Section 40 deletes obsolete language.

Section 41 corrects a cross-reference to a provision in Chapter 58. The current cross-reference is to an Article number before Chapter 58 was recodified.

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 24, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 24, 2001, at 12:30 p.m. Representative Dockham called the meeting to order and introduced the pages Elizabeth Brock (Davie County) and Josh Nealy (Iredell County-Rep. Mitchell). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Barbee, Brubaker, Dedmon, Grady, Redwine, Saunders, Setzer, and Smith. Linda Attarian, Frank Folger and Trina Griffin, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes (Attachment). The following bills were considered.

HB 1123, entitled, AN ACT TO CHANGE THE NAME OF THE NORTH CAROLINA RATE BUREAU TO THE INSURANCE INDUSTRY OFFICE IN ORDER TO END THE PUBLIC MISCONCEPTION THAT THE BUREAU IS AN AGENCY OF THE STATE. The Chair recognized Representative Cary Allred to explain the bill. This bill would change the name of the NC Rate Bureau to the Insurance Industry Office and make the necessary conforming changes to the General Statues. The change is proposed to counter any misconception among the public that the Bureau is an agency of the State. Representative Redwine send forth an amendment to be drafted by Staff Counsel at a later date to change the title of the bill from NC Rate Bureau to NC Insurance Services Office. Glenn Jernigan, Lobbyist, was recognized and suggested to change the name to NC Insurance Industry Services Office. Due to Staff Counsel not being present at this time, the bill was displaced.

HB 1122, entitled, AN ACT TO REQUIRE THE NORTH CAROLINA RATE BUREAU TO REVISE AND REFILE A CLASSIFICATION PLAN FOR LOSS MODIFICATIONS IN WORKERS' COMPENSATION INSURANCE; AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY WORKERS' COMPENSATION INSURANCE CLASSIFICATIONS, INCLUDING THE DEVELOPMENT AND IMPLEMENTATION OF LOSS MODIFICATIONS. Representative Allred was recognized to explain the bill. This bill would require, rather than authorize, the Rate Bureau to file, with respect to loss modification, a classification plan subject to review, modification, promulgation, and approval to classify employers for workers' compensation insurance rate making. The bill would require the Bureau to file a revised classification plan by October 1, 2001, and account for any consequent rate adjustments by making them at the base rate levels for the affected coverage. It would also authorize an LRC study of the topic. It would give the Commissioner of Insurance the authority to require that the Bureau file change in the classification plan, to give the Commissioner the flexibility to give a more flexible rate when the claim was not as great as the current rating system would dictate. Mr. George Teague, Alliance of American Insurers, was recognized and stated that he believes the Commissioner already has the flexibility to lower rates. Bill Hale was recognized to explain the bill. Mr. Robert Paschal, State Farm Insurance Companies, was recognized to speak in opposition to the bill. After further discussion and questions by the Committee members, and due to the absence of Staff Counsel, the bill was displaced.

HB 1160, entitled, AN ACT TO PROVIDE FOR UNIFORM PROVIDER CREDENTIALING BY HEALTH INSURANCE PLANS. Representative Alexander was recognized to explain the bill, and she presented a proposed committee substitude. Representative Saunders moved to adopt the proposed committee substitude for consideraton.

The motion passed. This bill would establish a uniform application for provider credentialing. An insurer that provides health benefit plans would have to assess and verify the qualification of a licensed health care practitioner or an applicant for licensure as a health care practitioner within 60 days of receipt of the completed application form and could not require information beyond that in the form. Ben Regalado, Medac Inc. and Byron Grimmett, Presbyterian Inpatient Care Specialist, were recognized to speak in favor of the bill. After some discussion by the Committee members, Representative Saunders moved to give the committee substitute a favorable report, unfavorable to the original bill. The motion passed.

There being no further business, the Chair adjourned the meeting at 1:30 PM.

Respectfully submitted,

Representative Jerry C. Dockham
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Form
HB 1123, HB 1122, HB 1160
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — April 24, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joy Barbour	Concerned Bikers Assoc./ABATE of N.C.
Darlene Kinsey	Concerned Bikers Assoc. of High Point
Phil Kirk	NCCBI
[illegible]	NCAHP
BEN REGALADO	Medac, Inc. (anesthesiologists)
Byron Grimmett	Presbyterian Inpatient Care Specialists
Linda G. Boyds	Pediatric Surgical Associates
Amy Jo Bain	NC Medical Society
Mike Causey	NC Glass Assn, I.A.B.A
William Williford	NCCH.
Barbara Canales	Manning, Fulton & Skinner

VISITOR REGISTRATION SHEET

INSURANCE — April 24, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julie Campbell	NCCBI
LuAnne Barbrut	NCAHP
Ellen Ann Harris	ZHHA
Anna Bridgers	Randolph Cloud + Ass.
[illegible]	NAIC NC
[illegible]	NFOS PA
[illegible]	Moore & Van Allen
Margaret Westbrook	Kennedy Covington
J Ramquist	NCSOS
Susan Valaoras	Nationwide

VISITOR REGISTRATION SHEET

INSURANCE — April 24, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Marshall	Young, Moore
Harry Payne	NCAIP
Ken McHoul	Alley Associates
Matt Mulvihill	NCEOA
Sasha Berger	NCCBI
Dawn Jernigan	BMAC Insurance
John May	NC Coop
Michelle Frazier	NC Bar Assoc
Amy Fullbright	Hunton & Williams

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 1

HOUSE BILL 1123

Short Title:	Change Name of N.C. Rate Bureau.	(Public)
Sponsors:	Representative Allred.	
Referred to:	Insurance.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO CHANGE THE NAME OF THE NORTH CAROLINA RATE BUREAU TO THE INSURANCE INDUSTRY OFFICE IN ORDER TO END THE PUBLIC MISCONCEPTION THAT THE BUREAU IS AN AGENCY OF THE STATE.

The General Assembly of North Carolina enacts:

SECTION 1. Except for those sections of the General Statutes amended in this act, the Revisor of Statutes shall substitute the term "Insurance Industry Office" for the terms "North Carolina Rate Bureau" everywhere that term appears in the General Statutes and shall substitute the term "Insurance Industry Office" for the term "Rate Bureau" everywhere that term appears in G.S. 20-279.21, G.S. 95-250, and Chapter 58 of the General Statutes. In addition, the Revisor of Statutes shall substitute the term "Office" for the term "Bureau" and the term "Office's" for the term "Bureau's" everywhere those term appears in Chapter 58 of the General Statutes and G.S. 20-279.21.

SECTION 2. G.S. 58-2-190 reads as rewritten:

"**§ 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, the Insurance Industry Office, 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."

SECTION 3. The title of Article 36 of Chapter 58 of the General Statues reads as rewritten:

"Article 36.

~~North Carolina Rate Bureau.~~Insurance Industry Office."

SECTION 4. G.S. 58-36-1 reads as rewritten:

"**§ 58-36-1. ~~North Carolina Rate Bureau~~ Insurance Industry Office created.**

There is hereby created ~~a Bureau~~ an Office to be known as the ~~'North Carolina Rate Bureau',~~'Insurance Industry Office' with the following objects and functions:

(1) To assume the functions formerly performed by the North Carolina Rate Bureau, the North Carolina Fire Insurance Rating Bureau, the North Carolina Automobile Rate Administrative Office, and the Compensation Rating and Inspection Bureau of North Carolina, with regard to the promulgation of rates, for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof and valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; for theft of and physical damage to private passenger (nonfleet) motor vehicles as the same are defined under Article 40 of this Chapter; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and for workers' compensation and employers' liability insurance written in connection therewith except for insurance excluded from the ~~Bureau's~~Office's jurisdiction in G.S. 58-36-1(3).

(2) The ~~Bureau~~Office 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 the person's authorized representative before the governing committee or other proper executive of the ~~Bureau.~~Office.

(3) The ~~Bureau~~Office shall 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 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. This subdivision 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~~ Office shall have no jurisdiction over excess workers'

compensation insurance for employers qualifying as self-insurers as provided in Article 47 of this Chapter or Article 5 of Chapter 97 of the General Statutes; nor shall the ~~Bureau's~~Office'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.

(4) Agreements may be made between or among members with respect to equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. The members may agree between or among themselves on the use of reasonable rate modifications for such insurance, agreements, and rate modifications to be subject to the approval of the Commissioner.

(5) a. It is the duty of every insurer that writes workers' compensation insurance in this State and is a member of the ~~Bureau,~~Office, as defined in this section and G.S. 58-36-5 to insure and accept any workers' compensation insurance risk that has been certified to be 'difficult to place' by any fire and casualty insurance agent who is licensed in this State. When any such risk is called to the attention of the ~~Bureau~~Office by receipt of an application with an estimated or deposit premium payment and it appears that the risk is in good faith entitled to such coverage, the ~~Bureau~~Office will bind coverage for 30 days and will designate a member who must issue a standard workers' compensation policy of insurance that contains the usual and customary provisions found in those policies. Multiple coordinated policies, as defined by the ~~Bureau~~Office and approved by the Commissioner, may be used for the issuance of coverage under this subdivision for risks involved in employee leasing arrangements. Coverage will be bound at 12:01 A.M. on the first day following the postmark time and date on the envelope in which the application is mailed including the

estimated annual or deposit premium, or the expiration of existing coverage, whichever is later. If there should be no postmark, coverage will be effective 12:01 A.M. on the date of receipt by the ~~Bureau~~Office unless a later date is requested. Those applications hand delivered to the ~~Bureau~~Office will be effective as of 12:01 A.M. of the date following receipt by the ~~Bureau~~Office unless a later date is requested. The ~~Bureau~~Office will make and adopt such rules as are necessary to carry this section into effect, subject to final approval of the Commissioner. As a prerequisite to the transaction of workers' compensation insurance in this State, every member of the ~~Bureau~~Office that writes such insurance must file with the ~~Bureau~~Office written authority permitting the ~~Bureau~~Office to act in its behalf, as provided in this section, and an agreement to accept risks that are assigned to the member by the ~~Bureau,~~Office, as provided in this section.

b. The ~~Bureau~~Office shall maintain a compendium of employers refused voluntary coverage, which shall be made available by the ~~Bureau~~Office to all insurers, licensed agents, and self-insureds' administrators doing business in this State. It shall be stored and indexed to allow access to information by industry, primary classifications of employees, geography, experience modification, and in any other manner the ~~Bureau~~Office determines is commercially useful to facilitate voluntary coverage of listed employers. The ~~Bureau~~Office shall be immune from civil liability for erroneous information released by the ~~Bureau~~Office pursuant to this section, provided that the ~~Bureau~~Office acted in good faith and without malicious or willful intent to harm in releasing the erroneous information.

c. Failure or refusal by any assigned employer risk to make full disclosure to the ~~Bureau,~~Office, 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 termination of the policy of that employer.

(6) The ~~Bureau~~Office shall maintain and furnish to the Commissioner on an annual basis the statistics on earnings derived by member companies from the investment of unearned premium, loss, and loss expense reserves on nonfleet private passenger motor vehicle insurance policies written in this State. Whenever the ~~Bureau~~Office proposes rates under this Article, it shall prepare a separate exhibit for the experience years in question showing the combined earnings realized from the investment of such reserves on policies written in

this State. The amount of earnings may in an equitable manner be included in the ratemaking formula to arrive at a fair and equitable rate. The Commissioner may require further information as to such earnings and may require calculations of the ~~Bureau~~Office bearing on such earnings.

(7) Member companies shall furnish, upon request of any person carrying nonfleet private passenger motor vehicle insurance in the State upon whose risk a rate has been promulgated, information as to rating, including the method of calculation."

SECTION 5. G.S. 58-47-110(a) reads as rewritten:

"(a) As used in this section:

~~(1) 'Bureau' means the North Carolina Rate Bureau in Article 36 of this Chapter.~~

(2) 'Expenses' means that portion of a premium rate attributable to acquisition, field supervision, collection expenses, and general expenses, as determined by the group.

(3) 'Multiplier' means a group's determination of the expenses, other than loss expense and loss adjustment expense, associated with writing workers' compensation and employers' liability insurance, which shall be expressed as a single nonintegral number to be applied equally and uniformly to the prospective loss costs approved by the Commissioner in making rates for each classification of risks utilized by that group.

(3a) 'Office' means the Insurance Industry Office created in Article 36 of this Chapter.

(4) 'Prospective loss costs' means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit and that is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and forecasted through trending to a future point in time.

(5) 'Supplementary rating information' means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, rate-related underwriting rule, experience rating plan, statistical plan, and any other similar information needed to determine the applicable rate in effect or to be in effect."

SECTION 6. G.S. 136-18(24) reads as rewritten:

"(24) The Department of Transportation is further authorized to pave driveways leading from ~~state-maintained~~State-maintained roads to rural fire district firehouses which are approved by the ~~North Carolina Fire Insurance Rating Bureau~~ Insurance Industry Office and to facilities of rescue squads furnishing ambulance services which are approved by the North Carolina State Association of Rescue Squads, Inc."

SECTION 7. This act becomes effective October 1, 2001.

HOUSE BILL 1123:
Change Name of N.C. Rate Bureau

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Allred
Date:	April 23, 2001	**Summary by:**	Linda Attarian
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1123 would change the name of the North Carolina Rate Bureau to the Insurance Industry Office and makes the necessary conforming changes to the General Statutes. The change is proposed to counter any misconception among the public that the Bureau is an agency of the State.***

CURRENT LAW: The North Carolina Rate Bureau was created by statute in 1977.

BILL ANALYSIS: Sections 1-6 effectuate the intent of this bill to change all statutory references to the North Carolina Rate Bureau to the "Insurance Industry Office". Section 7 makes the act effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1122

Short Title:	Workers' Comp Loss Modifications and Study.	(Public)
Sponsors:	Representative Allred.	
Referred to:	Insurance.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE NORTH CAROLINA RATE BUREAU TO REVISE AND REFILE A CLASSIFICATION PLAN FOR LOSS MODIFICATIONS IN WORKERS' COMPENSATION INSURANCE; AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY WORKERS' COMPENSATION INSURANCE CLASSIFICATIONS, INCLUDING THE DEVELOPMENT AND IMPLEMENTATION OF LOSS MODIFICATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-10(4) reads as rewritten:

"(4) Risks may be grouped by classifications and lines of insurance for establishment of rates, loss costs, and base premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions or both. Those standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. With respect to loss modifications for workers' compensation insurance premium rates, the Bureau shall file, subject to review, modification, and promulgation by the Commissioner, a classification plan that the Commissioner deems to be desirable and equitable to classify employers for insurance purposes. Subsequently, the Commissioner may require the Bureau to file changes in the classification plan. The Bureau shall establish and implement a comprehensive classification rating plan for motor vehicle insurance under its 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 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."

SECTION 2. The North Carolina Rate Bureau shall file, in accordance with G.S. 58-36-15, a revised classification plan to reflect the provisions of this act. The Bureau shall make the filing no later than October 1, 2001, and the plan shall become effective six months after the date the plan is approved by the Commissioner. The revised plan shall apply only to new and renewal workers' compensation insurance policies written on and after the effective date of the plan.

SECTION 3. Any adjustments in rates for workers' compensation insurance that are necessary to offset any change in the premium level due to the implementation of the provisions of this act shall be made through adjustments in the base rates for the affected coverages. The adjustments shall be filed by the Bureau with the Commissioner in accordance with Article 36 of Chapter 58 of the General Statutes.

SECTION 4. The Legislative Research Commission may study workers' compensation insurance classifications, including the development and implementation of loss modifications. The Commission may report its findings and recommendations, including recommended legislation, to the 2002 Regular Session of the 2001 General Assembly.

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 1122:
Workers' Comp Loss Modifications and Study

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Allred
Date:	April 24, 2001	**Summary by:**	Frank W. Folger
Version:	First Edition		Committee Counsel

SUMMARY: ***This bill would require, rather than authorize, the Rate Bureau to file, with respect to loss modification, a classification plan subject to review, modification, promulgation, and approval to classify employers for workers' compensation insurance rate making. The bill would require the Bureau to file a revised classification plan by October 1, 2001, and account for any consequent rate adjustments by making them at the base rate levels for the affected coverage. It would also authorize an LRC study of the topic.***

CURRENT LAW: N.C.G.S. §58-36-10 in Article 36 of G.S. Chapter 58 establishes the ratemaking procedures for insurance falling under the North Carolina Rate Bureau's "governance." Workers' compensation insurance falls under the purview of the Bureau. Among other provisions, the statute, in subsection (4), *allows* in the rate making process risks to be grouped by classifications and lines of insurance and *allows* for modification for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions or both. The section also requires that classification plans filed be reviewed at least once every three years to determine if proper and statistically supported.

BILL ANALYSIS: Section 1 would *mandate* the Rate Bureau, with respect to loss modification for workers' compensation rates, file a classification plan that is subject to review, modification, and promulgation by the Commissioner, that the Commissioner deems desirable and equitable to classify employers for insurance purposes, and that the Commissioner may require the Bureau file changes regarding. This section also makes a technical change in removing the parenthetically enclosed word "(nonfleet)".

Section 2 would require the Bureau to file a revised classification plan, under the filing requirements of N.C.G.S. §58-36-15, by October 1, 2001, to be effective six months after Commissioner approval. It would apply only to new or renewal policies written on or after the plan's effective date.

Section 3 would require that any adjustments in premiums resulting from implementation of the act be made at the base rate levels for the affected coverage and be filed in accordance with Article 36. .

Section 4 would authorize the Legislative Research Commission to study workers' compensation insurance classifications, including the development and implementation of loss modifications, and to report to the 2002 Regular Session of the 2001 General Assembly.

EFFECTIVE DATE: Effective upon becoming law.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1160 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR UNIFORM PROVIDER CREDENTIALING BY HEALTH INSURANCE PLANS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, unfavorable as to original bill.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1160
PROPOSED COMMITTEE SUBSTITUTE H1160-CSSO-27 [v.2]

4/24/2001 1:13:11 AM

Short Title: Health Ins./Uniform Provider Credentialing. (Public)

Sponsors:

Referred to:

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR UNIFORM PROVIDER CREDENTIALING BY HEALTH INSURANCE PLANS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan shall maintain a process to assess and verify the qualifications of a licensed health care practitioner, or applicant for licensure as a health care practitioner, within 60 days of receipt of a completed provider application form approved by the Commissioner.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide credentialing entities with the information necessary to adequately assess and verify the qualifications of an applicant. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

(c) As used in this section the terms 'health benefit plan' and 'insurer' shall have the meaning provided under G.S. 58-3-167.

SECTION 2. G.S. 58-65-2 reads as rewritten:

"**§ 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. 58-3-230	Uniform provider credentialing.
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 3. G.S. 58-67-171 reads as rewritten:

"**§ 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. 58-3-230	Uniform provider credentialing.
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 4. This act becomes effective October 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1160

Short Title:	Health Ins./Uniform Provider Credentialing.	(Public)
Sponsors:	Representatives Alexander, C. Wilson (Primary Sponsors); and Harrington.	
Referred to:	Insurance.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR UNIFORM PROVIDER CREDENTIALING BY HEALTH INSURANCE PLANS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan shall maintain a process to assess and verify the qualifications of a licensed health care practitioner, or applicant for licensure as a health care practitioner, within 60 days of receipt of a completed provider application form approved by the Commissioner.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide credentialing entities with the information necessary to adequately assess and verify the qualifications of an applicant. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

(c) As used in this section the terms 'health benefit plan' and 'insurer' shall have the meaning provided under G.S. 58-3-167.

SECTION 2. This act becomes effective October 1, 2001.

HOUSE BILL 1160:
Health Ins./Provider Credentialing

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representatives Alexander and C. Wilson
Date:	April 24, 2001		
Version:	First Edition	**Summary by:**	Frank W. Folger Committee Counsel

SUMMARY: ***This bill would establish a uniform application for provider credentialing. An insurer that provides health benefit plans would have to assess and verify the qualification of a licensed health care practitioner or an applicant for licensure as a health care practitioner within 60 days of receipt of the completed application form and could not require information beyond that in the form.***

CURRENT LAW: There is no statutory requirement for how provider credentialing by an insurer is to be accomplished.

BILL ANALYSIS: This bill would direct the Commissioner to adopt a uniform provider credentialing application form to assess and verify an applicant's qualifications as a licensed health care practitioner or applicant for licensure as a health care practitioner. It would prohibit an insurer that provides a health benefit plan from requiring an applicant to submit information not required by the uniform application.

It would further require an insurer that provides a health benefit plan to maintain a process for assessing and verifying these qualifications within 60 days of receipt of the completed uniform application

EFFECTIVE DATE: October 1, 2001

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 25, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 25, 2001, at 8:00 a.m. Representative Hurley called the meeting to order and introduced the pages, Elizabeth Brock (Davie County – Tar Heel Challenge) and Drew McCall (Cumberland County – Representative Lucas). The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Baddour, Barbee, Brubaker, Cunningham, Dedmon, Earle, Hall, Johnson, Justus, Redwine, Saunders, Setzer, Smith, Wainwright, and C. Wilson. Linda Attarian, Frank Folger, and Trina Griffin, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 360, entitled, AN ACT TO CLARIFY THE LAW ON STIPULATIONS AS TO JURISDICTION AND LIMITATIONS OF ACTION AND THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; CLARIFY THE HMO POINT-OF-SERVICE LAW; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS; TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS; TO CLARIFY THE LAWS ON RECONSTRUCTIVE SURGERY NOTICES; AND TO CLARIFY THE LAW ON DEEMER PROVISIONS. This bill was heard on April 24, 2001, in the INSURANCE Committee and received a favorable report to the committee substitute. However, when it was reported out a page was missing; therefore, Representative Saunders moved to reconsider HB 360 (on the prevailing side). Committee substitute #2 was adopted for consideration. Representative Saunders moved to give a favorable report to committee substitute # 2, unfavorable to committee substitute #1. The motion passed.

HB 1329, entitled, AN ACT PROHIBITING AN INSURER FROM AUTHORIZING OR REQUIRING THE USE OF NONORIGINAL CRASH REPAIR PARTS FOR MOTOR VEHICLE REPAIRS WITHOUT THE WRITTEN CONSENT FROM THE INSURED OR CLAIMANT. Representative Carpenter was recognized, and presented a proposed committee substitute.

Representative Saunders moved to adopt the proposed committee substitute for consideration. The motion passed. Trina Griffin, Staff Counsel, was recognized to explain the bill. Basically, this bill gives an individual who has had an accident the right to have a vehicle restored to its pre-loss condition. This bill requires the insurer or repair facility to notify a customer if nonoriginal crash repair parts are to be used, and makes it insurance fraud to use such parts and bill for them as original parts. Violation of the section is punishable by $2,000 fine. After some discussion, Representative Smith moved to report the bill without prejudice, and recommendation that the bill be re-referred to the Committee on Rules, Calendar, and Operations of the House, with a recommendation that it be sent to a Study Committee. The motion passed.

HB 808, entitled, AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY. Representative Alexander was recognized, and she presented a proposed committee substitute. Representative C. Wilson moved for adoption of the committee substitute for discussion. The motion passed. Representative Alexander explained the four major changes in the committee substitute. Linda Attarian, Staff Counsel, was recognized to further explain the changes that included a benefit rider. After committee discussion, Harry Kaplan, NC Association of Health Plans, was recognized and indicated he could not readily provide the industry's position on the committee substitute since he had not had time to study it. Representative C. Wilson moved that a sub-committee be formed within the Insurance Committee for further consideration of this bill. The motion passed, and the Co-Chairs are to appoint members to the sub-committee.

HB 1266, entitled, AN ACT TO PROVIDE FOR DIRECT PAYMENT OF REGISTERED NURSE FIRST ASSISTANTS UNDER HEALTH INSURANCE POLICIES AND PLANS. Representative Wright was recognized to explain the bill. This bill adds registered nurse first assistants (surgical nurses) to the list of individuals being directly reimbursed by insurance companies. C. J. Cosar, Nursing Association, was recognized to speak in favor of the bill. Representative Wainwright moved for a favorable report. The motion passed.

HB 1253, entitled, A BILL TO BE ENTITLED AN ACT TO AMEND THE DEFINITION OF UNDERINSURED HIGHWAY VEHICLE TO PROVIDE GREATER PROTECTION TO CONSUMERS INJURED IN MOTOR VEHICLE ACCIDENTS. Representative Goodwin was recognized, and presented a proposed committee substitute, which would send the bill to a Study Committee. Representative Hurley moved for adoption of the committee substitute for discussion. The motion passed. Representative Hurley moved for a favorable report to the committee substitute, unfavorable to the original bill. The motion passed.

There being no further business, the meeting was adjourned at 9:30 a.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
House Bills 360, 1329, 808, 1266, and 1253
Bill Summaries

VISITOR REGISTRATION SHEET

INSURANCE — April 25, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Webb	N.C. Glass Assoc
William Willford	NCGA
Jennifer Mahan	MHA/NC
Sally Cameron	NCPA
Robin Huffman	NC Psychiatric Assoc
Judeene Bennett	NCAHP
Mac Swin	NCAHP
J. Dorsett	NCAHP
Chris Fitzsimon	Common Sense Fdtn.
Frank Lewis	OSBPA
Ken Melton	Alley Associates

VISITOR REGISTRATION SHEET

INSURANCE — April 25, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Causey	NC Glass Assn -
Julie Campbell	NCCBI
Emily Fulghum	Smith Anderson
Lori Ann Harris	~~ZHHA~~
Joyce Peters	JP Assoc / MAMSI
Bill Scoggin	KCCH
Robert Rashkof	Young, Moore
[illegible]	NCDOI
[illegible]	NCCHFS
[illegible]	MF&S P.A.
Susan Valauri	Nationwide

VISITOR REGISTRATION SHEET

INSURANCE — April 25, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tony Mulvihill	Alcohol/Drug Council of NC
Hugh Tisdale	NCHA
D. J. Kozar	NC RNFA Assoc.
Barbara Carsten	Manning, Fulton & Skinner
Chris Porter	Fain & Associates
Steve Woodie	NCFB
Perri Morgan	NFIB
Steve Keene	NC Medical Society
Amy Jo Bain	NCMS
Sally Jones	SEIP
Ken Wright	BCBSNC

VISITOR REGISTRATION SHEET

INSURANCE — April 25, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
H H Webb	Johnson et al.
Henry Jones	[illegible]
Paul Mahoney	NCAHP
[illegible]	NC Council
[illegible]	[illegible]
[illegible]	KCNA
Joanne Stevens	KCNA
[illegible]	APPC
Margaret Westbrook	Kennedy Covington
[illegible]	[illegible]
John Bourdeau	Alley Assoc.

VISITOR REGISTRATION SHEET

INSURANCE — April 25, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allison C Capps	NCMS
	DCIA

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Committee Substitute for
H.B. 360 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE LAW ON STIPULATIONS AS TO JURISDICTION AND LIMITATIONS OF ACTION AND THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; CLARIFY THE HMO POINT-OF-SERVICE LAW; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS; TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS; TO CLARIFY THE LAWS ON RECONSTRUCTIVE SURGERY NOTICES; AND TO CLARIFY THE LAW ON DEEMER PROVISIONS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill # 2, unfavorable as to Committee Substitute Bill # 1.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 360*
PROPOSED COMMITTEE SUBSTITUTE H360*-PCS3434-SV-26

Short Title: Health Insurance Omnibus Changes. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAW ON STIPULATIONS AS TO JURISDICTION AND LIMITATIONS OF ACTION AND THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; CLARIFY THE HMO POINT-OF-SERVICE LAW; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS; TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS; TO CLARIFY THE LAWS ON RECONSTRUCTIVE SURGERY NOTICES; AND TO CLARIFY THE LAW ON DEEMER PROVISIONS.

The General Assembly of North Carolina enacts:

PART I. JURISDICTION AND LIMITATION OF ACTIONS IN HEALTH INSURANCE POLICIES

SECTION 1. G.S. 58-3-35 reads as rewritten:

"**§ 58-3-35. Stipulations as to jurisdiction and limitation of actions.**

(a) ~~No company or order, domestic or foreign, authorized to do business in this State under Articles 1 through 64 of~~ No insurer, self-insurer, service corporation, HMO,

or MEWA licensed under this ~~Chapter, may~~ Chapter shall make any condition or stipulation in its insurance contracts or policies concerning the court or jurisdiction ~~wherein~~ in which any suit or action ~~thereon~~ on the contract may be brought.

(b) ~~may be brought, nor may it~~ No insurer, self-insurer, service corporation, HMO, or MEWA licensed under this Chapter shall limit the time within which ~~such~~ any suit or action referred to in subsection (a) of this section may be commenced to less than one year after the cause of action accrues or to less than six months from any time at which a plaintiff takes a nonsuit to an action begun within the legal time. ~~All conditions and stipulations forbidden by this section are void.~~

(c) All conditions and stipulations forbidden by this section are void."

PART II. PREFERRED PROVIDER PLAN CLARIFICATION

SECTION 2.1 G.S. 58-50-56(a)(3) reads as rewritten:

"(3) "Preferred provider benefit plan" means a health benefit plan offered by an insurer in which covered services are available from health care providers who are under a contract with the insurer in accordance with this section and in which enrollees are given incentives through differentials in deductibles, coinsurance, or copayments to obtain covered health care services from contracted health care providers. ~~both of the following features are present:~~

~~a. Utilization review or quality management programs are used to manage the provision of covered health care services; and~~services.

~~b. Enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those furnished by participating providers, and health care services are provided by preferred providers under a contract pursuant to this section.~~"

SECTION 2.2. G.S. 58-3-191(c) reads as rewritten:

"(c) For purposes of this section, "health benefit plan" or "plan" means (i) health maintenance organization (HMO) subscriber contracts and (ii) insurance company or hospital and medical service corporation preferred provider benefit plans ~~in which utilization review or quality management programs are used to manage the provision of covered health care services, and enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those provided by participating providers.~~as defined in G.S. 58-50-56."

PART III. SMALL EMPLOYER RATE GUARANTEES

SECTION 3. G.S. 58-50-130(b)(3) reads as rewritten:

"(3) ~~Small employer carriers~~ A small employer carrier shall not modify the premium rate ~~for~~ charged to a small employer or a small employer

group member, including changes in rates related to the increasing age of a group member, for 12 months from the initial issue date or renewal date, unless the group is composite rated and composition of the group changed by twenty percent (20%) or more or benefits are changed. The percentage increase in the premium rate charged to a small employer for a new rating period ~~may~~ shall not exceed the sum of the following:

a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period, and

b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer, and

c. Any adjustment because of change in coverage or change in case characteristics of the small employer group."

PART IV. PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION

SECTION 4. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-16. Promotion of alcohol and narcotic screening and intervention.**

G.S. 58-51-15(b)(11) does not apply to an accident or health insurance policy that provides hospital, medical, or surgical expense coverage."

PART V. NEWBORN AND FOSTER CHILD COVERAGE

SECTION 5. G.S. 58-31-30(b) reads as rewritten:

"(b) Every health benefit plan, as defined in G.S. 58-51-115(a)(1), 58-3-167, that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home. Every health benefit plan shall extend coverage to a foster child without requirements for prior notification unless an additional premium charge to add the foster child is due. If an additional premium charge is due to cover the foster child, the health benefit plan shall cover the foster child upon placement in the foster

home if the foster child is enrolled within 30 days after the placement in the foster home."

PART VI. SUCCESSOR PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY

SECTION 6. G.S. 58-51-110(b) reads as rewritten:

"(b) Whenever a contract described in subsection (a) of this section is replaced by another group contract within 15 days of termination of coverage of the previous group contract, the liability of the succeeding insurer for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding insurer's plan of ~~benefits with respect to classes eligible and activity at work and nonconfinement rules must~~ benefits, regardless of any other provisions of the new group contract relating to active employment or hospital confinement or pregnancy, shall be covered by the succeeding insurer's plan of benefits; and

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

PART VII. CONTINUATION ELECTION PERIOD

SECTION 7.1. G.S. 58-53-10 reads as rewritten:

"**§ 58-53-10. Eligibility.**

Continuation shall only be available to an employee or member who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately ~~prior to~~ before the date of termination. The employee or member may elect continuation for a period of not fewer than 60 days after the date of termination or loss of eligibility. The employee or member shall make the first contribution upon the election to continue coverage; and the coverage shall be retroactive to the date of termination or loss of eligibility."

SECTION 7.2. 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.~~policyholder or by the insurer."

PART VIII. HMO GROUP COVERAGE PREMIUM CHANGE NOTICE

SECTION 8.1. G.S. 58-67-50(b) reads as rewritten:

"(b) (1) Premium approval. – No schedule of premiums for ~~enrollee~~ coverage for health care services, or any amendment ~~thereto, may~~ to the schedule, shall be used in conjunction with any health care plan until a copy of ~~such schedule, or amendment thereto,~~ the schedule or amendment has been filed with and approved by the Commissioner.

(2) Individual coverage. – Premiums shall ~~Such premiums may~~ be established in accordance with actuarial principles for various categories of ~~enrollees, provided that premiums~~ enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of ~~his~~ the enrollee's health. ~~However, the premiums~~ Premiums shall not be excessive, inadequate, or unfairly discriminatory; and ~~must~~ shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. ~~Such~~ The premiums or any revisions ~~thereto~~ to the premiums with respect to nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 ~~months; or as an~~ months. As an alternative to giving ~~such~~ this guarantee ~~with respect only to~~ for nongroup enrollee coverage, ~~such~~ the premium or premium revisions may be made applicable to all similar category of enrollee coverage at one time if the health maintenance organization chooses to apply for ~~such~~ the premium revision with respect to such categories of coverages no more frequently than once in any 12-month period. ~~Such~~ The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the ~~corporation~~ HMO has given written notice of the premium revision to the enrollee 45 days ~~prior to~~ before the effective date of ~~such~~ the revision. The enrollee thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may ~~promulgate~~ adopt reasonable rules, after notice and hearing, to require the ~~submission~~ submittal of supporting data and such information ~~as is deemed~~ as the Commissioner considers necessary to determine

whether ~~such~~ the rate revisions meet ~~these standards.~~the standards in this subdivision.

(3) Group coverage. – Employer group premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate, or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any revisions to the premiums for employer group coverage shall be guaranteed for a period of not less than 12 months. No premium revision shall become effective for any category of group coverage unless the HMO has given written notice of the premium revision to the master group contract holder upon receipt of the group's finalized benefits or 45 days before the effective date of the revision, whichever is earlier. The master group contract holder thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision."

SECTION 8.2. G.S. 58-67-35(a)(6) reads as rewritten:

"(6) The offering and contracting for the provision or arranging of, in addition to health care services, of:

a. Additional health care services;

b. Indemnity benefits, covering out-of-area or emergency services;

c. Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or hospital or medical service corporations; and

d. Point-of-service products, for which an HMO may pre-certify out-of-plan covered services on the same basis as it pre-certifies in-plan covered services, and for which the Commissioner shall adopt rules governing:

1. The percentage of an HMO's total health care expenditures for out-of-plan covered services for all of its members that may be spent on those services, which may not exceed twenty percent (20%);

2. Product limitations, which may provide for payment differentials for services rendered by providers who are not in an HMO network, subject to G.S. 58-3-200(d).

3. Deposit and other financial requirements; and

4. Other requirements for marketing and administering those products."

PART IX. HIPAA COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE

SECTION 9. G.S. 58-68-30(d) reads as rewritten:

"(d) Exceptions. –

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. – A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5) Condition first diagnosed under previous coverage. – A group health insurer shall not impose any preexisting condition exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and the condition was covered under the qualifying previous coverage or prior creditable coverage; provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than 63 days before the enrollment date for the new coverage."

PART X. MEDICARE SUPPLEMENT GUARANTEED ISSUANCE

SECTION 10.1 G.S. 58-54-45 reads as rewritten:

"**§ 58-54-45. By reason of disability.**

(a) In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement ~~Plan A~~ Plans A, C, and J available to persons eligible for Medicare by

reason of disability before age 65. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B.

(b) Persons eligible for Medicare by reason of disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment have the guaranteed right to purchase Medicare Supplement Plans A and C from any insurer within 63 days after the date of termination or disenrollment.

(c) An insurer may develop premium rates specific to the disabled population. No insurer shall discriminate in the pricing of the Medicare supplement plans referred to in this section because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the plan is submitted during an open enrollment or is submitted within 63 days after the managed care plan is terminated. The rates and any applicable rating factors for the Medicare supplement plans referred to in this section shall be filed with and approved by the Commissioner."

SECTION 10.2. Section 39 of S.L. 1998-211 reads as rewritten:

"Section 39. Except as otherwise provided herein, this act is effective as follows: this section and Sections 1, 2, 3, 4, 5, 6, 7, 9.1, 10, 11, 14, 15, 17, 18, 22, 27, 29, 32, 33, 34, 37.1, and 38 of this act are effective when they become law. Sections 9, 12, 13, 19, 20, 21, 23, 24, 25, 28, 30, 31, 35, 36, and 37 of this act become effective November 1, 1998. Sections 8, 16, and 26 of this act become effective January 1, 1999. ~~G.S. 58-54-45, as enacted by Section 13 of this act, expires November 1, 2001.~~"

PART XI. MEDICARE SUPPLEMENT AND LONG-TERM CARE RULES

SECTION 11.1. G.S. 58-54-50 reads as rewritten:

"**§ 58-54-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements.

(2) Establishing a uniform methodology for calculating and reporting loss ratios.

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.

(4) Establishing standards for Medicare Select policies and certificates.

(5) Any other changes required by Congress or the U.S. Department of Health and Human Services, or any successor agency."

SECTION 11.2. Article 55 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-55-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies."

PART XII. SHPPA REPEAL TECHNICAL CORRECTIONS

SECTION 12.1. G.S. 58-50-110(1) is repealed.

SECTION 12.2. G.S. 58-50-110(14) reads as rewritten:

"(14) 'Late enrollee' has the same meaning as defined in G.S. 58-68-30(b)(2); provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. In addition to the special enrollment provisions in G.S. 58-68-30(f), an eligible employee or dependent shall not be considered a late enrollee under a small employer health benefit plan if:

a. Repealed by Session Laws 1998-211, s. 9.

1, 2. Repealed by Session Laws 1998-211, s. 9.

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

b. The individual elects a different health benefit plan offered ~~through the Alliance or~~ by the small employer during an open enrollment period;

c. Repealed by Session Laws 1998-211, s. 9.

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

e. Repealed by Session Laws 1998-211, s. 9."

SECTION 12.3. G.S. 58-50-130(a)(4a) reads as rewritten:

"(4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. ~~An accountable health carrier shall~~

~~not enforce participation or contribution requirements on member small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.~~"

PART XIII. RECONSTRUCTIVE SURGERY NOTICES

SECTION 13.1 G.S. 58-51-62(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ policyholder under ~~the~~ an individual policy, contract, or plan and to every certificate holder under a group policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the policyholder or certificate holder."

SECTION 13.2. G.S. 58-65-96(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ subscriber under ~~the~~ an individual certificate, contract, or plan and to every certificate holder under a group policy, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the subscriber or certificate holder."

SECTION 13.3. G.S. 58-67-79(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ subscriber under the plan upon enrollment and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the subscriber."

PART XIV. DEEMER PROVISIONS

SECTION 14. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-151. Deemer provisions.**

No entity subject to the Commissioner's jurisdiction and regulation shall be fined or penalized by the Commissioner for using forms, contracts, schedules of premiums, or other documents required to be filed and approved under this Chapter or for executing contracts required to be filed and approved under this Chapter if those forms, contracts, schedules of premiums, or other documents have been by law deemed to have been approved, and the entity has notified the Commissioner before using the filing or executing the contract that the law has deemed the filing or the contract to be approved."

PART XV. SEVERABILITY

SECTION 15. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

PART XVI. EFFECT OF HEADINGS

SECTION 16. 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 XVII. EFFECTIVE DATES

SECTION 17. Parts I through X of this act become effective October 1, 2001. The remainder of this act is effective when it becomes law.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1329 --- A BILL TO BE ENTITLED AN ACT PROHIBITING AN INSURER FROM AUTHORIZING OR REQUIRING THE USE OF NONORIGINAL CRASH REPAIR PARTS FOR MOTOR VEHICLE REPAIRS WITHOUT THE WRITTEN CONSENT FROM THE INSURED OR CLAIMANT.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☒ Without prejudice, and recommendation that the bill be re-referred to the Committee on Rules, Calendar, and Operations of the House.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1329

Short Title:	MV Insurers-No Mandate/Nonoriginal Crash Parts.	(Public)
Sponsors:	Representatives Carpenter, Teague, and West.	
Referred to:	Insurance.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT PROHIBITING AN INSURER FROM AUTHORIZING OR REQUIRING THE USE OF NONORIGINAL CRASH REPAIR PARTS FOR MOTOR VEHICLE REPAIRS WITHOUT THE WRITTEN CONSENT FROM THE INSURED OR CLAIMANT.

The General Assembly of North Carolina enacts:

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

"**§ 58-36-105. Use of nonoriginal crash repair parts.**

(a) As used in this section, the following definitions apply:

(1) "Insurer" includes any person authorized to represent an insurer with respect to a claim.

(2) "Nonoriginal crash repair part" means a part for a motor vehicle made or remanufactured by a company other than the original manufacturer or a licensed affiliate and is limited to only the following: metal, fiberglass, or plastic motor vehicle crash repair parts; hood; fender; radiator support; cowl panel; doors; roof; rocker panel; quarter panel; and trunk lid.

(b) An insurer may not authorize or require the use of a nonoriginal crash repair part on a motor vehicle that is five years old or newer without first obtaining the written consent of the insured or other claimant, verifiable by the insured's or other claimant's signature on the repair estimate, appraisal, or work order.

(c) An insurer or automotive body repair facility shall notify the customer anytime that a nonoriginal crash repair part is to be installed.

(d) It is insurance fraud for any insurer, automobile repair facility, or parts person to place a nonoriginal crash repair part on a motor vehicle and to submit an invoice for an original repair part.

(e) Any insurer or other person who has reason to believe that fraud has occurred under this section shall report that fraud to the Commissioner for further action pursuant to G.S. 58-2-160.

(f) A violation of the provisions of this act is punishable by a fine of two thousand dollars ($2,000)."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 808*
PROPOSED COMMITTEE SUBSTITUTE H808-CSRM-30 [v.1]

4/24/2001 5:52:17 PM

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

Sponsors:

Referred to:

March 26, 2001

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-50 reads as rewritten:

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

(a) Definitions. – As used in this section, the ~~term "chemical~~ term:

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

(2) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(3) 'Insurer' has the same meaning as in G.S. 58-3-167.

(b) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance ~~that is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds~~ that includes coverage for the necessary care and treatment of chemical dependency shall ensure that benefits under the chemical dependency coverage ~~benefits for the necessary care and treatment of chemical dependency that~~ are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for treatment of chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may

impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

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

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

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

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

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

a. Chemical dependency units in licensed facilities; ~~facilities licensed after October 1, 1984;~~

b. Medical units;

c. Psychiatric units; and

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

a. Chemical dependency units in psychiatric hospitals;

b. Chemical dependency hospitals;

c. Residential chemical dependency treatment facilities;

d. Social setting detoxification facilities or programs;

e. Medical detoxification or programs; and

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

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

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

SECTION 2. G.S. 58-51-55 reads as rewritten:

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

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

(b) Coverage of Physical Illness. – No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

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

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

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

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

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

~~(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected~~

~~physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires an insurer to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-51-50.~~

~~(d) Applicability. Subsection (b1) of this section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).~~"

SECTION 3. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

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

(a) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that includes coverage for the necessary care and treatment of mental illness shall ensure that benefits under the mental illness coverage are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Average. – If a health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Definitions. – As used in this section:

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(2) 'Insurer' has the same meaning as in G.S. 58-3-167.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes."

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

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

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

(b) Chemical Dependency Parity Requirement. – Every group insurance certificate or group subscriber contract under any hospital or medical plan governed by this Article and Article 66 of this Chapter that includes coverage for the necessary care and treatment of chemical dependency shall ensure that benefits under the chemical dependency coverage ~~is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds benefits for the necessary care and treatment of chemical dependency that~~ are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a hospital or medical plan governed by this Article contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, then the group insurance certificate or group subscriber contract may impose limits on the chemical

dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

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

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

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

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

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

a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~licensed facilities;

b. Medical units;

c. Psychiatric units; and

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

a. Chemical dependency units in psychiatric hospitals;

b. Chemical dependency hospitals;

c. Residential chemical dependency treatment facilities;

d. Social setting detoxification facilities or programs;

e. Medical detoxification facilities or programs; and

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

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

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

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

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in ~~G.S. 58-65-75~~G.S. 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires a service corporation to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-65-75.~~

~~(d) Applicability. Subsection (b1) of this section applies only to subscriber contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

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

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

(a) Definition. – As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that

produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Chemical Dependency Requirement. – ~~On and after January 1, 1985, every~~Every health maintenance organization that writes a health care plan on a group basis ~~and that is subject to this Article shall offer~~ that provides benefits for the necessary care and treatment of chemical dependency shall ensure that benefits under the chemical dependency coverage ~~that~~ are not less favorable than benefits under the health care plan generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a group health plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, then the health maintenance organization may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

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

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

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

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

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

a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~licensed facilities;

b. Medical units;

c. Psychiatric units; and

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

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

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

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

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

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

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

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in ~~G.S. 58-67-70~~G.S. 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Disorders, DSM-IV, or subsequent editions of this manual.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires an HMO to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-67-70.~~

~~(d) Applicability. Subsection (b1) of this section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

SECTION 8. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(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.

(c) Notwithstanding G.S. 58-50-125(c), if the standard health plan developed and approved under G.S. 58-51-125 provides coverage for treatment of chemical dependency and mental illness, the plan shall offer as part of the policy's coverage, a benefit rider that shall offer coverage that includes benefits that are at least equal to the coverage required by G.S. 58-51-50 and G.S. 58-3-220, respectively. The benefits included in the rider may use a case management program in accordance with G.S. 58-51-50 and G.S. 58-3-220, respectively."

SECTION 9. The Department of Insurance shall monitor premium costs incurred by group health plans as a result of the enactment of this act and shall report its findings and recommendations to the 2007 General Assembly. The Commissioner may adopt rules to require reports from group health plans in a forms prescribed by the

Commissioner to enable the Department to monitor these premium costs and report to the General Assembly

SECTION .10. This act becomes effective December 1, 2001 and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after that date. 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. The act shall expire on December 1, 2006.

HOUSE BILL 808:
Mental Health/Chemical Dependency Parity

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Alexander
Date:	April 19, 2001	**Summary by:**	Linda Attarian
Version:	First Edition		Committee Counsel

SUMMARY: House bill 808 would mandate coverage of mental illness and chemical dependency for and require that the coverage would be at full parity with covered benefits for physical illness. Thus the plan must provide the same day and visit limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits and nay other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. The act is effective on January 1, 2002.

CURRENT LAW: *Chemical Dependency:* Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. If the group policyholder accepts the coverage, the benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than $8,000 in total annual benefits for all illnesses under the policy, it must also provide chemical dependency coverage of at least $8,000 *per year* and at least $16,000 over the *lifetime* of the policy.

Mental illness: Insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans. However, if the plan does provide mental health benefits, it must ensure that any lifetime and annual limits on that coverage is no less favorable than the benefits provided for physical benefits generally under the plan. Any plan that can show a 1% increase in costs as a result of this requirement can opt out of the requirement, and any plan that has 50 or fewer employees is exempt. This law expires October 1, 2001.

Self-funded plans: Plans governed by ERISA are subject to the federal Mental Health Parity Act of 1996. The Act prohibits these plans from imposing annual or lifetime dollar limits on reimbursement ceilings for mental health benefits that are more restrictive than those applied to care for physical illness. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement

BILL ANALYSIS:

Coverage and Parity Requirements:

The proposed bill requires all insurers to cover chemical dependency benefits and mental illness benefits. Group plans are required to be in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual and lifetime dollar limits, different deductibles, co-payments, or coinsurance factors, lower maximum out-of-pocket limits, or for more restrictive day and visit limits for mental illness and chemical dependency benefits than it provides for physical benefits generally under the policy

Cost Control Provisions:

Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case. Plans will meet the parity requirements in the bill if at least one of the patient's choices of treatment options within the patient's policy meets the parity requirement.

Utilization Review for Chemical Dependency Treatment:

The bill requires the use of ASAM (American Society of Addiction Medicine Patient Placement) criteria or other criteria adopted by the insurer or its utilization review organization in the utilization review of placement decisions relating to the treatment of chemical dependency.

Definitions of Mental Illness and Chemical Dependency:

- *Chemical Dependency:*
  Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as the *"pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal."* Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines "chemically dependent" in the same manner, but the bill adds a requirement that the dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions).

- *Mental Illness:*
  Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MH/DD/SA Act defines "mental illness" as follows: *"(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment."(GS 122C-3(21)).*

- *Exclusions:* The bill specifically excludes from the mental illness coverage requirement the following disorders:
  - Mental disorders coded in the DSM-IV as substance abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders,

phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.

- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

Effective Date: January 1, 2002.

BACKGROUND: According to a study conducted by Medstat Group for the Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD, 56% of the funding for mental health and substance abuse treatment in 1997 was paid by the public sector, up from 53% in 1987. According to the same study, spending for mental health and substance abuse treatment nationwide reached $85.3 billion in 1997. There has been a decline in private insurers' real spending for substance abuse services between 1987 and 1997 of 0.6%.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1266 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR DIRECT PAYMENT OF REGISTERED NURSE FIRST ASSISTANTS UNDER HEALTH INSURANCE POLICIES AND PLANS.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

HOUSE BILL 1266

Short Title:	Surgical Nurses/3rd Party Pmt.	(Public)
Sponsors:	Representatives Wright, Hiatt, and Brubaker.	
Referred to:	Insurance.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR DIRECT PAYMENT OF REGISTERED NURSE FIRST ASSISTANTS 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, advanced practice nurse, registered nurse first assistant, or physician assistant.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of 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 that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, registered nurse first assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral

counselor, a registered nurse first assistant, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, registered nurse first assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly certified substance abuse professional, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, registered nurse first assistant, 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.

(d1) For purposes of this section, a "registered nurse first assistant" is a person who:

(1) Is licensed as a registered nurse in this State,

a. Is certified in perioperative nursing, and

b. Has successfully completed a registered nurse first assistant education program that meets the Association of Perioperative Registered Nurses, Inc.'s education standard for the registered nurse first assistant; or

(2) Was holding the title of and practicing as a registered nurse first assistant as of January 1, 1993.

This section shall not apply to a registered nurse first assistant who is employed by the requesting physician or renders services in the capacity as an employee of the hospital where services are rendered.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1."

SECTION 2.(a) G.S. 58-65-1(a) 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, a registered nurse first assistant, 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, a duly licensed physician assistant, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed

chiropractor, a duly licensed psychologist, a duly licensed pharmacist, a registered nurse first assistant, 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, a duly licensed physician assistant, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes."

SECTION 2.(b) G.S. 58-65-1 is amended by adding the following new subsection to read:

"(c1) For purposes of this section, a "registered nurse first assistant" is a person who:

(1) Is licensed as a registered nurse in this State,

a. Is certified in perioperative nursing, and

b. Has successfully completed a registered nurse first assistant education program that meets the Association of Perioperative Registered Nurses, Inc.'s education standard for the registered nurse first assistant; or

(2) Was holding the title of and practicing as a registered nurse first assistant as of January 1, 1993.

This section shall not apply to a registered nurse first assistant who is employed by the requesting physician or renders services in the capacity as an employee of the hospital where services are rendered."

SECTION 3. This act becomes effective October 1, 2001, and applies to claims for payment or reimbursement for services rendered on or after that date.

HOUSE BILL 1266:
Surgical Nurses/3rd Party Pmt.

BILL ANALYSIS

Committee:	House Health	**Introduced by:**	Rep. Wright
Date:	April 24, 2001	**Summary by:**	Linda Attarian
Version:	Introduced		Committee Counsel

SUMMARY: ***House Bill 1266, if enacted, will prohibit most health benefit plans from denying payment or reimbursement for any covered service that is within the scope of practice of a registered nurse first assistant. The bill does not apply to HMO plans. The act is effective October 1, 2001, and applies to claims for payment or reimbursement for services rendered on or after that date.***

CURRENT LAW: G.S. 58-50-30 together with G.S. 58-65-1, requires insurers, with respect to a specified list of categories or classes of health care providers, to reimburse for a covered service regardless of the class of provider performing the service, as long as the service is within the scope of practice of the provider.

BILL ANALYSIS:

Section 1 adds " ***Registered Nurse First Assistant (RNFA)"*** to the list of professions that are designated in G.S. 58-50-30.

Section 2(a) and 2(b) add "***Registered Nurse First Assistant (RNFA)"*** to G.S. 58-65-1.

Section 3 makes the bill effective on October 1, 2001 and applies to claims for reimbursement for services rendered on or after that date.

Registered Nurse First Assistant (RNFA) has:

- Received a college education ADN/ Diploma / BSN prepared Registered Nurse Licensed in NC
- Been certified in perioperative nursing
- Been certified in Basic Life Support and ACLS Advanced Cardiac Life Support
- Minimum of 2 years (about 2000 hours) operating room experience as Scrub nurse (one who passes instruments to surgeon) and as Circulator (nurse in charge of the operating room during the surgery)
- Successfully completed a "registered nurse first assistant education program" that meets the association of Perioperative Registered Nurses, Inc.'s education standard for this category
- Been credentialed by the Medical Staff / Hospital administrator and granted Privileges to practice in facility
- Held the title of and practicing as a RNFA as of January 1, 1993

Does not include:

1. RNFA who is employed by the "requesting" physician
2. RNFA who renders services in the capacity of an employee of the hospital where the services are rendered

BACKGROUND: A RNFA in perioperative care stands across form the surgeon and helps perform the operation under the direction and constant supervision of the surgeon. Approximately 60 RNFAs are registered in North Carolina. There is current inconsistency with insurance companies, as some pay for RNFA services and others do not.

Eight other sates have passed RNFA legislation including. Such states as Texas, South Carolina, Iowa, and Missouri are currently considering RNFA legislation.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1253 A BILL TO BE ENTITLED AN ACT TO AMEND THE DEFINITION OF UNDERINSURED HIGHWAY VEHICLE TO PROVIDE GREATER PROTECTION TO CONSUMERS INJURED IN MOTOR VEHICLE ACCIDENTS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, ☒ which changes the title, unfavorable as to original bill.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1253
PROPOSED COMMITTEE SUBSTITUTE H1253-PCS4169-SO-28

Short Title: Uninsured Motorist Coverage. (Public)

Sponsors:

Referred to:

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY WHETHER THE DEFINITION OF UNDERINSURED HIGHWAY VEHICLE SHOULD BE AMENDED TO PROVIDE GREATER PROTECTION TO CONSUMERS INJURED IN MOTOR VEHICLE ACCIDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Research Commission may study whether the definition of underinsured highway vehicle should be amended to provide greater protection to consumers injured in motor vehicle accidents. The Commission may address all issues that the Commission considers relevant to the study.

If the Legislative Research Commission undertakes the study, it shall report its findings and recommendations, including any recommended legislation, to the 2002 Regular Session of the 2001 General Assembly.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

HOUSE BILL 1253

Short Title:	Uninsured Motorist Coverage.	(Public)
Sponsors:	Representative Goodwin.	
Referred to:	Insurance.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF UNDERINSURED HIGHWAY VEHICLE TO PROVIDE GREATER PROTECTION TO CONSUMERS INJURED IN MOTOR VEHICLE ACCIDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-279.21(b)(4) reads as rewritten:

"(4) Shall, in addition to the coverages set forth in subdivisions (2) and (3) of this subsection, provide underinsured motorist coverage, to be used only with a policy that is written at limits that exceed those prescribed by subdivision (2) of this section and that afford uninsured motorist coverage as provided by subdivision (3) of this subsection, in an amount not to be less than the financial responsibility amounts for bodily injury liability as set forth in G.S. 20-279.5 nor greater than one million dollars ($1,000,000) as selected by the policy owner. An "uninsured motor vehicle," as described in subdivision (3) of this subsection, includes an "underinsured highway vehicle," which means a highway vehicle with respect to the ownership, maintenance, or use of which, the sum of the limits of liability under all bodily injury liability bonds and insurance policies applicable at the time of the accident and available for payment for bodily injury are insufficient to pay damages for bodily injury of all persons injured at the time of the accident. ~~is less than the applicable limits of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner's policy.~~ For the purposes of this subdivision, the term "highway vehicle" means a land motor vehicle or trailer other than (i) a farm-type tractor or other vehicle designed for use principally off public roads and while not upon public roads, (ii) a vehicle operated on rails or crawler-treads, or (iii) a vehicle while located for use as a

residence or premises. The provisions of subdivision (3) of this subsection shall apply to the coverage required by this subdivision. Underinsured motorist coverage is deemed to apply when, by reason of payment of judgment or settlement, all liability bonds or insurance policies providing coverage for bodily injury caused by the ownership, maintenance, or use of the underinsured highway vehicle have been exhausted. Exhaustion of that liability coverage for the purpose of any single liability claim presented for underinsured motorist coverage is deemed to occur when either (a) the limits of liability per claim have been paid upon the claim, or (b) by reason of multiple claims, the aggregate per occurrence limit of liability has been paid. Underinsured motorist coverage is deemed to apply to the first dollar of an underinsured motorist coverage claim beyond amounts paid to the claimant under the exhausted liability policy.

In any event, the limit of underinsured motorist coverage applicable to any claim is determined to be the difference between the amount ~~paid~~ available for payment to the claimant under the exhausted liability policy or policies and the limit of underinsured motorist coverage applicable to the motor vehicle involved in the accident. Furthermore, if a claimant is an insured under the underinsured motorist coverage on separate or additional policies, the limit of underinsured motorist coverage applicable to the claimant is the difference between the amount paid to the claimant under the exhausted liability policy or policies and the total limits of the claimant's underinsured motorist coverages as determined by combining the highest limit available under each policy; provided that this sentence shall apply only to insurance on nonfleet private passenger motor vehicles as described in G.S. 58-40-15(9) and (10). The underinsured motorist limits applicable to any one motor vehicle under a policy shall not be combined with or added to the limits applicable to any other motor vehicle under that policy.

An underinsured motorist insurer may at its option, upon a claim pursuant to underinsured motorist coverage, pay moneys without there having first been an exhaustion of the liability insurance policy covering the ownership, use, and maintenance of the underinsured highway vehicle. In the event of payment, the underinsured motorist insurer shall be either: (a) entitled to receive by assignment from the claimant any right or (b) subrogated to the claimant's right regarding any claim the claimant has or had against the owner, operator, or maintainer of the underinsured highway vehicle, provided that the amount of the insurer's right by subrogation or assignment shall not exceed payments made to the claimant by the insurer. No insurer shall exercise any right of subrogation or any right to approve settlement with the original owner, operator, or maintainer of the underinsured

highway vehicle under a policy providing coverage against an underinsured motorist where the insurer has been provided with written notice before a settlement between its insured and the underinsured motorist and the insurer fails to advance a payment to the insured in an amount equal to the tentative settlement within 30 days following receipt of that notice. Further, the insurer shall have the right, at its election, to pursue its claim by assignment or subrogation in the name of the claimant, and the insurer shall not be denominated as a party in its own name except upon its own election. Assignment or subrogation as provided in this subdivision shall not, absent contrary agreement, operate to defeat the claimant's right to pursue recovery against the owner, operator, or maintainer of the underinsured highway vehicle for damages beyond those paid by the underinsured motorist insurer. The claimant and the underinsured motorist insurer may join their claims in a single suit without requiring that the insurer be named as a party. Any claimant who intends to pursue recovery against the owner, operator, or maintainer of the underinsured highway vehicle for moneys beyond those paid by the underinsured motorist insurer shall before doing so give notice to the insurer and give the insurer, at its expense, the opportunity to participate in the prosecution of the claim. Upon the entry of judgment in a suit upon any such claim in which the underinsured motorist insurer and claimant are joined, payment upon the judgment, unless otherwise agreed to, shall be applied pro rata to the claimant's claim beyond payment by the insurer of the owner, operator or maintainer of the underinsured highway vehicle and the claim of the underinsured motorist insurer.

A party injured by the operation of an underinsured highway vehicle who institutes a suit for the recovery of moneys for those injuries and in such an amount that, if recovered, would support a claim under underinsured motorist coverage shall give notice of the initiation of the suit to the underinsured motorist insurer as well as to the insurer providing primary liability coverage upon the underinsured highway vehicle. Upon receipt of notice, the underinsured motorist insurer shall have the right to appear in defense of the claim without being named as a party therein, and without being named as a party may participate in the suit as fully as if it were a party. The underinsured motorist insurer may elect, but may not be compelled, to appear in the action in its own name and present therein a claim against other parties; provided that application is made to and approved by a presiding superior court judge, in any such suit, any insurer providing primary liability insurance on the underinsured highway vehicle may upon payment of all of its applicable limits of liability be released from further liability or obligation to participate in the defense of such proceeding. However, before approving any such

application, the court shall be persuaded that the owner, operator, or maintainer of the underinsured highway vehicle against whom a claim has been made has been apprised of the nature of the proceeding and given his right to select counsel of his own choice to appear in the action on his separate behalf. If an underinsured motorist insurer, following the approval of the application, pays in settlement or partial or total satisfaction of judgment moneys to the claimant, the insurer shall be subrogated to or entitled to an assignment of the claimant's rights against the owner, operator, or maintainer of the underinsured highway vehicle and, provided that adequate notice of right of independent representation was given to the owner, operator, or maintainer, a finding of liability or the award of damages shall be res judicata between the underinsured motorist insurer and the owner, operator, or maintainer of underinsured highway vehicle.

As consideration for payment of policy limits by a liability insurer on behalf of the owner, operator, or maintainer of an underinsured motor vehicle, a party injured by an underinsured motor vehicle may execute a contractual covenant not to enforce against the owner, operator, or maintainer of the vehicle any judgment that exceeds the policy limits. A covenant not to enforce judgment shall not preclude the injured party from pursuing available underinsured motorist benefits, unless the terms of the covenant expressly provide otherwise, and shall not preclude an insurer providing underinsured motorist coverage from pursuing any right of subrogation.

The coverage required under this subdivision shall not be applicable where any insured named in the policy rejects the coverage. An insured named in the policy may select different coverage limits as provided in this subdivision. If the named insured does not reject underinsured motorist coverage and does not select different coverage limits, the amount of underinsured motorist coverage shall be equal to the highest limit of bodily injury liability coverage for any one vehicle in the policy. Once the option to reject underinsured motorist coverage or to select different coverage limits is offered by the insurer, the insurer is not required to offer the option in any renewal, reinstatement, substitute, amended, altered, modified, transfer, or replacement policy unless a named insured makes a written request to exercise a different option. The selection or rejection of underinsured motorist coverage by a named insured or the failure to select or reject is valid and binding on all insureds and vehicles under the policy.

Rejection of or selection of different coverage limits for underinsured motorist coverage for policies under the jurisdiction of the North Carolina Rate Bureau shall be made in writing by the named insured on a form promulgated by the Bureau and approved by the Commissioner of Insurance."

SECTION 2. This act becomes effective October 1, 2001, and applies to accidents occurring on or after that date.

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 16, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 16, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Jennie Dickens (Wake County – Speaker Black) and Brandon Diggs (Pender County - Representative Wright). The following Committee members were present: Representatives Barbee, Blue, Brubaker, Dedmon, Grady, Hall, Johnson, Justus, Setzer, Smith, Wainwright, and Warner. Frank Folger, Staff Counsel, was in attendance. A list of visitors attending is attached. The following bills were considered:

SB 852, entitled, AN ACT TO AUTHORIZE THE STATE TO PURCHASE OWNER-CONTROLLED OR WRAP-UP INSURANCE FOR PUBLIC WORKS PROJECTS. Senator Hoyle was recognized to explain the bill. SB 852 would allow the Department of Insurance to purchase owner-controlled or wrap-up insurance for the purposes of general liability, property damage, and workers' compensation for the State's construction projects as opposed to the contractors and subcontractors purchasing their own insurance and passing the cost to the State in their bids. Dascheil Propes, Chief Deputy Commissioner, Department of Insurance, was recognized and indicated the State would contract with a third party administrator who would decide about the placement of insurance coverage. They would act as a risk manager. Mr. Propes indicated this would be a cost saving measure. Representative Brubaker moved for a favorable report. The motion passed.

SB 321, entitled, AN ACT TO PROVIDE FOR SHARING OF INFORMATION PRODUCED BY, OBTAINED BY, OR DISCLOSED TO THE INSURANCE COMMISSIONER UNDER THE EXAMINATION LAW; AND TO CLARIFY THAT THE EXAMINATION LAW APPLIES TO ALL ENTITIES SUBJECT TO REGULATION BY THE INSURANCE COMMISSIONER. Senator Wellons was recognized to explain the bill. SB 321 would clarify the law that the Commissioner may examine the financial operations and the compliance with the law of all entities subject to regulation by the Commissioner rather than referring only to insurers. It would not make anything that comes to the Commissioner confidential that is not now. It would allow entities to maintain their claims of privilege for their documents. This bill would also allow the Commissioner to share this information with other federal, state and international regulatory and law enforcement agencies, and with the National Association of Insurance Commissioners (NAIC). Representative Blue moved for a favorable report. The motion passed.

SB 241, entitled, AN ACT TO STRENGTHEN THE LAW MAKING IT A FELONY FOR AN INSURANCE FIDUCIARY TO CAUSE TERMINATION OF GROUP HEALTH OR LIFE INSURANCE COVERAGE BY NONPAYMENT OF PREMIUM WITHOUT GIVING NOTICE TO MEMBERS OF THE GROUP.

Senator Dalton, bill sponsor, was not available to explain the bill. Frank Folger, Staff Counsel, was recognized to explain the bill. SB 241 amends GS 58-50-40 to clarify that section which applies to group health plans as defined in the federal Employment Retirement Income Security Act. It makes violations a class G felony (currently, class H). Requires insurers to notify the Commissioner of Insurance when an insurance fiduciary fails to pay group health or life insurance premiums, and to notify insureds by publication of notice of the fiduciary's failure to pay. Authorizes insurer to recover costs of publication and related administrative expenses from the insurance fiduciary. Makes additional technical and conforming changes. Representative Smith moved for a favorable report. The motion passed.

There being no further business, the meeting was adjourned at 12:40 p.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
Senate Bills 852, 321, and 241
Bill Summaries
Handout

VISITOR REGISTRATION SHEET

INSURANCE — May 16, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Price	Jordan Price
Bill Scoggin	Kennedy Covington
Robert Pasthal	Young, Moore
Lisa Piercy	NCAIFA
David Gotte	Raleigh CBA
Dave Lust	Sgmc
Sheila McKinney	NC DOI
Barbara Morales Burke	NC DOI

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☐ Committee Substitute for
S.B. 852 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE STATE TO PURCHASE OWNER-CONTROLLED OR WRAP-UP INSURANCE FOR PUBLIC WORKS PROJECTS.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 852

Short Title:	Insurance for Public Works Projects.	(Public)
Sponsors:	Senator Hoyle.	
Referred to:	Insurance and Consumer Protection.	

April 4, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE STATE TO PURCHASE OWNER-CONTROLLED OR WRAP-UP INSURANCE FOR PUBLIC WORKS PROJECTS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 31 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-31-65. Owner-controlled or wrap-up insurance authorized.**

(a) To the extent it is determined necessary and in the best interest of this State, the Department may obtain design and construction insurance or provide for self-insurance against property damage caused by this State, its departments, agencies, boards, and commissions and all officers and employees of this State in connection with the construction of public works projects. Workers' compensation and general liability insurance may be purchased to cover both general contractors and subcontractors doing work on a specific contracted work site. In connection with the construction of public works projects, the Department may also use an owner-controlled or wrap-up insurance program if all of the following conditions are met:

(1) The total cost of the project or group of projects is over fifty million dollars ($50,000,000).

(2) The program maintains completed operations coverage for a term during which coverage is reasonably commercially available as determined by the Commissioner, but in no event for fewer than three years.

(3) Bid specifications clearly specify for all bidders the insurance coverage provided under the program and the minimum safety requirements that shall be met.

(4) The program does not prohibit a contractor or subcontractor from purchasing any additional insurance coverage that a contractor believes is necessary for protection from any liability arising out of the

contract. The cost of the additional insurance shall not be passed through to this State on a contract bid.

(5) The program does not include surety insurance.

(6) The State may purchase an owner-controlled or wrap-up policy that has a deductible or self-insured retention as long as the deductible or self-insured retention does not exceed one million dollars ($1,000,000).

(b) For the purposes of subsection (a) of this section:

(1) "Owner-controlled or wrap-up insurance" means a series of insurance policies issued to cover this State and all of the construction managers, contractors, subcontractors, architects, and engineers on a specified contracted work site or work sites for purposes of general liability, property damage, and workers' compensation. A State agency or the State may be a secondary insured under owner-controlled or wrap-up insurance.

(2) "Specific contracted work site" means construction being performed at one site or a series of contiguous sites separated only by a street, roadway, waterway, or railroad right-of-way, or along a continuous system for the provision of water and power."

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

SENATE BILL 852:
Insurance for Public Works Projects

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Hoyle
Date:	May 9, 2001	**Summary by:**	Linda Attarian
Version:	First Edition		Committee Counsel

SUMMARY: ***S842 would allow the Department of Insurance to purchase owner-controlled or wrap-up insurance for purposes of general liability, property damage, and workers' compensation for the State's construction projects as opposed to the contractors and subcontractors purchasing their own insurance and passing the cost to the State in their bids. The act is effective when it becomes law.***

BILL ANALYSIS: Section 1 amends Article 31 of Chapter 58 to authorize the Department of Insurance to obtain design and construction insurance or provide for self-insurance against property damage connection with the construction of public works projects.

The Department may also use an owner-controlled or wrap-up insurance to handle insurance for the State's construction projects. Under this program the State would purchase workers' compensation and general liability insurance to cover both general contractors and subcontractors doing work on a specific contracted work site. Typically the cost of this insurance when purchased by contractors and subcontractors is passed on to the State in the bidding process.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 321 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR SHARING OF INFORMATION PRODUCED BY, OBTAINED BY, OR DISCLOSED TO THE INSURANCE COMMISSIONER UNDER THE EXAMINATION LAW; AND TO CLARIFY THAT THE EXAMINATION LAW APPLIES TO ALL ENTITIES SUBJECT TO REGULATION BY THE INSURANCE COMMISSIONER.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 321*

Insurance and Consumer Protection Committee Substitute Adopted 4/23/01

Short Title: Insurance Exam Law Amendments. (Public)

Sponsors:

Referred to:

March 5, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR SHARING OF INFORMATION PRODUCED BY, OBTAINED BY, OR DISCLOSED TO THE INSURANCE COMMISSIONER UNDER THE EXAMINATION LAW; AND TO CLARIFY THAT THE EXAMINATION LAW APPLIES TO ALL ENTITIES SUBJECT TO REGULATION BY THE INSURANCE COMMISSIONER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-131(d) reads as rewritten:

"(d) The Commissioner may conduct an examination of any ~~insurer~~ entity whenever the Commissioner deems it to be prudent for the protection of policyholders or the public, but shall at a minimum conduct a regular examination of every domestic insurer not less frequently than once every five years. In scheduling and determining the nature, scope, and frequency of examinations, the Commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the NAIC Examiners' Handbook."

SECTION 2. G.S. 58-2-131(e) reads as rewritten:

"(e) To complete an examination of any ~~insurer,~~ entity, the Commissioner may authorize an examination or investigation of any person, or the business of any person, insofar as the examination or investigation is necessary or material to the ~~insurer~~ entity under examination."

SECTION 3. G.S. 58-2-131(l) reads as rewritten:

"(l) Pending, during, and after the examination of any ~~insurer~~ entity, the Commissioner shall not make public the financial statement, findings, or examination report, or any report affecting the status or standing of the ~~insurer~~ entity examined, until the ~~insurer~~ entity examined has either accepted and approved the final examination report or has been given a reasonable opportunity to be heard on the report and to answer or rebut any statements or findings in the report. The hearing, if requested, shall be informal and private."

SECTION 4. G.S. 58-2-132 reads as rewritten:

"**§ 58-2-132. Examination reports.**

(a) All examination reports shall comprise only facts appearing upon the books, records, or other documents of the ~~insurer,~~ entity, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and conclusions and recommendations that the examiners find reasonably warranted from the facts.

(b) No later than 60 days following completion of an examination, the examiners shall file with the Department a verified written examination report under oath. Upon receipt of the verified report, the Department shall send the report to the ~~insurer~~ entity examined, together with a notice that affords the ~~insurer~~ entity examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. Within 30 days ~~of~~ after the date of the examination report, the ~~insurer~~ entity examined shall file affidavits executed by each of its directors stating under oath that they have received and read a copy of the report.

(c) At the end of the 30 days provided for the receipt of written submissions or rebuttals, the Commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant parts of the examiners' work papers and enter an order:

(1) Adopting the examination report as filed or with modifications or corrections. If the examination report reveals that the ~~insurer~~ entity examined is operating in violation of any law, rule, or prior order of the Commissioner, the Commissioner may order the ~~insurer~~ entity examined to take any action the Commissioner considers necessary and appropriate to cure the violation; or

(2) Rejecting the examination report with directions to the examiners to reopen the examination to obtain additional data, documentation of the information, and refiling under subdivision (1) of this subsection; or

(3) Calling for an investigatory hearing with no less than 20 days' notice to the insurer for purposes of obtaining additional documentation, data, and testimony.

(d) All orders entered under subdivision (c)(1) of this section shall be accompanied by findings and conclusions resulting from the Commissioner's consideration and review of the examination report, relevant examiner work papers, and any written submissions or rebuttals. Any such order shall be considered a final administration decision and shall be served upon the ~~insurer~~ entity examined by certified mail. Any hearing conducted under subdivision (c)(3) of this section shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent on the face of the filed examination report or raised by or as a result of the Commissioner's review of relevant work papers or by the written submission or rebuttal of the ~~insurer.~~entity examined. Within 20 days after the conclusion of any such hearing, the Commissioner

shall enter an order under subdivision (c)(1) of this section. The Commissioner may not appoint a member of the Department's examination staff as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the ~~insurer~~ entity examined limited to the examiner's work papers that tend to substantiate any assertions set forth in any written submission or rebuttal. The Commissioner may issue subpoenas for the attendance of any witnesses or the production of any documents the Commissioner considers to be relevant to the investigation, whether they are under the control of the Department, the ~~insurer,~~ entity examined, or other persons. The documents produced shall be included in the record, and testimony taken by the Commissioner shall be under oath and preserved for the record. Nothing in this section requires the Department to disclose any information or records that would show the existence or content of any investigation or activity of any federal or state criminal justice agency. In the hearing, the Commissioner shall question the persons subpoenaed. Thereafter the ~~insurer~~ entity examined and the Department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the Commissioner. The ~~insurer~~ entity examined and the Department may make closing statements and may be represented by counsel of their choice.

(e) Upon completion of the examination report under subdivision (c)(1) of this section, the Commissioner shall hold the content of the examination report as private and confidential information for the 30-day period provided for written submissions or rebuttals. If after 30 days after the examination report has been submitted to it, the ~~insurer~~ entity examined has neither notified the Commissioner of its acceptance and approval of the report nor requested to be heard on the report, the report shall then be filed as a public document and shall be open to public inspection, as long as no court of competent jurisdiction has stayed its publication. Nothing in the Examination Law prohibits the Commissioner from disclosing the content of the examination report, preliminary examination report or results, or any related matter, to an insurance regulator or to law enforcement officials of this or any other state or country or of the United States government at any time, as long as the person or agency receiving the report or related matters agrees in writing and is authorized by law to hold it confidential and in a manner consistent with this section. If the Commissioner determines that further regulatory action is appropriate as a result of any examination, the Commissioner may initiate such proceedings or actions as provided by law.

(f) All working papers, ~~recorded~~ information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person ~~during~~ in connection with an examination or financial analysis shall be given confidential ~~treatment and is~~ treatment, are not subject to ~~subpoena~~ subpoena, and ~~may~~ shall not be made public by the Commissioner or any other ~~person, except to the extent provided in G.S. 58-2-131(l) or subsection (e) of this section.~~person. ~~Access may also be granted to the NAIC. Such parties must agree in writing before receiving the information to give it the same confidential treatment as this section requires, unless the prior written consent of the insurer to which it pertains has been obtained. The provisions of this section do not prohibit the Commissioner from taking any action provided for, or from exercising~~

~~any power conferred by, any provision of this Chapter to suspend or revoke the license of any insurer.~~ The Commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

(g) In order to assist in the performance of the Commissioner's duties, the Commissioner may:

(1) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (f) of this section, with other state, federal, and international regulatory agencies, with the NAIC, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information.

(2) Receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(3) Enter into agreements governing sharing and use of information consistent with this section.

(h) No waiver of an existing privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (g) of this section.

(i) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, this State.

(j) In this section, 'department,' 'insurance regulator,' 'law enforcement official or authority,' 'NAIC,' and 'regulatory official or agency' include employees, agents, consultants, and contractors of those entities."

SECTION 5. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

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

SENATE BILL 321:
Insurance Exam Law Amendments

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Wellons
Date:	May 16, 2001	**Summary by:**	Frank W. Folger
Version:	Second Edition		Committee Counsel

SUMMARY: ***This bill would clarify that the insurance examination laws apply to all "entities" subject to regulation by the Insurance Commissioner; authorize an examination when the Commissioner deems it prudent for the protection of the public, and authorize sharing of information produced by, obtained by, or disclosed to the Commissioner under these same examination laws.***

CURRENT LAW: Persons Subject to Examination - Only insurers are expressly subject to examination by the Commissioner under N.C.G.S. §58-2-131. Other entities subject to the regulatory authority of the Commissioner are not explicitly included.

Grounds for Examination – The Commissioner can examine an insurer whenever the Commissioner deems it prudent for the protection of policyholders, but must examine each domestic insurer once every five years.

Sharing of Information/Confidentiality – Until the insurer subject to an examination has accepted and approved the final examination report or been given an opportunity to be heard on the report and rebut statements in the report, the Commissioner cannot make public the financial statement, findings or examination report or any report affecting the status or standing of the insurer. All working papers, recorded information, documents and copies (hereinafter "documented information") produced by, obtained by, or disclosed to the Commissioner or any other person *during* an examination is given "confidential treatment", not subject to subpoena, and "may not be made public by the Commissioner or any other person". Access may be granted to the National Association of Insurance Commissioners (NAIC) subject to the same confidentiality treatment unless prior written consent of the subject insurer is obtained. Despite the confidentiality rules, the Commissioner may take any authorized action against an insurer.

BILL ANALYSIS: Sections 1 – 3 would expand the express scope of the Commissioner's authority to examine under its regulatory authority. It would provide that under the insurance examination laws, the Commissioner could examine any "entity" subject to the Commissioner's regulatory authority, rather than only an "insurer:" It would expand the grounds on which the Commissioner could conduct an examination to allow for it when the Commissioner deems it prudent for the protection of the public, in addition to allowing for it when the Commissioner deems it prudent for the protection of the policyholders.

Section 4 would change the law on examination reports to conform to the changes in scope in Sections 1-3, make clarifying technical changes, codify in this section that information subject to confidentiality includes "financial analysis", and rewrite the disclosure rules to provide for sharing of information as follows:

- For the Commissioner to use the documented information in furtherance of legal or regulatory action brought as part of the Commissioner's duties;
- For the Commissioner to share the documented information, including confidential and privileged documented information with other state, federal, and international regulatory agencies and law

enforcement and with the NAIC provided the recipient agrees to maintain the privileged and confidential status of such information;

- For the Commissioner to receive documented information or communications form the NAIC and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and maintain as confidential and privileged such documented information when it has notice or understands that the information is confidential and privileged under the laws of the jurisdiction that is the source of the information.
- For the Commissioner to be able to enter into agreements governing the sharing and use of information consistent with this statute;
- Disclosure as provided in the sharing provisions would not waive any existing privilege or claim of confidentiality;
- Reciprocity would be provided for any privilege from another state substantially similar to that provided in this statute;

This section also clarifies that references to "department", "insurance regulator", "law enforcement official or authority", "NAIC", and "regulatory official or agency" includes employees, agents, consultants, and contractors of those entities.

Section 5 is a severability clause.

Section 6 would make the act effective upon becoming law.

BACKGROUND: The Department of Insurance requires this legislation for NAIC accreditation.

DIFFERENCES FROM THE ORIGINAL BILL: The Proposed Committee Substitute replaces the original bill's "person" each time it appears with the word "entity" in expanding the scope of the Commissioner's examination law authority. It also adds on page 3, line 37 of the original bill the phrase "or financial analysis" to expressly codify in this section the confidentiality of such analysis connected with examination under these laws.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

May 16, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 321– Insurance Exam Law Amendments

This bill would clarify the law that the Commissioner may examine the financial operations and the compliance with the law of all entities subject to regulation by the Commissioner rather than referring only to insurers.

This bill would also allow these entities to share information that they might otherwise claim as privileged. The information shared by an entity with the Commissioner's examiners during an examination or in connection with financial analysis of an entity would be given confidential treatment and not subject to subpoena, as the law provides now. In other words, this bill would not make anything that comes to the Commissioner confidential that is not now. It would allow entities to maintain their claims of privilege for their documents.

This bill would also allow the Commissioner to share this information with other federal, state, and international regulatory and law enforcement agencies, and with the National Association of Insurance Commissioners (NAIC). If the Commissioner considers it necessary to share information with these other agencies, the privilege would be maintained, provided those other agencies agree to maintain the confidentiality and privileged status of the documents in question.

This bill is necessary for NAIC accreditation of the Department's Financial Evaluation Division. This is very important to our domestic insurance companies in their dealings with other state insurance departments. It would allow the Department access to internal audit reports that the entities claim are privileged. It would also allow North Carolina to participate with other agencies that are moving forward with similar legislation.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 241 A BILL TO BE ENTITLED AN ACT TO STRENGTHEN THE LAW MAKING IT A FELONY FOR AN INSURANCE FIDUCIARY TO CAUSE TERMINATION OF GROUP HEALTH OR LIFE INSURANCE COVERAGE BY NONPAYMENT OF PREMIUM WITHOUT GIVING NOTICE TO MEMBERS OF THE GROUP.

☐ With a favorable report.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on Judiciary II ☒.

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 241

Insurance and Consumer Protection Committee Substitute Adopted 4/10/01

Short Title: Health Insurance Termination Notice. (Public)

Sponsors:

Referred to:

February 26, 2001

A BILL TO BE ENTITLED

AN ACT TO STRENGTHEN THE LAW MAKING IT A FELONY FOR AN INSURANCE FIDUCIARY TO CAUSE TERMINATION OF GROUP HEALTH OR LIFE INSURANCE COVERAGE BY NONPAYMENT OF PREMIUM WITHOUT GIVING NOTICE TO MEMBERS OF THE GROUP.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-40 reads as rewritten:

"**§ 58-50-40. Willful failure to pay group insurance premiums; notice to persons insured; penalty; restitution; examination of insurance transactions.**

(a) As used in this section and in G.S. 58-50-45, the term "group health insurance" means: (1) any policy described in G.S. 58-51-75, 58-51-80, or 58-51-90; (2) any group insurance certificate or group subscriber contract issued by a ~~hospital~~ service corporation pursuant to Articles 65 and 66 of this Chapter; (3) any health care plan provided or arranged by a health maintenance organization pursuant to Article 67 of this Chapter; ~~or~~ (4) any multiple employer welfare arrangement as defined in ~~G.S. 58-49-30(a).~~ G.S. 58-49-30(a); or (5) a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

As used in this section and in G.S. 58-50-45, the term "insurance fiduciary" means any person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or group life insurance premiums. As used in this section and in G.S. 58-50-45, "premiums" includes contributions to a group health plan or to a multiple employer welfare arrangement.

(b) No insurance fiduciary shall:

(1) Cause the cancellation or nonrenewal of group health or group life insurance and the consequential loss of the coverages of the persons insured by willfully failing to pay such premiums in accordance with the terms of a group health or group life insurance contract; and

(2) Willfully fail to deliver, at least 45 days before the termination of such insurance, to all persons covered by the group policy a written notice of the insurance fiduciary's intention to stop payment of premiums.

(c) Any insurance fiduciary who violates subsection (b) of this section shall be guilty of a Class ~~H~~ G felony.

(e) Upon conviction under subsection (c) of this section the court shall order the insurance fiduciary to make full restitution to persons insured who incurred expenses that would have been covered by the group health insurance or full restitution to beneficiaries of the group life insurance for death benefits that would have been paid if the coverage had not been terminated.

(f) Insurance fiduciaries subject to this section shall be subject to the provisions of G.S. 58-2-200 with respect only to transactions involving group health or life insurance.

(g) In the notice required by subsection (b) of this section, the insurance fiduciary shall also notify those persons of their rights to health insurance conversion policies under Article 53 of this Chapter and their rights ~~under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA).~~ to purchase individual policies under the federal Health Insurance Portability and Accountability Act (HIPAA) and Article 68 of this Chapter.

(h) In the event of the insolvency of an employer or insurance fiduciary who has violated this section, any person specified in subsection (e) of this section shall have a lien upon the assets of the employer or insurance fiduciary for the expenses or benefits specified in subsection (e) of this section. With respect to personal property within the estate of the insolvent employer or insurance fiduciary, the lien shall have priority over unperfected security interests.

(i) Upon the termination of a group health insurance contract by the insurer, the insurer shall notify every subscriber and certificate holder under the contract of the termination of the contract along with the certification required to be provided under G.S. 58-68-30(e)."

SECTION 2. G.S. 58-50-45 reads as rewritten:

"**§ 58-50-45. Group health or life insurers to notify insurance fiduciaries of obligations.**

(a) ~~On and after January 1, 1986, upon~~ Upon the issuance or renewal of any policy, contract, certificate, or evidence of coverage of group health or life insurance, the insurer, corporation, or health maintenance organization shall give written notice to the insurance fiduciary of the provisions of G.S. 58-50-40.

(b) The notice required by subsection (a) of this section shall be printed in 10 point type and shall read as follows:

"UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH ~~CARE~~ PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP

HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH ~~CARE~~ PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY ~~SUCH~~ THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS ~~PRIOR TO~~ BEFORE THE TERMINATION OF ~~SUCH~~ THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES ~~CHAPTER 58~~ AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL ~~CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA).~~ HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE."

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

SENATE BILL 241:
Health Insurance Termination Notice

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Dalton
Date:	May 15, 2001	**Summary by:**	Linda Attarian
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 241, if enacted, will make group health plans that are currently regulated by the US Department of Labor pursuant to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), subject to the provisions of G.S. 58-50-40 which set forth requirements for the provision of prior notice to insureds of the fiduciary's intent to stop paying health insurance premiums and remedies for violation of those provisions. The act will also require insurers to notify every subscriber or certificate holder personally upon termination of the contract when the insurer provides the subscriber or certificate holder their "written certification of creditable coverage" for purposes obtaining continuing coverage under COBRA – which is required under State and federal law. Last, the act will enhance the penalty provided for an insurance fiduciary to cause the termination of group health or life insurance coverage by nonpayment of premium without giving notice to members of group. The act is effective when it becomes law.***

CURRENT LAW: Chapter 58 statutes generally do not require insurers to provide notification of insurance matters *directly* to subscribers or certificate holders, instead relying on the insurance fiduciary to provide notification. However, there are a few exceptions for special circumstances. Two such instances occur in G.S. 58-68-45(c)(1) and (2) and require the insurer to send notification of a uniform termination of coverage to an employer group as well as all to the plan's participants under the coverage of an *impending* termination.

While not requiring the insurer to notify the subscriber or certificate holder directly, G.S. 58-50-40 requires *an insurance fiduciary* who is responsible for the payment of group health premiums to provide at least 45 days notice *before the termination* of the health insurance to enrollees of the fiduciary's intent to stop paying premiums. Currently, a fiduciary that violates this provision is guilty of a class H felony and must make full restitution to persons insured. In the event of insolvency, the persons insured shall have a lien on the employer's or fiduciary's assets. This section only applies to group health plans regulated under Chapter 58.

BILL ANALYSIS: Section 1:

1. Adds "a group health plan as defined in Section 609(l) of the Employee Retirement Income Security Act of 1974" to the types of plans that are subject to the requirements set forth in G.S. 58-50-40. Section 609(l) defines "group health plan" to mean an employee welfare benefit plan providing medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.
2. Enhances the penalty from a class H felony to a class G felony for an insurance fiduciary to cause the cancellation or nonrenewal of group health policy for the willful failure to pay premiums, or to fail to provide a 45 day notice of before the termination of a group health plan to all persons covered under the plan of the fiduciary's intent to stop paying premiums.
3. Requires an insurer or MEWA underwriting the group insurance to notify every subscriber or certificate holder personally *upon termination* of the contract when the insurer provides the

subscriber or certificate holder their "written certification of creditable coverage" for purposes of obtaining continuing coverage under COBRA –which is currently required under State and federal law.

Section 2. Makes conforming changes to G.S. 58-40-45.

Section 3. Makes the act effective when it becomes law.

BACKGROUND ON ERISA: The following information on ERISA preemption was copied and edited from "*ERISA Preemption Manual for State Health Policy Makers*", by Patricia Butler, January 2000. The document was published by the Alpha Center and the National Academy for State Health Policy.

What is ERISA and why was it enacted?

Congress enacted ERISA primarily to establish uniform federal standards to protect private employee pension plans from fraud and mismanagement. But the federal statute also covers most other types of employee benefits plans, including health plans.

What kinds of plans does ERISA regulate?

ERISA applies to all employee pension, health, and other benefits plans established by private-sector employers (other than churches) or by employee organizations such as unions. If they meet certain requirements, employee plans are "ERISA plans" even if they offer benefits through state-licensed insurers. ERISA does not apply to plans administered by federal, state, or local governments.

How does ERISA's original preemption clause affect state health policy?

Several of ERISA's provisions preempt state law. ERISA's "preemption clause," Section 514, makes void all state laws to the extent that they "relate to" employer-sponsored health plans. (This clause states that "the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...") The Supreme Court has interpreted the preemption clause very broadly to carry out the congressional objective of national uniformity in rules for employee benefits programs. The Court has held that ERISA preempts state laws that either refer explicitly to ERISA plans (i.e., all plans offered by private-sector employers) or have a substantial financial or administrative impact on them. Consequently, courts have held that ERISA prohibits both state laws that *directly* regulate employer-sponsored health plans, such as mandating that employers offer health insurance, and some laws that only *indirectly* affect plans, such as regulating the provider networks ERISA plans may use.

Are there exceptions to ERISA preemption?

ERISA's preemption provisions contain an exception important to state health policy; it allows states to continue to regulate "the business of insurance" (authority that Congress gave to the states in the McCarran-Ferguson Act of 1945). **Courts have interpreted ERISA's insurance regulation "savings clause" to allow states to regulate traditional insurance carriers conducting traditional insurance business.** This includes, for example, mandating the benefits that insurers must offer. Some courts have held, however, that states cannot regulate all activities of insurers. For instance, when insurers act only in an administrative capacity, such as administering a health plan but not bearing any risk, some courts have held that states cannot impose insurance requirements, such as health benefits mandates.

What does ERISA's insurance "savings clause" permit?

Under the insurance regulation savings clause, states can regulate the terms and conditions of health insurance, for example, the benefits in an insurance policy or the rules under which the health insurance market must operate. **But through its so-called "deemer clause," the statute prohibits states from regulating plans that "self-insure,"** by bearing the primary insurance risk, even though by bearing risk, they appear to be acting like insurance companies. The Supreme Court recognized that this distinction creates two classes of employer-sponsored health plans. **Plans funding coverage through insurance are subject to state insurance regulation, while those that self-insure are completely beyond state jurisdiction.** This creates an important distinction between insured and self-insured employer-sponsored health plans. Both types of plans are still ERISA plans, but only the former are subject to some types of state oversight.

How many people are enrolled in insured health plans compared to self-insured health plans?

While no detailed data are currently available, it is estimated that between 33 and 50 percent of employees throughout the country are in self-insured plans, though the number varies among states.

In general, what can states do and not do under ERISA?

Based on ERISA case law, including Supreme Court decisions, states generally **can:**

- tax and regulate traditional insurers performing traditional insurance functions;
- regulate multiple employer welfare arrangements (where two or more employers jointly sponsor health coverage);
- regulate hospital rates charged to insurers and others who pay health care bills, and by extension, probably tax health care providers; and
- provide remedies for injuries when a health plan controls medical care delivery (traditional medical malpractice cases).

Court decisions have also made clear that states generally **cannot**:

- directly regulate private employer-sponsored health plans;
- mandate that private employers offer or pay for insurance;
- tax private employer-sponsored health plans themselves;
- regulate self-insured private employee plan benefits or financial solvency; or
- indirectly affect employer-sponsored health plans by imposing substantial costs on plans.

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 23, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 23, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the pages Justin Jetton (Wake County – Rep. Miner) and Gary Quiller (Wake County - Rep. Pope). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Grady, Hall, Blue, Johnson, Justus, Saunders, Setzer, Smith, and Wilson. Frank Folger and Trina Griffin, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes (Attachment). The following bills were considered.

SB 801, entitled, AN ACT TO TO STREAMLINE THE FIREMEN REPORTING REQUIREMENTS. The Chair recognized Senator Bingham to explain the bill. Senate Bill 801 amends the law governing the Firemen's and Rescue Squad Workers' Pension Fund relating to the reporting of those firemen that meet the eligibility qualifications. Under current law, each fire department is required to determine and report the names of eligible firemen to its governing body, on an annual basis. The governing body must then determine the accuracy and validity of the qualifications and certify the list to the Board of Trustees of the Pension Fund. This bill would change the requirement that the certification of the list of eligible firemen be sent to the Board of Trustees. Rather, this bill would require that the list be certified to the North Carolina State Fireman's Association and directs the Association to provide a list of those meeting the eligibility requirements to the State Treasurer by July 1 of each year. The Department of State Treasurer administers the Pension Fund. Ms. Deborah Brown, Deputy Director Retirement Systems, spoke in favor of the bill. Representative Blue moved for a favorable report. The motion passed.

SB 318, entitled, AN ACT TO REVISE THE LAWS ON LICENSING OF INSURANCE AGENTS AND BROKERS TO MAKE THEM CONFORM TO A MODEL UNIFORM INSURANCE PRODUCER LICENSING ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND THEREBY, ALONG WITH THE OTHER STATES, ACHIEVE NATIONAL UNIFORMITY IN LICENSING INSURANCE PRODUCERS, AS PROVIDED BY THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102. Senator Wellons, bill sponser, was not available to explain the bill. Representative Dockham presented a proposed committee substitute for consideration. Representative Setzer moved to adopt the PCS for consideration. The motion passed. Representative Dockham presented a technical amendment to the bill and moved for approval. The motion passed. Trina Griffin, Staff Counsel, was recognized to explain the changes as follows: on page 14, line 20 by inserting the word "of" between the words "or" and "a". Bill Hale, Legislative Counsel N.C. Dept. of Insurance, was recognized to explain the proposed bill substitute. Senate Bill 318 is a blend of provisions from the Producer Licensing Model Act of the National Association of Insurance Commissioners, which was adopted by the NAIC to provide the states with a uniform and reciprocal system of licensing for insurance agents and brokers (referred to as insurance "producers"). The Model Act was developed in response to the federal Gramm-Leach-Bliley Act (P.L. 106-102), in which Congress modernized the financial services industry by eliminating the

legal separations between the banking, insurance, and securities industries. Most of the existing agent and broker licensing provisions in Article 33 of Chapter 58 of the General Statutes are repealed and re-enacted in this bill. This is a cleaner and more efficient way of combining the Model Act and North Carolina law to achieve the desired uniformity. Representative Hall moved to have the amendment rolled into a committee substitute with a favorable report to the committtee substitute, unfavorable to the original bill. The motion passed.

SB 466, entitled, AN ACT TO INCREASE THE AMOUNT OF BURIAL EXPENSES COVERAGE UNDER THE WORKERS' COMPENSATION ACT; TO CHANGE A REQUIREMENT IN THE LOSS COSTS RATE-MAKING LAW; AND TO AMEND THE RATE BUREAU APPEAL STATUTE TO PROVIDE THAT MEMBER COMPANIES ARE NOT ALLOWED TO APPEAL BUREAU DECISIONS ON RATES OR LOSS COSTS. Senator Wellons, bill sponser, was not available to explain the bill. Representative Dockham presented a proposed committee substitute for consideration. Representative Hall moved to adopt the proposed committee substitute for consideration. The motion passed. Frank Folger, Staff Counsel, was recognized to explain the technical changes in the proposed committee substitute. Bill Hale, Legislative Counsel N.C. Dept. of Insurance, was recognized to explain the proposed committee substitute. Senate Bill 466 would amend the Workers' Compensation Act to increase burial expense coverage in the event of death resulting from a compensable injury or occupational disease under the Act; to clarify that only current approved loss cost filings may be used by workers' compensation insurers to determine their rates; and to prohibit appeals to the Commissioner by companies when the NC Rate Bureau decides in favor of policyholders in appeals concerning rates or loss costs. Representative Blue was recognized and asked the following questions; are licenses to insurance agents granted by the Department of Insurance included in the kinds licenses, which can be suspended or revoked under the "deadbeat dad" license-revocation provisions of the child support laws; are spouses entitled to recover anything under the provisions of G.S.97-40 which references 97-38; and is there a reason why spouses are not included in this "next of kin" provision? Frank Folger, Staff Counsel, will research these issues and provide Representative Blue with an answer before the bill goes to the floor of the House for discussion. Representative Hurley moved for a favorable report to the committtee substitute, unfavorable to the original bill. The motion passed.

There being no further business, the Chair adjourned the meeting at 12:30 PM.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham
Presiding Chair

Regina M. Irwin

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Form
SB 318, SB 466, SB 801
Bill Summaries
Handouts

VISITOR REGISTRATION SHEET

INSURANCE — May 23, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Gorn	Raleigh CBA
Joy Barbour	Concerned Bikers Assoc./ABATE of N.C.
Joyce Peters	SP Assoc/MAMSI
Russ Porter	Bone and Associates
Joan Perry	NCAIFA
Joe Blasco	Rossdale Leggett
Lucius Pullen	Attorney
Barbara Carsley	Manning, Fulton & Skinner
Emily Fulghum	Smith Anderson
Charlie Diehl	NC Trucking Assn.
Steve Woodson	NC Farm Bureau

VISITOR REGISTRATION SHEET

INSURANCE — May 23, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Cymus	NC State Grange
David Crawford	AIA North Carolina
Stacia McKenna	NCDOT
Randy Martin	Morehead City
Jerry Jones	Morehead City

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 801 A BILL TO BE ENTITLED AN ACT TO STREAMLINE THE FIREMEN REPORTING REQUIREMENTS.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 801

Pensions & Retirement and Aging Committee Substitute Adopted 4/19/01

Short Title: Firemen Reporting. (Public)

Sponsors:

Referred to:

April 3, 2001

A BILL TO BE ENTITLED

AN ACT TO STREAMLINE THE FIREMEN REPORTING REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-86-25 reads as rewritten:

"**§ 58-86-25. "Eligible firemen" defined; determination and certification of volunteers meeting qualifications.**

"Eligible firemen" shall mean all firemen of the State of North Carolina or any political subdivision thereof, including those performing such functions in the protection of life and property through fire fighting within a county or city governmental unit and so certified to the Commissioner of Insurance by the governing body thereof, and who belong to a bona fide fire department which, as determined by the Commissioner, is classified as not less than class "9" or class "A" and "AA" departments in accordance with rating methods, schedules, classifications, underwriting rules, bylaws or regulations effective or applied with respect to the establishment of rates or premiums used or charged pursuant to ~~Articles~~Article 36 or 40 of this Chapter or by such other reasonable methods as the Commissioner may determine, and which operates fire apparatus and equipment of the value of five thousand dollars ($5,000) or more, and said fire department holds drills and meetings not less than four hours monthly and said firemen attend at least 36 hours of all drills and meetings in each calendar year. "Eligible firemen" shall also mean an employee of a county whose sole duty is to act as fire marshal of the county, provided the board of county commissioners of that county certifies the fire marshal's attendance at no less than 36 hours of all drills and meetings in each calendar year. "Eligible firemen" shall also mean those persons meeting the other qualifications of this section, not exceeding 25 volunteer firemen plus one additional volunteer fireman per 100 population in the area served by their respective departments. Each department shall annually determine and report the names of those firemen meeting the eligibility qualifications of this section to its respective governing body, which upon determination of the validity and accuracy of the qualification shall promptly certify the list to the ~~board.~~North Carolina State Firemen's

Association. The Firemen's Association shall provide a list of those persons meeting the eligibility requirements of this section to the State Treasurer by July 1 of each year. For the purposes of the preceding sentence, the governing body of a fire department operated: by a county is the county board of commissioners; by a city is the city council; by a sanitary district is the sanitary district board; by a corporation, whether profit or nonprofit, is the corporation's board of directors; and by any other entity is that group designated by the board."

SECTION 2. This act becomes effective January 1, 2002, and applies to reports issued on or after that date.

SENATE BILL 801:
Firemen Reporting

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Bingham
Date:	May 23, 2001	**Summary by:**	Frank W. Folger
Version:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 801 amends the law governing the Firemen's and Rescue Squad Workers' Pension Fund (Pension Fund) relating to the reporting of those firemen that meet the eligibility qualifications.***

CURRENT LAW:

Under current law, each fire department is required to determine and report the names of eligible firemen to its governing body, on an annual basis. The governing body must then determine the accuracy and validity of the qualifications and certify the list to the Board of Trustees of the Pension Fund.

BILL ANALYSIS:

This bill would change the requirement that the certification of the list of eligible firemen be sent to the Board of Trustees. Rather, this bill would require that the list be certified to the North Carolina State Fireman's Association and directs the Association to provide a list of those meeting the eligibility requirements to the State Treasurer by July 1 of each year. The Department of State Treasurer administers the Pension Fund.

BACKGROUND:

This bill is intended to eliminate inefficiency in the certification of eligibility for the Pension Fund and prevent the circulation and use of inconsistent lists of eligible firemen.

This act would become effective October 1, 2001, and would apply to reports issued on or after that date.

Karen Cochrane-Brown, counsel to the Senate Committee on Pensions and Retirement and Aging, contributed to this summary.

S801-SMRO-001

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley and Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 318 A BILL TO BE ENTITLED AN ACT TO REVISE THE LAWS ON LICENSING OF INSURANCE AGENTS AND BROKERS TO MAKE THEM CONFORM TO A MODEL UNIFORM INSURANCE PRODUCER LICENSING ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND THEREBY, ALONG WITH THE OTHER STATES, ACHIEVE NATIONAL UNIFORMITY IN LICENSING INSURANCE PRODUCERS, AS PROVIDED BY THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 318*

Insurance and Consumer Protection Committee Substitute Adopted 4/23/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S318-CSSV-34 [v.2]

5/22/2001 2:58:36 PM

Short Title: Insurance Producer Licensing. (Public)

Sponsors:

Referred to:

March 5, 2001

A BILL TO BE ENTITLED

AN ACT TO REVISE THE LAWS ON LICENSING OF INSURANCE AGENTS AND BROKERS TO MAKE THEM CONFORM TO A MODEL UNIFORM INSURANCE PRODUCER LICENSING ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND THEREBY, ALONG WITH THE OTHER STATES, ACHIEVE NATIONAL UNIFORMITY IN LICENSING INSURANCE PRODUCERS, AS PROVIDED BY THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-1 reads as rewritten:

"**§ 58-33-1. Scope.**

This Article governs the qualifications and procedures for the licensing of agents, brokers, limited representatives, adjusters, and motor vehicle damage appraisers. This Article applies to any and all kinds of insurance and insurers under ~~Articles 1 through 67 of~~ this Chapter. ~~Except as provided in G.S. 58-33-125, this Article does not apply to the licensing of surplus lines licensees under Article 21 of this Chapter.~~ For purposes of this Article, all references to insurance include annuities, unless the context otherwise requires."

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

"**§ 58-33.5. License required.**

A person shall not sell, solicit, or negotiate insurance in this State unless the person is licensed for that kind of insurance in accordance with this Article."

SECTION 3. G.S. 58-33-10 reads as rewritten:

"**§ 58-33-10. Definitions.**

As used in this Article, the following definitions apply:

~~(a)~~(1) 'Agent' means a person licensed to solicit applications for, or to negotiate a policy of, insurance. A person not duly licensed who

solicits or negotiates a policy of insurance on behalf of an insurer is an agent within the intent of this Article, and thereby becomes liable for all the duties, requirements, liabilities and penalties to which an agent of such company is subject, and such company by compensating such person through any of its officers, agents or employees for soliciting policies of insurance shall thereby accept and acknowledge such person as its agent in such transaction.

~~(b)~~(2) 'Adjuster' means any individual who, for salary, fee, commission, or other compensation of any nature, investigates or reports to his principal relative to claims arising under insurance contracts other than life or annuity. An attorney at law who adjusts insurance losses from time to time incidental to the practice of his profession or an adjuster of marine losses is not deemed to be an adjuster for purposes of this Article. An individual may not simultaneously hold an agent's and an adjuster's license in this State.

~~(c)~~(3) 'Broker' means a person who, being a licensed agent, procures insurance for a party other than himself through a duly authorized agent of an insurer that is licensed to do business in this State but for which the broker is not authorized to act as agent. A person not duly licensed who procures insurance for a party other than himself is a broker within the intent of this Article, and thereby becomes liable for all the duties, requirements, liabilities and penalties to which such licensed brokers are subject.

(4) 'Business entity' means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity. 'Business entity' does not mean a sole proprietorship.

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

(6) 'Insurance' means any of the kinds of insurance in G.S. 58-7-15.

(7) 'Insurance producer' or 'producer' means a person required to be licensed under this Article to sell, solicit, or negotiate insurance. 'Insurance producer' or 'producer' includes an agent, broker, and limited representative.

(8) '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 an insurance carrier.

(9) '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.

(10) '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.

(11) 'Limited lines insurance' means motor vehicle physical damage insurance and title insurance, or any other kind of insurance that the Commissioner considers necessary to recognize for the purposes of complying with G.S. 58-33-32(f).

(12) 'Limited lines producer' means a person authorized by the Commissioner to sell, solicit, or negotiate limited lines insurance.

~~(d)~~(13) 'Limited representative' means a person who is authorized by the Commissioner to solicit or negotiate contracts for the particular kinds of insurance identified in ~~G.S. 58-33-25(e)~~ G.S. 58-33-26(g) and which kinds of insurance are restricted in the scope of coverage afforded.

~~(e)~~(14) 'Motor vehicle damage appraiser' means an individual who, for salary, fee, commission, or other compensation of any nature, regularly investigates or advises relative to the nature and amount of damage to motor vehicles located in this State or the amount of money deemed necessary to effect repairs thereto and who is not:

~~(1)~~a. An adjuster licensed to adjust insurance claims in this State;

~~(2)~~b. An agent for an insurance company who is not required by law to be licensed as an adjuster;

~~(3)~~c. An attorney at law who is not required by law to be licensed as an adjuster; or

~~(4)~~d. An individual who, incident to his regular employment in the business of repairing defective or damaged motor vehicles, investigates and advises relative to the nature and amount of motor vehicle damage or the amount of money deemed necessary to effect repairs thereto.

(15) '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, only if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers. 'Negotiate' does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.

(16) 'Person' means an individual or a business entity, but does not mean a county, city, or other political subdivision of the State of North Carolina.

(17) 'Sell' means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company. 'Sell' does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.

(18) 'Solicit' means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company. 'Solicit' does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.

(19) 'Terminate' means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

(20) 'Uniform Business Entity Application' means the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

(21) 'Uniform Application' means the current version of the NAIC Uniform Application for resident and nonresident producer licensing."

SECTION 4. G.S. 58-33-17(d) reads as rewritten:

"(d) In the event that any provision of this section is violated by a limited licensee, the Commissioner may:

(1) Revoke or suspend a limited license issued under this section in accordance with the provisions of ~~G.S. 58-33-45;~~ G.S. 58-33-46; or

(2) After notice and hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this Article have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this section."

SECTION 5. G.S. 58-33-25 is repealed.

SECTION 6. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-26. General license requirements.**

(a) No person shall act as or hold himself or herself out to be an agent, broker, limited representative, adjuster, or motor vehicle damage appraiser unless duly licensed.

(b) No agent, broker, or limited representative shall make application for, procure, negotiate for, or place for others, any policies for any kinds of insurance as to which that person is not then qualified and duly licensed.

(c) An agent or broker may be licensed for the following kinds of insurance:

(1) Life and health insurance, meaning:

a. Life-insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income.

b. Variable life and variable annuity products-insurance coverage provided under variable life insurance contracts and variable annuities.

c. Accident and health or sickness-insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income.

(2) Property and liability insurance, meaning:

a. Coverage for the direct or consequential loss or damage to property of every kind.

b. Coverage against legal liability, including that for death, injury, or disability or damage to real or personal property.

(3) Personal lines, meaning property and liability insurance coverage sold to individuals and families for primarily noncommercial purposes.

(4) Medicare supplement insurance and long-term care insurance, as a supplement to a license for the kinds of insurance listed in subdivision (1) of this subsection.

(d) A property and liability insurance license does not authorize an agent to sell accident and health insurance. An agent must hold a life and health insurance license to sell accident and health insurance.

(e) A life and health insurance license authorizes a resident agent to sell variable contracts if the agent satisfies the Commissioner that the agent has met the National Association of Securities Dealers requirements of the Secretary of State of North Carolina.

(f) A life and health insurance license authorizes a resident agent to sell Medicare supplement and long-term care insurance policies as defined respectively in Articles 54 and 55 of this Chapter, provided that the licensee takes and passes a supplemental written examination for the insurance as provided in G.S. 58-33-30(e) and pays the supplemental registration fee provided in G.S. 58-33-125(c).

(g) A limited representative may receive qualification for one or more licenses without examination for the following kinds of insurance:

(1) Dental services.

(2) Limited line credit insurance.

(3) Limited lines insurance.

(4) Motor club.

(5) Prearrangement insurance, as defined in G.S. 58-60-35(a)(2), when offered or sold by a preneed sales licensee licensed under Article 13D of Chapter 90 of the General Statutes.

(6) Travel accident and baggage.

(7) Vehicle service agreements and mechanical breakdown insurance.

(h) No licensed agent, broker, or limited representative shall solicit anywhere in the boundaries of this State, or receive or transmit an application or premium of insurance, for a company not licensed to do business in this State, except as provided in G.S. 58-28-5 and Article 21 of this Chapter.

(i) No agent shall place a policy of insurance with any insurer unless the agent has a current appointment as agent for the insurer in accordance with G.S. 58-33-40 or has a valid temporary license issued in accordance with G.S. 58-33-66.

(j) A business entity that sells, negotiates, or solicits insurance shall be licensed in accordance with G.S. 58-33-31(b). Every member of the partnership and every officer, director, stockholder, and employee of the business entity personally engaged in this State in soliciting or negotiating policies of insurance shall qualify as an individual licensee.

(k) The license shall state the name and social security number, or other identifying number of the licensee, date of issue, kind or kinds of insurance covered by the license, and any other information as the Commissioner deems to be proper.

(l) A license issued to an agent authorizes him to act until his license is otherwise suspended or revoked. Upon the suspension or revocation of a license, the licensee or any person having possession of such license shall return it to the Commissioner.

(m) A license of a broker, limited representative, adjuster, or motor vehicle damage appraiser shall be renewed on April 1 each year and renewal fees shall be paid. The Commissioner is not required to print licenses for the purpose of renewing licenses. The Commissioner may establish for licenses 'staggered' license renewal dates that will apportion renewals throughout each calendar year. If the system of staggered licensing is adopted, the Commissioner may extend the licensure period for some licensees. License renewal fees prescribed by G.S. 58-33-125 shall be prorated to the extent they are commensurate with extensions.

(n) A license as an insurance producer is not required of the following:

(1) An officer, director, or employee of an insurer or of an insurance producer, provided that the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this State, except for indirect receipt of proceeds of commissions in the form of salary, benefits, or distributions, and:

a. The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance; or

b. The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

c. The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance.

(2) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans; issuing certificates under plans or otherwise assisting in administering plans; or performs administrative services related to mass-marketed property and casualty insurance; where no commission is paid to the person for the service.

(3) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts.

(4) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation, or negotiation of insurance.

(5) A person whose activities in this State are limited to advertising without the intent to solicit insurance in this State through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of this State, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this State.

(6) A person who is not a resident of this State who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that that person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state.

(7) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the

subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission.

(8) Licensed insurers authorized to write the kinds of insurance described in G.S. 58-7-15(1) through G.S. 58-7-15(3) that do business without the involvement of a licensed agent.

(9) A person indirectly receiving proceeds of commissions as part of the transfer of insurance business or in the form of retirement or similar benefits.

(o) Nothing in this Article requires an insurer to obtain an insurance producer license. In this subsection, 'insurer' does not include an insurer's officers, directors, employees, subsidiaries, or affiliates."

SECTION 7. G.S. 58-33-30 (b) and (c) are repealed.

SECTION 8. G.S. 58-33-30(d)(3) reads as rewritten:

"(3) Each resident applicant for a Medicare supplement and long-term care insurance license shall furnish evidence satisfactory to the Commissioner of successful completion of 10 hours of instruction, which shall in all cases include the principles of Medicare supplement and long-term care insurance and federal and North Carolina law relating to such insurance. ~~An~~ A resident applicant who submits satisfactory evidence of having successfully completed an agent training course that has been approved by the Commissioner and that is offered by or under the auspices of ~~an admitted~~ a licensed life or health insurer or a professional insurance association satisfies the educational requirements of this subdivision."

SECTION 9. G.S. 58-33-30(e) reads as rewritten:

"(e) Examination.

(1) After completion and filing of the application with the Commissioner, except as provided in G.S. 58-33-35, the Commissioner shall require each applicant for license as an agent or an adjuster to take ~~a written~~ an examination as to ~~his~~ the applicant's competence to be licensed. The applicant must take and pass the examination according to requirements prescribed by the Commissioner.

(2) The Commissioner may require any licensed agent, adjuster, or motor vehicle damage appraiser to take and successfully pass an examination in writing, testing his competence and qualifications as a condition to the continuance or renewal of his license, if the licensee has been found guilty of any violation of any provision of ~~Articles 1 through 67 of~~ this Chapter. If an individual fails to pass such an examination, the Commissioner shall revoke all licenses issued in his name and no license shall be issued until such individual has passed an examination as provided in this Article.

(3) Each examination shall be as the Commissioner prescribes and shall be of sufficient scope to test the applicant's knowledge of:

a. The terms and provisions of the policies or contracts of insurance ~~he~~ the applicant proposes to effect; or

b. The types of claims or losses ~~he~~ the applicant proposes to adjust; and

c. The duties and responsibilities of ~~such a~~ the license; and

d. The current laws of this State applicable to ~~such a~~ the license.

(4) The answers of the applicant to ~~any such~~ the examination shall be ~~written~~ provided by the applicant under the Commissioner's supervision. The Commissioner shall give examinations at such times and places within this State as ~~he deems~~ the Commissioner considers necessary reasonably to serve the convenience of both the Commissioner and applicants: Provided that the Commissioner ~~is authorized to~~ may contract directly with persons for the processing of examination application forms and for the administration and grading of the examinations required by this section; the Commissioner ~~is authorized to~~ may charge a reasonable fee in addition to the registration fee charged under G.S. 58-33-125, to offset the cost of the examination contract authorized by this subsection; and such contracts shall not be subject to Article 3 of Chapter 143 of the General Statutes.

(5) The Commissioner shall collect in advance the examination and registration fees provided in G.S. 58-33-125 and in subsection (4) of this section. The Commissioner shall make or cause to be made available to all applicants, for a reasonable fee to offset the costs of production, materials that he ~~deems~~ considers necessary for the applicants' proper preparation for ~~such exams.~~ examinations. The Commissioner ~~is empowered to~~ may contract directly with publishers and other suppliers for the production of ~~such~~ the preparatory materials, and contracts so let by the Commissioner shall not be subject to Article 3 of Chapter 143 of the General Statutes.

(6) In addition to the examinations for the kinds of insurance specified in G.S. 58-33-25(c)(1) and (2), before any ~~person~~ resident may sell Medicare supplement or long-term care insurance policies defined respectively in Articles 54 and 55 of this Chapter, ~~he~~ the resident must take and pass a supplemental written examination according to requirements prescribed by the Commissioner.

(7) An individual who fails to appear for the examination as scheduled or fails to pass the examination, shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination."

SECTION 10. G.S. 58-33-30(g) reads as rewritten:

"(g) Denial of License. – If the Commissioner finds that the applicant has not fully met the requirements for licensing, he shall refuse to issue the license and shall notify in writing the applicant and the appointing insurer, if any, of such denial, stating the

grounds therefor. The application may also be denied for any reason for which a license may be suspended or revoked or not renewed under ~~G.S. 58-33-45(a).~~ G.S. 58-33-46. Within 30 days after service of the notification, the applicant may make a written demand upon the Commissioner for a review to determine the reasonableness of the Commissioner's action. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing as to the outcome of the review. Within 30 days after service of the notification as to the outcome, the applicant may make a written demand upon the Commissioner for a hearing under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome."

SECTION 11. G.S. 58-33-30(i) reads as rewritten:

"(i) Retaliatory Provision. – Whenever, by the laws or regulations of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or any other requirements are imposed upon residents of this State who are nonresident applicants or licensees of such other state or jurisdiction in addition to, or in excess of, those imposed on nonresidents under this Article, the same such requirements shall be imposed upon such residents of such other state or jurisdiction. This subsection does not apply to fees charged to insurance producers."

SECTION 12. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-31. Application for license.**

(a) A person applying for a resident insurance producer license shall make application to the Commissioner on the Uniform Application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the Commissioner shall find that the individual:

(1) Is at least 18 years of age.

(2) Has not committed any act that is a ground for probation, suspension, nonrenewal, or revocation set forth in G.S. 58-33-46.

(3) Has satisfied any applicable requirements of G.S. 58-33-30(d).

(4) Has paid the applicable fees set forth in G.S. 58-33-125.

(5) Has successfully passed any examinations required by G.S. 58-33-30(e).

(b) A business entity selling, soliciting, or negotiating insurance shall obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application. Before approving the application, the Commissioner shall find that:

(1) The business entity has paid the applicable fees set forth in G.S. 58-33-125.

(2) The business entity has designated a licensed producer, who is a natural person, responsible for the business entity's compliance with the insurance laws and administrative rules of this State and orders of the Commissioner.

(c) The Commissioner may require any documents reasonably necessary to verify the information contained in an application."

SECTION 13. G.S. 58-33-32 reads as rewritten:

"**§ 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.

~~(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 in the form prescribed by the Commissioner and has paid the applicable fees required by G.S. 58-33-125;

(3) The person has submitted or transmitted to the Commissioner a copy of 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~~ a reciprocal 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~~ 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~~ under subsection (c) 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~~ 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~~ under subsection (c) of 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~~ A person licensed as a limited line credit insurance producer or other type of ~~insurance~~ limited lines producer in that person's home state ~~shall~~ may, under subsection (c) of this section, 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. For the purposes of this subsection, limited lines insurance is any authority granted by the home state that restricts the authority of the license to less than the total authority prescribed in the associated major lines under G.S. 58-33-26(c)(1), 58-33-26(c)(2), 58-33-26(c)(3), and 58-33-26(c)(4).

(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.

A person licensed as an insurance producer in another state who moves to this State and who wants to be licensed as a resident under G.S. 58-33-31 shall apply within 90 days after establishing legal residence.

(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.~~information or documents filed in the proceeding necessary to describe the action.

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

SECTION 14. G.S. 58-33-40(e) reads as rewritten:

"(e) An appointment shall continue in effect as long as the appointed agent is properly licensed and the appointing insurer is authorized to transact business in this State, unless the appointment is cancelled. ~~Upon the cancellation of an appointment the insurer shall, within 30 days, file written notice of cancellation with the Commissioner in a form prescribed by him indicating the date of cancellation. A copy shall be provided to the agent by the insurer.~~"

SECTION 15. G.S. 58-33-45 is repealed.

SECTION 16. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-46. Suspension, probation, revocation, or nonrenewal of licenses.**

(a) The Commissioner may place on probation, suspend, revoke, or refuse to renew any license issued under this Article, in accordance with the provisions of Article 3A of Chapter 150B of the General Statutes, for any one or more of the following causes:

(1) Providing materially incorrect, misleading, incomplete, or materially untrue information in the license application.

(2) Violating any insurance laws, or violating any administrative rule, subpoena, or order of the Commissioner or of another state's insurance regulator.

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud.

(4) Improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business.

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.

(6) Having been convicted of a felony or a misdemeanor involving dishonesty or a breach of trust.

(7) Having admitted or been found to have committed any insurance unfair trade practice or fraud.

(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere.

(9) Having an insurance producer license, or its equivalent, denied, suspended, or revoked in any other jurisdiction for reasons substantially similar to those listed in this subsection.

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction.

(11) Willfully failing to provide the notification required by subsection (c) of this section.

(12) Knowingly accepting brokered insurance business from an individual who is not licensed to broker that kind of insurance.

(13) Failing to comply with an administrative or court order imposing a child support obligation, after entry of a final judgment or order finding the violation to have been willful.

(14) Failing to pay State income tax or comply with any administrative or court order directing payment of State income tax, after entry of a final judgment or order finding the violation to have been willful.

(15) Cheating on an examination for an insurance license or for a prelicensing or continuing education course, including improperly

using notes or any other reference material to complete an examination for an insurance license or for a prelicensing or continuing education course.

(16) Willfully overinsuring property.

(17) Any cause for which issuance of the license could have been refused had it then existed and been known to the Commissioner at the time of issuance.

(b) G.S. 58-2-50 applies to any investigation under this section. G.S. 58-2-70 applies to any person subject to licensure under this Article.

(c) Any person licensed under this Article shall notify the Commissioner of the commencement of any bankruptcy, insolvency, or receivership proceeding affecting the person licensed, or upon making an assignment for the benefit of creditors of the person licensed. Each owner, manager, or officer of a business entity that is a licensed person shall be responsible for providing this notification. Any person responsible for notifying the Commissioner shall provide the notice within three business days after the commencement of the proceeding or the making of the assignment.

(d) If the Commissioner refuses to grant a license, or suspends or revokes a license, any appointment of the applicant or licensee shall likewise be revoked. No individual whose license is revoked shall be issued another license without first complying with all requirements of this Article.

(e) No person shall be issued a license or appointment to enter the employment of any other person, which other person is at that time found by the Commissioner to be in violation of any of the insurance laws of this State, or which other person has been in any manner disqualified under any state or federal law to engage in the insurance business.

(f) The Commissioner shall retain the authority to enforce the provisions of, and impose any penalty or remedy authorized by, this Chapter against any person who is under investigation for or charged with a violation of this Chapter even if the person's license or registration has been surrendered or has lapsed by operation of law."

SECTION 17. G.S. 58-33-55 is repealed.

SECTION 18. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-56. Notification to Commissioner of termination.**

(a) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with a producer shall notify the Commissioner within 30 days after the effective date of the termination, using a form prescribed by the Commissioner, if the reason for termination is for or related to one of the causes listed in G.S. 58-33-46(a) or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in G.S. 58-33-46(a). Upon the written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

(b) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason that is not for or related to one of the causes listed in G.S. 58-33-46(a), shall notify the Commissioner within 30 days after the effective date of the termination, using a form prescribed by the Commissioner. Upon written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination.

(c) The insurer or the authorized representative of the insurer shall promptly notify the Commissioner in a form acceptable to the Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Commissioner in accordance with subsection (a) of this section had the insurer then known of its existence.

(d) Within 15 days after making the notification required by subsections (a), (b), and (c) of this section, the insurer shall mail a copy of the notification to the producer at the producer's last known address. If the producer is terminated for cause for any of the reasons listed in G.S. 58-33-46(a), the insurer shall provide a copy of the notification to the producer at the producer's last known address by certified mail, return receipt requested, postage prepaid, or by overnight delivery using a nationally recognized carrier.

(e) Within 30 days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the Commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the Commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (h) of this section.

(f) In the absence of actual malice, neither an insurer, the authorized representative of the insurer, a producer, the Commissioner, an organization of which the Commissioner is a member, nor the respective employees and agents of such persons acting on behalf of such persons shall be subject to civil liability as a result of any statement or information provided pursuant to this section.

(g) In any action brought against a person that may have immunity under subsection (f) of this section for making any statement required by this section or for providing any information relating to any statement that may be requested by the Commissioner, the party bringing the action shall plead specifically in any allegation that subsection (f) of this section does not apply because the person making the statement or providing the information did so with actual malice. Subsections (f) and (g) of this section do not abrogate or modify any existing statutory or common law privileges or immunities.

(h) Notwithstanding any other provision of this Chapter, any documents, materials, or other information in the control or possession of the Commissioner or any organization of which the Commissioner is a member that is (i) furnished by an insurer, producer, or an employee or agent thereof acting on behalf of the insurer or producer under this section, or (ii) obtained by the Commissioner in an investigation under this

section shall be confidential by law and privileged, shall not be subject to or public records under G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery in any civil action other than a proceeding brought by the Commissioner against a person to whom such documents, materials, or other information relate. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's duties. Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any civil action other than a proceeding brought by the Commissioner against a person to whom such documents, materials, or other information relate, concerning any such documents, materials, or information.

(i) In order to assist in the performance of the Commissioner's duties under this Article, the Commissioner may:

(1) Share documents, materials, or other information, including the confidential documents, materials, or information described in this section, with other state, federal, and international regulatory agencies, with the NAIC, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities. The Commissioner may condition such sharing on an agreement by the recipient to maintain the confidentiality and privileged status of the document, material, or other information;

(2) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from other state, federal, and international regulatory agencies, from the NAIC, its affiliates or subsidiaries, and from state, federal, and international law enforcement authorities, and may agree to maintain the confidential and privileged status of the document, material, or other information received under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) Enter into agreements governing sharing and use of information consistent with this subsection.

(j) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (i) of this section.

(k) Nothing in this Article prohibits the Commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection under G.S. 58-2-100 to a database or other clearinghouse service maintained by the NAIC, its affiliates, or subsidiaries of the NAIC.

(l) An insurer, the authorized representative of the insurer, or producer that fails to report as required under this section or that is found to have reported with actual

malice by a court of competent jurisdiction may, after notice and hearing, have its license suspended or revoked and may be fined in accordance with G.S. 58-2-70."

SECTION 19. G.S. 58-33-65 is repealed.

SECTION 20. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-66. Temporary licensing.**

(a) The Commissioner may issue a temporary insurance producer license for a period not to exceed 180 days or longer, for good cause, without requiring an examination if the Commissioner deems that the temporary license is necessary for the servicing of an insurance business in any of the following cases:

(1) To the spouse or surviving spouse or court-appointed personal representative or guardian of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the transfer of the insurance business owned by the producer, for the recovery or return of the producer to the business, or for the training and licensing of new personnel to operate the producer's business.

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license.

(3) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America.

(4) In any other circumstance where the Commissioner deems that the public interest will be served best by the issuance of this license.

(b) The Commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The Commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The Commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license terminates upon the transfer of the business.

(c) An individual requesting a temporary license on account of death or disability of an agent or broker shall be licensed to represent only those insurers that had appointed such agent at the time of death or commencement of disability."

SECTION 21. G.S. 58-33-75 reads as rewritten:

"**§ 58-33-75. Twisting with respect to insurance policies; penalties.**

No licensee 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 and ~~58-33-45.~~G.S. 58-33-46."

SECTION 22. G.S. 58-33-76(c) reads as rewritten:

"(c) Any person who violates this section is subject to the provisions of G.S. 58-2-70 and ~~G.S. 58-33-45.~~G.S. 58-33-46."

SECTION 23. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-82. Commissions.**

(a) An insurance company or insurance producer shall not pay a commission, service fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this State if that person is required to be licensed under this Article and is not so licensed.

(b) A person shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this State if that person is required to be licensed under this Article and is not so licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this State if the person was required to be licensed under this Article at the time of the sale, solicitation, or negotiation and was so licensed at that time.

(d) Except as provided in subsection (e) of this section, only agents who are duly licensed with appropriate company appointments, licensed brokers, licensed limited lines producers, or licensed limited representatives may accept, directly or indirectly, any commission, fee, or other valuable consideration for the sale, solicitation, or negotiation of insurance.

(e) Commissions, fees, or other valuable consideration for the sale, solicitation, or negotiation of insurance may be assigned or directed to be paid in the following circumstances:

(1) To a business entity by a person who is an owner, shareholder, member, partner, director, employee, or agent of that business entity.

(2) To a producer in connection with renewals of insurance business originally sold by or through the licensed person or for other deferred commissions.

(3) In connection with the indirect receipt of commissions in circumstances in which a license is not required under G.S. 58-33-26(m)."

SECTION 24. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-83. Assumed names.**

An insurance producer doing business under any name other than the producer's legal name shall notify the Commission before using the assumed name."

SECTION 25. G.S. 58-33-85(b) reads as rewritten:

"(b) No insurer, agent, broker, or limited representative shall knowingly charge to or demand or receive from an applicant for insurance any money or other consideration in return for the processing of applications or other forms or for the rendering of services associated with a contract of insurance, which money or other consideration is in addition to the premium for such contract, unless the applicant consents in writing

before any services are rendered. This subsection does not apply to the charging or collection of any fees otherwise provided for by law."

SECTION 26. G.S. 58-3-180(c) reads as rewritten:

"(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and ~~G.S. 58-33-45,~~ G.S. 58-33-46, provided that the maximum civil penalty that can be assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars ($2,000)."

SECTION 27. G.S. 58-9-2(5) reads as rewritten:

"(5) "Intermediary" means any person who acts as a broker, as defined in ~~G.S. 58-33-10(c),~~ G.S. 58-33-10(3), in soliciting, negotiating, or procuring the making of any reinsurance contract or binder on behalf of a ceding insurer; or acts as a broker, as defined in ~~G.S. 58-33-10(c),~~ G.S. 58-33-10(3), in accepting any reinsurance contract on behalf of an assuming insurer. "Intermediary" includes a broker or a manager, as those terms are defined in this section."

SECTION 28. G.S. 58-21-40 reads as rewritten:

"**§ 58-21-40. Surplus lines ~~advisory organizations.~~regulatory support organization.**

(a) A surplus lines ~~advisory~~ regulatory support organization of surplus lines licensees ~~may~~ shall be formed to:

(1) Facilitate and encourage compliance by ~~its members~~ resident and nonresident surplus lines licensees with the laws of this State and the rules and regulations of the Commissioner relative to surplus lines insurance;

(2) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market; ~~and~~

(3) Receive and disseminate to ~~its members~~ surplus lines licensees information ~~relative to~~ about surplus lines ~~coverages.~~insurance, including, without limitation, new electronic filing procedures approved by the Commissioner, changes in the list of eligible surplus lines insurers, and modifications in coverages, procedures, and requirements as may be requested by the Commissioner; and

(4) Certify satisfactory evidence of current nonresident surplus lines licensure in this State by countersigning nonresident produced surplus lines coverages by means satisfactory to the Commissioner; and charge the nonresident surplus lines licensee a fee for the certification and countersignature as approved by the Commissioner.

(b) ~~Every such advisory~~ The regulatory support organization shall file with the Commissioner:

(1) A copy of its constitution, articles of agreement or association, or certificate of incorporation;

(2) A copy of its bylaws and rules governing its activities;

(3) ~~A current~~ An annually updated list of ~~its members;~~resident and nonresident licensees;

(4) The name and address of a resident of this State upon whom notices or orders of the Commissioner or processes issued at his direction may be served; and

(5) An agreement that the Commissioner may examine the ~~advisory~~ regulatory support organization in accordance with ~~the provisions of~~ subsection (c) of this section.

(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each ~~advisory~~ regulatory support 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~~ regulatory support organization or any ~~member thereof~~ surplus lines licensee, whether resident or nonresident, to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation.

(d) Each resident surplus lines licensee shall maintain active membership in ~~an advisory~~ a regulatory support organization as a condition of continued licensure under this Article."

SECTION 29. G.S. 58-33-30(a) reads as rewritten:

(a) Application. – ~~Application shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner.~~The applicable license application requirements of G.S. 58-33-31 shall be satisfied."

SECTION 30. G.S. 58-39-15(3) reads as rewritten:

(3) "Agent" ~~shall have~~ has the meaning as set forth in ~~Article 33 of this Chapter~~ G.S. 58-33-10, and ~~shall include~~ includes limited representatives, limited line credit insurance producers, limited lines producers, insurance producers, and surplus lines ~~licensees, salesmen, or representatives of a medical, surgical, hospital, dental, or optometric service plan, and salesmen or representatives of a health maintenance organization.~~licensees.

SECTION 31. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 32. Section 28 is effective October 1, 2001. Sections 25, 30, and this section are effective when they become law. The remaining sections of this act become effective July 1, 2002.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 318*

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

S318-ASV-14 [v.1]

Date 5/23 ,2001

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Representative Dockham:

moves to amend the bill on page 14, line 20 by inserting the word "of" between the words "or" and "a".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 318*

Insurance and Consumer Protection Committee Substitute Adopted 4/23/01

Short Title: Insurance Producer Licensing. (Public)

Sponsors:

Referred to:

March 5, 2001

A BILL TO BE ENTITLED

AN ACT TO REVISE THE LAWS ON LICENSING OF INSURANCE AGENTS AND BROKERS TO MAKE THEM CONFORM TO A MODEL UNIFORM INSURANCE PRODUCER LICENSING ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND THEREBY, ALONG WITH THE OTHER STATES, ACHIEVE NATIONAL UNIFORMITY IN LICENSING INSURANCE PRODUCERS, AS PROVIDED BY THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-1 reads as rewritten:

"**§ 58-33-1. Scope.**

This Article governs the qualifications and procedures for the licensing of agents, brokers, limited representatives, adjusters, and motor vehicle damage appraisers. This Article applies to any and all kinds of insurance and insurers under ~~Articles 1 through 67 of~~ this Chapter. ~~Except as provided in G.S. 58-33-125, this Article does not apply to the licensing of surplus lines licensees under Article 21 of this Chapter.~~ For purposes of this Article, all references to insurance include annuities, unless the context otherwise requires."

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

"**§ 58-33.5. License required.**

A person shall not sell, solicit, or negotiate insurance in this State unless the person is licensed for that kind of insurance in accordance with this Article."

SECTION 3. G.S. 58-33-10 reads as rewritten:

"**§ 58-33-10. Definitions.**

As used in this Article, the following definitions apply:

~~(a)~~(1) 'Agent' means a person licensed to solicit applications for, or to negotiate a policy of, insurance. A person not duly licensed who solicits or negotiates a policy of insurance on behalf of an insurer is an

agent within the intent of this Article, and thereby becomes liable for all the duties, requirements, liabilities and penalties to which an agent of such company is subject, and such company by compensating such person through any of its officers, agents or employees for soliciting policies of insurance shall thereby accept and acknowledge such person as its agent in such transaction.

~~(b)~~(2) 'Adjuster' means any individual who, for salary, fee, commission, or other compensation of any nature, investigates or reports to his principal relative to claims arising under insurance contracts other than life or annuity. An attorney at law who adjusts insurance losses from time to time incidental to the practice of his profession or an adjuster of marine losses is not deemed to be an adjuster for purposes of this Article. An individual may not simultaneously hold an agent's and an adjuster's license in this State.

~~(c)~~(3) 'Broker' means a person who, being a licensed agent, procures insurance for a party other than himself through a duly authorized agent of an insurer that is licensed to do business in this State but for which the broker is not authorized to act as agent. A person not duly licensed who procures insurance for a party other than himself is a broker within the intent of this Article, and thereby becomes liable for all the duties, requirements, liabilities and penalties to which such licensed brokers are subject.

(4) 'Business entity' means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity. 'Business entity' does not mean a sole proprietorship.

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

(6) 'Insurance' means any of the kinds of insurance in G.S. 58-7-15.

(7) 'Insurance producer' or 'producer' means a person required to be licensed under this Article to sell, solicit, or negotiate insurance. 'Insurance producer' or 'producer' includes an agent, broker, and limited representative.

(8) '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 an insurance carrier.

(9) '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.

(10) '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.

(11) 'Limited lines insurance' means motor vehicle physical damage insurance and title insurance, or any other kind of insurance that the Commissioner considers necessary to recognize for the purposes of complying with G.S. 58-33-32(f).

(12) 'Limited lines producer' means a person authorized by the Commissioner to sell, solicit, or negotiate limited lines insurance.

~~(d)~~(13) 'Limited representative' means a person who is authorized by the Commissioner to solicit or negotiate contracts for the particular kinds of insurance identified in ~~G.S. 58-33-25(e)~~ G.S. 58-33-26(a) and which kinds of insurance are restricted in the scope of coverage afforded.

~~(e)~~(14) 'Motor vehicle damage appraiser' means an individual who, for salary, fee, commission, or other compensation of any nature, regularly investigates or advises relative to the nature and amount of damage to motor vehicles located in this State or the amount of money deemed necessary to effect repairs thereto and who is not:

~~(1)~~a. An adjuster licensed to adjust insurance claims in this State;

~~(2)~~b. An agent for an insurance company who is not required by law to be licensed as an adjuster;

~~(3)~~c. An attorney at law who is not required by law to be licensed as an adjuster; or

~~(4)~~d. An individual who, incident to his regular employment in the business of repairing defective or damaged motor vehicles, investigates and advises relative to the nature and amount of motor vehicle damage or the amount of money deemed necessary to effect repairs thereto.

(15) '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, only if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers. 'Negotiate' does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.

(16) 'Person' means an individual or a business entity, but does not mean a county, city, or other political subdivision of the State of North Carolina.

(17) 'Sell' means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company. 'Sell' does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.

(18) 'Solicit' means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company. 'Solicit' does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.

(19) 'Terminate' means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

(20) 'Uniform Business Entity Application' means the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

(21) 'Uniform Application' means the current version of the NAIC Uniform Application for resident and nonresident producer licensing."

SECTION 4. G.S. 58-33-17(d) reads as rewritten:

"(d) In the event that any provision of this section is violated by a limited licensee, the Commissioner may:

(1) Revoke or suspend a limited license issued under this section in accordance with the provisions of ~~G.S. 58-33-45;~~ G.S. 58-33-46; or

(2) After notice and hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this Article have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this section."

SECTION 5. G.S. 58-33-25 is repealed.

SECTION 6. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-26. General license requirements.**

(a) No person shall act as or hold himself or herself out to be an agent, broker, limited representative, adjuster, or motor vehicle damage appraiser unless duly licensed.

(b) No agent, broker, or limited representative shall make application for, procure, negotiate for, or place for others, any policies for any kinds of insurance as to which that person is not then qualified and duly licensed.

(c) An agent or broker may be licensed for the following kinds of insurance:

(1) Life and health insurance, meaning:

a. Life-insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income.

b. Variable life and variable annuity products-insurance coverage provided under variable life insurance contracts and variable annuities.

c. Accident and health or sickness-insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income.

(2) Property and liability insurance, meaning:

a. Coverage for the direct or consequential loss or damage to property of every kind.

b. Coverage against legal liability, including that for death, injury, or disability or damage to real or personal property.

(3) Personal lines, meaning property and liability insurance coverage sold to individuals and families for primarily noncommercial purposes.

(4) Medicare supplement insurance and long-term care insurance, as a supplement to a license for the kinds of insurance listed in subdivision (1) of this subsection.

(d) A property and liability insurance license does not authorize an agent to sell accident and health insurance. An agent must hold a life and health insurance license to sell accident and health insurance.

(e) A life and health insurance license authorizes a resident agent to sell variable contracts if the agent satisfies the Commissioner that the agent has met the National Association of Securities Dealers requirements of the Secretary of State of North Carolina.

(f) A life and health insurance license authorizes a resident agent to sell Medicare supplement and long-term care insurance policies as defined respectively in Articles 54 and 55 of this Chapter, provided that the licensee takes and passes a supplemental written examination for the insurance as provided in G.S. 58-33-30(e) and pays the supplemental registration fee provided in G.S. 58-33-125(c).

(g) A limited representative may receive qualification for one or more licenses without examination for the following kinds of insurance:

(1) Dental services.

(2) Limited line credit insurance.

(3) Limited lines insurance.

(4) Motor club.

(5) Prearrangement insurance, as defined in G.S. 58-60-35(a)(2), when offered or sold by a preneed sales licensee licensed under Article 13D of Chapter 90 of the General Statutes.

(6) Travel accident and baggage.

(7) Vehicle service agreements and mechanical breakdown insurance.

(h) No licensed agent, broker, or limited representative shall solicit anywhere in the boundaries of this State, or receive or transmit an application or premium of insurance, for a company not licensed to do business in this State, except as provided in G.S. 58-28-5 and Article 21 of this Chapter.

(i) No agent shall place a policy of insurance with any insurer unless the agent has a current appointment as agent for the insurer in accordance with G.S. 58-33-40 or has a valid temporary license issued in accordance with G.S. 58-33-66.

(j) A business entity that sells, negotiates, or solicits insurance shall be licensed in accordance with G.S. 58-33-31(b). Every member of the partnership and every officer, director, stockholder, and employee of the business entity personally engaged in this State in soliciting or negotiating policies of insurance shall qualify as an individual licensee.

(k) The license shall state the name and social security number, or other identifying number of the licensee, date of issue, kind or kinds of insurance covered by the license, and any other information as the Commissioner deems to be proper.

(l) A license issued to an agent authorizes him to act until his license is otherwise suspended or revoked. Upon the suspension or revocation of a license, the licensee or any person having possession of such license shall return it to the Commissioner.

(m) A license of a broker, limited representative, adjuster, or motor vehicle damage appraiser shall be renewed on April 1 each year and renewal fees shall be paid. The Commissioner is not required to print licenses for the purpose of renewing licenses. The Commissioner may establish for licenses 'staggered' license renewal dates that will apportion renewals throughout each calendar year. If the system of staggered licensing is adopted, the Commissioner may extend the licensure period for some licensees. License renewal fees prescribed by G.S. 58-33-125 shall be prorated to the extent they are commensurate with extensions.

(n) A license as an insurance producer is not required of the following:

(1) An officer, director, or employee of an insurer or of an insurance producer, provided that the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this State, except for indirect receipt of proceeds of commissions in the form of salary, benefits, or distributions, and:

a. The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance; or

b. The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

c. The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance.

(2) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans; issuing certificates under plans or otherwise assisting in administering plans; or performs administrative services related to mass-marketed property and casualty insurance; where no commission is paid to the person for the service.

(3) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts.

(4) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation, or negotiation of insurance.

(5) A person whose activities in this State are limited to advertising without the intent to solicit insurance in this State through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of this State, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this State.

(6) A person who is not a resident of this State who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that that person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state.

(7) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission.

(8) Licensed insurers authorized to write the kinds of insurance described in G.S. 58-7-15(1) through G.S. 58-7-15(3) that do business without the involvement of a licensed agent.

(9) A person indirectly receiving proceeds of commissions as part of the transfer of insurance business or in the form of retirement or similar benefits.

(o) Nothing in this Article requires an insurer to obtain an insurance producer license. In this subsection, 'insurer' does not include an insurer's officers, directors, employees, subsidiaries, or affiliates."

SECTION 7. G.S. 58-33-30(a), (b), and (c) are repealed.

SECTION 8. G.S. 58-33-30(d)(3) reads as rewritten:

"(3) Each resident applicant for a Medicare supplement and long-term care insurance license shall furnish evidence satisfactory to the Commissioner of successful completion of 10 hours of instruction, which shall in all cases include the principles of Medicare supplement and long-term care insurance and federal and North Carolina law relating to such insurance. ~~An~~ A resident applicant who submits satisfactory evidence of having successfully completed an agent training course that has been approved by the Commissioner and that is offered by or under the auspices of ~~an admitted~~ a licensed life or health insurer or a professional insurance association satisfies the educational requirements of this subdivision."

SECTION 9. G.S. 58-33-30(e) reads as rewritten:

"(e) Examination.

(1) After completion and filing of the application with the Commissioner, except as provided in G.S. 58-33-35, the Commissioner shall require each applicant for license as an agent or an adjuster to take ~~a written~~ an examination as to ~~his~~ the applicant's competence to be licensed. The applicant must take and pass the examination according to requirements prescribed by the Commissioner.

(2) The Commissioner may require any licensed agent, adjuster, or motor vehicle damage appraiser to take and successfully pass an examination in writing, testing his competence and qualifications as a condition to the continuance or renewal of his license, if the licensee has been found guilty of any violation of any provision of ~~Articles 1 through 67 of~~ this Chapter. If an individual fails to pass such an examination, the Commissioner shall revoke all licenses issued in his name and no license shall be issued until such individual has passed an examination as provided in this Article.

(3) Each examination shall be as the Commissioner prescribes and shall be of sufficient scope to test the applicant's knowledge of:

a. The terms and provisions of the policies or contracts of insurance ~~he~~ the applicant proposes to effect; or

b. The types of claims or losses ~~he~~ the applicant proposes to adjust; and

c. The duties and responsibilities of ~~such a~~ the license; and

d. The current laws of this State applicable to ~~such a~~ the license.

(4) The answers of the applicant to ~~any such~~ the examination shall be ~~written~~ provided by the applicant under the Commissioner's supervision. The Commissioner shall give examinations at such times and places within this State as ~~he deems~~ the Commissioner considers necessary reasonably to serve the convenience of both the Commissioner and applicants: Provided that the Commissioner ~~is authorized to~~ may contract directly with persons for the processing of examination application forms and for the administration and grading of the examinations required by this section; the Commissioner ~~is authorized to~~ may charge a reasonable fee in addition to the registration fee charged under G.S. 58-33-125, to offset the cost of the examination contract authorized by this subsection; and such contracts shall not be subject to Article 3 of Chapter 143 of the General Statutes.

(5) The Commissioner shall collect in advance the examination and registration fees provided in G.S. 58-33-125 and in subsection (4) of this section. The Commissioner shall make or cause to be made available to all applicants, for a reasonable fee to offset the costs of production, materials that he ~~deems~~ considers necessary for the applicants' proper preparation for ~~such exams.~~ examinations. The Commissioner ~~is empowered to~~ may contract directly with publishers and other suppliers for the production of ~~such~~ the preparatory materials, and contracts so let by the Commissioner shall not be subject to Article 3 of Chapter 143 of the General Statutes.

(6) In addition to the examinations for the kinds of insurance specified in G.S. 58-33-25(c)(1) and (2), before any ~~person~~ resident may sell Medicare supplement or long-term care insurance policies defined respectively in Articles 54 and 55 of this Chapter, ~~he~~ the resident must take and pass a supplemental written examination according to requirements prescribed by the Commissioner.

(7) An individual who fails to appear for the examination as scheduled or fails to pass the examination, shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination."

SECTION 10. G.S. 58-33-30(g) reads as rewritten:

"(g) Denial of License. – If the Commissioner finds that the applicant has not fully met the requirements for licensing, he shall refuse to issue the license and shall notify in writing the applicant and the appointing insurer, if any, of such denial, stating the grounds therefor. The application may also be denied for any reason for which a license may be suspended or revoked or not renewed under ~~G.S. 58-33-45(a).~~ G.S. 58-33-46. Within 30 days after service of the notification, the applicant may make a written demand upon the Commissioner for a review to determine the reasonableness of the Commissioner's action. The review shall be completed without undue delay, and the

applicant shall be notified promptly in writing as to the outcome of the review. Within 30 days after service of the notification as to the outcome, the applicant may make a written demand upon the Commissioner for a hearing under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome."

SECTION 11. G.S. 58-33-30(i) reads as rewritten:

"(i) Retaliatory Provision. – Whenever, by the laws or regulations of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or any other requirements are imposed upon residents of this State who are nonresident applicants or licensees of such other state or jurisdiction in addition to, or in excess of, those imposed on nonresidents under this Article, the same such requirements shall be imposed upon such residents of such other state or jurisdiction. This subsection does not apply to fees charged to insurance producers."

SECTION 12. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-31. Application for license.**

(a) A person applying for a resident insurance producer license shall make application to the Commissioner on the Uniform Application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the Commissioner shall find that the individual:

(1) Is at least 18 years of age.

(2) Has not committed any act that is a ground for denial, probation, suspension, nonrenewal, or revocation set forth in G.S. 58-33-46.

(3) Where required by the Commissioner, has completed a prelicensing course of study for the kinds of insurance for which the person has applied.

(4) Has paid the applicable fees set forth in G.S. 58-33-125.

(5) Has successfully passed the examinations for the kinds of insurance for which the person has applied.

(b) A business entity selling, soliciting, or negotiating insurance shall obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application. Before approving the application, the Commissioner shall find that:

(1) The business entity has paid the applicable fees set forth in G.S. 58-33-125.

(2) The business entity has designated a licensed producer, who is a natural person, responsible for the business entity's compliance with the insurance laws and administrative rules of this State and orders of the Commissioner.

(c) The Commissioner may require any documents reasonably necessary to verify the information contained in an application."

SECTION 13. G.S. 58-33-32 reads as rewritten:

"**§ 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.

~~(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 in the form prescribed by the Commissioner and has paid the applicable 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~~ a reciprocal 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~~ 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 subsection (c) 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~~ 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~~ A person licensed as a limited ~~line~~ lines credit insurance producer or other type of insurance producer in that person's home state ~~shall~~ may, in accordance with subsection (c) of this section, 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. For the purposes of this subsection, limited lines insurance is any authority granted by the home state that restricts the authority of the license to less than the total authority prescribed in the associated major lines under G.S. 58-33-26(c)(1), 58-33-26(c)(2), 58-33-26(c)(3), and 58-33-26(c)(4).

(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.

A person licensed as an insurance producer in another state who moves to this State shall make application within 90 days after establishing legal residence to become a resident licensee pursuant to G.S. 58-33-31.

(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.~~information or documents filed in the proceeding necessary to describe the action.

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

SECTION 14. G.S. 58-33-40(e) reads as rewritten:

"(e) An appointment shall continue in effect as long as the appointed agent is properly licensed and the appointing insurer is authorized to transact business in this State, unless the appointment is cancelled. ~~Upon the cancellation of an appointment the insurer shall, within 30 days, file written notice of cancellation with the Commissioner in a form prescribed by him indicating the date of cancellation. A copy shall be provided to the agent by the insurer.~~"

SECTION 15. G.S. 58-33-45 is repealed.

SECTION 16. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-46. Suspension, probation, revocation, or nonrenewal of licenses.**

(a) The Commissioner may place on probation, suspend, revoke, or refuse to renew any license issued under this Article, in accordance with the provisions of Article 3A of Chapter 150B of the General Statutes, for any one or more of the following causes:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in the license application.

(2) Violating any insurance laws, or violating any administrative rule, subpoena, or order of the Commissioner or of another state's insurance regulator.

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud.

(4) Improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business.

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.

(6) Having been convicted of a felony or a misdemeanor involving dishonesty or a breach of trust.

(7) Having admitted or been found to have committed any insurance unfair trade practice or fraud.

(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere.

(9) Having an insurance producer license, or its equivalent, denied, suspended, or revoked in any other jurisdiction for reasons substantially similar to those listed in this subsection.

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction.

(11) Willfully failing to provide the notification required by subsection (c) of this section.

(12) Knowingly accepting brokered insurance business from an individual who is not licensed to broker that kind of insurance.

(13) Failing to comply with an administrative or court order imposing a child support obligation, after entry of a final judgment or order finding the violation to have been willful.

(14) Failing to pay State income tax or comply with any administrative or court order directing payment of State income tax, after entry of a final judgment or order finding the violation to have been willful.

(15) Cheating on an examination for an insurance license or for a prelicensing or continuing education course, including improperly using notes or any other reference material to complete an examination for an insurance license or for a prelicensing or continuing education course.

(16) Willfully overinsuring property.

(17) Any cause for which issuance of the license could have been refused had it then existed and been known to the Commissioner at the time of issuance.

(b) G.S. 58-2-50 applies to any investigation under this section. G.S. 58-2-70 applies to any person subject to licensure under this Article.

(c) Any person licensed under this Article shall notify the Commissioner of the commencement of any bankruptcy, insolvency, or receivership proceeding affecting the person licensed, or upon making an assignment for the benefit of creditors of the person licensed. Each owner, manager, or officer of a business entity that is a licensed person shall be responsible for providing this notification. Any person responsible for notifying the Commissioner shall provide the notice within three business days after the commencement of the proceeding or the making of the assignment.

(d) If the Commissioner refuses to grant a license, or suspends or revokes a license, any appointment of the applicant or licensee shall likewise be revoked. No individual whose license is revoked shall be issued another license without first complying with all requirements of this Article.

(e) No person shall be issued a license or appointment to enter the employment of any person, which person is at that time found by the Commissioner to be in violation of any of the insurance laws of this State, or which person has been in any manner disqualified under any state or federal law to engage in the insurance business.

(f) The Commissioner shall retain the authority to enforce the provisions of, and impose any penalty or remedy authorized by, this Chapter against any person who is under investigation for or charged with a violation of this Chapter even if the person's license or registration has been surrendered or has lapsed by operation of law."

SECTION 17. G.S. 58-33-55 is repealed.

SECTION 18. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-56. Notification to Commissioner of termination.**

(a) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with a producer shall notify the Commissioner within 30 days after the effective date of the termination, using a form prescribed by the Commissioner, if the reason for termination is for or related to one of the causes listed in G.S. 58-33-46(a) or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in G.S. 58-33-46(a). Upon the written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

(b) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason that is not for or related to one of the causes listed in G.S. 58-33-46(a), shall notify the Commissioner within 30 days after the effective date of the termination, using a form prescribed by the

Commissioner. Upon written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination.

(c) The insurer or the authorized representative of the insurer shall promptly notify the Commissioner in a form acceptable to the Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Commissioner in accordance with subsection (a) of this section had the insurer then known of its existence.

(d) Within 15 days after making the notification required by subsections (a), (b), and (c) of this section, the insurer shall mail a copy of the notification to the producer at the producer's last known address. If the producer is terminated for cause for any of the reasons listed in G.S. 58-33-46(a), the insurer shall provide a copy of the notification to the producer at the producer's last known address by certified mail, return receipt requested, postage prepaid, or by overnight delivery using a nationally recognized carrier.

(e) Within 30 days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the Commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the Commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (h) of this section.

(f) In the absence of actual malice, neither an insurer, the authorized representative of the insurer, a producer, the Commissioner, an organization of which the Commissioner is a member, nor the respective employees and agents of such persons acting on behalf of such persons shall be subject to civil liability as a result of any statement or information provided pursuant to this section.

(g) In any action brought against a person that may have immunity under subsection (f) of this section for making any statement required by this section or for providing any information relating to any statement that may be requested by the Commissioner, the party bringing the action shall plead specifically in any allegation that subsection (f) of this section does not apply because the person making the statement or providing the information did so with actual malice. Subsections (f) and (g) of this section do not abrogate or modify any existing statutory or common law privileges or immunities.

(h) Notwithstanding any other provision of this Chapter, any documents, materials, or other information in the control or possession of the Commissioner or any organization of which the Commissioner is a member that is (i) furnished by an insurer, producer, or an employee or agent thereof acting on behalf of the insurer or producer under this section, or (ii) obtained by the Commissioner in an investigation under this section shall be confidential by law and privileged, shall not be subject to or public records under G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery in any civil action other than a proceeding brought by the Commissioner against a person to whom such documents,

materials, or other information relate. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's duties. Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any civil action other than a proceeding brought by the Commissioner against a person to whom such documents, materials, or other information relate, concerning any such documents, materials, or information.

(i) In order to assist in the performance of the Commissioner's duties under this Article, the Commissioner may:

(1) Share documents, materials, or other information, including the confidential documents, materials, or information described in this section, with other state, federal, and international regulatory agencies, with the NAIC, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities. The Commissioner may condition such sharing on an agreement by the recipient to maintain the confidentiality and privileged status of the document, material, or other information;

(2) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from other state, federal, and international regulatory agencies, from the NAIC, its affiliates or subsidiaries, and from state, federal, and international law enforcement authorities, and may agree to maintain the confidential and privileged status of the document, material, or other information received under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) Enter into agreements governing sharing and use of information consistent with this subsection.

(j) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (i) of this section.

(k) Nothing in this Article prohibits the Commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection under G.S. 58-2-100 to a database or other clearinghouse service maintained by the NAIC, its affiliates, or subsidiaries of the NAIC.

(l) An insurer, the authorized representative of the insurer, or producer that fails to report as required under this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license suspended or revoked and may be fined in accordance with G.S. 58-2-70."

SECTION 19. G.S. 58-33-65 is repealed.

SECTION 20. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-33-66. Temporary licensing.

(a) The Commissioner may issue a temporary insurance producer license for a period not to exceed 180 days without requiring an examination if the Commissioner deems that the temporary license is necessary for the servicing of an insurance business in any of the following cases:

(1) To the spouse or surviving spouse or court-appointed personal representative or guardian of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the transfer of the insurance business owned by the producer, for the recovery or return of the producer to the business, or for the training and licensing of new personnel to operate the producer's business.

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license.

(3) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America.

(4) In any other circumstance where the Commissioner deems that the public interest will be served best by the issuance of this license.

(b) The Commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The Commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The Commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license terminates upon the transfer of the business.

(c) An individual requesting a temporary license on account of death or disability of an agent or broker shall be licensed to represent only those insurers that had appointed such agent at the time of death or commencement of disability."

SECTION 21. G.S. 58-33-75 reads as rewritten:

"**§ 58-33-75. Twisting with respect to insurance policies; penalties.**

No licensee 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 and ~~58-33-45.~~G.S. 58-33-46."

SECTION 22. G.S. 58-33-76(c) reads as rewritten:

"(c) Any person who violates this section is subject to the provisions of G.S. 58-2-70 and ~~G.S. 58-33-45.~~G.S. 58-33-46."

SECTION 23. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-33-82. Commissions.

(a) An insurance company or insurance producer shall not pay a commission, service fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this State if that person is required to be licensed under this Article and is not so licensed.

(b) A person shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this State if that person is required to be licensed under this Article and is not so licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this State if the person was required to be licensed under this Article at the time of the sale, solicitation, or negotiation and was so licensed at that time.

(d) Only agents who are duly licensed with appropriate company appointments, licensed brokers, licensed limited lines producers, or licensed limited representatives may accept, directly or indirectly, any commission, fee, or other valuable consideration for the sale, solicitation, or negotiation of insurance.

(e) Commissions, fees, or other valuable consideration for the sale, solicitation, or negotiation of insurance may be assigned or directed to be paid in the following circumstances:

(1) To a business entity by a person who is an owner, shareholder, member, partner, director, employee, or agent of that business entity.

(2) To a producer in connection with renewals of insurance business originally sold by or through the licensed person or for other deferred commissions.

(3) In connection with the indirect receipt of commissions in circumstances in which a license is not required under G.S. 58-33-26(m)."

SECTION 24. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-83. Assumed names.**

An insurance producer doing business under any name other than the producer's legal name shall notify the Commission before using the assumed name."

SECTION 25. G.S. 58-33-85(b) reads as rewritten:

"(b) No insurer, agent, broker, or limited representative shall knowingly charge to or demand or receive from an applicant for insurance any money or other consideration in return for the processing of applications or other forms or for the rendering of services associated with a contract of insurance, which money or other consideration is in addition to the premium for such contract, unless the applicant consents in writing before any services are rendered. This subsection does not apply to the charging or collection of any fees otherwise provided for by law."

SECTION 26. G.S. 58-3-180(c) reads as rewritten:

"(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and ~~G.S. 58-33-45,~~ G.S. 58-33-46, provided that the maximum civil

penalty that can be assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars ($2,000)."

SECTION 27. G.S. 58-9-2(5) reads as rewritten:

"(5) "Intermediary" means any person who acts as a broker, as defined in ~~G.S. 58-33-10(c),~~ G.S. 58-33-10(3), in soliciting, negotiating, or procuring the making of any reinsurance contract or binder on behalf of a ceding insurer; ~~or~~ acts as a broker, as defined in ~~G.S. 58-33-10(c),~~ G.S. 58-33-10(3), in accepting any reinsurance contract on behalf of an assuming insurer. "Intermediary" includes a broker or a manager, as those terms are defined in this section."

SECTION 28. G.S. 58-21-40 reads as rewritten:

"**§ 58-21-40. Surplus lines ~~advisory organizations.~~regulatory support organization.**

(a) A surplus lines ~~advisory~~ regulatory support organization of surplus lines licensees ~~may~~ shall be formed to:

(1) Facilitate and encourage compliance by ~~its members~~ resident and nonresident surplus lines licensees with the laws of this State and the rules and regulations of the Commissioner relative to surplus lines insurance;

(2) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market; ~~and~~

(3) Receive and disseminate to ~~its members~~ surplus lines licensees information ~~relative to~~ about surplus lines ~~coverages.~~insurance, including, without limitation, new electronic filing procedures approved by the Commissioner, changes in the list of eligible surplus lines insurers, and modifications in coverages, procedures, and requirements as may be requested by the Commissioner; and

(4) Certify satisfactory evidence of current nonresident surplus lines licensure in this State by countersigning nonresident produced surplus lines coverages by means satisfactory to the Commissioner; and charge the nonresident surplus lines licensee a fee for the certification and countersignature as approved by the Commissioner.

(b) ~~Every such advisory~~ The regulatory support organization shall file with the Commissioner:

(1) A copy of its constitution, articles of agreement or association, or certificate of incorporation;

(2) A copy of its bylaws and rules governing its activities;

(3) ~~A current~~ An annually updated list of ~~its members;~~resident and nonresident licensees;

(4) The name and address of a resident of this State upon whom notices or orders of the Commissioner or processes issued at his direction may be served; and

(5) An agreement that the Commissioner may examine the ~~advisory~~ regulatory support organization in accordance with ~~the provisions of~~ subsection (c) of this section.

(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each ~~advisory~~ regulatory support 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~~ regulatory support organization or any ~~member thereof~~ surplus lines licensee, whether resident or nonresident, to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation.

(d) Each resident surplus lines licensee shall maintain active membership in ~~an advisory~~ a regulatory support organization as a condition of continued licensure under this Article."

SECTION 29. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 30. Section 28 is effective October 1, 2001. Sections 25, 29, and 30 are effective when they become law. The remaining sections of this act become effective July 1, 2002.

SENATE BILL 318:
Insurance Producer Licensing

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Sen. Wellons
Date:	May 23, 2001	**Summary by:**	Trina Griffin
Version:	PCS for 2nd Edition S318-CSSV-34 (v.2)		Committee Counsel

SUMMARY: ***Senate Bill 318 revises the laws on licensing insurance agents and brokers to conform to the Model Uniform Insurance Producer Licensing Act of the NAIC and thereby achieve national uniformity in licensing insurance producers as provided by the federal Gramm-Leach-Bliley Act. The proposed committee substitute makes several technical changes to the bill.***

BACKGROUND: In 1999 Congress passed the Gramm-Leach-Bliley Act which, among other things, mandates that a majority of states 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 enact reciprocity laws and regulations governing the licensure of nonresident individuals and entities authorized to sell and solicit insurance within those states. If states do not enact these uniform laws by November 12, 2002, the National Association of Registered Agents and Brokers 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 applies on a multistate basis. Senate Bill 318 is designed to comply with the federal mandate of the Gramm-Leach-Bliley Act.

BILL ANALYSIS:

I. New Sections

Senate Bill 318 amends Chapter 58 by adding several new sections that conform to the Model Uniform Insurance Producer Licensing Act. The new sections include:

A. General License Requirements (pp. 4-8 of PCS). This section sets out the general license requirements for agents, brokers, limited representatives, adjusters, or motor vehicle damage appraisers. Some of the provisions include:

- A property and liability insurance license does not authorize an agent to sell accident and health insurance.
- A life and health license authorizes a resident agent to sell variable contracts and Medicare supplement and long-term care insurance policies, assuming certain standards are met.
- A business entity that sells, negotiates, or solicits insurance must be licensed. In order to receive a license, the Commissioner must find that the entity has paid the applicable fees and that the entity has a designated licensed producer who is responsible for the entity's compliance with the insurance laws. Every member of the partnership and every officer, director, stockholder, and employee of the entity engaged in selling or negotiating insurance policies shall qualify as an individual licensee.

- A list of individuals who are **not** required to be licensed, including:
  - An officer, director, or employee that does not receive any commission on policies written or sold where the person's activities are executive, administrative, managerial or clerical and are only indirectly related to the sale of negotiation of insurance.
  - A person whose function relates to underwriting, loss control, inspection, or the processing or settling of a claim, or to providing technical advice as a special agent or agency supervisor.
  - Employers engaged in the administration or operation of an employee benefits program
  - Employees of insurers not engaged in selling or negotiating insurance
  - A nonresident who sells insurance to an insured with risks located in more than one state and the nonresident is otherwise licensed in another state that is his principal place of business.
  - A salaried full-time employee who advises his employer regarding the employer's insurance interests.
  - A person indirectly receiving proceeds of commissions as part of the transfer of insurance business or in the form of retirement or similar benefits.

B. Application Requirements (p. 10 of PCS). This section sets out the application requirements for obtaining a resident insurance producer license for both individuals and business entities.

C. Suspension, probation, revocation, or nonrenewal of licenses (pp. 14-15 of PCS). This sectio creates uniform standards for license suspension, probation, revocation, and nonrenewal, including:

- A list of 17 "for cause" reasons for which the Commissioner may take adverse action against a licensee.
- A requirement that licensees notify the Commissioner within 3 days of the commencement of a bankruptcy, insolvency, or receivership proceeding.
- Any appointment by a licensee whose license has been suspended or revoked shall likewise be revoked.

D. Notification to Commissioner of termination (pp. 15-18 of PCS). This section creates uniform procedures for regulators, companies, and agents to report and administratively resolve for cause and not for cause terminations with producers.

E. Temporary licensing (p. 18 of PCS). This section authorizes the Commissioner to issue a temporary license for up to 180 days without an exam in certain circumstances, including:

- In the event of death or disability of an insurance producer to allow adequate time for the transfer of the business.
- In the event of a licensed insurance producer entering active service in the armed forces.

F. Commissions (p. 19 of PCS). This section establishes uniform standards regarding what entities may and may not receive or assign a commission related to the sale of an insurance policy.

II. Amendments to Existing Law

Senate Bill 318 also amends existing law to conform to the Model Act, including:

A. Definitions (pp. 1-4 of PCS). It creates several new defined terms including "business entity", "sell", "negotiate", and "solicit".

B. Examinations (pp. 8-9 of PCS). Under the bill, a ***written*** exam is no longer required and applicants who fail to appear for an exam or do not pass are required to reapply and pay all required fees before being rescheduled for another exam.

C. Interstate reciprocity in producer licensing (pp. 11-13 of PCS). This section makes conforming changes with regard to the licensing requirements of nonresidents.

D. Surplus lines regulatory support organization (pp. 20-21 of PCS). This section renames the former "Surplus lines advisory organizations" section and makes modifications regarding nonresident surplus lines licensees.

EFFECTIVE DATE: Sections 28 is effective October 1, 2001. Sections 25, 30 and the effective date section are effective when they become law. The remaining sections become effective July 1, 2002.

North Carolina General Assembly
Legislative Services Office

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Memorandum

DATE: April 20, 2001
TO: Senator Wellons
FROM: Trina Griffin, Staff Attorney, Research Division
Fax: 715-5460; Trinag@ncleg.net

Marilyn Chism, Fiscal Analyst, Fiscal Research Division
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RE: S318 – Revised Certification of Legislation Required by Federal Law

BACKGROUND

G.S. 120-36.8 requires that every introduced bill proposing any change in the law which purports to implement federal law or purports to be required or necessary for compliance with federal law, or on which is conditioned the receipt of federal funds, shall have attached a certification identifying the federal law. The certification is to be provided by the Fiscal Research Division in consultation with Bill Drafting and General Research.

Senate Bill 318 purports to implement a provision of the Gramm-Leach-Bliley Act, P.L. 106-102 (November 12, 1999). This memorandum provides a summary of and citations to the relevant sections of P.L. 106-102 and S318. The Fiscal Research Division's certification with respect to fiscal impact is included as the last section of this memorandum.

GRAMM-LEACH-BLILEY ACT

In 1999 Congress passed the Gramm-Leach-Bliley Act ("Act"), which modernized the financial services industry by eliminating the legal separations among the banking, insurance, and securities industries.

Title III, Subtitle C, Section 321 of the Act provides that unless the States enact uniform laws governing the licensure of resident insurance producers ***or*** enact reciprocity laws governing the licensure of nonresident insurance producers within three years of Act's passage, the National Association of Registered Agents and Brokers 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 on a multistate basis. Through the oversight of this organization, individual states would no longer have jurisdiction over these areas. At the end of the three-year period, the

National Association of Insurance Commissioner ("NAIC") shall determine, in consultation with the insurance commissioners of the States, whether the uniformity or reciprocity required by the Act has been achieved.

In 2000, the General Assembly enacted reciprocity laws governing the licensure of nonresident insurance producers (S.L. 2000-0122) to comply with the Act. Having enacted this legislation, North Carolina has complied with the requirements of Section 321 of the Act. Nevertheless, S318 purports to implement the resident licensure provisions sanctioned, but not required, by the Act. It is noteworthy that the Act specifically states that nothing in [Section 321] requires any State to adopt new or additional licensing requirements in order to achieve the uniformity necessary to satisfy the provisions of the Act.

Section 321 of the Act provides that states will be deemed to have established the uniformity necessary to satisfy the uniform licensure provisions if they:

(1) Establish uniform criteria regarding the integrity, personal qualifications, education, training, and experience of licensed insurance producers, including the qualification and training of sales personnel in ascertaining the appropriateness of a particular insurance product for a prospective customer;

(2) Establish uniform continuing education requirements for licensed insurance producers;

(3) Establish uniform ethics course requirements for licensed insurance producers in conjunction with the continuing education requirements under paragraph (2);

(4) Establish uniform criteria to ensure that an insurance product, including any annuity contract, sold to a consumer is suitable and appropriate for the consumer based on financial information disclosed by the consumer; and

(5) Do not impose any requirement upon any insurance producer to be licensed or otherwise qualified to do business as a nonresident that has the effect of limiting or conditioning that producer's activities because of its residence or place of operations, except that countersignature requirements imposed on nonresident producers shall not be deemed to have the effect of limiting or conditioning a producer's activities because of its residence or place of operations under this section.

SENATE BILL 318

Senate Bill 318 purports to implement the above-referenced federal law by enacting uniform laws to govern the licensure of individuals authorized to sell and solicit insurance as provided by the Gramm-Leach-Bliley Act. The bill is a blend of provisions from the Producer Licensing Model Act of the NAIC, which was adopted by the NAIC to provide the States with a uniform and reciprocal system of licensing for insurance agents and brokers. The Model Act was developed in response to the Gramm-Leach-Bliley Act.

CERTIFICATION OF FISCAL IMPACT

The Fiscal Research Division certifies that Senate Bill 318 has no impact on the Department of Insurance. This bill revises the laws on licensing insurance agents and borkers to conform to the Model Uniform Insurance Producer Licensing Act of the NAIC and thereby achieve national uniformity in licensing insurance producers as provided by the federal Gramm-Leach-Bliley Act as discussed above, but such implementation requires no additional resources.

PROPOSED COMMITTEE SUBSTITUTE FOR S.B. 318
INSURANCE PRODUCER LICENSING

This bill is a blend of provisions from the Producer Licensing Model Act of the National Association of Insurance Commissioners, which was adopted by the NAIC to provide the states with a uniform and reciprocal system of licensing for insurance agents and brokers (referred to as insurance "producers").

The Model Act was developed in response to the federal Gramm-Leach-Bliley Act (P.L. 106-102), in which Congress modernized the financial services industry by eliminating the legal separations between the banking, insurance, and securities industries.

Most of the existing agent and broker licensing provisions in Article 33 of Chapter 58 of the General Statutes are repealed and re-enacted in this bill. This is a cleaner and more efficient way of combining the Model Act and North Carolina law to achieve the desired uniformity.

The following is a section-by-section analysis of the bill:

SECTION 1. Makes technical amendments to the "Scope" section of Article 33.

SECTION 2. States the obvious that no person can sell, solicit, or negotiate insurance in North Carolina unless the person is licensed.

SECTION 3. Rewrites the "definitions" section for Article 33. Transfers a number of definitions from G.S. 58-33-32, which is the reciprocity law enacted in 2000.

SECTION 4. Technical cross-reference amendment.

SECTION 5. Repeals the statute on licensing requirements, most of which reappears in new G.S. 58-33-26 in SECTION 6 of the bill.

SECTION 6. The only new provisions in this section are the further refined definitions of life and health and property and liability insurance and a new license type for personal lines, which are private passenger auto insurance, homeowners' insurance, etc. The licensing exceptions in G.S. 58-33-26(n) for the most part were in G.S. 58-33-25(o), but a number of new exceptions are taken from the Model Act.

SECTION 7. Repeals provisions reincorporated later in the bill.

SECTION 8. Changes the Medicare supplement prelicense education requirements to apply only to residents.

SECTION 9. Makes technical and stylistic changes to the prelicensing examination requirements, allowing for electronic exams and adding a provision from the Model Act.

SECTION 10. Technical cross-reference amendment.

SECTION 11. Amends a retaliatory law to prohibit discrimination against nonresidents in charging fees.

SECTION 12. Adds the license application language from the Model Act.

SECTION 13. Amends the 2000 reciprocity law by repealing definitions that are re-enacted in SECTION 3 of the bill, makes stylistic changes, and adds Model Act language on limited lines insurance (auto physical damage and title insurance).

SECTION 14. Repeals a provision that is re-enacted in SECTION 18 of the bill.

SECTION 15. Repeals provisions on license sanctions.

SECTION 16. Re-enacts provisions on license sanctions in new G.S. 58-33-46. The grounds listed are presently in G.S. 58-33-45, except for subdivisions (12) through (14). Subdivision (6) is a modification of existing law to read like the federal insurance crime law (18 U.S.C. § 1033). Subsection (f), under which the Commissioner may seek sanctions on a former licensee, is from the Model Act.

SECTION 17. Repeals provisions on terminations by insurance companies of agent appointments.

SECTION 18. Re-enacts provisions on terminations by insurance companies of agent appointments, using the Model Act provisions.

SECTION 19. Repeals provisions on temporary licensing.

SECTION 20. Re-enacts provisions on temporary licensing, using the Model Act provisions.

SECTION 21. Technical cross-reference amendment.

SECTION 22. Technical cross-reference amendment.

SECTION 23. Incorporates the Model Act provisions on payments of commissions, replacing existing provisions that were in G.S. 58-33-25(j) and (k).

SECTION 24. Incorporates the Model Act provisions requiring a producer to notify the Commissioner if the producer plans to use an assumed name.

SECTION 25. Clarifies existing law to allow producers to collect worthless check fees or any other fee authorized by law.

SECTION 26. Technical cross-reference amendment.

SECTION 27. Technical cross-reference amendment.

SECTION 28. Amends existing law on surplus lines insurance (e.g., Lloyds of London, specialty lines of insurance) to provide for countersignatures of policies written by nonresidents. This is for the protection of North Carolina residents. A surplus lines regulatory support organization has been operating as an association since 1985, and has and will continue to provide valuable services to the public in assuring that surplus lines brokers are up to date on changes in the law and in the marketplace.

SECTION 29. Amends G.S. 58-33-30(a) to reflect the enactment of G.S. 58-33-31 with respect to license applications.

SECTION 30. Amends the definition of "agent" in the Insurance Information and Privacy Protection Act to comport with the definitions in this bill.

SECTION 31. Severability clause.

SECTION 32. Makes the licensing changes effective July 1, 2002. The rest of the bill is effective upon signing by the Governor.

Prepared by:

William K. Hale
Legislative Counsel
N.C. Department of Insurance
May 23, 2001

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 466 A BILL TO BE ENTITLED AN ACT TO INCREASE THE AMOUNT OF BURIAL EXPENSES COVERAGE UNDER THE WORKERS' COMPENSATION ACT; TO CHANGE A REQUIREMENT IN THE LOSS COSTS RATE-MAKING LAW; AND TO AMEND THE RATE BUREAU APPEAL STATUTE TO PROVIDE THAT MEMBER COMPANIES ARE NOT ALLOWED TO TO APPEAL BUREAU DECISIONS ON RATES OR LOSS COSTS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 466*

Insurance and Consumer Protection Committee Substitute Adopted 4/4/01
Third Edition Engrossed 4/5/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S466-CSSO-40 [v.1]

5/22/2001 3:15:30 PM

Short Title: Workers' Compensation Amendments. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE AMOUNT OF BURIAL EXPENSES COVERAGE UNDER THE WORKERS' COMPENSATION ACT; TO CHANGE A REQUIREMENT IN THE LOSS COSTS RATE-MAKING LAW; AND TO AMEND THE RATE BUREAU APPEAL STATUTE TO PROVIDE THAT MEMBER COMPANIES ARE NOT ALLOWED TO APPEAL BUREAU DECISIONS ON RATES OR LOSS COSTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-38 reads as rewritten:

"**§ 97-38. Where death results proximately from compensable injury or occupational disease; dependents; burial expenses; compensation to aliens; election by partial dependents.**

If death results proximately from a compensable injury or occupational disease and within six years thereafter, or within two years of the final determination of disability, whichever is later, the employer shall pay or cause to be paid, subject to the provisions of other sections of this Article, weekly payments of compensation equal to sixty-six and two-thirds percent (66 2/3%) of the average weekly wages of the deceased employee at the time of the accident, but not more than the amount established annually to be effective October 1 as provided in G.S. 97-29, nor less than thirty dollars ($30.00), per week, and burial expenses not exceeding ~~two thousand dollars ($2,000),~~ three thousand five hundred dollars ($3,500), to the person or persons entitled thereto as follows:

(1) Persons wholly dependent for support upon the earnings of the deceased employee at the time of the accident shall be entitled to receive the entire compensation payable share and share alike to the exclusion of all other persons. If there be only one person wholly

dependent, then that person shall receive the entire compensation payable.

(2) If there is no person wholly dependent, then any person partially dependent for support upon the earnings of the deceased employee at the time of the accident shall be entitled to receive a weekly payment of compensation computed as hereinabove provided, but such weekly payment shall be the same proportion of the weekly compensation provided for a whole dependent as the amount annually contributed by the deceased employee to the support of such partial dependent bears to the annual earnings of the deceased at the time of the accident.

(3) If there is no person wholly dependent, and the person or all persons partially dependent is or are within the classes of persons defined as "next of kin" in G.S. 97-40, whether or not such persons or such classes of persons are of kin to the deceased employee in equal degree, and all so elect, he or they may take, share and share alike, the commuted value of the amount provided for whole dependents in (1) above instead of the proportional payment provided for partial dependents in (2) above; provided, that the election herein provided may be exercised on behalf of any infant partial dependent by a duly qualified guardian; provided, further, that the Industrial Commission may, in its discretion, permit a parent or person standing in loco parentis to such infant to exercise such option in its behalf, the award to be payable only to a duly qualified guardian except as in this Article otherwise provided; and provided, further, that if such election is exercised by or on behalf of more than one person, then they shall take the commuted amount in equal shares.

When weekly payments have been made to an injured employee before his death, the compensation to dependents shall begin from the date of the last of such payments. Compensation payments due on account of death shall be paid for a period of 400 weeks from the date of the death of the employee; provided, however, after said 400-week period in case of a widow or widower who is unable to support herself or himself because of physical or mental disability as of the date of death of the employee, compensation payments shall continue during her or his lifetime or until remarriage and compensation payments due a dependent child shall be continued until such child reaches the age of 18.

Compensation payable under this Article to aliens not residents (or about to become nonresidents) of the United States or Canada, shall be the same in amounts as provided for residents, except that dependents in any foreign country except Canada shall be limited to surviving spouse and child or children, or if there be no surviving spouse or child or children, to the surviving father or mother."

SECTION 2. G.S. 58-36-100(j) reads as rewritten:

"(j) For reference filings filed by the Bureau:

(1) If the insurer has filed to have its loss multiplier remain on file, applicable to subsequent reference filings, and a new reference filing is filed and approved and if:

a. The insurer decides to use the revision of the prospective loss costs and effective date as filed, then the insurer does not file anything with the Commissioner. Rates are the combination of the prospective loss costs and the on-file loss multiplier and become effective on the effective date of the loss costs.

b. The insurer decides to use the prospective loss costs as filed but with a different effective date, then the insurer must notify the Commissioner of its effective date before the effective date of the loss costs.

c. The insurer decides to use the revision of the prospective loss costs, but wishes to change its loss multiplier, then the insurer must file a revised reference filing adoption form before the effective date of the reference filing.

d. The insurer decides not to revise its rates using the prospective loss costs, then the insurer must notify the Commissioner before the effective date of the loss costs.

(2) If an insurer has not elected to have its loss multiplier remain on file, applicable to future prospective loss costs reference filings, and a new reference filing is filed and approved, and if:

a. The insurer decides to use the prospective loss costs to revise its rates, then the insurer must file a reference filing adoption form including its effective date.

b. The insurer decides not to use the revisions, then the insurer does not file anything with the Commissioner.

c. The insurer decides to change its multiplier, then the insurer must file a reference filing adoption form referencing the current approved prospective loss costs, including its effective date and, if applicable, its loss costs modification factor and supporting documentation. The insurer shall not make a change to its loss costs multiplier based on any reference filing other than the current approved reference filing."

SECTION 3. G.S. 58-36-35 reads as rewritten:

"**§ 58-36-35. Appeal to Commissioner from decision of Bureau.**

(a) Any member of the Bureau may appeal to the Commissioner from any decision of the ~~Bureau.~~ Bureau, except for a decision made under G.S. 58-36-1(2). After a hearing held on not ~~less~~ fewer than 10 days' written notice to the appellant and to the Bureau, the Commissioner shall issue an order approving the decision or directing the Bureau to reconsider the decision. ~~In the event~~ If the Commissioner directs the Bureau to reconsider the decision and the Bureau fails to take action satisfactory to the

Commissioner, the Commissioner shall make such order as ~~he~~ the Commissioner may see fit.

(b) No later than 20 days before ~~each~~ the 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 case and any evidence ~~he~~ the appellant intends to offer at the hearing. No later than five days before such hearing, the appellee shall file with the Commissioner or ~~his~~ the Commissioner's designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ the appellee intends to offer at the hearing. Each such hearing shall be recorded and transcribed. 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. Each party shall, on a date determined by the Commissioner or ~~his~~ the Commissioner's 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 Commissioner's designated hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the Commissioner's designated hearing officer shall then issue an order."

SECTION 3.1. G.S. 97-40 reads as rewritten:

"**§ 97-40. Commutation and payment of compensation in absence of dependents; "next of kin" defined; commutation and distribution of compensation to partially dependent next of kin; payment in absence of both dependents and next of kin.**

Subject to the provisions of G.S. 97-38, if the deceased employee leaves neither whole nor partial dependents, then the compensation which would be payable under G.S. 97-38 to whole dependents shall be commuted to its present value and paid in a lump sum to the next of kin as herein defined. For purposes of this section and G.S. 97-38, "next of kin" shall include only child, father, mother, brother or sister of the deceased employee, including adult children or adult brothers or adult sisters of the deceased, but excluding a parent who has willfully abandoned the care and maintenance of his or her child and who has not resumed its care and maintenance at least one year prior to the first occurring of the majority or death of the child and continued its care and maintenance until its death or majority. For all such next of kin who are neither wholly nor partially dependent upon the deceased employee and who take under this section, the order of priority among them shall be governed by the general law applicable to the distribution of the personal estate of persons dying intestate. In the event of exclusion of a parent based on abandonment, the claim for compensation benefits shall be treated as though the abandoning parent had predeceased the employee. For all such next of kin who were also partially dependent on the deceased employee but who exercise the election provided for partial dependents by G.S. 97-38, the general law applicable to the distribution of the personal estate of persons dying intestate shall not apply and such person or persons upon the exercise of such election, shall be

entitled, share and share alike, to the compensation provided in G.S. 97-38 for whole dependents commuted to its present value and paid in a lump sum.

If the deceased employee leaves neither whole dependents, partial dependents, nor next of kin as hereinabove defined, then no compensation shall be due or payable on account of the death of the deceased employee, except that the employer shall pay or cause to be paid the burial expenses of the deceased employee not exceeding ~~two thousand dollars ($2,000)~~ three thousand five hundred dollars ($3,500) to the person or persons entitled thereto."

SECTION 4. Sections 1 and 3.1 of this act become effective October 1, 2001. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 3

SENATE BILL 466*

Insurance and Consumer Protection Committee Substitute Adopted 4/4/01
Third Edition Engrossed 4/5/01

Short Title: Workers' Compensation Amendments. (Public)

Sponsors:

Referred to:

March 15, 2001

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SECTION 1. G.S. 97-38 reads as rewritten:

"**§ 97-38. Where death results proximately from compensable injury or occupational disease; dependents; burial expenses; compensation to aliens; election by partial dependents.**

If death results proximately from a compensable injury or occupational disease and within six years thereafter, or within two years of the final determination of disability, whichever is later, the employer shall pay or cause to be paid, subject to the provisions of other sections of this Article, weekly payments of compensation equal to sixty-six and two-thirds percent (66 2/3%) of the average weekly wages of the deceased employee at the time of the accident, but not more than the amount established annually to be effective October 1 as provided in G.S. 97-29, nor less than thirty dollars ($30.00), per week, and burial expenses not exceeding ~~two thousand dollars ($2,000),~~ three thousand five hundred dollars ($3,500), to the person or persons entitled thereto as follows:

(1) Persons wholly dependent for support upon the earnings of the deceased employee at the time of the accident shall be entitled to receive the entire compensation payable share and share alike to the exclusion of all other persons. If there be only one person wholly dependent, then that person shall receive the entire compensation payable.

(2) If there is no person wholly dependent, then any person partially dependent for support upon the earnings of the deceased employee at the time of the accident shall be entitled to receive a weekly payment of compensation computed as hereinabove provided, but such weekly payment shall be the same proportion of the weekly compensation provided for a whole dependent as the amount annually contributed by the deceased employee to the support of such partial dependent bears to the annual earnings of the deceased at the time of the accident.

(3) If there is no person wholly dependent, and the person or all persons partially dependent is or are within the classes of persons defined as "next of kin" in G.S. 97-40, whether or not such persons or such classes of persons are of kin to the deceased employee in equal degree, and all so elect, he or they may take, share and share alike, the commuted value of the amount provided for whole dependents in (1) above instead of the proportional payment provided for partial dependents in (2) above; provided, that the election herein provided may be exercised on behalf of any infant partial dependent by a duly qualified guardian; provided, further, that the Industrial Commission may, in its discretion, permit a parent or person standing in loco parentis to such infant to exercise such option in its behalf, the award to be payable only to a duly qualified guardian except as in this Article otherwise provided; and provided, further, that if such election is exercised by or on behalf of more than one person, then they shall take the commuted amount in equal shares.

When weekly payments have been made to an injured employee before his death, the compensation to dependents shall begin from the date of the last of such payments. Compensation payments due on account of death shall be paid for a period of 400 weeks from the date of the death of the employee; provided, however, after said 400-week period in case of a widow or widower who is unable to support herself or himself because of physical or mental disability as of the date of death of the employee, compensation payments shall continue during her or his lifetime or until remarriage and compensation payments due a dependent child shall be continued until such child reaches the age of 18.

Compensation payable under this Article to aliens not residents (or about to become nonresidents) of the United States or Canada, shall be the same in amounts as provided for residents, except that dependents in any foreign country except Canada shall be limited to surviving spouse and child or children, or if there be no surviving spouse or child or children, to the surviving father or mother."

SECTION 2. G.S. 58-36-100(j) reads as rewritten:

"(j) For reference filings filed by the Bureau:

(1) If the insurer has filed to have its loss multiplier remain on file, applicable to subsequent reference filings, and a new reference filing is filed and approved and if:
   a. The insurer decides to use the revision of the prospective loss costs and effective date as filed, then the insurer does not file anything with the Commissioner. Rates are the combination of the prospective loss costs and the on-file loss multiplier and become effective on the effective date of the loss costs.
   b. The insurer decides to use the prospective loss costs as filed but with a different effective date, then the insurer must notify the Commissioner of its effective date before the effective date of the loss costs.
   c. The insurer decides to use the revision of the prospective loss costs, but wishes to change its loss multiplier, then the insurer must file a revised reference filing adoption form before the effective date of the reference filing.
   d. The insurer decides not to revise its rates using the prospective loss costs, then the insurer must notify the Commissioner before the effective date of the loss costs.

(2) If an insurer has not elected to have its loss multiplier remain on file, applicable to future prospective loss costs reference filings, and a new reference filing is filed and approved, and if:
   a. The insurer decides to use the prospective loss costs to revise its rates, then the insurer must file a reference filing adoption form including its effective date.
   b. The insurer decides not to use the revisions, then the insurer does not file anything with the Commissioner.
   c. The insurer decides to change its multiplier, then the insurer must file a reference filing adoption form referencing the current approved prospective loss costs, including its effective date and, if applicable, its loss costs modification factor and supporting documentation. The insurer shall not make a change to its loss costs multiplier based on any reference filing other than the current approved reference filing."

SECTION 3. G.S. 58-36-35 reads as rewritten:

"**§ 58-36-35. Appeal to Commissioner from decision of Bureau.**

(a) Any member of the Bureau may appeal to the Commissioner from any decision of the ~~Bureau.~~ Bureau, except for a decision made under G.S. 58-36-1(2). After a hearing held on not ~~less~~ fewer than 10 days' written notice to the appellant and to the Bureau, the Commissioner shall issue an order approving the decision or directing the Bureau to reconsider the decision. ~~In the event~~ If the Commissioner directs the Bureau to reconsider the decision and the Bureau fails to take action satisfactory to the

Commissioner, the Commissioner shall make such order as ~~he~~ the Commissioner may see fit.

(b) No later than 20 days before ~~each~~ the 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 case and any evidence ~~he~~ the appellant intends to offer at the hearing. No later than five days before such hearing, the appellee shall file with the Commissioner or ~~his~~ the Commissioner's designated hearing officer and shall serve on the appellant a written statement of ~~his~~ the appellee's case and any evidence ~~he~~ the appellee intends to offer at the hearing. Each such hearing shall be recorded and transcribed. 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. Each party shall, on a date determined by the Commissioner or ~~his~~ the Commissioner's 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 Commissioner's designated hearing officer and serve on the other party, a proposed order. The Commissioner or ~~his~~ the Commissioner's designated hearing officer shall then issue an order."

SECTION 3.1. G.S. 97-40 reads as rewritten:

"**§ 97-40. Commutation and payment of compensation in absence of dependents; "next of kin" defined; commutation and distribution of compensation to partially dependent next of kin; payment in absence of both dependents and next of kin.**

Subject to the provisions of G.S. 97-38, if the deceased employee leaves neither whole nor partial dependents, then the compensation which would be payable under G.S. 97-38 to whole dependents shall be commuted to its present value and paid in a lump sum to the next of kin as herein defined. For purposes of this section and G.S. 97-38, "next of kin" shall include only child, father, mother, brother or sister of the deceased employee, including adult children or adult brothers or adult sisters of the deceased, but excluding a parent who has willfully abandoned the care and maintenance of his or her child and who has not resumed its care and maintenance at least one year prior to the first occurring of the majority or death of the child and continued its care and maintenance until its death or majority. For all such next of kin who are neither wholly nor partially dependent upon the deceased employee and who take under this section, the order of priority among them shall be governed by the general law applicable to the distribution of the personal estate of persons dying intestate. In the event of exclusion of a parent based on abandonment, the claim for compensation benefits shall be treated as though the abandoning parent had predeceased the employee. For all such next of kin who were also partially dependent on the deceased employee but who exercise the election provided for partial dependents by G.S. 97-38, the general law applicable to the distribution of the personal estate of persons dying intestate shall not apply and such person or persons upon the exercise of such election, shall be

entitled, share and share alike, to the compensation provided in G.S. 97-38 for whole dependents commuted to its present value and paid in a lump sum.

If the deceased employee leaves neither whole dependents, partial dependents, nor next of kin as hereinabove defined, then no compensation shall be due or payable on account of the death of the deceased employee, except that the employer shall pay or cause to be paid the burial expenses of the deceased employee not exceeding ~~two thousand dollars ($2,000)~~ three thousand five hundred dollars ($3,500) to the person or persons entitled thereto."

SECTION 4. Section 1 of this act becomes effective October 1, 2001. The remainder of this act is effective when it becomes law.

SENATE BILL 466:
Workers' Compensation Amendments - AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Wellons
Date:	May 23, 2001	**Summary by:**	Frank W. Folger and Linda Attarian, Committee Counsel
Version:	PCS to Third Edition (S466-CSSO-40)		

SUMMARY: ***Senate Bill 466 would amend the Workers' Compensation Act to increase burial expense coverage in the event of death resulting from a compensable injury or occupational disease under the Act; to clarify that only current approved loss cost filings may be used by workers' compensation insurers to determine their rates; and to prohibit appeals to the Commissioner by companies when the NC Rate Bureau decides in favor of policyholders in appeals concerning rates or loss costs.***

CURRENT LAW and BILL ANALYSIS:

Sections 1 and 3.1: Burial Expense Coverage Under the Workers' Compensation Act

G.S. 97-38 governs compensation under the Workers' Compensation Act when an employee dies from a compensable injury or occupational disease within 6 years thereafter or 2 years from the final determination of disability, whichever is later. G.S. 97-40 governs compensation when there are no dependants. Currently, the Act, in both statutes, provides coverage of burial expenses up to $2000. This amount has been the same since 1987.

This section would increase the coverage for burial expenses under the Act to a maximum of $3500.

Section 2. Workers' Compensation Loss Cost Filings with the NC Rate Bureau:

Article 36 of Chapter 58 governs the North Carolina Rate Bureau, which sets rates for insurance covering risks over which it has statutory jurisdiction. Workers' compensation and employers' liability insurance is within the Bureau's jurisdiction. All companies that write policies covering these risks are members of the Bureau, so the Bureau is authorized to set rates as if it were a single company. The Commissioner of Insurance may review, approve, disapprove, and modify rates promulgated by the Bureau in accordance with Article 36.

G.S. 58-36-100 requires the Bureau to file "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 the loss costs. Once approved by the Commissioner, all insurance companies use these filings in setting their final rates. Each insurer must determine its final rates independently, but may use the approved reference filing in support of its rate. The companies should use the latest approved filing, but according to the Department of Insurance, some companies will select a prior approved reference filing to support its rate. Therefore, the Department proposes that G.S. 58-36-100 be amended to specifically require the use of the "current" approved reference filing.

Section 3: Appeal to the Commissioner from a Decision of the Rate Bureau:

Under G.S. 58-36-35 any company that is a member of the Bureau may appeal to the Commissioner if it is adversely affected by any decision of the Bureau in accordance with the procedures set forth in the statute.

Under G.S. 58-36-1(2) any policyholder may appeal to the Bureau if the policyholder is adversely affected by the Bureau's insurance rate setting. If the Bureau finds in favor of the insurance company, the policyholder has no further appeal rights. If the Bureau finds in favor of the policyholder, the insurance company may file an appeal to the Commissioner under G.S. 58-36-35. The Department of Insurance proposes to close this avenue of appeal by amending G.S. 58-36-35 to specifically exclude such appeals.

Section 4. This section makes sections 1 and 3.1 effective October 1, 2001 and the remainder of the bill effective when it becomes law.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

May 23, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 466 -- Worker's Compensation Amendments

SECTIONS 1 AND 3.1. These would increase the maximum amount available under the Workers' Compensation Act for funeral expenses from $2,000 (last set in 1989) to $3,500, to keep up with the cost of funerals.

SECTION 2. In workers' compensation insurance, the Rate Bureau makes filings with the Commissioner, and the filings contain a loss cost basis that all insurance companies use in setting their final rates. Once a Bureau loss cost filing is approved, individual companies start with the loss cost basis and add their own expenses and profit margins (known as "multipliers") to arrive at their own rates. Some companies are filing their new multipliers referencing whatever Bureau loss cost filing suits their needs instead of the loss cost filing that is currently approved. The Bureau makes a new loss cost filing every year. When a new filing is made, it supercedes all prior filings. The current statute does not prohibit this and this is the purpose of the statute change.

SECTION 3. This section would keep the Commissioner from having to hear an appeal from an insurance company that does not like a decision by the Bureau if the Bureau rules against the company when policyholders an appeal to the Bureau if they don't like the way a company has rated them. There is no further appeal for the policyholder if the Bureau rules for the company. Under the appeals statute being amended, any company may appeal any decision made by the Bureau. Under current law, if the Bureau rules for the policyholder (which does in about 40-45% of the cases), the company and not the policyholder could appeal to the Commissioner.

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 30, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 30, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Austin Redwine (Brunswick County – Representative Redwine) and John Rabold (Catawba County - Representative Setzer). The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Dedmon, Grady, Hall, Johnson, Justus, Saunders, Setzer, Smith, Wainwright, Warner, and C. Wilson. Linda Attarian and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

SB 459, entitled, AN ACT TO AMEND NORTH CAROLINA'S INSURANCE LAWS CONCERNING INSURANCE COMPANY RESERVING METHODS, LICENSING PROVISIONS, REINSURANCE FOR DOMESTIC COMPANIES, DOMESTIC COMPANY FORMATION, SOLVENCY PROTECTION, LIFE INSURANCE COMPANY VARIABLE ACCOUNTS, CONSOLIDATIONS, INVESTMENTS, MUTUAL INSURANCE COMPANIES, REINSURANCE INTERMEDIARIES, MORTGAGE GUARANTY INSURANCE, RISK-BASED CAPITAL REQUIREMENTS, ASSET PROTECTION, FOREIGN INSURANCE COMPANIES, PROMOTING AND HOLDING COMPANIES, HOLDING COMPANY SYSTEMS, SURPLUS LINES INSURANCE, RISK RETENTION GROUPS, INSURANCE COMPANY RECEIVERSHIPS, MANAGING GENERAL AGENTS, SELF-INSURED WORKERS' COMPENSATION, AND CONTINUING CARE RETIREMENT COMMUNITIES; AND TO ALLOW NORTH CAROLINA DOMESTIC INSURANCE COMPANIES TO FORM PROTECTED CELLS TO ACCESS ALTERNATIVE SOURCES OF CAPITAL AND ACHIEVE THE BENEFITS OF SECURITIZATION. Senator Wellons, bill sponsor, was not available to explain the bill. Bill Hale, NC Department of Insurance, was recognized to explain the bill. SB 459 would amend North Carolina's insurance laws in Chapter 58 of the General Statutes regarding the various items listed above. It would also allow domestic insurance companies to form protected cells to access alternative sources of capital and achieve the benefits of securitization.

One of the primary responsibilities of the Department of Insurance is to see that insurance companies remain solvent so that they will be around to pay claims when the claims become due. To further this goal, the insurance laws of this and other states require companies to set money aside to pay claims (reserving), specify with what other companies insurers can share their risks (reinsurers), control who can acquire our North Carolina companies, specify what kind of investments insurers can make, provide for handling bankrupt insurers, specify how insurers handle asset transfers, provide operational standards for persons who handle dealings between insurers and reinsurers and between insurers and affiliated companies, and the list goes on. <u>This is all for the protection of policyholders and the general public.</u>

This bill is the culmination of four years of effort by the Insurance Department financial evaluation professional staff and representatives of the insurance industry. It is a long, technical, and very complicated bill. It addresses all of these areas and has the enthusiastic support of the insurance industry, especially our North Carolina companies. There is certainly no opposition, and the bill is very consumer-friendly. Representative Saunders moved for a favorable report. The motion passed.

SB 468, entitled, AN ACT TO PROVIDE FOR GUIDELINES, RIGHTS, AND OBLIGATIONS IN WORKERS' COMPENSATION INSURANCE POLICY CANCELLATIONS AND NONRENEWALS. Senator Wellons, bill sponsor, was not available to explain the bill. A proposed committee substitute was presented. Representative Hall moved to adopt the proposed committee substitute for consideration. The motion passed. Bill Hale, NC Department of Insurance, was recognized to explain the proposed committee substitute. Presently, of all the kinds of insurance purchased by businesses in North Carolina, only in workers' compensation insurance are employers afforded less protection against inadequate notice of policy cancellations, nonrenewals, or changes in premium rates or coverages. In all other kinds of property and liability insurance purchased by businesses, there are stated grounds for cancellations and minimum notice requirements for non-renewals or renewals with premium rate increases or coverage changes that do not favor the purchaser. SB 468 would establish the same standards for workers' compensation insurance that are in North Carolina law (Article 41 of General Statute Chapter 58). The bill would prohibit workers' compensation insurance policy cancellations except for specified reasons, which are listed in the bill. It would require 15 days advance written notice of permitted cancellations by certified mail. It would require insurers to give 45 days advance written notice of a refusal to renew a policy and 30 days advance written notice of reductions in coverage limits or increases in deductibles or premiums. Frank Folger, Staff Counsel, was recognized and explained the differences between the original bill and the committee substitute, which added clarifying language. Representative Setzer moved for a favorable report to the House committee substitute bill, unfavorable to the Senate committee substitute bill. The motion passed.

SB 461, entitled, AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102. The Chair indicated a request had been made that SB 461 be taken up for discussion purposes only at the May 30th meeting, and he was honoring that request. Senator Wellons, bill sponsor, was not available to explain the bill. Bill Hale, NC Department of Insurance, was recognized to explain the bill. North Carolina law provides that no insured's personal information can be further disclosed by an insurance company or agent without that insured's written consent. This is known as an "opt in" standard. There are some exceptions to this. The law allows an insurer or agent to share an insured's personal information, including medical information, with affiliated companies for marketing insurance products without the insured's permission and even if the insured does not want his or her information

shared. SB 461 provides that no sharing of a consumer's medical record information for marketing purposes may occur unless the insurer or agent obtains the consumer's permission ("opt in"). The law requires insurance companies once every two years to give insureds a written notice about how the companies collect and share information about the insureds and the rights of the insureds under the law. SB 461 changes this to once every year.

SB 461 extends the notice protection to persons insured under a group insurance plan (usually employees insured under an employer's group health policy), who currently have no right to notice unless their policies are individually underwritten. SB 461 extends the protections of the law to the homeowner who pays for mortgage guaranty insurance even though the lender is the insured under the policy.

There being no further business, the meeting was adjourned at 12:27 p.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
Senate Bills 459,468, and 461
Bill Summaries
Handout

VISITOR REGISTRATION SHEET

INSURANCE — May 30, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Johnson	Reynolds Lifegard
Dana Simpson	Smith Anderson
Steve Woodson	NCFB
Charles Case	Hunton & Williams
Bill Scoggin	Kennedy Covington
Tom Coley	CWA
David Barnes	Poyner Spruill LLP
John Bowdish	Coley Associates
Barbara Carsten	Manning, Fulton & Skinner
Mack Paul	Smith Helms
Bob Price	Jordan Price

VISITOR REGISTRATION SHEET

INSURANCE — May 30, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Don Lampe	Smith Helms
Paul Stock	NC Bankers Assn.
Susan Valaani	Waterwise
Robert Raschup	Young, Moore
Jon Teague	Murchison Allen
Jon Carr	Jordan Price
Stella McKenzie	NC DOJ
Darrell Propst	NC DOJ

VISITOR REGISTRATION SHEET

Insurance
Name of Committee

5-30-01
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Dana Simpson	10 Smith Anderson

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 459 A BILL TO BE ENTITLED AN ACT TO AMEND NORTH CAROLINA'S INSURANCE LAWS CONCERNING INSURANCE COMPANY RESERVING METHODS, LICENSING PROVISIONS, REINSURANCE FOR DOMESTIC COMPANIES, DOMESTIC COMPANY FORMATION, SOLVENCY PROTECTION, LIFE INSURANCE COMPANY VARIABLE ACCOUNTS, CONSOLIDATIONS, INVESTMENTS, MUTUAL INSURANCE COMPANIES, REINSURANCE INTERMEDIARIES, MORTGAGE GUARANTY INSURANCE, RISK-BASED CAPITAL REQUIREMENTS, ASSET PROTECTION, FOREIGN INSURANCE COMPANIES, PROMOTING AND HOLDING COMPANIES, HOLDING COMPANY SYSTEMS, SURPLUS LINES INSURANCE, RISK RETENTION GROUPS, INSURANCE COMPANY RECEIVERSHIPS, MANAGING GENERAL AGENTS, SELF-INSURED WORKERS' COMPENSATION, AND CONTINUING CARE RETIREMENT COMMUNITIES; AND TO ALLOW NORTH CAROLINA DOMESTIC INSURANCE COMPANIES TO FORM PROTECTED CELLS TO ACCESS ALTERNATIVE SOURCES OF CAPITAL AND ACHIEVE THE BENEFITS OF SECURITIZATION.

☒ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 459*

Insurance and Consumer Protection Committee Substitute Adopted 4/17/01

Short Title: Insurance Financial Amendments. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO AMEND NORTH CAROLINA'S INSURANCE LAWS CONCERNING INSURANCE COMPANY RESERVING METHODS, LICENSING PROVISIONS, REINSURANCE FOR DOMESTIC COMPANIES, DOMESTIC COMPANY FORMATION, SOLVENCY PROTECTION, LIFE INSURANCE COMPANY VARIABLE ACCOUNTS, CONSOLIDATIONS, INVESTMENTS, MUTUAL INSURANCE COMPANIES, REINSURANCE INTERMEDIARIES, MORTGAGE GUARANTY INSURANCE, RISK-BASED CAPITAL REQUIREMENTS, ASSET PROTECTION, FOREIGN INSURANCE COMPANIES, PROMOTING AND HOLDING COMPANIES, HOLDING COMPANY SYSTEMS, SURPLUS LINES INSURANCE, RISK RETENTION GROUPS, INSURANCE COMPANY RECEIVERSHIPS, MANAGING GENERAL AGENTS, SELF-INSURED WORKERS' COMPENSATION, AND CONTINUING CARE RETIREMENT COMMUNITIES; AND TO ALLOW NORTH CAROLINA DOMESTIC INSURANCE COMPANIES TO FORM PROTECTED CELLS TO ACCESS ALTERNATIVE SOURCES OF CAPITAL AND ACHIEVE THE BENEFITS OF SECURITIZATION.

The General Assembly of North Carolina enacts:

PART I. INSURANCE COMPANY RESERVING METHODS.

SECTION 1.1. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-72. Premium deficiency reserves.**

(a) In determining the financial condition of any casualty, fidelity, and surety company and any fire and marine company referred to in G.S. 58-7-75, and in any financial statement or report of the company, there shall be included in the liabilities of the company premium deficiency reserves at least equal to the amounts required under this section. The date as of which the determination, statement, or report is made is known as the 'date of determination.'

(b) For all recorded unearned premium reserves, a premium deficiency reserve shall be calculated to include the amount by which the anticipated losses, loss adjustment expenses, commissions and other acquisition costs, and maintenance costs exceed the sum of those unearned premium reserves and any related expected future installment premiums as of the date of determination.

(c) Except as provided in subsection (f) of this section, commissions, other acquisition costs, and premium taxes do not have to be considered in the determination of the premium deficiency reserve, to the extent that they have previously been incurred.

(d) Except as provided in subsection (f) of this section, no reduction shall be taken for anticipated investment income in the determination of the premium deficiency reserve.

(e) For purposes of determining if a premium deficiency exists, insurance contracts shall be grouped in a manner consistent with the way in which such policies are marketed or serviced.

(f) If the Commissioner determines that the premium deficiency reserves of any company that have been calculated in accordance with this section are inadequate or excessive, the Commissioner may prescribe any other basis that will produce adequate and reasonable reserves."

SECTION 1.2. G.S. 58-3-81 reads as rewritten:

"**§ 58-3-81. Loss and loss expense reserves of casualty insurance and surety companies.**

(a) In determining the financial condition of any casualty insurance or surety company and in any financial statement or report of any such company, there shall be included in the liabilities of ~~such~~ that company loss reserves and loss expense reserves at least equal to the amounts required under ~~the provisions of~~ this ~~section, and the~~ section. The amount of ~~such~~ those reserves shall be diminished by an allowance or credit for reinsurance recoverable from assuming ~~insurers~~ reinsurers in accordance with ~~G.S. 58-7-21.~~G.S. 58-7-21 or G.S. 58-7-26. The date as of which ~~such~~ the determination, statement, or report is made is ~~hereinafter referred to~~ known as the date of determination.

(b) For all outstanding losses and loss expenses, the reserves shall be valued as of the date of determination and shall include the following:

(1) ~~The aggregate estimated amounts due or to become due on account of all known losses and claims and loss expenses incurred but not paid, including the estimated liability on any notice received by the company of the occurrence of any event which may result in a loss; and~~ The aggregate estimated amounts due for losses and loss adjustment expenses on account of all known claims.

(2) ~~The aggregate amounts of liability for all losses and loss expenses incurred but on which no notice has been received, estimated in accordance with the company's prior experience, if any, otherwise in~~

~~accordance with the experience of similar companies under similar contracts of insurance. The estimated liabilities for such losses under all its bonds, policies, or contracts of fidelity insurance, shall be not less than ten percent (10%) of the net premiums in force thereon, and the estimated liabilities for all such losses under all its surety contracts shall be not less than five percent (5%) of the net premium in force thereon.~~ The aggregate estimated amounts due for losses and loss adjustment expenses on account of all unknown, incurred but not reported claims.

(c) ~~Except as provided in subsection (e) of this section, the minimum reserves for outstanding losses and loss expenses under policies of personal injury liability insurance and under policies of employers' liability insurance, where the losses were incurred during the three years immediately preceding the date of determination, shall be calculated in accordance with any method adopted or approved by the NAIC and shall be not less than the aggregate of the estimated unpaid losses and loss expenses for claims incurred computed in accordance with subsection (b) of this section.~~ Except as provided in subsection (e) of this section, the minimum loss and loss expense reserves for workers' compensation insurance shall be determined as follows:

(1) In the case of indemnity benefits where tabular reserves are prescribed for the reporting of such benefits under the Workers' Compensation Statistical Plan (WCSP) of the National Council on Compensation Insurance, the minimum reserve shall be the result obtained by the application of the appropriate pension table in the WCSP, unless the reserve required by any method adopted or approved by the NAIC is greater, in which case that greater reserve shall be used.

(2) In all other cases, including other indemnity benefits, medical benefits, and loss adjustment expense, the reserve shall be determined by subsection (b) of this section, unless the reserve required by any method adopted or approved by the NAIC is greater, in which case that greater reserve shall be used.

~~(d) The minimum reserves for outstanding losses and loss expenses under policies of workers' compensation insurance, except as provided in subsection (e) of this section, shall be computed as follows:~~

~~(1) For all such compensation policies where losses were incurred more than three years prior to the date of determination, such reserves shall be the sum of the present values, at three and one half percent (3 1/2%) interest per annum, of the determined and estimated unpaid losses computed on an individual case basis plus the estimated unpaid loss expenses computed in accordance with subsection (b) of this section.~~

~~(2) Where losses were incurred during the three years immediately preceding the date of determination, such reserves shall be the sum of~~

~~the reserves for each year, which shall be calculated in accordance with any method adopted or approved by the NAIC and shall be not less than the sum of the present values, at three and one-half percent (3 1/2%) interest per annum, of the determined and estimated unpaid losses computed on an individual case basis plus the estimated unpaid loss expenses computed in accordance with subsection (b) of this section.~~

(e) Whenever in the judgment of the Commissioner the loss and loss expense reserves of any casualty or surety company doing business in this State calculated in accordance with the foregoing provisions are inadequate or excessive, he may prescribe any other basis that will produce adequate and reasonable reserves.

(f) Every casualty insurance and every surety company doing business in this State shall keep a complete and itemized record showing all losses and claims on which it has received notices, including all notices received by it of the occurrence of any event that may result in a loss."

PART II. INSURANCE COMPANY LICENSING PROVISIONS.

SECTION 2.1. G.S. 58-3-90 is repealed.

SECTION 2.2. G.S. 58-3-100 reads as rewritten:

"**§ 58-3-100. ~~Revocation, suspension and refusal to renew license.~~ Insurance company licensing provisions.**

(a) ~~The Commissioner may revoke, suspend, or refuse to renew the license of any insurer if:~~ The Commissioner may, after notice and opportunity for a hearing, revoke, suspend, restrict, or refuse to renew the license of any insurer if:

(1) The insurer fails or refuses to comply with any law, order or rule applicable to the insurer.

(2) The insurer's financial condition is unsound, or its assets above its liabilities, exclusive of capital, are less than the amount of its capital or required minimum surplus.

(3) The insurer has published or made to the Department or to the public any false statement or report.

(4) The insurer or any of the insurer's officers, directors, employees, or other representatives ~~refuses~~ refuse to submit to any examination authorized by ~~law.~~law or refuse to perform any legal obligation in relation to an examination.

(5) The insurer 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 an insurer's license under this section may also be made applicable to the license or registration of any ~~natural person~~ individual 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 an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic 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.~~ one of the following:

(1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) 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.~~ insurer, HMO, service corporation, or MEWA. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225.

(d) If a foreign insurance company's license is suspended or revoked, the Commissioner shall cause written notification of the suspension or revocation to be given to all of the company's agents in this State. Until the Commissioner restores the company's license, the company shall not write any new business in this State.

(e) The Commissioner may, after considering the standards under G.S. 58-30-60(b), restrict an insurer's license by prohibiting or limiting the kind or amount of insurance written by that insurer. For a foreign insurer, this restriction relates to the insurer's business conducted in this State. The Commissioner shall remove any restriction under this subsection once the Commissioner determines that the operations of the insurer are no longer hazardous to the public or the insurer's policyholders or creditors. As used in this subsection, 'insurer' includes an HMO, service corporation, and MEWA."

SECTION 2.3. This Part becomes effective July 1, 2001.

PART III. REINSURANCE FOR DOMESTIC COMPANIES.

SECTION 3.1. G.S. 58-7-21 reads as rewritten:

"**§ 58-7-21. Credit allowed a domestic ceding insurer.**

(a) ~~As used in this section and in G.S. 58-7-26, 58-7-30, and 58-7-31:~~

~~(1) "Reinsurance" means a transfer of insurance risk from a ceding insurer to an assuming insurer.~~

~~(2) "Insurance risk" means an uncertainty regarding the ultimate amount of any claim payment (underwriting risk) or an uncertainty regarding the timing of the payments (timing risk), or both.~~

The purpose of this section and G.S. 58-7-26 is to protect the interest of insureds, claimants, ceding insurers, assuming insurers, and the public generally. The General

Assembly declares its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that interest, the General Assembly provides a mandate that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations in accordance with this section and G.S. 58-7-26, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed, in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The General Assembly declares that the matters contained in this section and G.S. 58-7-26 are fundamental to the business of insurance in accordance with 15 U.S.C. §§ 1011-1012.

(b) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a ~~deduction~~ reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subdivisions (1), (2), (3), (4), or (5) of this subsection. Credit shall be allowed under subdivision (1), (2), or (3) of this subsection only with regard to cessions of those kinds or classes of business in which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. ~~If meeting the requirements of subdivisions (3) or (4) of this subsection, the reinsurer must also meet the requirements of subdivision (6) of this subsection.~~ Credit shall be allowed under subdivision (3) or (4) of this subsection only if the applicable requirements of subdivision (6) of this section have been satisfied.

(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this State.

(2) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this State. An accredited reinsurer is one that:

a. Files with the Commissioner evidence of its submission to this State's jurisdiction;

b. Submits to this State's authority to examine its books and records;

c. Is licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state;

d. Files annually with the Commissioner a copy of its annual statement filed with the insurance regulator of its state of domicile, a copy of its most recent audited financial statement, and a fee of five hundred dollars ($500.00); and either

1. Maintains a policyholders' surplus in an amount that is not less than twenty million dollars ($20,000,000) and whose accreditation has not been denied by the Commissioner within 90 days after its submission; or
2. Maintains a policyholders' surplus in an amount less than twenty million dollars ($20,000,000) and whose accreditation has been approved by the Commissioner.

~~No credit~~ Credit shall not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the Commissioner after notice and opportunity for a hearing.

(3) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled ~~and licensed~~ in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that uses standards regarding credit for reinsurance substantially similar to those applicable under this section and the assuming insurer or United States branch of an alien assuming insurer:

a. Maintains a policyholders' surplus in an amount not less than twenty million dollars ($20,000,000); and
b. Submits to the authority of this State to examine its books and records.

~~However, the~~ The requirement in sub-subdivision (3)a. of this subsection does not apply to reinsurance ceded and assumed under pooling arrangements among insurers in the same holding company system.

(4) a. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in G.S. 58-7-26(b), for the payment of the valid claims of its United States ~~policyholders and~~ ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Commissioner information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers to enable the Commissioner to determine the sufficiency of the trust fund. The assuming insurer shall submit to examination of its books and records by the Commissioner and bear the expense of examination. ~~In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars ($20,000,000). In the case of a group of insurers, which~~

~~includes individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group; and the group shall make available to the Commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent certified public accountants.~~

~~b. In the case of a group of incorporated insurers under common administration which (i) complies with the filing requirements contained in the previous paragraph, (ii) has continuously transacted an insurance business outside the United States for at least three years immediately before making application for accreditation, (iii) submits to this State's authority to examine its books and records, and (iv) has aggregate policyholders' surplus of ten billion dollars ($10,000,000,000); the trust shall be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group under reinsurance contracts issued in the name of the group. In addition, the group shall maintain a joint trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities, and each member of the group shall make available to the Commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.~~

b1. Credit for reinsurance shall not be granted under this subdivision unless the form of the trust and any amendments to the trust have been approved by:

1. The insurance regulator of the state where the trust is domiciled; or
2. The insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

b2. The form of the trust and any trust amendments also shall be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent

jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns, and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the Commissioner.

b3. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustees of the trust shall report to the Commissioner in writing the balance of the trust, shall list the trust's investments at the end of the preceding year, and shall certify the date of termination of the trust, if so planned, or shall certify that the trust will not expire before the following December 31.

c. ~~The trust shall be established in a form approved by the Commissioner. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the Commissioner. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.~~

The following requirements apply to the following categories of assuming insurer:

1. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a surplus in trust of not less than twenty million dollars ($20,000,000).

2. In the case of a group including incorporated and individual unincorporated underwriters:

I. For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of an account in trust in an amount not less than the group's several liabilities attributable to business ceded by United States

domiciled ceding insurers to any member of the group.

II. For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of this section and G.S. 58-7-26, the trust shall consist of an account in trust in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

In addition to these trusts, the group shall maintain in trust a surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account. Each incorporated member of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary insurance regulator as are the unincorporated members. Within 90 days after its financial statements are due to be filed with the group's domiciliary insurance regulator, the group shall provide to the Commissioner an annual certification by the group's domiciliary insurance regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements prepared by independent public accountants of each underwriter member of the group.

~~d. No later than February 28 of each year the trustees of the trust shall report to the Commissioner in writing, setting forth the balance of the trust and listing the trust's investments at the end of the preceding year, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire before the next following December 31.~~

(5) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subdivisions (1), (2), (3), or (4) of this subsection, but only with respect to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(6) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this State, the credit permitted by

subdivisions (3) and (4) of this subsection shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

a. That if the assuming insurer fails to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the ceding insurer's request, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, shall comply with all requirements necessary to give the court jurisdiction, and shall abide by the final decision of the court or of any appellate court if there is an appeal; and

b. To designate the Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding begun by or on behalf of the ceding company.

This subdivision does not affect the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if ~~such an~~ the obligation is created in the agreement.

(7) If the assuming insurer does not meet the requirements of subdivision (1), (2), or (3) of this subsection, the credit permitted by subdivision (4) of this subsection shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

a. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by sub-subdivision (4)c. of this subsection, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the public official with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the public official with regulatory oversight all of the assets of the trust fund.

b. The assets shall be distributed by, and claims shall be filed with and valued by, the public official with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

c. If the public official with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, those assets shall be returned by the public

official with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

d. The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

(c) This section applies to all reinsurance cessions made on or after January 1, 1992, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 1992."

SECTION 3.2. G.S. 58-7-26 reads as rewritten:

"**§ 58-7-26. ~~Reduction~~ Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming ~~insurer.~~insurer not meeting the requirements of G.S. 58-7-21.**

(a) ~~A~~ An asset or a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of G.S. 58-7-21 shall be allowed in an amount not exceeding the liabilities carried by the ceding ~~insurer; and such~~ insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution as defined in subsection (c) of this section. This security may be in the form of:

(1) Cash;

(2) Securities that are listed by the Securities Valuation Office of the NAIC and qualifying as admitted assets;

(3) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in subsection (b) of this section, no later than December 31 of the year for which the filing is being made, and in the possession ~~of~~ of, or in trust for, the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever occurs first; or

(4) Any other form of security acceptable to the Commissioner.

(b) For purposes of subdivision (a)(3) of this section, a "qualified United States financial institution" means an institution that:

(1) Is organized, or in the case of a United States office of a foreign banking organization licensed, under the laws of the United States or any of its states;

(2) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the Commissioner or the Securities Valuation Office of the NAIC to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

(c) A "qualified United States financial institution" means, for purposes of those provisions of this section specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(1) Is organized, or in the case of a United States branch or agency office of a foreign banking organization licensed, under the laws of the United States or any of its states and has been granted authority to operate with fiduciary powers; and

(2) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(d) This section applies to all reinsurance cessions made on or after January 1, 1992, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 1992."

SECTION 3.3. G.S. 58-7-30 reads as rewritten:

"**§ 58-7-30. ~~Insolvency of~~ Insolvent ceding ~~insurer; exceptions; written reinsurance agreements.~~insurer.**

(a) Notwithstanding any other provision of this Article, no credit shall be allowed, as an admitted asset or as a ~~deduction~~ reduction from liability, to any ceding insurer for reinsurance, unless the reinsurance is payable by the assuming insurer, on the basis of reported claims allowed by the court overseeing the liquidation against the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer, directly to the ceding insurer or to its domiciliary receiver except (1) where the contract or other written agreement specifically provides for another payee of the reinsurance in the event of the insolvency of the ceding insurer or (2) where the assuming insurer, with the consent of the direct insured or insureds, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution of the obligations of the ceding insurer to the payees.

(b) No credit shall be allowed, as an admitted asset or as a ~~deduction~~ reduction from liability, to any ceding insurer for reinsurance, unless the reinsurance is documented by a policy, certificate, treaty, or other form of agreement that is properly executed by an authorized officer of the assuming insurer. If the reinsurance is ceded through an underwriting manager or agent, the manager or agent shall provide to the domestic ceding insurer evidence of the manager or agent's authority to assume reinsurance for and on behalf of the assuming insurer. The evidence shall consist of

either an acceptable letter of authority executed by an authorized officer of the assuming insurer or a copy of the actual agency agreement between the underwriting manager or agent and the assuming insurer; and the evidence shall be specific as to the classes of business within the authority and as to the term of the authority. If there is any conflict between this subsection and Article 9 of this Chapter, the provisions of Article 9 govern.

(c) The reinsurance agreement may provide that the domiciliary liquidator of an insolvent ceding insurer shall give written notice to the assuming insurer of the pendency of a claim against the ceding insurer on the contract reinsured within a reasonable time after the claim is filed in the liquidation proceeding. During the pendency of the claim, any assuming insurer may investigate the claim and interpose at its own expense in the proceeding where the claim is to be adjudicated, any defenses which it deems available to the ceding insurer or its liquidator. The expense may be filed as a claim against the insolvent ceding insurer to the extent of a proportionate share of the benefit which may accrue to the ceding insurer solely as a result of the defense undertaken by the assuming insurer. Where two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose a defense to the claim, the expense shall be apportioned in accordance with the terms of the reinsurance agreement as though the expense had been incurred by the ceding insurer."

SECTION 3.4. G.S. 58-7-31(c) reads as rewritten:

"(c) Notwithstanding subsection ~~(a)~~(b) of this section, an insurer may, with the prior approval of the Commissioner, take such reserve credit or establish such asset as the Commissioner deems to be consistent with the insurance laws or rules of this State, including actuarial interpretations or standards adopted by the Commissioner."

SECTION 3.5. G.S. 58-7-31(d)(1) reads as rewritten:

"(1) Reinsurance agreements entered into after October 1, 1993, that involve the reinsurance of business issued prior to the effective date of the reinsurance agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days after its date of execution. Each filing shall include data detailing the ~~final~~ financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this statute and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Commissioner. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this statute."

SECTION 3.6. G.S. 58-57-85 is repealed.

SECTION 3.7. Sections 3.1 and 3.2 of this act apply to all reinsurance cessions made on or after January 1, 2002, under reinsurance agreements that have an inception, anniversary, or renewal date on or after January 1, 2002. The remainder of this part is effective when it becomes law.

PART IV. DOMESTIC COMPANY FORMATION AND RELOCATION.

SECTION 4.1. Article 7 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-7-37. Background of incorporators and proposed management personnel.**

(a) Before a license is issued to a new domestic insurance company, each key person must furnish the Commissioner a complete set of the applicant's fingerprints and a recent passport size full-face photograph of the applicant. The applicant's fingerprints shall be certified by an authorized law enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. An applicant shall pay the cost of the State and any national criminal history record check of the applicant.

(b) As used in this section, 'key person' means a proposed officer, director, or any other individual who will be in a position to influence the operating decisions of a domestic insurance company.

(c) The Commissioner may refuse to approve the formation or initial license of a new domestic insurance company under this Article if, after notice to the applicant and an opportunity for a hearing, the Commissioner finds as to the incorporators or other key person any one or more of the following conditions:

(1) Any untrue material statement regarding the background or experience of any incorporator or other key person;

(2) Violation of, or noncompliance with, any insurance laws, or of any rule or order of the Commissioner or of a commissioner of another state by any incorporator or other key person;

(3) Obtaining or attempting to obtain the license through misrepresentation or fraud;

(4) An incorporator or other key person has been convicted of a felony;

(5) An incorporator or other key person has been found to have committed any unfair trade practice or fraud;

(6) An incorporator or other key person has used fraudulent, coercive, or dishonest practices, or has acted in a manner that is incompetent, untrustworthy, or financially irresponsible; or

(7) An incorporator or other key person has held such a position in another insurance company that has had its license suspended or revoked by any state.

(d) If the Commissioner disapproves of the formation or initial license, the Commissioner shall notify the applicant and advise the applicant in writing of the reasons for the disapproval. Within 30 days after receipt of notification, the applicant may make written demand upon the Commissioner for a hearing to determine the

reasonableness of the Commissioner's action. The hearing shall be scheduled within 30 days after the date of receipt of the written demand.

(e) For the purposes of investigation under this section, the Commissioner shall have all the power conferred by G.S. 58-2-50 and other applicable provisions of this Chapter.

(f) The Commissioner may adopt rules to set standards for obtaining background information on each incorporator or other key person of a proposed new domestic insurance company."

SECTION 4.2. G.S. 58-7-70 reads as rewritten:

"**§ 58-7-70. Effects of redomestication.**

The license, agent appointments and licenses, rates, and other items that the Commissioner authorizes or grants, in his discretion, that are in existence at the time any insurer licensed ~~to transact the business of insurance in this State~~ by the Commissioner transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method, shall continue in full force and effect upon ~~such~~ the transfer if ~~such~~ the insurer remains duly licensed ~~to transact the business of insurance in this State.~~by the Commissioner. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to any new name of the insurer or its new location unless so ordered by the Commissioner. Every transferring insurer shall file new policy forms with the Commissioner on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the Commissioner: Provided, however, every such transferring insurer shall (i) notify the Commissioner of the details of the proposed transfer and (ii) promptly file any resulting amendments to corporate documents filed or required to be filed with the Commissioner."

PART V. INSURANCE COMPANY SOLVENCY PROTECTION.

SECTION 5.1. G.S. 58-7-75(10) reads as rewritten:

"(10) Impairment of Capital and/or Surplus. – Whenever the Commissioner finds from a financial statement made by any company, or from a report of examination of any company, that its admitted assets are less than the aggregate amount of its liabilities and its outstanding capital ~~stock and/or~~ stock, required minimum surplus, or both, the Commissioner shall ~~determine~~ determine, in accordance with G.S. 58-2-165 and other applicable provisions of this Chapter, the amount of the impairment of ~~capital and/or surplus~~ capital, surplus, or both and issue an order in writing requiring the company to eliminate the impairment within such period of not more than 90 days as the Commissioner shall designate. The Commissioner may, by order served upon the company, prohibit the company from issuing any new policies while the impairment exists. If at the expiration of the

designated period the company has not satisfied the Commissioner that the impairment has been eliminated, an order for the rehabilitation or liquidation of the company may be entered as provided in Article 30 of this Chapter."

SECTION 5.2. G.S. 58-7-130 reads as rewritten:

"**§ 58-7-130. ~~Payment of dividends impairing financial soundness of company or detrimental to policyholders.~~Dividends and distributions to stockholders.**

(a) Each domestic insurance company in North Carolina shall be restricted by the Commissioner from the payment of any dividends or other distributions to its stockholders whenever the Commissioner determines from examination of ~~such~~ the company's financial condition that the payment of future dividends or other distributions would cause a hazardous financial condition, impair the financial soundness of the company or be detrimental to its policyholders, and ~~such~~ those restrictions shall continue in force until ~~such future date when~~ the Commissioner ~~may~~ specifically ~~permit~~ permits the payment of dividends or other distributions to stockholders by the company through a written authorization. ~~Nothing contained in this section and no action taken by the Commissioner shall in any way restrict the liability of stockholders under G.S. 58-7-125.~~

(b) No domestic stock insurance company shall declare dividends to its stockholders except from the unassigned surplus of the company as reflected in the company's most recent financial statement filed with the Commissioner under G.S. 58-2-165.

(c) A transfer out of paid-in and contributed surplus to common or preferred capital stock will be permitted on a case-by-case basis, with the Commissioner's prior approval, depending on the necessity for a company to make the transfer.

(d) Nothing in this section and no action taken by the Commissioner in any way restricts the liability of stockholders under G.S. 58-7-125.

(e) Dividends and other distributions paid to stockholders are subject to the requirements and limitations of G.S. 58-19-25(d) and G.S. 58-19-30(c)."

PART VI. LIFE INSURANCE COMPANY VARIABLE ACCOUNTS.

SECTION 6.1. G.S. 58-7-95(b) reads as rewritten:

"(b) Any domestic life insurance company may, pursuant to resolution of its board of directors, establish one or more separate accounts and may allocate to such account or accounts amounts ~~received or retained in connection with variable contracts~~ (including without limitation proceeds applied under optional modes of settlement or under dividend options) to provide for life ~~insurance~~ insurance, guaranteed investment contracts, or annuities (and benefits incidental thereto) payable in fixed or variable amounts or both."

SECTION 6.2. G.S. 58-7-95(c) reads as rewritten:

"(c) In addition to the amounts allocated under subsection (b), such company may allocate from its general accounts to such separate account or accounts additional

amounts, which may include an initial allocation to establish such account; provided, ~~that the aggregate amount so allocated shall not exceed one per centum (1%) of its admitted assets as of the preceding December 31, or one million dollars ($1,000,000), whichever is less, and, provided further,~~ that such company shall be entitled to withdraw at any time, in whole or in part, its participation in any separate account to which funds have been allocated as provided in this subsection (c), and to receive, upon withdrawal, its proportionate share of the value of the assets of the separate account at the time of withdrawal."

SECTION 6.3. G.S. 58-7-95(e) and G.S. 58-7-95(f) are repealed.

SECTION 6.4. G.S. 58-7-95(g) reads as rewritten:

"(g) ~~The limitations provided in subsections (e) and (f) above shall not apply to the investment with respect to a separate account in the securities of an investment company registered under the Investment Company Act of 1940, provided that the investments of such investment company comply in substance with subsections (e) and (f) hereof.~~The life insurance company shall maintain in each separate account assets with a value at least equal to the reserves and other contract liabilities with respect to the account, except as may otherwise be approved by the Commissioner."

PART VII. INSURANCE COMPANY CONSOLIDATION.

SECTION 7.1. G.S. 58-7-150(a) reads as rewritten:

"(a) A domestic insurer may consolidate with another insurer, subject to the following conditions:

(1) The plan of consolidation must be submitted to and be approved by the Commissioner ~~in advance of~~ before the consolidation.

(2) The Commissioner shall not approve ~~any such plan unless, after a hearing, he~~ the plan unless the Commissioner finds that it is fair, equitable to policyholders, consistent with law, and will not conflict with the public interest. If the Commissioner ~~fails to approve~~ disapproves the plan, ~~he~~ the Commissioner shall state ~~his~~ the reasons for ~~such failure in his order made on such hearing.~~the disapproval and call for a hearing.

(3) No director, officer, member or subscriber of any such insurer, except as is expressly provided by the plan of consolidation, shall receive any fee, commission, other compensation or valuable consideration whatever, for in any manner aiding, promoting or assisting in the consolidation.

(4) Any consolidation as to an incorporated domestic insurer shall in other respects be governed by the general laws of this State relating to business ~~corporations, except that the~~ corporations. The consolidation of a domestic mutual insurer may be effected by vote of two thirds of the members voting thereon pursuant to such notice and procedure as the Commissioner may prescribe."

SECTION 7.2. G.S. 58-7-150(b) reads as rewritten:

"(b) Reinsurance of all or substantially all of the insurance ~~in-force~~ obligations or risks of existing or in-force policies of a domestic insurer by another insurer under an ~~agreement whereby the reinsuring company succeeds to all of the liabilities of and supplants the domestic insurance company thereon~~ assumption reinsurance agreement, as defined in G.S. 58-10-25(a)(2), shall be deemed a consolidation for the purposes of this section. This section does not apply to consolidations to the extent regulated by Article 19 or other Articles of this Chapter."

PART VIII. INSURANCE COMPANY INVESTMENTS.

SECTION 8.1. G.S. 58-7-170(b) reads as rewritten:

"(b) Investments eligible under subsection (a), except investments acquired under G.S. 58-7-183, are subject to the following ~~limitations:~~limitations, other limitations of this section, and any other limitations that are expressly provided for in any provision under which the investment is authorized:

(1) The cost of investments made by insurers in stock authorized by G.S. 58-7-173 shall not exceed twenty-five percent (25%) of the insurer's admitted assets, provided that no more than twenty percent (20%) of the insurer's admitted assets shall be invested in common stock; and the cost of an investment in stock of any one corporation shall not exceed three percent (3%) of the insurer's admitted assets. Notwithstanding any other provision in this Chapter, the financial statement carrying value of all stock investments shall be used for the purpose of determining the asset value against which the percentage limitations are to be applied.

(2) ~~Other limitations, if any, that are expressly provided for in any provision under which the investment is authorized.~~The cost of Canadian investments authorized by G.S. 58-7-173 shall not exceed forty percent (40%) of the insurer's admitted assets in the aggregate, provided that no more than twenty-five percent (25%) of the insurer's admitted assets shall be invested in Canadian investments authorized by G.S. 58-7-173(11)."

SECTION 8.2. G.S. 58-7-170(d) reads as rewritten:

"(d) Without the Commissioner's prior written approval, the cost of investments ~~in bonds, debentures, notes, commercial paper, or other debt obligations issued, assumed, or guaranteed by any solvent United States institution, any state, Canada, or any Canadian province,~~ permitted under G.S. 58-7-173 and G.S. 58-7-178, and that are classified as medium to lower quality obligations, other than obligations of subsidiaries or affiliated corporations as that term is defined in ~~G.S. 58-7-177,~~ G.S. 58-19-5, shall be limited to:

(1) No more than twenty percent (20%) of an insurer's admitted assets;

(2) No more than ten percent (10%) of an insurer's admitted assets in obligations that have been given a rating of 4, 5, or 6 by the Securities Valuation Office of the NAIC;

(3) No more than three percent (3%) of an insurer's admitted assets in obligations that have been given a rating of 5 or 6 by the Securities Valuation Office of the NAIC; and

(4) No more than one percent (1%) of an insurer's admitted assets in obligations that have been given a rating of 6 by the Securities Valuation Office of the NAIC.

(5), (6) Repealed by Session Laws 1993, c. 452, s. 11."

SECTION 8.3. G.S. 58-7-173(9) reads as rewritten:

"(9) Bonds, debentures, or other securities of public housing authorities, issued under the Housing Act, of 1949, the Municipal Housing Commission Act, or the Rural Housing Commission Act, or issued by any public housing authority or agency in the United States, if the bonds, debentures, or other securities are secured by a pledge of annual contributions to be paid by the United States or any United States ~~agency; and the cost of investments made under this subdivision shall not exceed the lesser of three percent (3%) of the insurer's admitted assets or ten percent (10%) of the insurer's capital and surplus.~~agency."

SECTION 8.4. G.S. 58-7-173(10) reads as rewritten:

"(10) Obligations issued, assumed, or guaranteed by the International Bank for Reconstruction and Development, the International Finance Corporation, the Inter-American Development Bank, the Asian Development Bank, or the African Development Bank; and the cost of investments made under this subdivision in any one institution shall not exceed ~~the lesser of~~ three percent (3%) of the insurer admitted ~~assets or ten percent (10%) of the insurer's capital and surplus.~~assets."

SECTION 8.5. G.S. 58-7-173(11) reads as rewritten:

"(11) Bonds, notes, or other interest-bearing or interest-accruing obligations of any solvent institution organized under the laws of the United States, of any state, Canada or any Canadian province; provided such instruments are rated and valued by the Securities Valuation Office of the NAIC. The cost of investments made under this subdivision in ~~issuers from any one industry shall not exceed ten percent (10%) of an insurer's admitted assets, and the cost of investments made in~~ any one issuer shall not exceed three percent (3%) of an insurer's admitted ~~assets or ten percent (10%) of an insurer's capital and surplus, whichever is greater. As used in this subdivision, "industry" means a distinct and recognized area of economic activity that consists of the production, manufacture, or distribution of common goods, products, commodities, or services.~~assets."

SECTION 8.6. G.S. 58-7-173(12) reads as rewritten:

"(12) Secured obligations of duly constituted churches and of church-holding companies; and the cost of investments made under this subdivision shall not exceed ~~the lesser of one percent (1%)~~ three percent (3%) of the insurer's admitted ~~assets or five percent (5%) of the insurer's capital and surplus.~~assets."

SECTION 8.7. G.S. 58-7-173(14) reads as rewritten:

"(14) Share or savings accounts of savings and loan associations or building and loan ~~associations; and the cost of investments made under this subdivision shall not exceed the lesser of three percent (3%) of the insurer's admitted assets or five percent (5%) of the insurer's capital and surplus.~~associations."

SECTION 8.8. G.S. 58-7-173(16) reads as rewritten:

"(16) Stocks, common or preferred, of any corporation created or existing under the laws of the United States, any U.S. territory, Canada or any Canadian province, or of any state. An insurer may invest in stocks, common or preferred, of any corporation created or existing under the laws of any foreign country other than Canada ~~if the stocks are listed and traded on a national securities exchange in the United States or if the investment in stocks of any corporation created or existing under the laws of any foreign country are first approved by the Commissioner. Nothing in this section applies to qualifying investments made by an insurer in a foreign country under authority of G.S. 58-7-178.~~subject to the provisions of G.S. 58-7-178."

SECTION 8.9. G.S. 58-7-177 is repealed.

SECTION 8.10. 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 8.11. G.S. 58-7-178 reads as rewritten:

"**§ 58-7-178. Foreign or territorial investments.**

(a) An insurer authorized to transact insurance in a foreign country or any U.S. territory may have funds invested in securities that may be required for that authority and for the transaction of that ~~business.~~business, provided the funds and securities are substantially of the same kinds, classes, and investment grades as those otherwise eligible for investment under this Chapter. ~~Canadian securities eligible for investment~~

~~under other provisions of this Chapter are not subject to this section. Unless disapproved by the Commissioner:~~

~~(1) An insurer may invest in Eurodollar certificates of deposit issued by foreign branches of United States commercial banks.~~

~~(2) In addition to Canadian securities eligible for investment and to investments in countries in which an insurer transacts insurance, an insurer may invest in bonds, notes, or stocks of any foreign country or alien corporation if the security meets the general requirements of G.S. 58-7-167 and does not exceed, in total, five~~ percent (5%) of admitted assets.

The aggregate amount of investments under this subsection shall not exceed the amount that the insurer is required by law to invest in the foreign country or United States territory, or one and one-half times the amount of reserves and other obligations under the contracts, whichever is greater.

(b) An insurer, whether or not it is authorized to do business or has outstanding insurance contracts on lives or risks in any foreign country, may invest in bonds, notes, or stocks of any foreign country or alien corporation that are substantially of the same kinds, classes, and investment grades as those otherwise eligible for investment under this Chapter. The aggregate amount of investments under this subsection shall not exceed ten percent (10%) of the insurer's admitted assets, provided that the cost of investments in any foreign country under this subsection shall not exceed three percent (3%) of the insurer's admitted assets.

(c) Canadian securities eligible for investment under other provisions of this Chapter are not subject to this section."

SECTION 8.12. G.S. 58-7-185(a)(2) reads as rewritten:

"(2) Except with the Commissioner's consent, securities issued by any corporation or enterprise, the controlling interest of which is or will after acquisition by the insurer be held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, parent corporation, subsidiaries, or controlling stockholders. Investments in subsidiaries under ~~G.S. 58-7-177~~ G.S. 58-19-10 are not subject to this provision."

SECTION 8.13. G.S. 58-7-185(a)(3) is repealed.

SECTION 8.14. G.S. 58-7-192(d) reads as rewritten:

"(d) No valuations under this section shall be greater than any applicable valuation or method contained in the latest edition of the NAIC ~~publication~~ publications entitled 'Valuations of ~~Securities',~~ Securities' or the 'Accounting Practices and Procedures Manual', unless the Commissioner determines that another valuation method is appropriate when it results in a more conservative valuation."

SECTION 8.15. G.S. 58-7-200(b) reads as rewritten:

"(b) ~~Notwithstanding any expressed or implied prohibitions, an insurer may effect or maintain bona fide hedging transactions pertaining to securities otherwise eligible for~~

~~investment under this section, including, but not limited to (i) financial futures contracts, warrants, options, calls and other rights to purchase; and (ii) puts and other rights to require another person to purchase the securities. The contracts, options, calls, puts and rights shall be traded on a securities exchange or board of trade regulated under the laws of the United States. For the purposes of this subsection, "bona fide hedging transaction" means a purchase or sale of such a contract, warrant, option, call, put or right, entered into for the purpose of offsetting changes in the market value of a security held by the company.~~An insurer may engage in derivative transactions under the provisions and limitations of G.S. 58-7-205."

SECTION 8.16. G.S. 58-7-200(c) reads as rewritten:

"(c) ~~No insurer shall make any direct or indirect loan to any of its directors, officers, or controlling stockholders; nor shall the insurer make any loan to any other person in which the officer, director, or stockholder is substantially interested; nor shall any such director, officer, or stockholder directly or indirectly accept any such loan.~~ No insurer shall directly or indirectly invest in, or lend its funds to, any of its directors, officers, controlling stockholders, or any other person in which an officer, director, or controlling stockholder is substantially interested, nor shall any director, officer, or controlling stockholder directly or indirectly accept the funds."

SECTION 8.17. Article 7 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-7-205. Derivative transactions.**

(a) As used in this section, the following terms have the following meanings:

(1) 'Business entity' includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether for-profit or not-for-profit.

(2) 'Counterparty exposure' amount means:

a. The amount of credit risk attributable to a derivative instrument entered into with a business entity other than through a qualified exchange, qualified foreign exchange, or cleared through a qualified clearinghouse ('over-the-counter derivative instrument'). The amount of credit risk equals:

1. The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

2. Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

b. If over-the-counter derivative instruments are entered into under a written master agreement which provides for netting of payments owed by the respective parties and the domicile of the counterparty is either within the United States or, if not within the United States, within a foreign jurisdiction listed in the

Purposes and Procedures of the Securities Valuation Office of the NAIC as eligible for netting, the net amount of credit risk shall be the greater of zero or the net sum of:

1. The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and
2. The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

c. For open transactions, market value shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

(3) 'Derivative instrument' means an agreement, option, instrument, or a series or combination thereof:

a. To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

b. That has a price, performance, value, or cash flow based primarily upon the actual or expected price level, performance, value, or cash flow of one or more underlying interests.

Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, and any other agreements, options, or instruments substantially similar thereto or any series or combination thereof. Derivative instruments shall additionally include any agreements, options, or instruments permitted under rules adopted under subsection (c) of this section. Derivative instruments shall not include an investment authorized by G.S. 58-7-173, 58-7-175, 58-7-178, 58-7-179, 58-7-180, and 58-7-187.

(4) 'Derivative transaction' means any transaction involving the use of one or more derivative instruments.

(5) 'Qualified clearinghouse' means a clearinghouse for, and subject to the rules of, a qualified exchange or a qualified foreign exchange. The clearinghouse provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk as to each other.

(6) 'Qualified exchange' means:

a. A securities exchange registered as a national securities exchange, or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. §§ 78, et seq.), as amended;
b. A board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission, or any successor thereof;
c. Private Offerings, Resales and Trading through Automated Linkages (PORTAL);
d. A designated offshore securities market as defined in Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended; or
e. A qualified foreign exchange.

(7) 'Qualified foreign exchange' means a foreign exchange, board of trade, or contract market located outside the United States, its territories or possessions:
a. That has received regulatory comparability relief under Commodity Futures Trading Commission Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations, 17 C.F.R. Part 30);
b. That is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under Commodity Futures Trading Commission Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations, 17 C.F.R. Part 30) as to futures transactions in the jurisdiction where the exchange, board of trade, or contract market is located; or
c. Upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the CFTC's Office of General Counsel, but an exchange, board of trade, or contract market that qualifies as a 'qualified foreign exchange' only under this paragraph shall only be a 'qualified foreign exchange' as to foreign stock index futures contracts that are the subject of the no-action relief under this paragraph.

(8) 'Replication transaction' means a derivative transaction that is intended to replicate the investment in one or more assets that an insurer is authorized to acquire or sell under this section or G.S. 58-7-165. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

(b) An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section under the following conditions:

(1) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions as may be further defined by rules adopted by the Commissioner.

(2) An insurer shall be able to demonstrate to the Commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analyses.

(c) The Commissioner may adopt reasonable rules for investments and transactions under this section including, but not limited to, rules which impose financial solvency standards, valuation standards, and reporting requirements.

(d) An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions then engaged in by the insurer does not exceed seven and one-half percent (7.5%) of its admitted assets;

(2) The aggregate statement value of options, caps, and floors written in hedging transactions then engaged in by the insurer does not exceed three percent (3%) of its admitted assets; and

(3) The aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions then engaged in by the insurer does not exceed six and one-half percent (6.5%) of its admitted assets.

(e) An insurer may enter into the following types of income generation transactions if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten percent (10%) of its admitted assets:

(1) Sales of covered call options on noncallable fixed-income securities, callable fixed-income securities if the option expires by its terms before the end of the noncallable period, or derivative instruments based on fixed income securities;

(2) Sales of covered call options on equity securities, if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;

(3) Sales of covered puts on investments that the insurer is permitted to acquire under this Chapter, if the insurer has escrowed or entered into a custodian agreement segregating cash or cash equivalents with a

market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold; or

(4) Sales of covered caps or floors, if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding.

(f) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of G.S. 58-7-170.

(g) Under rules that may be adopted by the Commissioner, additional transactions involving the use of derivative instruments in excess of the limits of subsection (d) of this section or for other risk management purposes may be approved by the Commissioner.

(h) An insurer shall establish guidelines and internal procedures as follows:

(1) Before engaging in a derivative transaction, an insurer shall establish written guidelines that shall be used for effecting and maintaining the transactions. The guidelines shall:

a. Address investment or, if applicable, underwriting objectives, and risk constraints such as credit risk limits;

b. Address permissible transactions and the relationship of those transactions to its operations, such as a precise identification of the risks being hedged by a derivative transaction; and

c. Require compliance with internal control procedures.

(2) An insurer shall have a system for determining whether a derivative instrument used for hedging has been effective.

(3) An insurer shall have a credit risk management system for over-the-counter derivative transactions that measures credit risk exposure using the counterparty exposure amount.

(4) An insurer's board of directors shall, in accordance with G.S. 58-7-168:

a. Approve the guidelines required by subdivision (1) of this subsection and the systems required by subdivisions (2) and (3) of this subsection; and

b. Determine whether the insurer has adequate professional personnel, technical expertise and systems to implement investment practices involving derivatives.

(i) An insurer shall maintain documentation and records relating to each derivative transaction, such as:

(1) The purpose or purposes of the transaction;

(2) The assets or liabilities to which the transaction relates;

(3) The specific derivative instrument used in the transaction;

(4) For over-the-counter derivative instrument transactions, the name of the counterparty and counterparty exposure amount; and

(5) For exchange-traded derivative instruments, the name of the exchange and the name of the firm that handled the trade.

(j) Each derivative instrument shall be:

(1) Traded on a qualified exchange;

(2) Entered into with, or guaranteed by, a business entity;

(3) Issued or written by or entered into with the issuer of the underlying interest on which the derivative instrument is based; or

(4) Entered into with a qualified foreign exchange."

SECTION 8.18. G.S. 58-67-60 reads as rewritten:

"**§ 58-67-60. Investments.**

With the exception of investments made in accordance with G.S. 58-67-35(a)(1) and (2) and G.S. 58-67-35(b), the ~~investable~~ funds of a health maintenance organization shall be invested or maintained only in ~~securities or~~ securities, other ~~investments~~ investments, or other assets permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the Commissioner may permit."

PART IX. MUTUAL INSURANCE COMPANIES.

SECTION 9.1. G.S. 58-8-5(a)(3) reads as rewritten:

"(3) ~~Said officers shall cause said certificate to be published once a week for two consecutive weeks in a newspaper in Raleigh and in the county where the company's principal office is located, or posted at the courthouse door if no newspaper be published within the county. Said printed or posted notices shall be in such form and of such size as the Commissioner may approve, and in addition to setting forth in full the certificate required in subdivision (2) shall state that application for amending the company's charter in the manner specified has been proposed by the board of directors, and shall also state the time set for a meeting of policyholders thereby called to be held at the principal office of the company to take action on the proposed amendment. A true copy of such notice shall be filed with the Commissioner, and also with that official who performs the functions of Commissioner in each state where the company is licensed to do business. Such publication and filing of notices shall be completed at least 30 days prior to the date set therein for the meeting of policyholders and due proof thereof shall be filed with the Commissioner at least 15 days prior to the date of such meeting.~~ If the meeting at which the proposed amendment is to be considered is a special meeting, rather than a regular annual meeting of policyholders, such special meeting can be called only after the Commissioner has given his approval in ~~writing, and the published notice shall show the fact of such approval;~~writing;"

SECTION 9.2. G.S. 58-8-25 reads as rewritten:

"**§ 58-8-25. Dividends to policyholders.**

(a) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes other than life insurance or workers' compensation insurance and employers' liability insurance in connection therewith, may declare and pay a dividend to policyholders from its ~~surplus;~~unassigned surplus, as reflected in the company's most recent annual or quarterly statement filed with the Commissioner under G.S. 58-2-165, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period, upon the basis of each general kind of insurance covered by ~~such~~ those policies and by territorial divisions of the location of risks by states, except that in fixing the amount of dividends to be paid on each general kind of insurance, ~~which~~ the dividends shall be uniform in rate and applicable to the majority of risks within ~~such~~ that general kind of insurance, and exceptions may be made as to any class or classes of risk and a different rate or amount of dividends paid on ~~such~~ the class or classes if the conditions applicable to ~~such~~ the class or classes differ substantially from the condition applicable to the kind of insurance as a whole. Every such company shall have an equal rate of dividend for the same term on all policies insuring risks in the same classification. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders of policies of insurance issued by a company in compliance with the orders of any public official, bureau or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks.

(b) Any participating or dividend-paying company, stock or mutual or foreign or domestic, that writes workers' compensation insurance and employers' liability insurance in connection therewith may declare and pay a dividend to policyholders from its ~~surplus,~~ unassigned surplus, as reflected in the company's most recent statement filed with the Commissioner under G.S. 58-2-165, which shall include only its surplus in excess of any required minimum surplus. No such dividend shall be paid unless it is fair and equitable and for the best interest of the company and its policyholders. In declaring any dividend to its policyholders, any such company may make reasonable classifications of policies expiring during a fixed period. The payment of dividends to policyholders shall not be contingent upon the maintenance or renewal of the policy. All dividends shall be paid to the policyholder unless a written assignment ~~thereof be~~ of those dividends is executed. Neither the payment of dividends nor the rate ~~thereof~~ of the dividends may be guaranteed by any company, or its agent, ~~prior to~~ before the declaration of the dividend by the board of directors of ~~such~~ the company. The holders

of policies of insurance issued by a company in compliance with the orders of any public official, bureau, or committee, in conformity with any statutory requirement or voluntary arrangement, for the issuance of insurance to risks not otherwise acceptable to the company, may be established as a separate class of risks."

SECTION 9.3. The title of G.S. 58-10-1 reads as rewritten:

"**§ 58-10-1. ~~Domestic stock life insurance corporations authorized to convert into mutual corporations; procedure.~~Stock to mutual insurer conversion.**"

SECTION 9.4. The title of Part 1 of Article 10 of Chapter 58 of the General Statutes reads as rewritten:

"Article 10.

Miscellaneous Insurer Financial Provisions.

Part 1. Conversion ~~from~~ of Stock ~~to~~ and Mutual ~~Corporation.~~Insurers."

SECTION 9.5. The title of G.S. 58-10-10 reads as rewritten:

"**§ 58-10-10. Mutual ~~conversion~~ to stock ~~insurer.~~insurer conversion.**"

SECTION 9.6. Part 1 of Article 10 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-10-12. Conversion plan requirements.**

(a) As used in this section:

(1) 'Closed block' means an allocation of assets for a defined group of in-force policies which, together with the premiums of those policies and related investment earnings, are expected to be sufficient to maintain the payments of guaranteed benefits, certain expenses, and continuation of the current dividend scale on the closed block, if experience does not change.

(2) 'Converting mutual' means a domestic mutual insurance company that has adopted a plan of conversion and an amendment to its articles of incorporation under this section that will, upon consummation, result in the domestic mutual insurance company converting into a domestic stock insurance company.

(3) 'Eligible member' means a person who:

a. Is a member of the converting mutual on the date the converting mutual's board of directors adopts a resolution proposing a plan of conversion and an amendment to the articles of incorporation; and

b. Continues to be a member of the converting mutual on the effective date of the conversion.

(4) 'Former mutual' means the domestic stock insurance company resulting from the conversion of a converting mutual to a stock insurance company under a plan of conversion and an amendment to its articles of incorporation under this section.

(5) 'Member' means a person that, according to the records, articles of incorporation, and bylaws of a converting mutual, is a member of the converting mutual.

(6) 'Membership interests' means:

a. The voting rights of members of a domestic mutual insurance company as provided by law and by the company's articles of incorporation and bylaws; and

b. The rights of members of a domestic mutual insurance company to receive cash, stock, or other consideration in the event of a conversion to a stock insurance company under this section or a dissolution as provided by the company's articles of incorporation and bylaws.

(7) 'Parent company' means a corporation that, upon the effective date of a conversion, owns all of the stock of the former mutual.

(8) 'Plan of conversion' means the plan of conversion described in subsection (b) of this section.

(b) The plan of conversion under G.S. 58-10-10 shall:

(1) Describe the manner in which the proposed conversion will occur and the insurance and any other companies that will result from or be directly affected by the conversion, including the former mutual and any parent company.

(2) Provide that the membership interests in the converting mutual will be extinguished as of the effective date of the conversion.

(3) Require the distribution to the eligible members, upon the extinguishing of their membership interests, of aggregate consideration equal to the fair value of the converting mutual.

(4) Describe the manner in which the fair value of the converting mutual has been or will be determined.

(5) Describe the form or forms and amount, if known, of consideration to be distributed to the eligible members.

(6) Specify relevant classes, categories, or groups of eligible members and describe and explain any differences in the form or forms and amount of consideration to be distributed to or among the eligible members.

(7) Require and describe the method or formula for the fair and equitable allocation of the consideration among the eligible members.

(8) Provide for the determination and preservation of the reasonable dividend expectations of eligible members and other policyholders with policies that provide for the distribution of policy dividends, through establishment of a closed block or other method acceptable to the Commissioner.

(9) Provide that each member and other policyholder of the converting mutual will receive notification of the address and telephone number

of the converting mutual and the former mutual, if different, along with the notice of hearing as approved by the Commissioner.

(10) Include other provisions as the converting mutual determines to be necessary.

(c) After the adoption by the board of directors of the resolution proposing the plan of conversion under G.S. 58-10-10 and the amendment to its articles of incorporation, the converting mutual shall file with the Commissioner an application for approval of the plan and amendment. The application must contain the following information, together with any additional information as the Commissioner may require:

(1) The plan of conversion and a certificate of the secretary of the converting mutual certifying the adoption of the plan by the board of directors.

(2) A statement of the reasons for the proposed conversion and why the conversion is in the best interests of the converting mutual, the eligible members, and the other policyholders. The statement must include an analysis of the risks and benefits to the converting mutual and its members of the proposed conversion and a comparison of the risks and benefits of the conversion with the risks and benefits of reasonable alternatives to a conversion.

(3) A five-year business plan and at least two years of financial forecasts of the former mutual and any parent company.

(4) Any plans that the former mutual or any parent company may have to:

a. Raise additional capital through the issuance of stock or otherwise;

b. Sell or issue stock to any person, including any compensation or benefit plan for directors, officers, or employees under which stock may be issued;

c. Liquidate or dissolve any company or sell any material assets;

d. Merge or consolidate or pursue any other form of reorganization with any person; or

e. Make any other material change in investment policy, business, corporate structure, or management.

(5) Any plans for a delayed distribution of consideration to eligible members or restrictions on sale or transfer of stock or other securities.

(6) A copy of the form of trust agreement, if a distribution of consideration is to be delayed by more than six months after the effective date of the conversion.

(7) A plan of operation for a closed block, if a closed block is used for the preservation of the reasonable dividend expectations of eligible members and other policyholders with policies that provide for the distribution of policy dividends.

(8) Copies of the amendment to the articles of incorporation proposed by the board of directors and proposed bylaws of the former mutual and copies of the existing and any proposed articles of incorporation and bylaws of any parent company.

(9) A list of all individuals who are or have been selected to become directors or officers of the former mutual and any parent company, or the individuals who perform or will perform duties customarily performed by a director or officer, and the following information concerning each individual on the list unless the information is already on file with the Commissioner:

a. The individual's principal occupation.

b. All offices and positions the individual has held in the preceding five years.

c. Any crime of which the individual has been convicted (other than traffic violations) in the preceding 10 years.

d. Information concerning any personal bankruptcy of the individual or the individual's spouse during the previous seven years.

e. Information concerning the bankruptcy of any corporation or other entity of which the individual was an officer or director during the previous seven years.

f. Information concerning allegations of state or federal securities law violations made against the individual that within the previous 10 years resulted in (i) a determination that the individual violated state or federal securities laws; (ii) a plea of nolo contendere; or (iii) a consent decree.

g. Information concerning the suspension, revocation, or other disciplinary action during the previous 10 years of any state or federal license issued to the individual.

h. Information as to whether the individual was refused a bond during the previous 10 years.

(10) A fairness opinion addressed to the board of directors of the converting mutual from a qualified, independent financial adviser asserting:

a. That the provision of stock, cash, policy benefits, or other forms of consideration upon the extinguishing of the converting mutual's membership interests under the plan of conversion and the amendment to the articles of incorporation is fair to the eligible members, as a group, from a financial point of view; and

b. Whether the total consideration under sub-subdivision a. of this subdivision is equal to or greater than the surplus of the converting mutual.

The Commissioner may waive the fairness opinion in situations involving a straightforward issuance of stock to members of the former mutual.

(11) An actuarial opinion as to the following:

a. The reasonableness and appropriateness of the methodology or formulas used to allocate consideration among eligible members, consistent with this Article.

b. The reasonableness of the plan of operation and sufficiency of the assets allocated to the closed block, if a closed block is used for the preservation of the reasonable dividend expectations of eligible members and other policyholders with policies that provide for the distribution of policy dividends.

(12) If any of the consideration to be distributed to eligible members consists of stock or other securities, subject to the limitations of G.S. 58-10-10(b)(6), a description of the plans made by the former mutual or its parent company to assure that an active public trading market for the stock or other securities will develop within a reasonable amount of time after the effective date of the plan of conversion and that eligible members who receive stock or other securities will be able to sell their stock or other securities, subject to any delayed distribution or transfer restrictions, at reasonable cost and effort.

(13) Any additional information, documents, or materials that the converting mutual determines to be necessary.

(d) Distribution of all or part of the consideration to some or all of the eligible members may be delayed, or restrictions on sale or transfer of any stock or other securities to be distributed to eligible members may be required, for a reasonable period of time following the effective date of the conversion. However, the period of time shall not exceed six months unless otherwise approved by the Commissioner.

(e) Except as specifically provided in a plan of conversion, for five years following the effective date of the conversion, no person or persons acting in concert (other than the former mutual, any parent company, or any employee benefit plans or trusts sponsored by the former mutual or a parent company) shall directly or indirectly acquire, or agree or offer to acquire, in any manner the beneficial ownership of five percent (5%) or more of the outstanding shares of any class of a voting security of the former mutual or any parent company without the prior approval of the Commissioner of a statement filed by that person with the Commissioner. The statement shall contain the information required by G.S. 58-19-15(b) and any other information required by the Commissioner. The Commissioner shall not approve an acquisition under this subsection unless the Commissioner finds that:

(1) The requirements of G.S. 58-19-15(e) will be satisfied.

(2) The acquisition will not frustrate the plan of conversion or the amendment to the articles of incorporation as approved by the members and the Commissioner.

(3) The boards of directors of the former mutual and any parent company have approved the acquisition.

(4) The acquisition would be in the best interest of the present and future policyholders of the former mutual without regard to any interest of policyholders as shareholders of the former mutual or any parent company."

PART X. REINSURANCE INTERMEDIARIES.

SECTION 10.1. G.S. 58-9-6(a) reads as rewritten:

"(a) The Commissioner shall issue an intermediary license or an exemption from the license, subject to G.S. 58-9-2(b)(2) or G.S. 58-9-2(c)(3), to any person who has complied with the requirements of this Article. A license issued to a non corporate entity authorizes all of the members of the entity and any designated employees to act as intermediaries under the license, and those persons shall be named in the application and any supplements. A license issued to a corporation authorizes all of the officers and any designated employees and directors of the corporation to act as intermediaries on behalf of the corporation, and those persons shall be named in the application and any supplements."

SECTION 10.2. G.S. 58-9-11(b) reads as rewritten:

"(b) An insurer shall not engage the services of any person to act as a broker on its behalf unless the person is licensed under ~~G.S. 58-9-6.~~G.S. 58-9-6 or exempted under this Article. An insurer shall not employ an individual who is employed by a broker with which it transacts business, unless the broker is under common control with the insurer under Article 19 of this Chapter."

SECTION 10.3. G.S. 58-9-21(a) reads as rewritten:

"(a) A reinsurer shall not engage the services of any person to act as a manager on its behalf unless the person is licensed under ~~G.S. 58-9-6.~~G.S. 58-9-6 or exempted under this Article."

PART XI. MORTGAGE GUARANTY INSURANCE.

SECTION 11. Article 10 of Chapter 58 of the General Statutes is amended by adding the following new Part to read:

"Part 5. Mortgage Guaranty Insurance.

"**§ 58-10-120. Definitions.**

As used in this Part:

(1) 'Mortgage guaranty insurers report of policyholders position' means the annual supplementary report required by the Commissioner.

(2) 'Policyholders position' means the contingency reserve established under G.S. 58-10-135 and policyholders' surplus. 'Minimum policyholders position' is calculated as described in G.S. 58-10-125.

(3) 'Policyholders surplus' means an insurer's net worth; the difference between its assets and liabilities, as reported in its annual statement.

"**§ 58-10-125. Minimum policyholders position.**

(a) For the purpose of complying with G.S. 58-7-75, a mortgage guaranty insurer shall maintain at all times a minimum policyholders position in the amount required by this section. The policyholders position shall be net of reinsurance ceded but shall include reinsurance assumed.

(b) If a mortgage guaranty insurer does not have the minimum amount of policyholders position required by this section it shall cease transacting new business until the time that its policyholders position is in compliance with this section.

(c) If a policy of mortgage guaranty insurance insures individual loans with a percentage claim settlement option on those loans, a mortgage guaranty insurer shall maintain a policyholders position based on each one hundred dollars ($100.00) of the face amount of the mortgage, the percentage coverage, and the loan-to-value category. The minimum amount of policyholders position shall be calculated in the following manner:

(1) If the loan-to-value is greater than seventy-five percent (75%), the minimum policyholders position per one hundred dollars ($100.00) of the face amount of the mortgage for the specific percent coverage shall be as shown in the schedule below:

Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage	Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage
5	$0.20	55	$1.50
10	0.40	60	1.55
15	0.60	65	1.60
20	0.80	70	1.65
25	1.00	75	1.75
30	1.10	80	1.80
35	1.20	85	1.85
40	1.30	90	1.90
45	1.35	95	1.95
50	1.40	100	2.00

(2) If the loan-to-value is at least fifty percent (50%) and not more than seventy-five percent (75%), the minimum amount of the policyholders

position shall be fifty percent (50%) of the minimum of the amount calculated under subdivision (c)(1) of this section.

(3) If the loan-to-value is less than fifty percent (50%), the minimum amount of policyholders position shall be twenty-five percent (25%) of the amount calculated under subdivision (c)(1) of this section.

(d) If a policy of mortgage guaranty insurance provides coverage on a group of loans subject to an aggregate loss limit, the policyholders position shall be:

(1) If the equity is not more than fifty percent (50%) and is at least twenty percent (20%), or equity plus prior insurance or a deductible is at least twenty-five percent (25%) and not more than fifty-five percent (55%), the minimum amount of policyholders position shall be calculated as follows:

Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage	Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage
1	$0.30	50	$0.825
5	0.50	60	0.85
10	0.60	70	0.875
15	0.65	75	0.90
20	0.70	80	0.925
25	0.75	90	0.95
30	0.775	100	1.00
40	0.80		

(2) If the equity is less than twenty percent (20%), or the equity plus prior insurance or a deductible is less than twenty-five percent (25%), the minimum amount of policyholders position shall be two hundred percent (200%) of the amount required by subdivision (d)(1) of this section.

(3) If the equity is more than fifty percent (50%), or the equity plus prior insurance or a deductible is more than fifty-five percent (55%), the minimum amount of policyholders position shall be fifty percent (50%) of the amount required by subdivision (d)(1) of this section.

(e) If a policy of mortgage guaranty insurance provides for layers of coverage, deductibles, or excess reinsurance, the minimum amount of policyholders position shall be computed by subtraction of the minimum position for the lower percentage coverage limit from the minimum position for the upper or greater coverage limit.

(f) If a policy of mortgage guaranty insurance provides for coverage on loans secured by junior liens, the policyholders position shall be:

(1) If the policy provides coverage on individual loans, the minimum amount of policyholders position shall be calculated as in subsection (c) of this section as follows:

a. The loan-to-value percent is the entire loan indebtedness on the property divided by the value of the property;

b. The percent coverage is the insured portion of the junior loan divided by the entire loan indebtedness on the collateral property; and

c. The face amount of the insured mortgage is the entire loan indebtedness on the property.

(2) If the policy provides coverage on a group of loans subject to an aggregate loss limit, the policyholders position shall be calculated according to subsection (d) of this section as follows:

a. The equity is the complement of the loan-to-value percent calculated as in subdivision (d)(1) of this section;

b. The percent coverage is calculated as in subdivision (d)(1) of this section; and

c. The face amount of the insured mortgage is the entire loan indebtedness on the property.

(g) If a policy of mortgage guaranty insurance provides for coverage on leases, the policyholders position shall be four dollars ($4.00) for each one hundred dollars ($100.00) of the insured amount of the lease.

(h) If a policy of mortgage guaranty insurance insures loans with a percentage loss settlement option coverage between any of the entries in the schedules in this section, then the factor for policyholders position per one hundred dollars ($100.00) of the face amount of the mortgage shall be prorated between the factors for the nearest percent coverage listed.

"**§ 58-10-130. Unearned premium reserve.**

(a) The unearned premium reserve shall be computed as follows:

(1) The unearned premium reserve for premiums paid in advance annually shall be calculated on the monthly pro rata fractional basis.

(2) Premiums paid in advance for 10-year coverage shall be placed in the unearned premium reserve and shall be released from this reserve as follows:

a. 1st month - 1/132;

b. 2nd through 12th month - 2/132 each month;

c. 13th month - 3/264;

d. 14th through 120th month - 1/132 per month;

e. 121st month - 1/264.

(3) Premiums paid in advance for periods in excess of 10 years. During the first 10 years of coverage the unearned portion of the premium shall be the premium collected minus an amount equal to the premium

that would have been earned had the applicable premium for 10 years of coverage been received. The premium remaining after 10 years shall be released from the unearned premium reserve monthly pro rata over the remaining term of coverage.

(b) Fifty percent (50%) of the premium remaining after establishment of the premium reserve specified in subsection (a) of this section shall be maintained as a special contingency reservation of premium and reported in the financial statement as a liability.

(c) The case basis method shall be used to determine the loss reserve which shall include a reserve for claims reported and unpaid and a reserve for claims incurred but not reported.

"**§ 58-10-135. Contingency reserve.**

(a) Subject to G.S. 58-7-21, a mortgage guaranty insurer shall make an annual contribution to the contingency reserve which in the aggregate shall be the greater of:

(1) Fifty percent (50%) of the net earned premium reported in the annual statement; or

(2) The sum of:

a. The policyholders position established under G.S. 58-10-125 on residential buildings designed for occupancy by not more than four families divided by seven;

b. The policyholders position established under G.S. 58-10-125 on residential buildings designed for occupancy by five or more families divided by five;

c. The policyholders position established under G.S. 58-10-125 on buildings occupied for industrial or commercial purposes divided by three; and

d. The policyholders position established under G.S. 58-10-125 for leases divided by 10.

(b) If the mortgage guaranty coverage is not expressly provided for in this section, the Commissioner may establish a rate formula factor that will produce a contingency reserve adequate for the risk assumed.

(c) The contingency reserve established by this section shall be maintained for 120 months. That portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.

(d) With the approval of the Commissioner, withdrawals may be made from the contingency reserve when incurred losses and incurred loss expenses exceed the greater of either thirty-five percent (35%) of the net earned premium or seventy percent (70%) of the amount which subsection (a) of this section requires to be contributed to the contingency reserve in such year. On a quarterly basis, provisional withdrawals may be made from the contingency reserve in an amount not to exceed seventy-five percent

(75%) of the withdrawal calculated in accordance with subdivision (d)(1) of G.S. 58-10-125.

(e) With the approval of the Commissioner, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts which are in excess of the minimum policyholders position as filed with the most recently filed annual statement. In reviewing a request for withdrawal pursuant to this subsection, the Commissioner may consider loss development and trends. If any portion of the contingency reserve for which withdrawal is requested pursuant to this subsection is maintained by a reinsurer, the Commissioner may also consider the financial condition of the reinsurer. If any portion of the contingency reserve for which withdrawal is requested pursuant to this subsection is maintained in a segregated account or segregated trust and such withdrawal would result in funds being removed from the segregated account or segregated trust, the Commissioner may also consider the financial condition of the reinsurer.

(f) Releases and withdrawals from the contingency reserve shall be accounted for on a first-in-first-out basis as prescribed by the Commissioner.

(g) The calculations to develop the contingency reserve shall be made in the following sequence:

(1) The additions required by subsections (a) and (b) of this section;

(2) The releases permitted by subsection (c) of this section;

(3) The withdrawals permitted by subsection (d) of this section; and

(4) The withdrawals permitted by subsection (e) of this section.

(h) Whenever the laws or regulations of another jurisdiction in which a mortgage guaranty insurer, subject to the requirements of this Part is licensed, require a larger unearned premium reserve or a larger contingency reserve in the aggregate than that set forth in this Part, the establishment and maintenance of the larger unearned premium reserve or contingency reserve shall be deemed to be in compliance with this Part."

PART XII. RISK-BASED CAPITAL REQUIREMENTS.

SECTION 12.1. G.S. 58-12-2(3) reads as rewritten:

"(3) Domestic insurer. – Any insurance company or health organization organized in this State under Article ~~7~~ 7, 15, 65, or 67 of this Chapter."

SECTION 12.2. G.S. 58-12-2(4) reads as rewritten:

"(4) Foreign insurer. – Any insurance company or health organization that is admitted to do business in this State under Article 16 or 67 of this Chapter but is not domiciled in this State."

SECTION 12.3. G.S. 58-12-2 is amended by adding the following new subdivision to read:

"(4b) Health organization. – Any health maintenance organization, limited health service organization, dental or vision plan, hospital, medical, or dental indemnity or service corporation, or other organization licensed

under Article 65 or 67 of this Chapter. 'Health organization' does not include an insurer that is licensed as either a life or health insurer or a property or casualty insurer under this Chapter and that is otherwise subject to either the life or property and casualty risk-based capital requirements."

SECTION 12.4. G.S. 58-12-6(d) reads as rewritten:

"(d) A property or casualty insurer's risk-based capital and a health organization's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account (and may adjust for the covariance between):

(1) Asset risk;
(2) Credit risk;
(3) Underwriting risk; and
(4) All business and other relevant risks set forth in the risk-based capital instructions, determined in each case by applying the factors in the manner set forth in the risk-based capital instructions."

SECTION 12.5. G.S. 58-12-11(a)(1)a. reads as rewritten:

"a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based ~~capital;~~ capital, if the insurer is a property or casualty insurer or a health organization; or".

SECTION 12.6. G.S. 58-12-11(b)(3) reads as rewritten:

"(3) Provides forecasts of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including forecasts of statutory operating income, net income, capital, or surplus (the forecasts for both new and renewal business should include separate forecasts for each major line of business and separately identify each significant income, expense, and benefit component). For a health organization, the forecasted financial results shall be for the current year and at least two succeeding years and shall include statutory balance sheets, operating income, net income, capital and surplus, and risk-based capital levels."

SECTION 12.7. G.S. 58-12-25(b) reads as rewritten:

"(b) In the event of a mandatory control level ~~event,~~ event with respect to a life insurer or a health organization, the Commissioner shall take actions as are necessary to cause the insurer to be placed under regulatory control under Article 30 of this Chapter. The mandatory control level event is sufficient grounds for the Commissioner to take action under Article 30 of this Chapter, and the Commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Article 30 of this Chapter. If the Commissioner takes actions pursuant to an adjusted risk-based capital report, the insurer shall be entitled to such protections as are afforded to insurers under

the provisions of Article 30 of this Chapter pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forego action for up to 90 days after the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period."

SECTION 12.8. G.S. 58-12-25 is amended by adding the following new subsection to read:

"(c) In the event of a mandatory control level event with respect to a property and casualty insurer, the Commissioner shall take actions as are necessary to cause the insurer to be placed under regulatory control under Article 30 of this Chapter, or, in the case of an insurer which is writing no business and which is running off its existing business, may allow the insurer to continue its runoff under the supervision of the Commissioner. In either event, the mandatory control level event is sufficient grounds for the Commissioner to take action under Article 30 of this Chapter, and the Commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Article 30 of this Chapter. If the Commissioner takes actions under an adjusted risk-based capital report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of Article 30 of this Chapter pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forego action for up to 90 days after the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period."

SECTION 12.9. Article 12 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-12-65. Health organization phase-in provision.**

For risk-based capital reports required to be filed by health organizations with respect to calendar year 2001, the following requirements apply in lieu of the provisions of G.S. 58-12-11, 58-12-16, 58-12-21, and 58-12-25:

(1) In the event of a company action level event with respect to a domestic insurer, the Commissioner shall take no regulatory action under this Article.

(2) In the event of a regulatory action level event under G.S. 58-12-16(a)(1), (2), or (3), the Commissioner shall take the actions required under G.S. 58-12-11.

(3) In the event of a regulatory action level event under G.S. 58-12-16(a)(4), (5), (6), (7), (8), or (9), or an authorized control level event, the Commissioner shall take the actions required under G.S. 58-12-16 with respect to the insurer.

(4) In the event of a mandatory control level event with respect to an insurer, the Commissioner shall take the actions required under G.S. 58-12-21 with respect to the insurer."

SECTION 12.10. Article 12 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-12-70. HMO net worth requirements.**

The Commissioner may require an HMO to have and maintain a larger amount of net worth than prescribed in G.S. 58-67-110, based upon the principles of risk-based capital as determined by the NAIC or the Commissioner."

PART XIII. INSURANCE COMPANY ASSET PROTECTION.

SECTION 13.1. 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 68 of~~ this Chapter. Foreign insurers shall comply in substance with the requirements and limitations of this 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.~~This Article does not apply to the following:

(1) Variable contracts or guaranteed investment contracts for which separate accounts are required to be maintained.

(2) Statutory deposits that are required by insurance regulatory agencies to be maintained as a requirement for doing business in such jurisdictions.

(3) Real estate, authorized under G.S. 58-7-187, encumbered by a mortgage loan with a first lien."

SECTION 13.2. G.S. 58-13-15(3) reads as rewritten:

"(3) "Reserve assets" means those assets of an insurer that are authorized investments for policy reserves in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~this Chapter."

SECTION 13.3. G.S. 58-13-15(4) reads as rewritten:

"(4) "Policyholder-related liabilities" means those liabilities that are required to be established by an insurer for all of its outstanding insurance policies in accordance with ~~Articles 1 through 64 of this Chapter and G.S. 58-65-95.~~this Chapter."

SECTION 13.4. G.S. 58-13-20(b) reads as rewritten:

"(b) The Commissioner has the right to examine any of such assets, reinsurance agreements, or deposit arrangements at any time in accordance with his authority to make examinations of insurers as conferred by other provisions ~~of Articles 1 through 64~~ of this Chapter."

PART XIV. FOREIGN INSURANCE COMPANIES.

SECTION 14.1. G.S. 58-16-5 reads as rewritten:

"**§ 58-16-5. Conditions of ~~admission.~~licensure.**

A foreign or alien insurance company may be ~~admitted and authorized~~ licensed 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~~ the form and detail ~~as he~~ that the Commissioner 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,~~ transact as direct insurance or assumed reinsurance, and that it has been successful in the conduct of ~~such~~ the 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~~ the capital, surplus, and other funds are invested ~~in substantial~~ substantially in accordance with the requirements of ~~Articles 1 through 64 of~~ this Chapter.

(3) Repealed by Session Laws 1995, c. 517, s. 6.

(4) Repealed by Session Laws 1987, c. 629, s. 20.

(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.

(8) Satisfies the Commissioner that the operation of the company in this State would not be hazardous to prospective policyholders, creditors, or the general public.

(9) Satisfies the Commissioner that it is in substantial compliance with the requirements of G.S. 58-7-37 pertaining to the background of its officers and directors.

(10) Files with the Commissioner an instrument appointing the Commissioner as the company's agent on whom any legal process under G.S. 58-16-30 may be served. This appointment is irrevocable as long as any liability of the company remains outstanding in this State. A copy of this instrument, certified by the Commissioner, is sufficient

evidence of this appointment; and service upon the Commissioner is sufficient service upon the company."

SECTION 14.2. G.S. 58-16-6 reads as rewritten:

"**§ 58-16-6. Conditions of continued licensure.**

In order for a foreign insurance company to continue to be licensed, it shall report any changes in the documents filed under G.S. 58-16-5(1) or G.S. 58-16-5(5), maintain the amounts of capital and surplus specified in G.S. 58-16-5(2), and remain in substantial compliance with the statutes listed in ~~G.S. 58-16-5(6) and G.S. 58-16-5(7).~~ G.S. 58-16-5(6), (7), and (8)."

PART XV. PROMOTING AND HOLDING COMPANIES.

SECTION 15. Article 18 of Chapter 58 of the General Statutes, comprising G.S. 58-18-1 through G.S. 58-18-25 is repealed.

PART XVI. INSURANCE HOLDING COMPANY SYSTEMS.

SECTION 16.1. G.S. 58-19-5(5) reads as rewritten:

"(5) "Person" means an individual, corporation, partnership, limited liability company, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing acting in concert."

SECTION 16.2. The introductory paragraph of G.S. 58-19-10(b) reads as rewritten:

"(b) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under ~~all other sections of Articles 1 through 64 of~~ this Chapter, a domestic insurer may also:".

SECTION 16.3. G.S. 58-19-10(b)(1) reads as rewritten:

"(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts that do not exceed the lesser of ten percent (10%) of ~~such~~ the insurer's admitted assets or fifty percent (50%) of ~~such~~ the insurer's ~~surplus as regards policyholders,~~ policyholders' surplus, provided that after ~~such~~ those investments, the insurer's ~~surplus as regards policyholders~~ policyholders' surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of ~~such~~ the investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included: (i) total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of ~~such~~the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and (ii) all amounts expended in acquiring additional common stock, preferred

stock, debt obligations, and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;".

SECTION 16.4. G.S. 58-19-10(b)(3) reads as rewritten:

"(3) With the approval of the Commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided that after such investment the insurer's ~~surplus as regards policyholders~~ policyholders' surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs."

SECTION 16.5. G.S. 58-19-15(h) reads as rewritten:

"(h) The provisions of this section do not apply to any offer, request, invitation, agreement, or acquisition that the Commissioner by order exempts therefrom as (i) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or (ii) as otherwise not comprehended within the purposes of this section. Any acquisition of stock of a former domestic mutual insurer by a parent company that occurs in connection with the conversion of a mutual insurer to a stock insurer under G.S. 58-10-10 is not subject to this section, provided that no person acquires control of the parent company."

SECTION 16.6. G.S. 58-19-25(a) reads as rewritten:

"(a) Every insurer that is licensed to do business in this State and that is a member of an insurance holding company system shall register with the Commissioner, except a foreign insurer subject to the registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained ~~in this section and G.S. 58-19-30 or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition. The insurer shall also file a copy of its registration statement and any amendments to the statement in each state in which that insurer is authorized to do business if requested by the insurance regulator of that state.~~ in:

(1) This section.

(2) G.S. 58-19-30(a), G.S. 58-19-30(c), and G.S. 58-19-30(d).

(3) G.S. 58-19-30(b) or a statutory or regulatory provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition. The insurer shall also file a copy of its registration statement and any amendments to the statement in each state in which that insurer is authorized to do business, if requested by the insurance regulator of that state.

Any insurer that is subject to registration under this section shall register within 30 days after it becomes subject to registration, and an amendment to the registration statement shall be filed by ~~March 1~~ April 1 of each year for the previous calendar year; unless the Commissioner for good cause shown extends the time for registration or filing, and then within the extended time. All registration statements shall contain a summary, on a form prescribed by the Commissioner, outlining all items in the current registration statement representing changes from the prior registration statement. The Commissioner may require any insurer that is a member of a holding company system that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulator of its domiciliary jurisdiction."

SECTION 16.7. G.S. 58-19-30(b)(4) reads as rewritten:

"(4) All management agreements, service contracts, guarantees, or cost-sharing arrangements."

PART XVII. SURPLUS LINES INSURANCE.

SECTION 17.1. G.S. 58-21-20(a)(2) reads as rewritten:

"(2) Qualifies under one of the following subdivisions:

a. Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equals either:

1. This State's minimum capital and surplus requirements under G.S. 58-7-75, or
2. Fifteen million dollars ($15,000,000),

whichever is greater, except that nonadmitted insurers already qualified under this Article must have ten million dollars ($10,000,000) by December 31, 1991, twelve million five hundred thousand dollars ($12,500,000) by December 31, 1992, and fifteen million dollars ($15,000,000) by December 31, 1993. The requirements of this sub-subdivision may be satisfied by an insurer possessing less than the commitment capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, and the insurer's record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).

In addition, an alien insurer qualifies under this subdivision if it complies with the capital and surplus requirements of this subdivision and maintains in the United States an irrevocable

trust fund in either a national bank or a member of the Federal Reserve System, in an amount not less than ~~two million five hundred thousand dollars ($2,500,000)~~ five million four hundred thousand dollars ($5,400,000) for the protection of all of its policyholders in the United States, and the trust fund consists of cash, securities, letters of credit, or of investment of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this State. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five years; or

b. In the case of any Lloyd's plans or other similar ~~unincorporated~~ group of insurers, which ~~includes individual insurers,~~ consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers, maintains a trust fund in an amount of not less than ~~fifty million dollars ($50,000,000)~~ one hundred million dollars ($100,000,000) as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and the trust shall likewise comply with the terms and conditions established in subdivision (2)a. of this section for alien insurers; and

c. In the case of an "insurance exchange" created by the laws of individual states, maintain capital and surplus, or the substantial equivalent thereof, of not less than ~~fifty million dollars ($50,000,000)~~ seventy-five million dollars ($75,000,000) in the aggregate. For insurance exchanges which maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent thereof, of not less than ~~three million dollars ($3,000,000).~~ five million dollars ($5,000,000). If the insurance exchange does not maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of subdivision (2)a. of this section.

d. In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three years immediately before this time, and which submits to this State's

authority to examine its books and records and bears the expense of the examination, and maintains an aggregate policyholders' surplus of not less than ten billion dollars ($10,000,000,000), and maintains in trust a surplus of not less than one hundred million dollars ($100,000,000) for the benefit of United States surplus lines policyholders of any member of the group, and each insurer maintains capital and surplus of not less than twenty-five million dollars ($25,000,000) per company."

SECTION 17.2. G.S. 58-21-30 reads as rewritten:

"**§ 58-21-30. Withdrawal of eligibility from a surplus lines insurer.**

If at any time the Commissioner has reason to believe that an eligible surplus lines insurer:

(1) Is in unsound financial ~~condition,~~condition or has acted in an untrustworthy manner,

(2) Is no longer eligible under G.S. 58-21-20,

(3) Has willfully violated the laws of this State, or

(4) Does not make reasonably prompt payment of just losses and claims in this State or elsewhere, the Commissioner may declare it ineligible. The Commissioner shall promptly mail notice of all such declarations to each surplus lines licensee."

PART XVIII. RISK RETENTION GROUPS.

SECTION 18. G.S. 58-22-10(3) reads as rewritten:

"(3) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention ~~group,~~ group is insolvent or, although not yet financially impaired or insolvent, is unlikely to be able:

a. To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

b. To pay other obligations in the normal course of business."

PART XIX. INSURANCE COMPANY RECEIVERSHIPS.

SECTION 19. G.S. 58-30-75(7) reads as rewritten:

"(7) Without first obtaining the written consent of the ~~Commissioner pursuant to G.S. 58-7-150,~~ Commissioner, the insurer has (i) transferred, or attempted to transfer, in a manner contrary to Article 19 of this Chapter, substantially its entire property or business, or (ii) has entered into any transaction, the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person."

PART XX. MANAGING GENERAL AGENTS.

SECTION 20.1. G.S. 58-34-2(a) reads as rewritten:

"(a) As used in this Article:

(1) "Control", including the terms "controlling", "controlled by", and "under common control", means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(1a) "Custodial agreement" means any agreement or contract under which any person is delegated authority to safekeep assets of the insurer.

(2) "Insurer" means a domestic insurer but does not mean a reciprocal regulated under Article 15 of this Chapter.

(2a) "Management contract" means any agreement or contract under which any person is delegated management duties or control of an insurer or transfers a substantial part of any major function of an insurer, such as adjustment of losses, production of business, investment of assets, or general servicing of the insurer's business.

(3) "Managing general agent" or "MGA" means any person who manages all or part of the insurance business of an insurer (including the management of a separate division, department, or underwriting office) and acts as an agent for the insurer, whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with persons under common control, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent (5%) of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following activities related to the business produced: (i) adjusts or pays any claims, or (ii) negotiates reinsurance on behalf of the insurer. "MGA" does not mean an employee of the insurer; an underwriting manager who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, is subject to Article 19 of this Chapter, and whose compensation is not based on the volume of premiums written; a person who, under Article 15 of this Chapter, is designated and authorized by subscribers as the attorney-in-fact for a reciprocal having authority to obligate them on reciprocal and other insurance contracts; or a U.S. Manager of the United States branch of an alien insurer.

(4) "Qualified actuary" means a person who meets the standards of a qualified actuary as specified in the NAIC Annual Statement Instructions, as amended or clarified by rule, order, directive, or bulletin of the Department, for the type of insurer for which the MGA is establishing loss reserves.

(5) "Underwrite" means the authority to accept or reject risk on behalf of the insurer."

SECTION 20.2. G.S. 58-34-2(j) reads as rewritten:

"(j) The Commissioner shall disapprove any such contract that:

(1) Does not contain the required contract provisions specified in subsection (d) of this section;

(2) Subjects the insurer to excessive charges for expenses or commission;

(3) Vests in the MGA any control over the management of the affairs of the insurer to the exclusion of the board of directors of the insurer;

(4) Is entered into with any person if the person or its officers and directors are of known bad character or have been affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relationships with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance; or

(5) Is determined by the Commissioner to contain provisions that are not fair and reasonable to the insurer.

Failure of the Commissioner to disapprove any such contract within 30 days after the contract has been filed with the Commissioner constitutes the Commissioner's approval of the contract. An insurer may continue to accept business from ~~such~~ the person until the Commissioner disapproves the contract. Any disapproval shall be in writing. The Commissioner ~~may, after a hearing held under G.S. 58-2-50,~~ may withdraw approval of any contract the Commissioner has previously approved ~~upon finding~~ if the Commissioner determines that the basis of the original approval no longer exists or that the contract has, in actual operation, shown itself to be subject to disapproval on any of the grounds in this subsection. If the Commissioner withdraws approval of a contract, the Commissioner shall give the insurer notice of, and written reasons for, the withdrawal of approval. The Commissioner shall grant any party to the contract a hearing upon request."

SECTION 20.3. G.S. 58-34-10 reads as rewritten:

"**§ 58-34-10. Management contracts.**

(a) Subject to G.S. 58-19-30(b)(4), any domestic insurer that enters into a management contract or custodial agreement must file that contract or agreement with the Commissioner on or before its effective date. ~~As used in this section, "management contract" means any agreement or contract under which any person is delegated management duties or control of an insurer, or transfers a substantial part of any major~~

~~function of an insurer, such as adjustment of losses, production of business, investment of assets, or general servicing of the insurer's business.~~

(b) Any domestic insurer that has a management contract or custodial agreement shall file a statement with the initial filing of that contract that discloses (i) criteria on which charges to the insurer are based for that contract; (ii) whether management personnel or other employees of the insurer are to be performing management functions and receiving any remuneration therefor through that contract in addition to the compensation by way of salary received directly from the insurer for their services; (iii) whether the contract transfers substantial control of the insurer or any of the powers vested in the board of directors, by statute, articles of incorporation, or bylaws, or substantially all of the basic functions of the insurer's management; (iv) biographical information for each officer and director of the management firm; and (v) other information concerning the contract or the management or custodian firm as may be included from time to time in any registration forms adopted or approved by the Commissioner. ~~Such~~ The statement shall be filed on a form prescribed by the Commissioner.

(c) Any domestic insurer that amends or cancels a management contract or custodial agreement filed ~~pursuant to~~ under subsection (a) of this section shall notify the Commissioner ~~thereof~~ within 15 business days after the amendment or cancellation. If the contract is amended, the notice shall provide a copy of the amended contract and shall disclose if the amendment affects any of the items in subsection (b) of this section. The Commissioner may prescribe a form to be used to provide notice under this subsection.

(d) Any domestic insurer that has a management contract or custodial agreement shall file a statement on or before March 1 of each year, for the preceding calendar year, disclosing (i) total charges incurred by the insurer under the contract; (ii) any salaries, commissions, or other valuable consideration paid by the insurer directly to any officer, director, or shareholder of the management or custodian firm; and (iii) other information concerning the contract or the management or custodian firm as may be included from time to time in any registration forms adopted or approved by the Commissioner. The Commissioner may prescribe a form to be used to provide the information required by this subsection.

(e) Any domestic insurer that has a management contract may request an exemption from the filing requirements of this section if the contract is for a group of affiliated insurers on a pooled funds basis or service company management basis, where costs to the individual member insurers are charged on an actually incurred or closely estimated basis. The request for an exemption must be in writing, must explain the basis for the exemption, and must be received by the Commissioner on or before the effective date of the contract. As used in this subsection, "affiliated" has the same meaning as in G.S. 58-19-5(1). Management contracts exempted under this subsection must still be reduced to written form."

SECTION 20.4. G.S. 58-34-15 reads as rewritten:

"**§ 58-34-15. Grounds for disapproval.**

(a) The Commissioner must disapprove any management contract or custodial agreement filed under G.S. 58-34-10 if, at any time, the Commissioner finds:

(1) That the service or management charges are based upon criteria unrelated either to the managed insurer's profits or to the reasonable customary and usual charges for ~~such~~ the services or are based on factors unrelated to the value of ~~such~~ the services to the insurer; or

(2) That management personnel or other employees of the insurer are to be performing management functions and receiving any remuneration ~~therefor~~for those functions through the management or service contract in addition to the compensation by way of salary received directly from the insurer for their services; or

(3) That the contract would transfer substantial control of the insurer or any of the powers vested in the board of directors, by statute, articles of incorporation, or bylaws, or substantially all of the basic functions of the insurance company management; or

(4) That the contract contains provisions that would be clearly detrimental to the best interest of policyholders, stockholders, or members of the insurer; or

(5) That the officers and directors of the management or custodial firm are of known bad character or have been affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions, or other insurance or business relations with any person known to have been involved in the improper manipulation of assets, accounts, or reinsurance.

(6) That the custodial agreement is not substantially the same as the form adopted by the Commissioner.

(b) If the Commissioner disapproves any management ~~contract,~~ contract or custodial agreement, notice of ~~such action~~ the disapproval shall be given to the insurer ~~assigning~~ stating the reasons ~~therefor~~ for the disapproval in writing. The Commissioner shall grant any party to the contract a ~~hearing upon request according to G.S. 58-2-50.~~ hearing if the party requests a hearing."

SECTION 20.5. G.S. 58-67-30 reads as rewritten:

"**§ 58-67-30. Management and ~~exclusive contracts.~~exclusive agreements; custodial agreements.**

(a) No health maintenance organization shall enter into an exclusive ~~agency contract or management contract~~ agency, management, or custodial agreement unless the ~~contract~~ agreement is first filed with the Commissioner and approved under this section within 45 days after filing or such reasonable extended period as the Commissioner shall specify by notice that is given within the 45 day period.

(b) The Commissioner shall disapprove ~~a contract~~ an agreement submitted under subsection (a) of this section if ~~he finds that:~~ the Commissioner determines that the agreement:

(1) ~~It subjects~~ Subjects the health maintenance organization to excessive charges;

(2) ~~The contract extends~~ Extends for an unreasonable period of time;

(3) ~~The contract does~~ Does not contain fair and adequate standards of performance;

(4) ~~The persons empowered~~ Enables persons under the contract to manage the health maintenance organization ~~are not~~ who are not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the health maintenance organization with due regard for the interests of its enrollees, creditors, or the public; or

(5) ~~The contract contains~~ Contains provisions that impair the interests of the organization's enrollees, creditors, or the public."

PART XXI. SELF-INSURED WORKERS' COMPENSATION.

SECTION 21.1. G.S. 58-47-60(9) reads as rewritten:

"(9) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a person is insolvent or, although not financially impaired or insolvent, is unlikely to be ~~able to meet obligations for known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.~~ able:

a. To meet obligations for known claims and reasonably anticipated claims; or

b. To pay other obligations in the normal course of business."

SECTION 21.2. G.S. 58-47-80 reads as rewritten:

"**§ 58-47-80. Assets and invested assets.**

Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, ~~58-7-177,~~ 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, ~~and 58-7-200.~~ 58-7-200, and 58-19-10."

SECTION 21.3. Part 3 of Article 47 of Chapter 58 of the General Statutes, comprising G.S. 58-47-210 through G.S. 58-47-220, is repealed.

PART XXII. CONTINUING CARE RETIREMENT COMMUNITIES.

SECTION 22.1. G.S. 58-64-005(a) reads as rewritten:

"(a) No provider shall engage in the business of offering or providing continuing care in this State without a license to do so obtained from the Commissioner as provided in this Article. It is a Class 1 misdemeanor for any person, other than a provider licensed under this Article, to advertise or market to the general public any product similar to continuing care through the use of such terms as 'life care', 'continuing care', or

'guaranteed care for life', or similar terms, words, or phrases. The licensing process may involve a series of steps pursuant to rules adopted by the Commissioner under this Article."

SECTION 22.2. G.S. 58-64-20 is amended by adding the following new subsections:

"(e) The disclosure statement shall be in plain English and in language understandable by a layperson and combine simplicity and accuracy to fully advise residents of the items required by this section.

(f) The Department may require a provider to alter or amend its disclosure statement in order to provide full and fair disclosure to prospective residents. The Department may also require the revision of a disclosure statement which it finds to be unnecessarily complex, confusing or illegible."

SECTION 22.3 G.S. 58-64-40(b) reads as rewritten:

"(b) The board of directors or other governing body of a facility or its designated representative shall hold ~~annual~~ semiannual meetings with the residents of the 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. Upon request of the most representative residents' organization, a member of the governing body of the provider, such as a board member, a general partner, or a principal owner shall attend such meetings. 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."

PART XXIII. MISCELLANEOUS TECHNICAL AMENDMENTS.

SECTION 23.1. The title of Article 4 of Chapter 58 of the General Statutes reads as rewritten:

"Article 4.

NAIC ~~Insurance Regulatory Information System.~~Filing Requirements."

SECTION 23.2. G.S. 58-5-63(a) reads as rewritten:

"(a) All insurance companies making deposits under this Article are entitled to interest on those ~~deposits, which shall remain in the deposit accounts.~~ deposits. The right to interest is subject to a company paying its insurance policy liabilities. If any company fails to pay those liabilities, interest accruing after the failure is payable to the Commissioner for the payment of those liabilities under subsection (b) of this section."

PART XXIV. INSURER INSOLVENCY REFUND THRESHOLDS.

SECTION 24.1. G.S. 58-5-70 reads as rewritten:

"**§ 58-5-70. Lien of policyholders; action to enforce.**

Upon the securities deposited with the Commissioner by any foreign or alien insurance company, the holders of all contracts of the company who are citizens or residents of this State at the time, or who hold policies issued upon property in the State,

shall have a lien for ~~the~~ amounts in excess of fifty dollars ($50.00) due them, respectively, under or in consequence of the contracts for losses, equitable values, return premiums, or otherwise, and shall be entitled to be paid ratably out of the proceeds of the securities, if the proceeds are not sufficient to pay all of the contract holders. When any foreign or alien insurance company depositing securities under this Article becomes insolvent or bankrupt or makes an assignment for the benefit of its creditors, any holder of the contract may begin an action in the Superior Court of the County of Wake to enforce the lien for the benefit of all the holders of the contracts. The Commissioner shall be a party to the suit, and the funds shall be distributed by the court, but the cost of the action shall not be adjudged against the Commissioner."

SECTION 24.2. G.S. 58-30-10(12) reads as rewritten:

"(12) 'General assets' means all real, personal, or other property that is not specifically mortgaged, pledged, hypothecated, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, 'general assets' includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets that are held in trust and on deposit for the security or benefit of all policyholders in more than one state or all policyholders and creditors in more than one state shall be treated as 'general assets'. No person shall have a claim against general assets unless that claim is in an amount in excess of fifty dollars ($50.00)."

SECTION 24.3. G.S. 58-30-10(19) reads as rewritten:

"(19) 'Special deposit claim' means any claim in excess of fifty dollars ($50.00) secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but does not include any claim secured by general assets."

SECTION 24.4. G.S. 58-48-95(c) reads as rewritten:

"(c) The Association shall account to the Commissioner and the insolvent insurer for all deposits received from the Commissioner under this ~~section, and shall repay to the Commissioner a portion of the deposits received, which shall be equal to the total amount of the claims against the insolvent insurer that are not covered claims under this Article solely by reason that the amount of the claim is fifty dollars ($50.00) or less. This repayment does not prejudice the rights of the Association with regard to the portion of the deposit repaid to the Commissioner.~~ section. After the deposits of the insolvent insurer received by the Association under this section have been expended by the Association for the purposes set out in this section, the member insurers shall be assessed as provided by this Article to pay any remaining liabilities of the Association arising under this Article."

SECTION 24.5. This section applies to estates that are pending.

PART XXV. DOMESTIC COMPANY PROTECTED CELLS.

SECTION 25. Article 10 of Chapter 58 of the General Statutes is amended by adding the following new Part:

"Part 4. Protected Cell Companies.

"**§ 58-10-75. Purpose and legislative intent.**

This Part provides a basis for the creation of protected cells by a domestic insurer as one means of accessing alternative sources of capital and achieving the benefits of insurance securitization. Investors in fully funded insurance securitization transactions provide funds that are available to pay the insurer's insurance obligations or to repay the investors or both. The creation of protected cells is intended to be a means to achieve more efficiencies in conducting insurance securitizations.

"**§ 58-10-80. Definitions.**

As used in this Part, unless the context requires otherwise, the following terms have the following meanings:

(1) 'Domestic insurer' means an insurer domiciled in the State of North Carolina.

(2) 'Fully funded' means that, with respect to any exposure attributed to a protected cell, the market value of the protected cell assets, on the date on which the insurance securitization is effected, equals or exceeds the maximum possible exposure attributable to the protected cell with respect to the exposures.

(3) 'General account' means the assets and liabilities of a protected cell company other than protected cell assets and protected cell liabilities.

(4) 'Indemnity trigger' means a transaction term by which relief of the issuer's obligation to repay investors is triggered by its incurring a specified level of losses under its insurance or reinsurance contracts.

(5) 'Fair value' means the amount at which that asset (or liability) could be bought (or incurred) or sold (or settled) in a current transaction between willing parties, that is, other than in a forced or liquidation sale. Quoted marked prices in active markets are the best evidence of fair value and shall be used as the basis for the measurement, if available. If a quoted market price is available, the fair value is the product of the number of trading units times market price. If quoted market prices are not available, the estimate of fair value shall be based on the best information available. The estimate of fair value shall consider prices for similar assets and liabilities and the results of valuation techniques to the extent available in the circumstances. Examples of valuation techniques include the present value of estimated expected future cash flows using a discount rate commensurate with the risks involved, option-pricing models, matrix pricing, option-adjusted spread models, and fundamental analysis. Valuation techniques for measuring financial assets and liabilities and

servicing assets and liabilities shall be consistent with the objective of measuring fair value. Those techniques shall incorporate assumptions that market participants would use in their estimates of values, future revenues, and future expenses, including assumptions about interest rates, default, prepayment, and volatility. In measuring financial liabilities and servicing liabilities at fair value by discounting estimated future cash flows, an objective is to use discount rates at which those liabilities could be settled in an arm's-length transaction. Estimates of expected future cash flows, if used to estimate fair value, shall be the best estimate based on reasonable and supportable assumptions and projections. All available evidence shall be considered in developing estimates of expected future cash flows. The weight given to the evidence shall be commensurate with the extent to which the evidence can be verified objectively. If a range is estimated for either the amount or timing of possible cash flows, the likelihood of possible outcomes shall be considered in determining the best estimate of future cash flows.

(6) 'Nonindemnity trigger' means a transaction term by which relief of the issuer's obligation to repay investors is triggered solely by some event or condition other than the individual protected cell company incurring a specified level of losses under its insurance or reinsurance contracts.

(7) 'Protected cell' means an identified pool of assets and liabilities of a protected cell company segregated and insulated by means of this Chapter from the remainder of the protected cell company's assets and liabilities.

(8) 'Protected cell account' means a specifically identified bank or custodial account established by a protected cell company for the purpose of segregating the protected cell assets of one protected cell from the protected cell assets of other protected cells and from the assets of the protected cell company's general account.

(9) 'Protected cell assets' means all assets, contract rights, and general intangibles, identified with and attributable to a specific protected cell of a protected cell company.

(10) 'Protected cell company' means a domestic insurer that has one or more protected cells.

(11) 'Protected cell company insurance securitization' means the issuance of debt instruments, the proceeds from which support the exposures attributed to the protected cell, by a protected cell company where repayment of principal or interest, or both, to investors under the transaction terms is contingent upon the occurrence or nonoccurrence of an event with respect to which the protected cell company is exposed to loss under insurance or reinsurance contracts it has issued.

(12) 'Protected cell liabilities' means all liabilities and other obligations identified with and attributable to a specific protected cell of a protected cell company.

"**§ 58-10-85. Establishment of protected cells.**

(a) A protected cell company may establish one or more protected cells with the prior written approval of the Commissioner of a plan of operation or amendments submitted by the protected cell company with respect to each protected cell in connection with an insurance securitization. Upon the Commissioner's written approval of the plan of operation, which plan shall include the specific business objectives and investment guidelines of the protected cell, the protected cell company, in accordance with the approved plan of operation, may attribute to the protected cell insurance obligations with respect to its insurance business and obligations relating to the insurance securitization and assets to fund the obligations. A protected cell shall have its own distinct name or designation, which shall include the words 'protected cell.' The protected cell company shall transfer all assets attributable to a protected cell to one or more separately established and identified protected cell accounts bearing the name or designation of that protected cell. Protected cell assets must be held in the protected cell accounts for the purpose of satisfying the obligations of that protected cell.

(b) All attributions of assets and liabilities between a protected cell and the general account must be in accordance with the plan of operation approved by the Commissioner. A protected cell company may make no other attribution of assets or liabilities between the protected cell company's general account and its protected cells. Any attribution of assets and liabilities between the general account and a protected cell, or from investors in the form of principal on a debt instrument issued by a protected cell company in connection with a protected cell company securitization, must be in cash or in readily marketable securities with established market values.

(c) The creation of a protected cell does not create, with respect to that protected cell, a legal person separate from the protected cell company. Amounts attributed to a protected cell under this Chapter, including assets transferred to a protected cell account, are owned by the protected cell company, and the protected cell company may not be, or may not hold itself out to be, a trustee with respect to those protected cell assets of that protected cell account. Notwithstanding the provisions of this subsection, the protected cell company may allow for a security interest to attach to protected cell assets or a protected cell account when in favor of a creditor of the protected cell and otherwise allowed under applicable law.

(d) This Part does not prohibit the protected cell company from contracting with or arranging for an investment advisor, commodity trading advisor, or other third party to manage the protected cell assets of a protected cell, if all remuneration, expenses, and other compensation of the third-party advisor or manager are payable from the protected cell assets of that protected cell and not from the protected cell assets of other protected cells or the assets of the protected cell company's general account.

(e) A protected cell company shall establish administrative and accounting procedures necessary to properly identify the one or more protected cells of the protected cell company and the protected cell assets and protected cell liabilities attributable to the protected cells. It shall be the duty of the directors of a protected cell company to keep protected cell assets and protected cell liabilities:

(1) Separate and separately identifiable from the assets and liabilities of the protected cell company's general account; and

(2) Attributable to one protected cell separate and separately identifiable from protected cell assets and protected cell liabilities attributable to other protected cells.

Notwithstanding the provisions of this subsection, if this subsection is violated, the remedy of tracing is applicable to protected cell assets when commingled with protected cell assets of other protected cells or the assets of the protected cell company's general account. The remedy of tracing is not an exclusive remedy.

(f) When establishing a protected cell, the protected cell company shall attribute to the protected cell assets a value at least equal to the reserves and other insurance liabilities attributed to that protected cell.

"**§ 58-10-90. Use and operation of protected cells.**

(a) The protected cell assets of a protected cell may not be charged with liabilities arising out of any other business the protected cell company may conduct. All contracts or other documentation reflecting protected cell liabilities shall clearly indicate that only the protected cell assets are available for the satisfaction of those protected cell liabilities.

(b) The income, gains and losses, realized or unrealized, from protected cell assets and protected cell liabilities must be credited to or charged against the protected cell without regard to other income, gains or losses of the protected cell company, including income, gains or losses of other protected cells. Amounts attributed to any protected cell and accumulations on the attributed amounts may be invested and reinvested without regard to any requirements or limitations of this Chapter and the investments in a protected cell or cells may not be taken into account in applying the investment limitations otherwise applicable to the investments of the protected cell company.

(c) Assets attributed to a protected cell must be valued at their fair value on the date of valuation.

(d) A protected cell company, with respect to any of its protected cells, shall engage in fully funded indemnity triggered insurance securitization to support in full the protected cell exposures attributable to that protected cell. A protected cell company insurance securitization that is nonindemnity triggered shall qualify as an insurance securitization under the terms of this Chapter only after the Commissioner adopts rules addressing the methods of funding of the portion of this risk that is not indemnity based and addressing accounting, disclosure, risk-based capital treatment, and assessing risks associated with the securitizations. A protected cell company insurance securitization that is not fully funded, whether indemnity triggered or nonindemnity triggered, is

prohibited. Protected cell assets may be used to pay interest or other consideration on any outstanding debt or other obligation attributable to that protected cell, and nothing in this subsection may be construed or interpreted to prevent a protected cell company from entering into a swap agreement or other transaction for the account of the protected cell that has the effect of guaranteeing interest or other consideration.

(e) In all protected cell company insurance securitizations, the contracts or other documentation effecting the transaction shall contain provisions identifying the protected cell to which the transaction will be attributed. In addition, the contracts or other documentation shall clearly disclose that the assets of that protected cell, and only those assets, are available to pay the obligations of that protected cell. Notwithstanding the provisions of this subsection and subject to the provisions of this Chapter and any other applicable law or rule, the failure to include such language in the contracts or other documentation may not be used as the sole basis by creditors, reinsurers, or other claimants to circumvent the provisions of this Part.

(f) A protected cell company shall only be authorized to attribute to a protected cell account the insurance obligations relating to the protected cell company's general account. Under no circumstances may a protected cell be authorized to issue insurance or reinsurance contracts directly to policyholders or reinsureds or have any obligation to the policyholders or reinsureds of the protected cell company's general account.

(g) At the cessation of business of a protected cell in accordance with the plan approved by the Commissioner, the protected cell company voluntarily shall close out the protected cell account.

"**§ 58-10-95. Reach of creditors and other claimants.**

(a) Protected cell assets shall only be available to the creditors of the protected cell company that are creditors with respect to that protected cell and, accordingly, are entitled, in conformity with this Chapter, to have recourse to the protected cell assets attributable to that protected cell and are absolutely protected from the creditors of the protected cell company that are not creditors with respect to that protected cell and who, accordingly, are not entitled to have recourse to the protected cell assets attributable to that protected cell. Creditors with respect to a protected cell are not entitled to have recourse against the protected cell assets of other protected cells or the assets or the protected cell company's general account. Protected cell assets are only available to creditors of a protected cell company after all protected cell liabilities have been extinguished or otherwise provided for in accordance with the plan of operation relating to that protected cell.

(b) When an obligation of a protected cell company to a person arises from a transaction, or is otherwise imposed, with respect to a protected cell:

(1) That obligation of the protected cell company extends only to the protected cell assets attributable to that protected cell, and the person, with respect to that obligation, is entitled to have recourse only to the protected cell assets attributable to that protected cell; and

(2) That obligation of the protected cell company does not extend to the protected cell assets of any other protected cell or the assets of the protected cell company's general account, and that person, with respect to that obligation, is not entitled to have recourse to the protected cell assets of any other protected cell or the assets of the protected cell company's general account.

(c) When an obligation of a protected cell company relates solely to the general account, the obligation of the protected cell company extends only to, and that creditor, with respect to that obligation, is entitled to have recourse only to the assets of the protected cell company's general account.

(d) The activities, assets, and obligations relating to a protected cell are not subject to the provisions of Articles 48 and 62 of this Chapter, and neither a protected cell nor a protected cell company may be assessed by, or otherwise be required to contribute to, any guaranty fund or guaranty association in this State with respect to the activities, assets, or obligations of a protected cell. Nothing in this subsection affects the activities or obligations of an insurer's general account.

(e) The establishment of one or more protected cells alone does not constitute a fraudulent conveyance, an intent by the protected cell company to defraud creditors, or the carrying out of business by the protected cell company for any other fraudulent purpose.

"**§ 58-10-100. Conservation, rehabilitation, or liquidation of protected cell companies;**

(a) Notwithstanding any other provision of law or rule, upon an order of conservation, rehabilitation, or liquidation of a protected cell company, the receiver shall deal with the protected cell company's assets and liabilities, including protected cell assets and protected cell liabilities, in accordance with the requirements set forth in this Part.

(b) With respect to amounts recoverable under a protected cell company insurance securitization, the amount recoverable by the receiver may not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation, or liquidation with respect to the protected cell company, notwithstanding any provisions to the contrary in the contracts or other documentation governing the protected cell company insurance securitization.

"**§ 58-10-105. No transaction of an insurance business.**

A protected cell company insurance securitization may not be deemed to be an insurance or reinsurance contract. An investor in a protected cell company insurance securitization, by sole means of this investment, may not be deemed to be conducting an insurance business in this State. The underwriters or selling agents and their partners, directors, officers, members, managers, employees, agents, representatives, and advisors involved in a protected cell company insurance securitization may not be deemed to be conducting an insurance or reinsurance agency, brokerage, intermediary, advisory, or consulting business by virtue of their activities in connection with that business.

"§ 58-10-110. Authority to adopt rules.

The Commissioner may adopt rules necessary to effectuate the purposes of this Part."

PART XXVI. EFFECT OF HEADINGS.

SECTION 26. The headings to the parts of this act are a convenience to the reader and for reference only. The headings do not expand, limit, or define the text of this act.

PART XXVII. SEVERABILITY.

SECTION 27. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

PART XXVIII. EFFECTIVE DATES.

SECTION 28. Except as otherwise provided in this act, this act is effective when it becomes law.

SENATE BILL 459:
Insurance Financial Amendments

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Wellons
Date:	May 23, 2001	**Summary by:**	Frank W. Folger
Version:	Second Edition		Committee Counsel

SUMMARY: ***This bill would amend North Carolina's insurance laws in Chapter 58 of the General Statutes regarding:***

- ***Insurance company reserving methods***
- ***Insurance company licensing provisions***
- ***Reinsurance for domestic companies***
- ***Domestic company formation***
- ***Insurance company solvency protection***
- ***Life insurance company variable accounts***
- ***Insurance company consolidations***
- ***Insurance company investments***
- ***Mutual insurance companies***
- ***Reinsurance intermediaries***
- ***Mortgage guaranty insurance***
- ***Risk-based capital requirements***
- ***Asset protection***
- ***Foreign insurance companies***
- ***Holding company systems***
- ***Surplus lines insurance***
- ***Risk retention groups***
- ***Insurance company receiverships***
- ***Managing general agents***
- ***Self-insured workers' compensation***
- ***Continuing care retirement communities***

It would also allow domestic insurance companies to form protected cells to access alternative sources of capital and achieve the benefits of securitization.

BILL ANALYSIS: The section-by-section analysis is as follows:

PART I. INSURANCE COMPANY RESERVING METHODS. [P.1 – 4]

Sections 1.1. and 1.2. would establish premium deficiency reserve requirements for insurance companies as standards to monitor its financial condition and would clarify and update provisions for loss and loss expense reserves for casualty insurance and surety companies.

PART II. INSURANCE COMPANY LICENSING PROVISIONS. [P.4-5]

Sections 2.1 - 2.3. would consolidate certain licensing provisions including revocation, suspension, and refusal to renew into one section to cover foreign and domestic companies, effective July 1, 2001.

PART III. REINSURANCE FOR DOMESTIC COMPANIES. [P.5 – 14]

Sections 3.1. - 3.3. would buttress the stated intent of provisions providing for credits to domestic insurers that cede to reinsurers, both foreign and domestic; strengthen regulatory control in this area; and provide acceptable reinsurance agreement provisions for insolvent ceding insurers.

Sections 3.4. - 3.6 would repeal G.S. 58-57-85, make technical changes and remove an unnecessary section.

Section 3.7. would apply Sects. 3.1 and 3.2 to all reinsurance cessions made on or after Jan. 1, 2002, under reinsurance agreements that have an inception, anniversary, or renewal date on or after Jan. 1, 2002 and make the remainder of the part effective when it becomes law.

PART IV. DOMESTIC COMPANY FORMATION AND RELOCATION. [P.15 – 16]

Sections 4.1. and 4.2. would require submission of background info on incorporators and proposed management personnel of proposed domestic insurer; and make technical changes to redomestication provisions.

PART V. INSURANCE COMPANY SOLVENCY PROTECTION. [P.16 –17]

Sections 5.1. and 5.2. would clarify how the Commissioner determines if an insurer's capital, surplus or both are impaired; restrict a domestic insurer's dividends and distributions to stockholders when it would cause a hazardous financial condition; and clarify other limitations on dividend and distribution making.

PART VI. LIFE INSURANCE COMPANY VARIABLE ACCOUNTS. [P. 17 – 18]

Sections 6.1. – 6.4 . would clarify how amounts are allocated to separate accounts; add guaranteed investment contracts as benefits provided under separate accounts; remove the limit on amounts that may be allocated to separate accounts; repeal the 10% limitation on investments in a single issuer and the 10% limitation on investments in more than 10% of the voting securities of a single issuer; remove language that is no longer needed because of the repeals of G.S. 58-7-95(e) and (f); and require life insurers to maintain assets in a separate account with a value at least equal to reserves and contract liabilities in the separate account, unless otherwise approved by the Commissioner.

PART VII. INSURANCE COMPANY CONSOLIDATION. [P. 18 – 19]

Sections 7.1. and 7.2 would more precisely define "assumption reinsurance agreements" and exempt consolidations from the provisions of 58-7-150 to the extent they are regulated under the holding company system provisions in Article 19 or other portions of the Chapter.

PART VIII. INSURANCE COMPANY INVESTMENTS. [P. 19 – 28]

Sections 8.1.- 8.18 would provide for limits on Canadian investments in relation to an insurer's admitted assets; clarify limitation language regarding medium to lower quality obligations; remove investment limits on public housing authority bonds, debentures, and other securities; remove investment limits on share and savings accounts; modify investment restricts on investment in industry, churches, and international banks; remove unnecessary investment provision language incorporated in other sections or Articles of the Chapter; define more clearly the conditions and limitations under which foreign investments may be made; make clarifying cross-reference changes; provide for additional methods of valuation of derivative investments; provide for a new statute (G.S. 58-7-205) to address derivative transactions; clarify the language in this subsection, which prohibits insurers from investing in or making loans to directors, officers, stockholders, or related persons; authorize insurers to engage in derivative transactions relative to hedging and certain income generation transactions; define conditions under which deivative transactions may be made and the types of investments that may be involved; authorize the Commissioner to adopt reasonable rules that impose financial solvency standards, valuation standards, reporting requirements, etc.; and clarify the language on health maintenance organization investments.

PART IX. MUTUAL INSURANCE COMPANIES. [P. 28 – 35]

Sections 9.1 – 9.6. would eliminate requirement of published notice when a special meeting is called to consider amending a charter of a mutual insurance company; clarify for purposes of dividend provisions that surplus means unassigned surplus in excess of required minimum surplus as reflected in the company's most recently filed financial statement; rename certain captions and titles in Article 10; and create a new section to safeguard policyholders in the event of a proposed conversion of mutual insurer to stock insurer.

PART X. REINSURANCE INTERMEDIARIES. [P. 35]

Sections 10.1 – 10.3. would provide for certain exemptions under reinsurance intermediaries provisions: to bypass requirement of intermediary license if compliant with Article 9, for insurer to engage services of a broker not licensed, for reinsurer to engage services of person to act as manager when that person is not licensed.

PART XI. MORTGAGE GUARANTY INSURANCE. [P. 35 – 40]

Section 11. would codify, through the creation of Part 5 of Article 10, administrative rules which, among other things, establish minimum policyholders position, a risk-based capital approach to determining the required capital and surplus for a mortgage guaranty insurer, and delineate the unearned premium reserve and contingency reserve requirements.

PART XII. RISK-BASED CAPITAL REQUIREMENTS. [P. 40 – 43]

Sections 12.1 –12.10 would subject both domestic health organizations (HMOs and service corporations) and foreign health organizations to risk-based capital requirements already applied to insurers in this State; to risk-based capital determinations applicable to property and casualty insurers; and to the company action level event provisions of Article 12. It would dictate forecasted financial results reporting, clarify applicability of certain mandatory control level event

provisions only to health organizations and life insurers and distinguish requirements for property and casualty insurers similarly situated; provide a phase-in for health organizations; and give the Commissioner authority to require an HMO to maintain a net worth greater than that required in Article 67, based upon risk-based capital principles determined by the Commissioner or the NAIC.

PART XIII. INSURANCE COMPANY ASSET PROTECTION. [P. 43]

Sections 13.1 - 13.4 would make technical corrections to simplify references to Chapter 58 and would add to the transactions exempted from the asset protection provisions, real estate (authorized under 58-7-187) encumbered by a mortgage with a first lien.

PART XIV. FOREIGN INSURANCE COMPANIES. [P. 43 – 45]

Sections 14.1 and 14.2. would make technical changes and add two new conditions for licensure of foreign companies: satisfying the Commissioner compliance with the new proposed 58-7-37 dealing with incorporators and proposed managers of the insurer; and irrevocably appointing the Commissioner as agent for service of process. It would further add that a company, to maintain licensure, among the existing requirements must satisfy the Commissioner that operation of the company would not be hazardous to prospective policyholder, creditors, or the general public.

PART XV. PROMOTING AND HOLDING COMPANIES [P. 45]

Section 15. would repeal Article 18, a now obsolete and unnecessary article on the sale of securities, an area covered by the N.C. Secretary of State's Office.

PART XVI. INSURANCE HOLDING COMPANY SYSTEMS. [P. 45 – 47]

Sections 16.1. - 16.7 would add LLCs to the definition of "person" under the holding company systems provisions; simplify references to Chapter 58; includes HMOs in the provisions on investments limitations regarding subsidiaries; make technical changes; exempt demutualizations from the Holding Company Act provisions on acquisition and control of stock of a domestic insurer as long as no person is acquiring control of the parent company; reorganize portions of the registration provisions to achieve clarity; change the amendment to registration filing deadline from March 1 to April 1; and add "guarantees" to the list of transactions requiring prior Commission approval.

PART XVII. SURPLUS LINES INSURANCE. [P. 47 – 49]

Sections 17.1. and 17.2 would expressly require alien surplus lines insurers to comply with certain capital and surplus requirements; increase the minimum trust fund balances that must be maintained and the capital and surplus amounts required to protect policyholders; provide for trust fund balance and capital and surplus requirements to protect policyholders of a group of incorporated insurers under common administration which has continuously transacted an insurance business outside of the U.S. for at least three years; and allow the Commissioner, in addition to other authority, to declare that a surplus lines insurer is no longer eligible to write coverage in this State if he has reason to believe the insurer has acted in an untrustworthy manner.

PART XVIII. RISK RETENTION GROUPS. [P. 49]

Section 18. would add insolvency to the definition of "hazardous financial condition".

PART XIX. INSURANCE COMPANY RECEIVERSHIPS. [P. 49]

Section 19. would remove the scope limitations regarding an insurer obtaining consent from the Commissioner before engaging in certain transactions.

PART XX. MANAGING GENERAL AGENTS. [P. 49 – 54]

Sections 20.1. – 20.5. would define "custodial agreements" and "management contracts"; clarify provisions regarding Commissioner withdrawal of approval of a managing general contract and notice and opportunity to be heard on the matter; and subject custodial agreements to the filing requirements for management contracts, to the grounds for disapproval of a management agreement, and to the requirement of Commissioner approval.

PART XXI. SELF-INSURED WORKERS' COMPENSATION. [P. 54]

Sections 21.1. – 21.3. would reorganize, for clarity, certain language in the definition of "hazardous financial condition", repeal an "unfunded" and now-unneeded 1998 third party administrator licensing law, and make conforming technical changes.

PART XXII. CONTINUING CARE RETIREMENT COMMUNITIES. [P. 54 – 55]

Sections 22.1. – 22.3. would make it a Class 1 misdemeanor for an unlicensed person to advertise or market products similar to continuing care via terminology associated with continuing care retirement communities; strengthen disclosure statement provisions; provide for semi-annual rather than annual meetings of the governing body with the residents; and allow the residents' representative organization to request a board member, partner, or principal owner to attend the meetings.

PART XXIII. MISCELLANEOUS TECHNICAL AMENDMENTS. [P. 55]

Sections 23.1. and 23.2. would change the title of Article 4 to more clearly reflect its contents, and remove unnecessary language in Article 5 on deposits.

PART XXIV. INSURER INSOLVENCY REFUND THRESHOLDS. [p. 55 – 56]

Sections 24.1. – 24.4. would set a threshold of $50 for claims under the Insurance Guaranty Association statutes and apply the change to estates still pending.

PART XXV. DOMESTIC COMPANY PROTECTED CELLS [p. 56 – 62]

Section. 25. would create a new Part 4 in Article 10. This new Part provides a basis for the creation of protected cells by domestic insurers as one means of accessing alternative sources of capital and achieving the benefits of insurance securitization. Investors in fully funded insurance securitization transactions provide funds that are available to pay the insurer's insurance obligations or to repay the investors or both. Under the terms of the typical debt instrument underlying an insurance securitization transaction, prepaid principal is repaid to the investor on a specified maturity date with interest, unless a trigger event occurs. The insurance securitization proceeds secure both the protected cell company's

insurance obligations if a trigger event occurs, as well as the protected cell company's obligation to repay the insurance securitization investors if a trigger event does not occur. This Part creates more efficiency in conducting insurance securitizations, allows domestic protected cell companies easier access to alternative sources of capital, and promotes the benefits of insurance securitization generally.

PART XXVI. EFFECT OF HEADINGS. [P. 62]

Section 26. – The headings are for convenience only.

PART XXVII. SEVERABILITY. [P. 62]

Section 27. – Severability clause.

PART XXVIII. EFFECTIVE DATES. [P. 62]

Section 28. – Except as otherwise provide, effective when it becomes law.

PROPOSED COMMITTEE SUBSTITUTE FOR S.B. 459
INSURANCE FINANCIAL AMENDMENTS
SECTION-BY-SECTION SUMMARY
PREPARED BY THE DEPARTMENT OF INSURANCE
FOR THE HOUSE INSURANCE COMMITTEE
MAY 30, 2001

PART I. INSURANCE COMPANY RESERVING METHODS.

SECTION 1.1/ G.S. 58-3-72: Establishes criteria for the establishment and maintenance of premium deficiency reserves to assure that an insurer's unearned premium reserves are based on appropriate premium charges.

SECTION 1.2/G.S. 58-3-81: Updates and clarifies existing requirements for the establishment of loss and loss expense reserves of casualty and surety insurers.

PART II. INSURANCE COMPANY LICENSING PROVISIONS.

SECTION 2.1/G.S. 58-3-90: Removes language that is already included in G.S. 58-3-100. Any language currently in G.S. 58-3-90 that is not already included in G.S. 58-3-100 is being placed in G.S. 58-3-100 in SECTION 2.2. This change will remove the redundancy in both statutes and consolidate all language regarding revocation, suspension, or refusal to renew the license of insurers into G.S. 58-3-100.

SECTION 2.2/G.S. 58-3-100: Consolidates all language regarding revocation, suspension, or refusal to renew the license of insurers into G.S. 58-3-100, as well as clarify some existing language. The new language in G.S. 58-3-100 represents language transferred from G.S. 58-3-90. Currently, G.S. 58-3-90 addresses only foreign insurers while G.S. 58-3-100 addresses all insurers in general. The amended version of G.S. 58-3-100 will cover both foreign and domestic insurers.

PART III. REINSURANCE FOR DOMESTIC COMPANIES.

SECTION 3.1/G.S. 58-7-21: Clarifies language that trusts are for the benefit of ceding insurers and the funding of liabilities for business ceded by U.S. ceding insurers; includes stronger language regarding regulatory approval of trusts; includes an improved definition of liabilities; and other changes to strengthen policyholder protection consistent with customary state regulatory laws.

SECTION 3.2/G.S. 58-7-26: Clarifies section title, language regarding trusts, and some clean-up changes.

SECTION 3.3/G.S. 58-7-30: Improves language by replacing "deduction" with "reduction" and sets forth permissible reinsurance agreement provisions when a ceding insurer is insolvent.

SECTION 3.4/G.S. 58-7-31(c): Technical correction: Changes an improper cross-reference.

SECTION 3.5/G.S. 58-7-31(d)(1): Technical correction: Changes "final" to "financial."

SECTION 3.6/G.S. 58-57-85: Removes this section because it is no longer needed. G.S. 58-7-21, 58-7-26, etc., supersede G.S. 58-57-85 for reinsurance requirements in credit insurance..

PART IV. DOMESTIC COMPANY FORMATION AND RELOCATION.

SECTION 4.1/G.S. 58-7-37: Adds requirements for reviewing the background and suitability of all key persons of a proposed domestic insurer.

SECTION 4.2: Makes technical corrections.

PART V. INSURANCE COMPANY SOLVENCY PROTECTION.

SECTION 5.1/G.S. 58-7-75(10): Explains the procedure that the Commissioner uses to determine the amount of the impairment of capital or surplus or both.

SECTION 5.2/G.S. 58-7-130: Clarifies the requirements and limitations on the payment of dividends and distributions to stockholders to prohibit payments that are above a certain amount or that would be detrimental to policyholders.

PART VI. LIFE INSURANCE COMPANY VARIABLE ACCOUNTS.

SECTION 6.1/G.S. 58-7-95(b): Clarifies how amounts are allocated to separate accounts. Also, adds guaranteed investment contracts to the benefits to be provided under separate accounts.

SECTION 6.2/G.S. 58-7-95(c): Removes the limit on amounts that may be allocated to separate accounts. The existing limit is overly restrictive.

SECTION 6.3/G.S. 58-7-95(e) and (f): Repeals the 10% limitation on investments in a single issuer and the 10% limitation on investments in more than 10% of the voting securities of a single issuer. The current limits are overly restrictive.

SECTION 6.4/G.S. 58-7-95(g): Removes language that is no longer needed because of the repeals of G.S. 58-7-95(e) and (f). The added language requires life insurers to maintain assets in a separate account with a value at least equal to reserves and contract liabilities in the separate account, unless otherwise approved by the Commissioner.

PART VII. INSURANCE COMPANY CONSOLIDATIONS.

SECTIONS 7.1 and 7.2/G.S. 58-7-150: Defines assumption reinsurance agreements more clearly and exempts consolidations to the extent they are regulated by Article 19 or other sections of Chapter 58.

PART VIII. INSURANCE COMPANY INVESTMENTS.

SECTION 8.1/G.S. 58-7-170(b): Consolidates the reference in the introductory paragraph to investment limitations that are contained throughout this section and under other sections that authorize such investments. Removes language proposed for inclusion in the introductory paragraph of G.S. 58-7-170(b). Places certain limits on the amount of Canadian investments that may be held by an insurer.

SECTION 8.2/G.S. 58-7-170(d): Simplifies which investments are subject to the limitations on medium and lower grade investments.

SECTION 8.3/G.S. 58-7-173(9): Removes overly restrictive limits on investments in public housing authorities backed by the United States or agency of the United States.

SECTION 8.4/G.S. 58-7-173(10): Changes the limits on investments in international banks, etc., to apply to any one institution rather than to all such investments.

SECTION 8.5/G.S. 58-7-173(11): Removes the overly restrictive limit on investments in any one industry. Limits investments in any one issuer to 3% of admitted assets, removing the additional limitation of 10% of capital and surplus.

SECTION 8.6/G.S. 58-7-173(12): Adjusts the investment limitations on secured investments in churches and church holding companies to a more reasonable level.

SECTION 8.7/G.S. 58-7-173(14): Removes overly restrictive limitations on investments in share or savings accounts in savings and loan or building and loan associations.

SECTION 8.8/G.S. 58-7-173(16): Removes unnecessary language relating to foreign investments, since those investments are now fully addressed under G.S. 58-7-178.

SECTION 8.9/G.S. 58-7-177: Removes provisions relating to investments in subsidiaries and affiliated corporations, which are fully addressed under the Holding Company Act (Article 19 of Chapter 58).

SECTION 8.10/G.S. 58-23-26(c): Removes the reference to G.S. 58-7-177, which is repealed in SECTION 8.9 and is addressed under the Holding Company Act.

SECTION 8.11/G.S. 58-7-178: Defines more clearly the conditions and limitations under which foreign investments may be made.

SECTION 8.12/G.S. 58-7-185(a)(2): Changes the statute reference on affiliated investments from G.S. 58-7-177, which is being repealed, to G.S. 58-19-10 (Holding Company Act).

SECTION 8.13/G.S. 58-7-185(a)(3): Removes a provision already included in G.S. 58-7-175, 58-7-185(2), and 58-7-200(e).

SECTION 8.14/G.S. 58-7-192(d): Provides for additional methods of valuation of derivative investments.

SECTION 8.15/G.S. 58-7-200(b): Provides for a new statute (G.S. 58-7-205) to address derivative transactions.

SECTION 8.16/G.S. 58-7-200(c): Clarifies the language in this subsection, which prohibits insurers from investing in or making loans to directors, officers, stockholders, or related persons.

SECTION 8.17/G.S. 58-7-205: Authorizes insurers to engage in derivative transactions relative to hedging and certain income generation transactions. Defines conditions under which such transactions may be made and the types of investments that may be involved. Authorizes the Commissioner to adopt reasonable rules that impose financial solvency standards, valuation standards, reporting requirements, etc.

SECTION 8.18/G.S. 58-67-60: Clarifies the language on health maintenance organization investments.

PART IX. MUTUAL INSURANCE COMPANIES.

SECTION 9.1/G.S. 58-8-5(a)(3): Reduces unnecessary notice requirements for a mutual insurer when attempting to amend its charter at a regular annual meeting of policyholders. The Commissioner must still approve a special meeting, but a published notice would no longer be required.

SECTION 9.2/G.S. 58-8-25: Clarifies certain language. Defines surplus as unassigned surplus, and only that in excess of any required minimum surplus, as reflected in the insurer's financial statement filed with the Commissioner under G.S. 58-2-165.

SECTION 9.3/G.S. 58-10-1: Changes caption to refer to all insurers that are authorized to convert from a stock to a mutual insurer.

SECTION 9.4/ Article 10 – Part 1: Changes the subtitle Part 1 to apply to the conversion of both stock and mutual insurers.

SECTION 9.5/G.S. 58-10-10: Changes caption to more accurately reflect the section.

SECTION 9.6/G.S. 58-10-12: Adds additional policyholder protections if an insurer proposes to convert from a mutual insurer to a stock insurer.

PART X. REINSURANCE INTERMEDIARIES.

SECTION 10.1/G.S. 58-9-6(a): Provides for an exemption to the requirement for an intermediary license to any person who has complied with the requirements of Article 9.

SECTION 10.2/G.S. 58-9-11(b): Provides for an exemption to the prohibition of an insurer engaging the services of any person or broker on its behalf unless the person is licensed under G.S. 58-9-6.

SECTION 10.3/G.S. 58-9-21(a): Provides for an exemption to the prohibition of a reinsurer engaging the services of any person to act as a manager on its behalf unless the person is licensed under G.S. 58-9-6.

PART XI. MORTGAGE GUARANTY INSURANCE.

SECTION 11/Article 10 – Part 5: This Part establishes statutory provisions relating to mortgage guaranty insurance that is currently addressed by administrative rules. It includes a contingency reserve requirement and introduces the concept of minimum policyholders' position, which is a risk-based capital approach to determining the amount of capital and surplus required for a mortgage guaranty insurer.

PART XII. RISK-BASED CAPITAL REQUIREMENTS.

SECTION 12.1/G.S. 58-12-2(3): Subjects domestic health organizations (defined as HMOs and service corporations) to risk based capital requirements.

SECTION 12.2/G.S. 58-12-2(4): Subjects foreign health organizations to risk based capital requirements.

SECTION 12.3/G.S. 58-12-2(4)(b): Adds new subsection G.S. 58-12-2(4b) to define a health organization.

SECTION 12.4/G.S. 58-12-6(d): Subjects health organizations to the same risk-based capital instructions as property or casualty insurers.

SECTION 12.5/G.S. 58-12-11(a)(1)a: Provides that health organizations and property or casualty insurers as those insurers that are subject to a company action level event as described in this sub-subdivision.

SECTION 12.6/G.S. 58-12-11(b)(3): Defines specifically the forecasted financial results that are applicable to health organizations.

SECTION 12.7/G.S. 58-12-25(b): Clarifies that only life insurers and health organizations are subject to this subsection.

SECTION 12.8/G.S. 58-12-25(c): Adds new subsection G.S. 58-12-25(c) detailing certain actions the Commissioner may take relative to a property or casualty insurer.

SECTION 12.9/G.S. 58-12-61: Adds new section to provide for a phase-in provision for health organizations.

SECTION 12.10/ 58-12-70: Adds new subsection that gives the Commissioner the authority to require a health maintenance organization to have and maintain a larger amount of net worth based upon the principles of risk-based capital as determined by the National Association of Insurance Commissioners or the Commissioner.

PART XIII. INSURANCE COMPANY ASSET PROTECTION.

SECTION 13.1/G.S. 58-13-10: Simplifies references to Chapter 58. Further defines certain transactions that are exempt from the Asset Protection Act (Article 13 of Chapter 58).

SECTION 13.2/G.S. 58-13-15(3): Simplifies references to Chapter 58.

SECTION 13.3/G.S. 58-13-15(4): Simplifies references to Chapter 58.

SECTION 13.4/G.S. 58-13-20(b): Simplifies references to Chapter 58.

PART XIV. FOREIGN INSURANCE COMPANIES.

SECTION 14.1/G.S. 58-16-5: Simplifies references to Chapter 58 and clarifies certain other language. Adds new subsection (9) requiring an insurer to satisfy the Commissioner that it is compliance with new G.S. 58-7-37; adds new subsection (10) requiring an insurer to file an instrument (power of attorney) appointing the Commissioner as the insurer's agent on whom any legal process under G.S. 58-16-30 may be served.

SECTION 14.2/G.S. 58-16-6: Adds an additional statute reference (G.S. 58-16-5(8)) with which an insurer must remain in substantial compliance.

PART XV. PROMOTING AND HOLDING COMPANIES.

SECTION 15/Article 18: Repeals G.S. 58-18-1, 58-18-5, 58-18-10, 58-18-15, 58-18-20, and 58-18-25. The Department's involvement in the sale of securities as currently provided for in Article 18 is not needed because the N.C. Secretary of State's Office currently regulates the sale

of securities in this State, including such transactions involving insurance corporations or promoting or holding corporations.

PART XVI. INSURANCE HOLDING COMPANY SYSTEMS.

SECTION 16.1/G.S. 58-19-5(5): Defines "person" further to include a "limited liability company."

SECTION 16.2/G.S. 58-19-10(b): Simplifies references to Chapter 58 in the introductory paragraph.

SECTION 16.3/G.S. 58-19-10(b)(1): Adds health maintenance organizations to the provision for determining the amount of investments in a subsidiary company.

SECTION 16.4/G.S. 58-19-10(b)(3): Improves terminology.

SECTION 16.5/G.S. 58-19-15(h): Exempts demutualizations from the provisions of the Holding Company Act on acquisition of control of domestic insurers as long as no person is acquiring control of the parent company.

SECTION 16.6/G.S. 58-19-25(a): Clarifies subsection (a) by using subdivisions. There is no substantive change in the law.

SECTION 16.7/G.S. 58-19-30(b)(4): Adds "guarantees" to the list of transactions that may not be entered into without the prior approval of the Commissioner.

PART XVII. SURPLUS LINES INSURANCE.

SECTION 17.1/G.S. 58-21-20(a)(2): Updates the requirements for surplus lines insurers by (1) expressly requiring alien insurers to comply with the capital and surplus requirements of G.S. 58-7-75 as well as increases the amount required to be maintained in a trust fund for the protection of all its policyholders from $2,500,000 to $5,400,000; (2) clarifies Lloyd's plans or similar group of insurers as well as increases the amount required to be maintained in a trust fund for the protection of all policyholders and creditors; (3) adds additional protection for policyholders of insurance exchanges by increasing capital and surplus requirements; and (4) adds policyholder protection in the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the U.S. for at least three years prior to this time.

SECTION 17.2/G.S. 58-21-30(1): Adds an additional basis that the Commissioner may use in declaring that a surplus lines insurer is no longer eligible to write coverage in this State.

PART XVIII. RISK RETENTION GROUPS.

SECTION 18/G.S. 58-22-10(3): Defines "hazardous financial condition" to include the condition of insolvency.

PART XIX. INSURANCE COMPANY RECEIVERSHIPS.

SECTION 19/G.S. 58-30-75(7): Subjects insurers to the prior approval of the Commissioner for certain transactions similar to but not limited to those addressed under G.S. 58-7-150.

PART XX. MANAGING GENERAL AGENTS.

SECTION 20.1: Adds definitions of terms used in the Article ("custodial agreements" and "management contracts").

SECTION 20.2/ 58-34-2: Clarifies existing language relative to the Commissioner giving notice for withdrawal of approval of a MGA contract and opportunity for hearing.

SECTION 20.3/G.S. 58-34-10: Subjects custodial agreements to the filing requirements under this section.

SECTION 20.4/G.S. 58-34-15: Subjects custodial agreements to the grounds for disapproval under this section.

SECTION 20.5/G.S. 58-67-30: Adds custodial agreement as one of the agreements requiring the approval of the Commissioner.

PART XXI. SELF-INSURED WORKERS' COMPENSATION.

SECTION 21.1/G.S. 58-47-60(9): Clarifies this section by using sub-subdivisions. There is no substantive change in the law.

SECTION 21.2/G.S. 58-47-80: Removes the reference to G.S. 58-7-177 because the section is being repealed. Adds G.S. 58-19-10 as investment authority for subsidiary investments to replace G.S. 58-7-177.

SECTION 21.3/G.S. 58-47-210 et. seq.: Repeals a 1998 TPA licensing law that never became effective because of lack of funding. It is not considered necessary by anyone now.

PART XXII. CONTINUING CARE RETIREMENT COMMUNITIES.

SECTION 22.1/G.S. 58-64-5(a): Makes it a Class 1 misdemeanor for an unlicensed person to advertise any product similar to continuing care by using terms normally associated with continuing care retirement communities.

SECTION 22.3/G.S. 58-64-20(e) and (f): Improves the law on disclosure statements provided by continuing care retirement communities to their residents.

SECTION 22.3/G.S. 58-64-40(b): Adds additional opportunities for input by residents of facilities.

PART XXIII. MISCELLANEOUS TECHNICAL AMENDMENTS.

SECTION 23.1/Article 4: Changes the title of Article 4 of Chapter 58 to more clearly reflect the contents of that Article.

SECTION 23.2/G.S. 58-5-63(a): Removes the unnecessary phrase, "which shall remain in the deposit accounts." This section already provides that insurers are entitled to interest on their accounts unless they become delinquent in making payments to claimants.

PART XXIV. INSURER INSOLVENCY REFUND THRESHOLDS.

Under the Insurance Guaranty Association statutes, the Association covers claims in excess of $50. The Commissioner is responsible for handling special deposit claims of $50 or less. From quick access special deposit monies, the guaranty association has to repay the Commissioner a pro rata amount of money needed to pay these claims. A pro rata sum may be for a very small amount of money. Also, it is usually years before the Association finishes paying claims so that that calculation can be made. By then it is often difficult to locate the persons with these small claims.

Processing and paying claims (usually unearned premium claims) in the amount of $50 or less is not cost or time efficient. The process includes determining whom the claimants are, locating current addresses, establishing the amounts of individual claims, and issuing and mailing checks. In a large estate, the number of claims can run into the thousands.

Each situation is different, but the typical situation would likely cost between $10,000 and $15,000 to process the under $50 checks and then follow up on the bad addresses. Of this cost, about $1,000 is materials cost (including postage) and the remainder is labor cost (imputed wages plus benefits).

This is money from the estate that could otherwise go toward claims or other obligations of the insolvent insurer. This is money that would otherwise go to the Guaranty Association and could be used to reduce or eliminate assessments and, therefore, reduce the premium tax credits filed by insurance companies.

PART XXV. DOMESTIC INSURANCE COMPANY PROTECTED CELLS

This new Part provides a basis for the creation of protected cells by domestic insurers as one means of accessing alternative sources of capital and achieving the benefits of insurance securitization. Investors in fully funded insurance securitization transactions provide funds that are available to pay the insurer's insurance obligations or to repay the investors or both. The creation of protected cells is intended to be a means to achieve more efficiency in conducting insurance securitizations. Under the terms of the typical debt instrument underlying an insurance securitization transaction, prepaid principal is repaid to the investor on a specified maturity date with interest, unless a trigger event occurs. The insurance securitization proceeds secure both the protected cell company's insurance obligations if a trigger event occurs, as well as the protected cell company's obligation to repay the insurance securitization investors if a trigger event does not occur. This Part creates more efficiency in conducting insurance securitizations, allows domestic protected cell companies easier access to alternative sources of capital, and promotes the benefits of insurance securitization generally.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

May 30, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 468 – Workers' Compensation Insurance

Presently, of all the kinds of insurance purchased by businesses in North Carolina, only in workers' compensation insurance are employers afforded less protection against inadequate notice of policy cancellations, nonrenewals, or changes in premium rates or coverages. In all other kinds of property and liability insurance purchased by businesses, there are stated grounds for cancellations and minimum notice requirements for nonrenewals or renewals with premium rate increases or coverage changes that do not favor the purchaser.

This bill would establish the same standards for workers' compensation insurance that are in North Carolina law (Article 41 of General Statute Chapter 58).

The bill would prohibit workers' compensation insurance policy cancellations except for one of the following reasons: (1) nonpayment of premium, (2) material misrepresentations or nondisclosures of material facts in policy transactions, (3) material changes in risk that could not have been contemplated by the parties, (4) substantial breach of contractual duties, conditions, or warranties materially affecting insurability, (5) an insured's fraudulent act that materially affects insurability, (6) an insured's willful failure to take reasonable loss control measures that materially affect insurability, (7) loss of facultative reinsurance or substantial changes in applicable reinsurance, (8) an insured's conviction of a crime arising out of acts that materially affect insurability, (9) a

(Continued on other side.)

determination by the Commissioner of Insurance that continuation of the policy would violate state law, or (10) the insured's failure to meet requirements in the insurer's corporate charter, articles of incorporation, or bylaws, when the insurer is a company organized for the sole purpose of providing members of an organization with insurance coverage in NC.

It would require 15 days advance written notice of permitted cancellations.

It would require insurers to give 45 days advance written notice of a refusal to renew a policy and 30 days advance written notice of reductions in coverage limits or increases in deductibles or premiums.

The effective date would be Oct. 1, 2001, and the act would apply to policies issued, renewed, or amended on or after that date.

SENATE BILL 468:
Worker's Comp. Cancellations & Renewals -AB

BILL ANALYSIS

Committee:	House Insurance Committee	**Introduced by:**	Sen. Wellons
Date:	May 30, 2001	**Summary by:**	Trina Griffin and Frank W. Folger
Version:	PCS for Second Edition (S468-CSSO-42		Committee Counsel

SUMMARY: ***Senate Bill 468 provides guidelines, rights, and obligations for worker's compensation insurance policy cancellations and nonrenewals consistent with the guidelines, rights, and obligations for other lines of property and liability insurance.***

CURRENT LAW: Presently, employers are afforded less protection against inadequate notice of policy cancellations, nonrenewals, or changes in premium rates or coverages with regard to worker's compensation insurance compared to other kinds of insurance purchased by businesses in North Carolina. In all other kinds of property and liability insurance purchased by businesses, there are stated grounds for cancellations and minimum notice requirements for nonrenewals or renewals with premium rate increases or coverage changes that do not favor the purchaser.

For worker's compensation policies, G.S. 97-99 requires only a 30-day written notice, by registered or certified mail, to the insured of a carrier's intention to cancel the policy. A carrier need only provide 10 days written notice for cancellation due to nonpayment of premium. There are no other statutory guidelines for the cancellation or nonrenewal of worker's compensation policies.

BILL ANALYSIS: Senate Bill 468 would establish the same standards for workers' compensation insurance that are currently in place for other lines of property and liability insurance purchased by North Carolina businesses:

Cancellations

1. The bill would prohibit workers' compensation insurance policy cancellations except for one of the following reasons:
   - Nonpayment of premium.
   - Material misrepresentations or nondisclosures of material facts in policy transactions.
   - Material changes in risk that could not have been contemplated by the parties.
   - Substantial breach of contractual duties, conditions, or warranties materially affecting insurability.
   - An insured's fraudulent act that materially affects insurability.
   - An insured's willful failure to take reasonable loss control measures that materially affect insurability.
   - Loss of facultative reinsurance or substantial changes in applicable reinsurance.
   - An insured's conviction of a crime arising out of acts that materially affect insurability.
   - A determination by the Commissioner of Insurance that continuation of the policy would violate state law.

- The insured's failure to meet requirements in the insurer's corporate charter, articles of incorporation, or bylaws, when the insurer is a company organized for the sole purpose of providing members of an organization with insurance coverage in NC.

2. It would require 15 days advance notice to the insured by registered or certified mail, return receipt requested, of a permitted cancellation and the reason for the cancellation.

Nonrenewals - It would require insurers to give 45 days advance notice by mail of a refusal to renew a policy.

Premium Rate Increase or Change in Coverage Limits - It would require insurers to give 30 days advance notice by mail of increases in deductibles or premiums or any lowering of coverage limits *for reasons within the exclusive control of the insurer or other than at the policyholder's request. Such reasons do not include changes in experience modification, exposure, or loss cost rate.*

Registered or Certified Mail Requirements - Regular first class mail would be sufficient for any required notice mailings except that registered or certified mail, return receipt requested, is required to be used to notify an insured of cancellation of a policy pursuant to one of the cancellation bases in new N.C.G.S. § 58-36-105.

EFFECTIVE DATE: The effective date is Oct. 1, 2001, and the act would apply to policies issued, renewed or subject to renewal, or amended on or after that date.

DIFFERENCE FROM SECOND EDITION *The PCS adds language of limitation to subsection (d) of new N.C.G.S. § 58-36-110 to clarify that notice of a raise in premium rates and deductibles or a decrease in coverage limits is only required when the change is initiated by the insurer for "reasons within the exclusive control of the insurer."*

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 468 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR GUIDELINES, RIGHTS, AND OBLIGATIONS IN WORKERS' COMPENSATION INSURANCE POLICY CANCELLATIONS AND NONRENEWALS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 468*

Insurance and Consumer Protection Committee Substitute Adopted 4/4/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S468*-PCS7243-SO-42

Short Title: Workers' Comp. Cancellations and Renewals-AB. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR GUIDELINES, RIGHTS, AND OBLIGATIONS IN WORKERS' COMPENSATION INSURANCE POLICY CANCELLATIONS AND NONRENEWALS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-99 reads as rewritten:

"**§ 97-99. Law written into each insurance policy; form of policy to be approved by Commissioner of Insurance; ~~cancellation;~~ single catastrophe hazards.**

(a) Every policy for the insurance of the compensation ~~herein provided,~~ in this Article, or against liability therefor, shall be deemed to be made subject to the provisions of this Article. No corporation, association or organization shall enter into any such policy of insurance unless its form ~~shall have~~ has been approved by the Commissioner of Insurance. ~~No policy form shall be approved unless the same shall provide a 30-day prior notice of an intention to cancel same by the carrier to the insured by registered mail or certified mail. This shall not apply to the expiration date shown in the policy. The carrier may cancel the policy for nonpayment of premium on 10 days' written notice to the insured, and the insured may cancel the policy on 10 days' written notice to the carrier. Whenever notice of intention to cancel is required to be given by registered or certified mail, no cancellation by the insurer shall be effective unless and until such method is employed and completed.~~

(b) This Article shall not apply to policies of insurance against loss from explosion of boilers or flywheels or other similar single catastrophe hazards: Provided, that nothing ~~herein contained shall be construed to relieve the~~ in this Article relieves an employer from liability for injury or death of an employee as a result of such an explosion or catastrophe."

SECTION 2. Article 36 of Chapter 58 of the General Statutes is amended by adding two new sections to read:

"§ 58-36-105. Certain workers' compensation insurance policy cancellations prohibited.

(a) No policy of workers' compensation insurance or employers' liability insurance written in connection with a policy of workers' compensation insurance shall be cancelled by the insurer before the expiration of the term or anniversary date stated in the policy and without the prior written consent of the insured, except for any one of the following reasons:

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

(2) An act or omission by the insured or the insured's 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 the insured's representative that materially affects the insurability of the risk.

(6) Willful failure by the insured or the insured's 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.

(10) The named insured fails to meet the requirements contained in the corporate charter, articles of incorporation, or bylaws of the insurer, when the insurer is a company organized for the sole purpose of providing members of an organization with insurance coverage in this State.

(b) Any cancellation permitted by subsection (a) of this section is not effective unless written notice of cancellation has been given by registered or certified mail, return receipt requested, to the insured not less than 15 days before the proposed effective date of cancellation. The notice shall be given by registered or certified mail, return receipt requested, to the insured and any other person designated in the policy to receive notice of cancellation at their addresses shown in the policy or, if not indicated in the policy, at their last known addresses. The notice shall state the precise reason for cancellation. Whenever notice of intention to cancel is required to be given by registered or certified mail, no cancellation by the insurer shall be effective unless and

until such method is employed and completed. Failure to send this notice, as provided in this section, to any other person designated in the policy to receive notice of cancellation invalidates the cancellation only as to that other person's interest.

(c) This section does not apply to any policy that has been in effect for fewer than 60 days and is not a renewal of a policy. That policy may be cancelled for any reason by giving at least 30 days' prior written notice of and reasons for cancellation to the insured by registered or certified mail, return receipt requested.

(d) Cancellation for nonpayment of premium is not effective if the amount due is paid before the effective date set forth in the notice of cancellation.

(e) Copies of the notice required by this section shall also be sent to the agent or broker of record though failure to send copies of the notice to those persons shall not invalidate the cancellation. Mailing copies of the notice by regular first-class mail to the agent or broker of record satisfies the requirements of this subsection.

"**§ 58-36-110. Notice of nonrenewal, premium rate increase, or change in workers' compensation insurance coverage required.**

(a) No insurer shall refuse to renew a policy of workers' compensation insurance or employers' liability insurance written in connection with a policy of workers' compensation insurance except in accordance with the provisions of this section, and any nonrenewal attempted or made that is not in compliance with this section is not effective. This section does not apply if the policyholder has obtained insurance elsewhere, has accepted replacement coverage, or has requested or agreed to nonrenewal.

(b) An 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 mailing written notice of nonrenewal to the insured not less than 45 days prior to the expiration date of the policy.

(c) An 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 mailing written notice of nonrenewal to the insured not less than 45 days prior to the anniversary date of the policy.

(d) Whenever an insurer lowers coverage limits, raises deductibles, or raises premium rates for reasons within the exclusive control of the insurer or other than at the request of the policyholder, the insurer shall mail to the policyholder written notice of the change at least 30 days in advance of the effective date of the change. As used in this subsection, the phrase, "reasons within the exclusive control of the insurer" does not mean experience modification changes, exposure changes, or loss cost rate changes.

(e) The notice required by this section shall be given by mail to the insured and any other person designated in the policy to receive this notice at their addresses shown in the policy or, if not indicated in the policy, at their last known addresses. The notice of nonrenewal shall state the precise reason for nonrenewal. Failure to send this notice, as provided in this section, to any other person designated in the policy to receive this notice invalidates the nonrenewal only as to that other person's interest.

(f) Copies of the notice required by this section shall also be sent to the agent or broker of record, though failure to send copies of the notice to such persons shall not invalidate the nonrenewal.

(g) Mailing copies of the notice by regular first-class mail satisfies the notice requirements of this section."

SECTION 3. This act becomes effective October 1, 2001, and applies to policies issued, renewed or subject to renewal, or amended on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 468*

Insurance and Consumer Protection Committee Substitute Adopted 4/4/01

Short Title: Workers' Comp. Cancellations and Renewals-AB. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR GUIDELINES, RIGHTS, AND OBLIGATIONS IN WORKERS' COMPENSATION INSURANCE POLICY CANCELLATIONS AND NONRENEWALS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-99 reads as rewritten:

"**§ 97-99. Law written into each insurance policy; form of policy to be approved by Commissioner of Insurance; ~~cancellation;~~ single catastrophe hazards.**

(a) Every policy for the insurance of the compensation ~~herein provided,~~ in this Article, or against liability therefor, shall be deemed to be made subject to the provisions of this Article. No corporation, association or organization shall enter into any such policy of insurance unless its form ~~shall have~~ has been approved by the Commissioner of Insurance. ~~No policy form shall be approved unless the same shall provide a 30-day prior notice of an intention to cancel same by the carrier to the insured by registered mail or certified mail. This shall not apply to the expiration date shown in the policy. The carrier may cancel the policy for nonpayment of premium on 10 days' written notice to the insured, and the insured may cancel the policy on 10 days' written notice to the carrier. Whenever notice of intention to cancel is required to be given by registered or certified mail, no cancellation by the insurer shall be effective unless and until such method is employed and completed.~~

(b) This Article shall not apply to policies of insurance against loss from explosion of boilers or flywheels or other similar single catastrophe hazards: Provided, that nothing ~~herein contained shall be construed to relieve the~~ in this Article relieves an employer from liability for injury or death of an employee as a result of such an explosion or catastrophe."

SECTION 2. Article 36 of Chapter 58 of the General Statutes is amended by adding two new sections to read:

"**§ 58-36-105. Certain workers' compensation insurance policy cancellations prohibited.**

(a) No policy of workers' compensation insurance or employers' liability insurance written in connection with a policy of workers' compensation insurance shall be cancelled by the insurer before the expiration of the term or anniversary date stated in the policy and without the prior written consent of the insured, except for any one of the following reasons:

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

(2) An act or omission by the insured or the insured's 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 the insured's representative that materially affects the insurability of the risk.

(6) Willful failure by the insured or the insured's 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.

(10) The named insured fails to meet the requirements contained in the corporate charter, articles of incorporation, or bylaws of the insurer, when the insurer is a company organized for the sole purpose of providing members of an organization with insurance coverage in this State.

(b) Any cancellation permitted by subsection (a) of this section is not effective unless written notice of cancellation has been given by registered or certified mail, return receipt requested, to the insured not less than 15 days before the proposed effective date of cancellation. The notice shall be given by registered or certified mail, return receipt requested, to the insured and any other person designated in the policy to receive notice of cancellation at their addresses shown in the policy or, if not indicated in the policy, at their last known addresses. The notice shall state the precise reason for cancellation. Whenever notice of intention to cancel is required to be given by registered or certified mail, no cancellation by the insurer shall be effective unless and until such method is employed and completed. Failure to send this notice, as provided in

this section, to any other person designated in the policy to receive notice of cancellation invalidates the cancellation only as to that other person's interest.

(c) This section does not apply to any policy that has been in effect for fewer than 60 days and is not a renewal of a policy. That policy may be cancelled for any reason by giving at least 30 days' prior written notice of and reasons for cancellation to the insured by registered or certified mail, return receipt requested.

(d) Cancellation for nonpayment of premium is not effective if the amount due is paid before the effective date set forth in the notice of cancellation.

(e) Copies of the notice required by this section shall also be sent to the agent or broker of record though failure to send copies of the notice to those persons shall not invalidate the cancellation. Mailing copies of the notice by regular first-class mail to the agent or broker of record satisfies the requirements of this subsection.

"**§ 58-36-110. Notice of nonrenewal, premium rate increase, or change in workers' compensation insurance coverage required.**

(a) No insurer shall refuse to renew a policy of workers' compensation insurance or employers' liability insurance written in connection with a policy of workers' compensation insurance except in accordance with the provisions of this section, and any nonrenewal attempted or made that is not in compliance with this section is not effective. This section does not apply if the policyholder has obtained insurance elsewhere, has accepted replacement coverage, or has requested or agreed to nonrenewal.

(b) An 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 mailing written notice of nonrenewal to the insured not less than 45 days prior to the expiration date of the policy.

(c) An 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 mailing written notice of nonrenewal to the insured not less than 45 days prior to the anniversary date of the policy.

(d) Whenever an insurer lowers coverage limits, raises deductibles, or raises premium rates other than at the request of the policyholder, the insurer shall mail to the policyholder written notice of the change at least 30 days in advance of the effective date of the change.

(e) The notice required by this section shall be given by mail to the insured and any other person designated in the policy to receive this notice at their addresses shown in the policy or, if not indicated in the policy, at their last known addresses. The notice of nonrenewal shall state the precise reason for nonrenewal. Failure to send this notice, as provided in this section, to any other person designated in the policy to receive this notice invalidates the nonrenewal only as to that other person's interest.

(f) Copies of the notice required by this section shall also be sent to the agent or broker of record though failure to send copies of the notice to such persons shall not invalidate the nonrenewal.

(g) Mailing copies of the notice by regular first-class mail satisfies the notice requirements of this section."

SECTION 3. This act becomes effective October 1, 2001, and applies to policies issued, renewed or subject to renewal, or amended on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 461*

Insurance and Consumer Protection Committee Substitute Adopted 4/24/01

Short Title: Insurance Information Privacy-AB. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-39-10 reads as rewritten:

"**§ 58-39-10. Scope.**

(a) The obligations imposed by this Article shall apply to those insurance institutions, agents, or insurance-support organizations that, on or after July 1, 1982:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance:

a. Collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this State; or

b. Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this State; and

(2) In the case of property or casualty insurance:

a. Collect, receive, or maintain information in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; ~~or~~

b. Engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~State; or

c. Engage in transactions involving mortgage guaranty insurance where the mortgage guaranty policies, contracts, or certificates of insurance are delivered, issued for delivery, or renewed in this State.

(b) The rights granted by this Article shall extend to:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance, the following persons who are residents of this State:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions;

(2) In the case of property or casualty insurance, the following persons:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in (i) insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~ State; or (ii) mortgage guaranty insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State.

(c) For purposes of this section, a person shall be considered a resident of this State if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance-support organization, is located in this State.

(d) Notwithstanding subsections (a) and (b) of this section, this Article shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this State."

SECTION 2. G.S. 58-39-15(1) reads as rewritten:

"(1) "Adverse underwriting decision" means:

a. Any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

1. A declination of insurance coverage;

2. A termination of insurance coverage;

3. Failure of an agent to apply for insurance coverage with a specific insurance institution that an agent represents and that is requested by an applicant;

4. In the case of a property or casualty insurance coverage:

I. Placement by an insurance institution or agent of a risk with a residual market ~~mechanism or~~ mechanism, an unauthorized insurer, or an

insurance institution that specializes in substandard risks; or

II. The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished; or

5. In the case of a ~~life or accident and health~~ life, health, or disability insurance coverage, an offer to insure at higher than standard rates.

b. Notwithstanding subdivision (1)a of this section, the following actions shall not be considered adverse underwriting decisions, but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

1. The termination of an individual policy form on a class or statewide basis;
2. A declination of insurance coverage solely because such coverage is not available on a class or statewide basis; or
3. The rescission of a policy."

SECTION 3. G.S. 58-39-15(9) reads as rewritten:

"(9) "Individual" means any natural person who:

a. In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder;
b. In the case of life or accident and health insurance, is a past, present, or proposed principal insured or certificate holder;
c. Is a past, present or proposed policy owner;
d. Is a past or present applicant;
e. Is a past or present claimant; ~~or~~
f. Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this ~~Article.~~Article; or
g. Is the subject of personal information collected or maintained by an insurance institution, agent, or insurance-support organization in connection with mortgage guaranty insurance."

SECTION 4. G.S. 58-39-25 reads as rewritten:

"**§ 58-39-25. Notice of insurance information practices.**

(a) An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided in this section:

(1) In the case of an application for insurance a notice shall be provided no later than:

a. At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records; ~~or~~

b. At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records; or

c. Before the initial disclosure of personal information under G.S. 58-39-75(11).

(2) In the case of a policy ~~renewal,~~ that has been issued, a notice shall be provided ~~no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:~~

~~a. Personal information is collected only from the policyholder or from public records; or~~

~~b.~~ ~~A notice meeting the requirements of this section has been given within the previous 24 months;~~ not less than annually while the policy is in force; or

(3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance ~~institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.~~ institution.

(b) The notice required by sub-subdivision (a)(1)a. and (a)(1)b. and subdivision (a)(3)of this section shall be in writing and shall state:

(1) Whether personal information may be collected from persons other than the individual or individuals proposed for ~~coverage;~~ coverage.

(2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such ~~information;~~ information.

(3) The types of disclosures identified in subsections (2), (3), (4), (5), (6), (9), (11), (12), and (14) of G.S. 58-39-75 and the circumstances under which such disclosures may be made without prior authorization: Provided, however, only those circumstances need be described that occur with such frequency as to indicate a general business ~~practice;~~practice.

(4) A description of the rights established under G.S. 58-39-45 and 58-39-50 and the manner in which such rights may be ~~exercised; and~~ exercised.

(5) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(6) The notice required by sub-subdivisions (a)(1)a and (a)(1)c and subdivision (a)(2) of this section shall include information relating to the policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the insurance institution or agent, consistent with Title V of P.L. 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided pursuant to Title V of P.L. 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(7) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with Title V of P.L. 106-102.

(8) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In lieu of the notice prescribed in ~~subsection (b)~~ subdivisions (b)(1) through (b)(5) of this section, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that:

(1) Personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) Such information, as well as other personal or privileged information subsequently collected by the insurance institution or agent, in certain circumstances, may be disclosed to third parties without authorization;

(3) A right of access and correction exists with respect to all personal information collected; and

(4) The notice prescribed in subsection (b) of this section will be furnished to the applicant or policyholder upon request.

For the purposes of this section only, the terms 'applicant' or 'policyholder' include respectively a person who applies for or obtains coverage under a group insurance contract, regardless of whether that person's coverage is individually underwritten. An insurance institution or agent that does not disclose personal information about an applicant or policyholder under a group insurance contract, as permitted by G.S. 58-39-75(11), may satisfy any notice requirement that otherwise exists under this section with respect to the applicant or policyholder by providing a notice of information practices to the holder of the group insurance contract.

(d) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

(e) An insurance institution may provide a joint notice from the insurance institution and one or more of its affiliates or other financial institutions, as defined in

the notice, as long as the notice is accurate with respect to the insurance institution and the other institutions.

(f) The notice requirements of this section may be satisfied by providing a single notice if two or more applicants or policyholders jointly obtain or apply for an insurance product.

(g) An insurance institution or agent may satisfy the notice requirements of this section and Title V of P.L. 106-102 through the use of separate or combined notices.

(h) An insurance institution or agent is not required to provide the notices required by this section to:

(1) Any applicant or policyholder whose last known address, according to the insurance institution's or agent's records is deemed invalid. The applicant's or policyholder's last known address shall be deemed invalid if mail sent to that address has been returned by the postal authorities as undeliverable and if subsequent reasonable attempts to obtain a current valid address for the applicant or policyholder have been unsuccessful; or

(2) Any policyholder whose policy is lapsed, expired, or otherwise inactive or dormant under the insurance institution's business practices, and the insurance institution has not communicated with the policyholder about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, or promotional materials.

(i) If an insurance agent does not share information with any person other than the agent's principal, and if the principal provides all notices required by this section, the insurance agent is not required to provide the notices required by this section."

SECTION 5. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-26. Exception for title and mortgage guaranty insurance.**

(a) A title insurance company shall give notice of its insurance information practices under G.S. 58-39-25 only at the time the final policy of title insurance is issued and is not subject to any annual notice requirement thereafter.

(b) In the case of mortgage guaranty insurance, a notice shall be provided at the time a master policy is issued and thereafter only if there is a material change in the insurer's policies and practices regarding the use or disclosure of personal information."

SECTION 6. G.S. 58-39-75(1) reads as rewritten:

"(1) With the written authorization of the individual, provided:

a. If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35; or

b. If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization,

the authorization meets the requirements of G.S. 58-39-35 and is:

1. Dated;
2. Signed by the individual; and
3. Obtained one year or less ~~prior to~~ before the date a disclosure is sought pursuant to this paragraph; or".

SECTION 7. G.S. 58-39-75(18) reads as rewritten:

"(18) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of ~~insurance; provided that~~ insurance only if:

a. No medical record information is disclosed unless the disclosure would otherwise be permitted by this section; and

b. ~~the~~ The information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy; or."

SECTION 8. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-76. Limits on sharing account number information for marketing purposes.**

(a) General Prohibition on Disclosure of Account Numbers. – An insurance institution, insurance agent, or insurance-support organization shall not disclose, other than to a consumer reporting agency, an account number or similar form of access number or access code for a credit card account, deposit account, or transaction account of a consumer to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) Definitions. – As used in this section:

(1) 'Account number' means an account number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the insurance institution, insurance agent, or insurance-support organization does not provide the recipient with a means to decode the number or code.

(2) 'Transaction account' means an account other than a deposit account or credit card account. A transaction account does not include an account to which third parties cannot initiate charges.

(c) Exceptions. – Subsection (a) of this section does not apply if an insurance institution, insurance agent, or insurance-support organization discloses an account number or similar form of access number or access code:

(1) To the insurance institution's, insurance agent's, or insurance-support organization's agent or service provider solely in order to perform marketing for the insurance institution's, insurance agent's, or insurance-support organization's own products or services, as long as

the agent or service provider is not authorized to directly initiate charges to the account; or

(2) To a participant in a private label credit card program or an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program."

SECTION 9. G.S. 58-39-75(12) reads as rewritten:

"(12) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated ~~persons; or~~ persons, provided that no medical record information may be disclosed to the affiliate; or".

SECTION 10. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 11. This act becomes effective January 1, 2002.

SENATE BILL 461:
Insurance Information Privacy- AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Wellons
Date:	May 30, 2001	**Summary by:**	Frank W. Folger
Version:	Second Edition		Committee Counsel

SUMMARY: This bill would amend Article 39 of Chapter 58 of the General Statutes, the North Carolina Insurance Information and Privacy Protection Act (the Act) to conform it to the consumer information privacy requirements of the federal Gramm-Leach-Bliley Act, Public Law 106-102, enhance certain consumer protections, and remove certain industry burdens without consumer impact.

CURRENT LAW: The Act governs the collection, use and disclosure of information gathered in connection with insurance transactions. Provisions which would be affected by the legislation include:

Notice of Insurance Information Practices Notice must be provided to applicants or policyholders no later than at delivery of the policy or certificate when information is gathered only from the applicant or public sources, and no later than beginning collection of information when information is collected from another source. For a policy renewal, notice is not required if personal information is only collected from the policyholder or public records; but if required, it must be provided by the renewal date unless given in the last 24 months. For policy reinstatement or change in benefits, notice is not required if personal information is collected only from the policyholder or from public records; but if required, it must be given no later than the time the insurance institution receives the policy reinstatement or change in benefits request.

Contents of Notice The notice must state: whether personal information may be collected from persons other than those proposed for coverage; the types of, sources of, and investigative techniques used in obtaining personal information; disclosures which may be made pursuant to G.S. 58-39-75 and how they may be disclosed without prior authorization, but only when such disclosure would be deemed a general business practice by its frequency; a description of the policyholders and/or applicants rights regarding personal information access, correction, amendment, and deletion; the fact that insurance-support organization report information may be kept by the insurance support organization and disclosed to others. It provides for an alternative abbreviated notice to be given in lieu of that just described.

Disclosure of Individual's Personal or Privileged Information An insurance institution, agent or insurance-support organization seeking to disclose an individual's privileged or personal information collected or received in connection with an insurance transaction must meet certain requirements to be able to do so. When disclosure is sought with written authorization of the individual but the authorization is submitted by a person other than the policyholder or insurance institution, insurance-support organization or agent, the authorization must be dated, signed by the individual, and obtained one year or less before disclosure is sought. The section provides for disclosure to lienholders and others with a legal or beneficial interest in a policy as long as it is limited to that reasonably necessary to permit protection of that party's interest.

BILL ANALYSIS: Section 1 would amend reference to "life or accident and health insurance" to "life, health, or disability insurance" to conform the language to the model act, incorporate mortgage guaranty insurance expressly into its scope, and make consistent conforming changes throughout the bill.

Section 2 would redefine "adverse underwriting decision" to include risk placement by an insurance institution with an insurance institution specializing in substandard risks.

Section 3 would provide protection under the Act (limited notice) to people whose mortgages are the subject of a mortgage guaranty insurance transaction or proposed transaction, even though these mortgagors are not the insured under such policies.

Section 4 would require, for policies already issued and in force, that notice be provided at least annually. For policy reinstatement or change in benefits situations, the exception to the notice requirement would be removed. *These change are required by the Gramm-Leach-Bliley Act.* It would also require notice be given before an insurance institution or agent makes initial disclosure of personal information to a person for marketing of a product or services, if notice had not already been required. It would also make technical and conforming changes.

It would add to the notice contents requirements to applicants or policyholders:

- The insurance institution or agent's policies and practices regarding disclosure of nonpublic personal information to nonaffiliated third parties, other than their agents, consistent with Title V, Privacy, of the Gramm-Leach Bliley Act, including the categories of persons to whom disclosure may be made and the policies and practices regarding disclosure about persons who are no longer customers.
- The insurance institution or agent's policies for protecting confidentiality and security of nonpublic personal information in accordance with Title V.
- Any required disclosures under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

This change is required by the Gramm-Leach-Bliley Act.

It would require notice be given to persons applying for or obtaining coverage under a group insurance contract whether individually underwritten or not, except an insurance institution that does not disclose personal information about an applicant or policyholder as permitted by G.S. 58-39-75(11) can satisfy the notice requirement with notice to the holder of the group contract.

Section 5 would create a new section, N.C.G.S. §58-39-26, to require a title insurance company to only provide notice at the time the final policy is issued, and to require, in the case of mortgage guaranty insurance, that notice need only be provided at the time the master policy is issued and whenever there is a material change in the insurer's disclosure policies and practices.

Section 6 would require that disclosure based on a person's written authorization submitted by a person other than the institution agent or insurance-support organization be based on an authorization meeting the requirements for content in N.C.G.S. §58-39-35.

Section 7 would further limit disclosure to lienholders and other persons having a legal or beneficial interest in an insurance policy to prohibit disclosure of medical record information not otherwise permitted by N.C.G.S. §58-39-75.

Section 8 would create a new section, N.C.G.S. §58-39-76, placing limits on the sharing of account number information for marketing purposes. *This change is required by the Gramm-Leach-Bliley Act.*

Section 9 would prohibit disclosure of medical record information to an affiliate for auditing or marketing of an insurance product or service.

Section 10 is a severability clause.

EFFECTIVE DATE: January 1, 2002

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

May 30, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 461 -- Insurance Information Privacy

The Department of Insurance is proposing to amend the current Insurance Information and Privacy Protection Act ("the Act") in three general ways. First, certain amendments are necessary to bring the Act into compliance with the privacy protection mandates of the federal Gramm-Leach-Bliley Act, P.L. 106-102. Second, the Department is proposing to enhance insurance consumer protections currently found in the Act. Third, where doing so does not reduce consumer protections, certain burdens can be lifted off of the industry.

G.S. 58-39-10(a)(2)(c) and (b)(2)(b). Clarifies that mortgage guaranty insurers are subject to the Act. This amendment is supported by the mortgage guaranty insurance industry.

G.S. 58-39-15(9)(g). Extends the protections of G.S. 58-39-75 (limitations on insurer disclosure of personal information) to the homeowner who pays for mortgage guaranty insurance even though that person is not an applicant or insured under the policy. This amendment is supported by the mortgage guaranty insurance industry.

G.S. 58-39-25(a)(2). Requires insurers or agents to send notices of their information practices to insureds every 12 months. Current law says every 24 months. The proposed annual notice requirement is required by Section 503(a) of the Gramm-Leach-Bliley Act.

G.S. 58-39-25(a)(3). Strikeouts are required by the Gramm-Leach- Bliley Act because that federal Act requires notices be sent to all insurance customers.

G.S. 58-39-25(b)(3). Strikeouts reflect proposed repeal of G.S. 58-39-75(11) and (12).

G.S. 58-39-25(b)(6), (7), and (8). These are additions to what must be included in the notice of information practices, as required by Sections 502 and 503 of the Gramm-Leach-Bliley Act.

G.S. 58-39-25(c). The strikeouts delete the abbreviated notice of information practices allowed under current law. An abbreviated notice does not comply with the notice requirements required by Sections 502 and 503 of the Gramm-Leach-Bliley Act.

The new language extends the notice protections to group certificate holders, who currently have no right to notice unless their policies are individually underwritten. However, notice only need be given certificate holders if the insurer or agent intends to share their personal information. Otherwise, an insurer can comply with the notice requirements of G.S. 58-39-25 by giving notice to the group master policyholder (typically an employer). This proposed amendment has wide industry backing, and gives something to group certificate holders that they do not have under current law.

G.S. 58-39-25(e). Allows a holding company to provide a joint notice of information practices on behalf of all of its subsidiaries. Included at industry's request.

G.S. 58-39-25(f). Allows an insurer or agent to provide one notice to co-policyholders, such as a husband and wife insured under the same auto policy. Included at industry's request.

G.S. 58-39-25(g). Allows an insurer or agent to send out notices required by G.S. 58-39-25 and Title V of the federal Gramm-Leach-Bliley Act as either two separate notices or one combined notice. Included at industry's request.

G.S. 58-39-25(h). Relieves an insurer or agent of providing notices to persons who do not keep their addresses current or whose policies have lapsed. Included at industry's request.

G.S. 58-39-25(i). Relieves an agent of notice requirements when (1) the agent is not sharing the insured's information with anyone but his or her principal (the insurer) and (2) where that principal gives the insured the notice required by G.S. 58-39-25. Included at industry's request.

G.S. 58-39-25(j). Requires an insurer or agent to give any notices required by the Gramm-Leach-Bliley Act in addition to the notice required by G.S. 58-39-25. This amendment is required by Title V of the Gramm-Leach-Bliley Act. This amendment has industry support.

G.S. 58-39-25(k). Requires insurers to file privacy notice forms with the Commissioner before they can be used in this State and imposes a $20 filing fee.

G.S. 58-39-26. Relieves title insurers and mortgage guaranty insurers of the annual notices required by G.S. 58-39-25(a)(2). The rationale is that in the title insurance context, the insured's only contact with the company is when the policy is purchased with a single premium payment at the closing. The only information held by the title insurer comes from public records. Thus, an annual notice seems expensive and does not appear to offer the insured any protections. In the mortgage insurance context, the homeowner paying the mortgage insurance premium is not the insured and is not entitled to any notice under current law. The lending institution is the insured. Requiring annual notices to sophisticated lending institutions seems burdensome and does nothing for the individual paying for the policy. The title insurers and mortgage guaranty insurers support this amendment.

G.S. 58-39-76(a). Limits the sharing of an individual's account number information. This is required by Section 502(d) of the Gramm-Leach-Bliley Act.

G.S. 58-39-76(b). Creates limited exceptions to the restrictions imposed on account sharing information by G.S. 58-39-76(a). These exceptions are taken verbatim from rules promulgated by the federal banking regulatory agencies in addressing Section 502(d) of the Gramm-Leach-Bliley Act. Included at industry's request.

Repeal of G.S. 58-39-75(11) and (12). Current law imposes a general requirement that no individual's personal information can be shared by an insurer or agent without that individual's written consent. This is known as an "opt in" standard. There are two marketing exceptions to the basic "opt in" standard. G.S. 58-39-75(11) currently allows an insurer or agent to share a consumer's personal information with others, both affiliates and non-affiliates, for general marketing purposes if the insured is given notice of the proposed sharing and an opportunity to say "no". This is known as the "opt out" standard. G.S. 58-39-75(12) currently allows an insurer or agent to share a consumer's personal information with affiliates for insurance marketing purposes without the consumer's permission and even if the consumer does not want his or her information shared. The Department believes that no sharing of a consumer's personal information for marketing purposes should occur unless the insurer agent obtains the permission of the consumer.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 13, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 13, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the pages Ashley Vickers (Cumberland County – Rep. Hurley) and Jonathan Grice (Guilford County – Rep. Bowie). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Blue, Brubaker, Dedmon, Grady, Hall, Hunter, Johnson, Justus, Saunders, Setzer, Warner, and Wilson. Frank Folger and Linda Attarian, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes (Attachment). The following bills were considered.

SB 729, entitled, AN ACT TO PROVIDE THAT MOTORCYCLE INSURANCE RATES ARE SET IN ACCORDANCE WITH THE LAW REGULATING INSURANCE RATES RATHER THAN ESTABLISHED BY THE NORTH CAROLINA RATE BUREAU. Representative Dockham recognized Senator Carrington, the bill sponsor, and he presented a proposed committee substitute. Representative Justus moved to adopt the proposed committee substitute for consideration. The motion passed. Senator Carrington was recognized to explain the proposed committee substitute. SB 729 would provide that motorcycle insurance rates would be set by insurer's filings with the Department of Insurance rather than being set by the N.C. Rate Bureau. Under the current law, the N.C. Rate Bureau establishes rates, subject to Commissioner approval, for motorcycle insurance as it does for nonfleet private passenger motor vehicle insurance and other insurance. Section 1 would expressly exclude motorcycle insurance from the types of insurance for which the Rate Bureau sets rates. Section 2 would remove a provision specifically referencing motorcycle insurance being governed by the Rate Bureau. Section 3 would bring motorcycle insurance into the coverage of Article 40, Regulation of Insurance Rates. Section 4 would make the act effective January 1, 2002, but would clarify those rates, rating systems, territories, classifications, and policy forms lawfully in use on that date can continue to be used past that date. Bill Hale, NC Department of Insurance, was recognized to expound on the proposed committee substitute (see handout). After some discussion, Representative Justus moved for a favorable report as to House committee substitute bill, unfavorable as to the original Senate Bill. The motion passed.

HB 359, entitled, AN ACT TO REVISE NORTH CAROLINA'S LAW REGULATING VIATICAL SETTLEMENTS IN ACCORDANCE WITH A MODEL ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. Representative Dockham recognized Representative Hurley, the bill sponsor, and he presented a proposed committee substitute and moved to adopt the proposed committee substitute for consideration. The motion passed and Representative Hurley explained the proposed committee substitute. This bill would expand North Carolina's current viatical settlement law, which presently regulates the purchase of a life insurance policy by a third party (the viatical settlement provider) from an insured who has a life threatening or terminal illness, to regulating the purchase of a life insurance policy by a third party, without regard to the insured's health. This bill requires licensing of viatical settlement providers, viatical settlement brokers, and viatical settlement investment agents. Bill Hale, NC Department of Insurance, was recognized to expound on the proposed committee substitute (see handout) and explain the differences between the original bill and the proposed committee substitute. The changes made in the

proposed committee substitute are: The provisions on antifraud initiatives and the fraud warning were taken out; the reporting of fraudulent acts were rewritten to mirror the existing provisions for insurers (GS 58-2-160 and 58-2-163); the time period for notice of change in ownership were set at 20 days (present NC law has 10 days, NAIC model has 30 days). The examination provisions were taken out, which are lengthy, from the bill, and make licensees subject to our existing examination laws for insurers. Only a fraudulent viatical settlement act will invoke a Class H felony, not any other violation of the viatical settlement law. The NAIC model and the present NC bill say any violation of the act is a felony. A Class H felony carries a minimum penalty of 4 months and a maximum penalty of 25 months depending on the facts and circumstances of each case. Fines range also. The rulemaking authority to delete any reference to discount tables was revised. The Department of Insurance is in support of this bill. Doug Head, Director of Viatical & Life Settlement Assn. of America and Bryan Freeman, Founder of Benefits America, spoke in support of the bill. After a lengthy discussion Representative Hall moved for a favorable report as to committee substitute bill, unfavorable as to the original bill, and to be re-referred to the Committee on Finance. The motion passed.

HB 1077, entitled, AN ACT TO PROVIDE FOR CAREER FIREFIGHTERS' AND RESCUE SQUAD WORKERS' BENEFITS IN THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM. Representative Arnold, the bill sponsor, was recognized to explain the bill. HB 1077 amends the law to provide retirement benefits from the Supplemental Retirement Income Plan (401K Plan) to all eligible career firefighters and career rescue squad workers. The bill also provides that career firefighters and career rescue squad workers who are members of the Local Governmental Employees' Retirement System (Local System) will be eligible for the same deferred, early, and service retirement benefits as are now available to law enforcement officers. It further raises the gross premiums tax on insurance contract from 1.9% to 2.0319%, and makes an appropriation from the General Fund to the Local System for fiscal years 2001-2002 and 2002-2003. Paul Miller, Executive Director, NC State Firemen's Association, spoke in favor of the bill. Ellis Hankins, N.C. League of Municipalities, and Robert Price, Life Insurance Cos., Association of NC, spoke in opposition of the bill. Representative Hunter moved to give the bill a favorable report, however the motion was tabled until the next time the bill will be considered in committee. Representative Dockham indicated that a vote would not be taken at this time since all interested parties had not been notified in time to consider HB 1077.

There being no further business, the Chair adjourned the meeting at 12:50 PM.

Respectfully submitted,

Representative Jerry C. Dockham
Presiding Chair

Regina Irwin
Assistant to the Committee

ATTACHMENTS:
Visitor Registration Form
SB 729, HB 359, HB 1077
Bill Summaries
Handouts

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 13, 2001 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cam Cree	BPMH
Jim Phillips	"
[illegible]	P.B. F.D.
Marcus J. Meltzer	Circle V Fire Department Inc.
Shug E. Toland	Pinebluff VFire Department Moore County
D.S. DOCKERY	RALEIGH FIRE DEPT.
J. W. PARKER	RAL. PROFESSIONAL FIREFIGHTERS
W.E. Holden	Ral. Prof. Firefighters
J.D. Poole	Ral Prof Fighters Assoc.
B.E Scales	WS PFFs

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 13, 2001 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Greg Massey	N. Chatham F.D. 45 Morris Rd Pittsboro NC 27312
Eric Solomon	Mebane F D
Richard Treller	Coltrane Fire P.O. Box 127, Coltrane NC 27235
Emily Fulghum	Smith Anderson
Bob Herlong	Allianz - Atlanta, GA
Nanny & Sermons	NC Asso. EMS + Res.
Jack Parker Jr.	West of New Bern V.F.D. 900 Chelsea Rd. New Bern NC 28562
Doris Comerford	6 Country Woods Ct Greensboro NC 27410
Gene Bridges	3902 Woodview Drive Winston-Salem NC 27106
Andy Holliman	Williamston Fire/Rescue 901 Washington St. Williamston, NC 27892
Steve Cary	Rocky Mount Fire Dept. 101 S. George St Rocky Mount N.C. 27801

VISITOR REGISTRATION SHEET

INSURANCE — June 13, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bryan Freeman	National & Life Settlement Assoc of America
Wayne Head	- 11 VLSAA
Roger Bone	Bone & Assoc - N.C. Fireman
Harry Taylor	NCAHP
Bob Pria	Jordan Price
Frank Sutherland	Jefferson Pilot
Vernon Wood	Pinecroft Sedgefield Fire Dept.
Larry Lain	Jamestown Fire Dept.
Steve M. Arndt	Northeast Guilford Fire Dept.
ELLIS HANKINS	NCLM
Mark Gunn	Capitol Group

VISITOR REGISTRATION SHEET

INSURANCE — June 13, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joy Barbour	Concerned Bikers Assoc./ABATE of N.C.
David Gore	Raleigh CBA
Glenn P. Brown Jr.	Ahoskie Fire Dept. Ahoskie, N.C.
Ken Dilday	N.C. Firemen Association, P.O. Box 186 Farmville N.C.
Cathy Lohr	NC Assn of Fire Chiefs PO Box 2107, Cary, NC 27512
Angie Callihan	Franklin County Emergency Services 8146 NC 56 Hwy, Louisburg, NC 27549
Paul Miller	NC State Firemen's Assoc.
Brunard King	Forsyth Co. Fire Dept. / NC State Firemen Assoc
Paul D. Brooks	NC State Firemens Assoc
Johnny Teeters	NC Fire Chiefs Association

VISITOR REGISTRATION SHEET

INSURANCE — June 13, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tim Bradley	NC DOI
John Schultz	Mebane Fire Dept 405 N. First St Mebane N.C.
Heather Ternune	Mebane Fire Dept. "
Charles Honeycutt	Mebane Fire Dept. "
John Payne	" " " "
Bob Louis	Mebane Fire Dept
Jerry Wiggins	Kinston Fire Dept
Spencer Lee	Kinson Fire Dept.
Wayne C Bayless	Kinston Fire + Rescue
Tommy Cole	Pleasant Grove F.D. / Guilford Co.
Jack Murray	Whitsett Fire Dept P.O. Box 148 Whitsett 27377

VISITOR REGISTRATION SHEET

INSURANCE — June 13, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Keith Wilder	Raleigh Fire Dept.
Sterling Wilder	age 6
Morgan Wilder	age 4
Jamie Beasley	New Hanover County Fire Department
Russell Kloosterman	New Hanover County Fire Department
Frankie Pridgen	Long Creek VFD 227 Scott Road Rocky Point NC 28457
David Anders	PFPWC

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
S.B. 729 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT MOTORCYCLE INSURANCE RATES ARE SET IN ACCORDANCE WITH THE LAW REGULATING INSURANCE RATES RATHER THAN ESTABLISHED BY THE NORTH CAROLINA RATE BUREAU.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate original bill.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 729
PROPOSED HOUSE COMMITTEE SUBSTITUTE S729-CSSO-47 [v.1]

6/13/2001 10:48:36 AM

Short Title: Motorcycle Insurance Rates. (Public)

Sponsors:

Referred to:

March 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT MOTORCYCLE INSURANCE RATES ARE SET IN ACCORDANCE WITH THE LAW REGULATING INSURANCE RATES RATHER THAN ESTABLISHED BY THE NORTH CAROLINA RATE BUREAU.

The General Assembly of North Carolina enacts:

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

"(3) The Bureau shall 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 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. This subdivision 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 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; motorcycles, as defined in G.S. 20-4.01(27)d.; 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."

SECTION 1.1 Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-3. Limitation of scope.**

Except as provided in G.S. 58-36-85, the term "nonfleet private passenger motor vehicle", as used in this Article, does not mean a motorcycle, as defined in G.S. 20-4.01(27)d.

SECTION 2. G.S. 58-36-65(m) is repealed.

SECTION 2.1 G.S. 58-37-1(6) reads as rewritten:

"(6) "Motor vehicle" means every self-propelled vehicle that is designed for use upon a highway, including trailers and semitrailers designed for use with such vehicles (except traction engines, road rollers, farm tractors, tractor cranes, power shovels, and well drillers). "Motor vehicle" also means a motorcycle, as defined in G.S. 20-4.01(27)d."

SECTION 2.2 G.S. 58-37-30(b) reads as rewritten:

"(b) It shall be the responsibility of the agent to write the coverage applied for at what he believes to be the appropriate rate level. If coverage is written at the Facility rate level and the company elects not to cede, the policy shall be rated at a rate under Article 36 or Article 40 of this ~~Chapter.~~ Chapter, whichever is appropriate. Coverage written at a rate under Article 36 or Article 40 of this Chapter that is not acceptable to the company must either be placed with another company or rated at the Facility rate level by the agent."

SECTION 2.3 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". For the purpose of this Article, a

"clean risk" 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. 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, the Commissioner shall issue an order specifying in what respect it is deficient and stating when, within a reasonable period thereafter, the rate is no longer effective. 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. The order shall not affect any contract or policy made or issued 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" 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 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. As used in this subsection, "nonfleet private passenger motor vehicle" does not mean a motorcycle, as defined in G.S. 20-4.01(27)d."

SECTION 3. G.S. 58-40-15 reads as rewritten:

"**§ 58-40-15. Scope of application.**

The provisions of this Article shall apply to all insurance on risks or on operations in this State, except:

(1) Reinsurance, other than joint reinsurance to the extent stated in G.S. 58-40-60;

(2) Any policy of insurance against loss or damage to or legal liability in connection with property located outside this State, or any motor vehicle or aircraft principally garaged and used outside of this State, or any activity wholly carried on outside this State;

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

(4) Accident, health, or life insurance;

(5) Annuities;

(6) Repealed by Session Laws 1985, c. 666, s. 43.
(7) Mortgage guaranty insurance;
(8) Workers' compensation and employers' liability insurance written in connection therewith;
(9) For private passenger (nonfleet) motor vehicle liability insurance, automobile medical payments insurance, uninsured motorists' coverage and other insurance coverages written in connection with the sale of such liability insurance; except this Article applies to liability insurance on motorcycles, as defined in G.S. 20-4.01(27)d.;
(10) Theft of or physical damage to private passenger (nonfleet) motor vehicles; except this Article applies to theft of or physical damage to motorcycles, as defined in G.S. 20-4.01(27)d.; and
(11) Insurance against loss to residential real property with not more than four housing units located in this State or any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance. Provided, however, that this Article shall apply to insurance against loss to farm dwellings, farm buildings and their appurtenant structures, farm personal property and 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; 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.

The provisions of this Article shall not apply to hospital service or medical service corporations, investment companies, mutual benefit associations, or fraternal beneficiary associations."

SECTION 4. This act becomes effective January 1, 2002. Rates, rating systems, territories, classifications, and policy forms lawfully in use on January 1, 2002, may continue to be used thereafter.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 1

SENATE BILL 729

Short Title:	Motorcycle Insurance Rates.	(Public)
Sponsors:	Senator Carrington.	
Referred to:	Rules and Operations of the Senate.	

March 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT MOTORCYCLE INSURANCE RATES ARE SET IN ACCORDANCE WITH THE LAW REGULATING INSURANCE RATES RATHER THAN ESTABLISHED BY THE NORTH CAROLINA RATE BUREAU.

The General Assembly of North Carolina enacts:

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

"(3) The Bureau shall 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 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. This subdivision 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 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; motorcycles, as defined in G.S. 20-4.01(27)d.; 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."

SECTION 2. G.S. 58-36-65(m) is repealed.

SECTION 3. G.S. 58-40-15 reads as rewritten:

"**§ 58-40-15. Scope of application.**

The provisions of this Article shall apply to all insurance on risks or on operations in this State, except:

(1) Reinsurance, other than joint reinsurance to the extent stated in G.S. 58-40-60;

(2) Any policy of insurance against loss or damage to or legal liability in connection with property located outside this State, or any motor vehicle or aircraft principally garaged and used outside of this State, or any activity wholly carried on outside this State;

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

(4) Accident, health, or life insurance;

(5) Annuities;

(6) Repealed by Session Laws 1985, c. 666, s. 43.

(7) Mortgage guaranty insurance;

(8) Workers' compensation and employers' liability insurance written in connection therewith;

(9) For private passenger (nonfleet) motor vehicle liability insurance, automobile medical payments insurance, uninsured motorists' coverage and other insurance coverages written in connection with the sale of such liability insurance; except this Article applies to liability insurance on motorcycles, as defined in G.S. 20-4.01(27)d.;

(10) Theft of or physical damage to private passenger (nonfleet) motor vehicles; except this Article applies to theft of or physical damage to motorcycles, as defined in G.S. 20-4.01(27)d.; and

(11) Insurance against loss to residential real property with not more than four housing units located in this State or any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance. Provided, however, that this Article shall apply to insurance against loss to farm dwellings, farm buildings and their appurtenant structures, farm personal property and 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; 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.

The provisions of this Article shall not apply to hospital service or medical service corporations, investment companies, mutual benefit associations, or fraternal beneficiary associations."

SECTION 4. This act becomes effective October 1, 2001. Rates, rating systems, territories, classifications, and policy forms lawfully in use on October 1, 2001, may continue to be used thereafter.

SENATE BILL 729:
Motorcycle Insurance Rates

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Carrington
Date:	June 13, 2001	**Summary by:**	Frank W. Folger
Version:	S729-CSSO-47		Committee Counsel

SUMMARY: ***This bill would provide that motorcycle insurance rates would be set by insurer's filings with the Department of Insurance rather than being set by the N.C. Rate Bureau. Motorcycle insurance would remain cedable to the Reinsurance Facility, but the existing "clean risk" provisions would be inapplicable. Motorcycle insurance would no longer be subject to the Safe Driver Incentive Plan, a creation of the Rate Bureau.***

CURRENT LAW: The N.C. Rate Bureau currently establishes rates, subject to Commissioner approval, for motorcycle insurance as it does for nonfleet private passenger motor vehicle insurance and other insurance.

BILL ANALYSIS: Section 1 would expressly exclude motorcycle insurance from the types of insurance for which the Rate Bureau sets rates.

Section 1.1 would clarify, by definition, that except for the termination provisions, reference to "nonfleet private passenger motor vehicle" in Article 36, the Rate Bureau article, does not include motorcycles.

Section 2 would remove a provision specifically referencing motorcycle insurance being governed by the Rate Bureau.

Section 2.1 would clarify that "motor vehicle," as used in Article 37, the Reinsurance Facility article, includes motorcycles. "Motor vehicles" is the term used predominantly in Article 37 because the Article generally governs insurance for all motor vehicles, not just "nonfleet private passenger motor vehicles."

Section 2.2 would make a conforming change to G.S. 58-37-30, a provision governing a default applicable to certain rates.

Section 2.3 would clarify that the existing "clean risk" provisions under the Reinsurance Facility article are inapplicable to motorcycles.

Section 3 would bring motorcycle insurance into the coverage of Article 40, Regulation of Insurance Rates.

Section 4 would make the act effective January 1, 2002, but would clarify that rates, rating systems, territories, classifications, and policy forms lawfully in use on that date can continue to be used past that date.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

June 13, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 729 – Motorcycle Insurance

The North Carolina Rate Bureau was created by the General Assembly to compile information from insurance companies that write automobile, homeowners' and workers' compensation insurance in North Carolina. The Bureau uses this information to establish premium rates for the different kinds of insurance as well as classifications of different risks for the purpose of rating them. All companies that write those kinds of insurance have to participate in and cooperate with the Bureau to do business in NC. Companies must follow the Bureau classifications and cannot deviate from them. They can deviate downward from the rates and give their customers discounts. They must use the policy forms (i.e., policy language) developed by the Bureau.

Companies that write motorcycle insurance must belong to the Bureau and do all of the above. Most, if not all, of these companies are automobile insurers. Apparently the classification system employed by the Bureau for motorcycle physical damage insurance has not been changed in years, while other states have allowed motorcycle insurers to change their classifications over time, the result of which is better coverage and lower rates for many motorcycle owners.

This bill would eliminate the Bureau's control over motorcycle insurance. It would allow companies that write motorcycle insurance to file their own rates, forms, and classifications with the Department of Insurance. Companies could be more innovative and competitive as a result. The same standards for rates would apply: They cannot be excessive, inadequate, or unfairly discriminatory.

SENATE BILL 729:
Motorcycle Insurance Rates

BILL ANALYSIS

Committee:	Senate Insurance and Consumer Protection	**Introduced by:**	Senator Carrington
		Summary by:	Frank W. Folger Committee Counsel
Date:	April 19, 2001		
Version:	First Edition		

SUMMARY: This bill would provide that motorcycle insurance rates would be set by insurer's filings with the Department of Insurance rather than being set by the N.C. Rate Bureau.

CURRENT LAW: The N.C. Rate Bureau currently establishes rates, subject to Commissioner approval, for motorcycle insurance as it does for nonfleet private passenger motor vehicle insurance and other insurance.

BILL ANALYSIS: Section 1 would expressly excluded motorcycle insurance from the types of insurance for which the Rate Bureau sets rates.

Section 2 would remove a provision referencing motorcycle insurance being governed by the Rate Bureau.

Section 3 would bring motorcycle insurance into the coverage of Article 40, Regulation of Insurance Rates.

Section 4 would make the act effective October 1, 2001 but would clarify that rates, rating systems, territories, classifications, and policy forms lawfully in use on that can continue to be used past that date.

SENATOR JOHN H. CARRINGTON
NORTH CAROLINA SENATE
36TH DISTRICT

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2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Dockham & Hurley** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 359 A BILL TO BE ENTITLED AN ACT TO REVISE NORTH CAROLINA'S LAW REGULATING VIATICAL SETTLEMENTS IN ACCORDANCE WITH A MODEL ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, unfavorable as to original bill, and recommendation that the committee substitute bill be re-referred to the Committee on FINANCE.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 359*
PROPOSED COMMITTEE SUBSTITUTE H359-CSSO-46 [v.8]

6/8/2001 3:56:45 PM

Short Title: Viatical Settlements Rewrite-AB. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REVISE NORTH CAROLINA'S LAW REGULATING VIATICAL SETTLEMENTS IN ACCORDANCE WITH A MODEL ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

THE GENERAL ASSEMBLY OF NORTH CAROLINA ENACTS:

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

"Article 58.

~~General Regulations of Business—Life Insurance.~~ Life Insurance and Viatical Settlements."

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

(1) By designating G.S. 58-58-1 through G.S. 58-58-40 as Part 1 with the heading "General Provisions."

(2) By designating G.S. 58-58-45 through G.S. 58-58-65 as Part 2 with the heading "Financial Provisions."

(3) By designating G.S. 58-58-70 through G.S. 58-58-120 as Part 3 with the heading "Insurable Interests and Other Rights."

(4) By designating G.S. 58-58-125 through G.S. 58-58-170 as Part 4 with the heading "Miscellaneous Provisions."

(5) By reserving G.S. 58-58-175 through G.S. 58-58-195 for future codification.

SECTION 3. Article 58 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 5. Viatical Settlements.

"§ 58-58-200. Short title.

This Part may be cited as the Viatical Settlements Act.

§ 58-58-205. Definitions.

(1) 'Advertising' means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to purchase or sell a life insurance policy or an interest in a life insurance policy under a viatical settlement contract or a purchase agreement.

(2) 'Business of viatical settlements' means an activity involved in, but not limited to, the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating, or in any other manner, of viatical settlement contracts or purchase agreements.

(3) 'Chronically ill' means:

a. Being unable to perform at least two activities of daily living (i.e., eating, toileting, transferring, bathing, dressing, or continence);

b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

c. Having a level of disability similar to that described in sub-subdivision a. of this subdivision as determined by the Secretary of Health and Human Services;

(4) 'Financing entity' means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy that is the subject of a viatical settlement contract, but:

a. Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and

b. Who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts.

'Financing entity' does not include a non-accredited investor or viatical settlement purchaser.

(5) 'Fraudulent viatical settlement act' includes:

a. Acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including:

1. Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, viatical settlement investment agent, financing entity, insurer, insurance producer, viator, insured or any other person, false material information, or concealing material information, as part of, in support of or concerning a fact material to one or more of the following:
   I. An application for the issuance of a viatical settlement contract or insurance policy.
   II. The underwriting of a viatical settlement contract or insurance policy.
   III. A claim for payment or benefit under a viatical settlement contract or insurance policy.
   IV. Premiums paid on an insurance policy or as a result of a viatical settlement purchase agreement.
   V. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract, viatical settlement purchase agreement, or insurance policy.
   VI. The reinstatement or conversion of an insurance policy.
   VII. In the solicitation, offer, effectuation, or sale of a viatical settlement contract, insurance policy, or viatical settlement purchase agreement.
   VIII. The issuance of written evidence of viatical settlement contract, viatical settlement purchase agreement or insurance.
   IX. A financing transaction.
2. Employing any device, scheme, or artifice to defraud related to viaticated policies.

b. In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to:
1. Remove, conceal, alter, destroy, or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;
2. Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;
3. Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or

other legal authority for the transaction of the business of viatical settlements; or

4. File with the Commissioner or the insurance regulator of another jurisdiction a document containing false information or otherwise conceals information about a material fact from the Commissioner.

c. Embezzlement, theft, misappropriation, or conversion of monies, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policy owner or any other person engaged in the business of viatical settlements or insurance; or

d. Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

(6) 'Policy' means an individual or group life insurance policy, group life insurance certificate, group life insurance contract, or any other arrangement of life insurance affecting the rights of a resident of this State or bearing a reasonable relation to this State, regardless of whether delivered or issued for delivery in this State.

(7) 'Related provider trust' means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the Commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

(8) 'Special purpose entity' means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or licensed viatical settlement provider.

(9) 'Terminally ill' means having an illness or sickness that can reasonably be xpected to result in death in 24 months or fewer.

(10) 'Viatical settlement investment agent' or 'investment agent' means a person who is an appointed or contracted agent of a licensed viatical settlement provider who solicits or arranges the funding for the purchase of a viatical settlement by a viatical settlement purchaser and who is acting on behalf of a viatical settlement provider.

(11) 'Viatical settlement broker' or '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 settlement contracts between a viator and one or more viatical settlement providers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent 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. The term does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

(12) 'Viatical settlement contract' means a written agreement establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the policy, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the policy. A viatical settlement contract also includes a contract for a loan or other financing transaction with a viator secured primarily by a policy, other than a loan by a life insurance company under the terms of the life insurance contract, or a loan secured by the cash value of a policy. A viatical settlement contract includes an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator.

(13) 'Viatical settlement provider' or 'provider' means a person, other than a viator, that enters into or effectuates a viatical settlement contract. Viatical settlement provider does not include:

a. A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

b. The issuer of a life insurance policy providing accelerated benefits under rules adopted by the Commissioner and under the contract;

c. An authorized or eligible insurer that provides stop loss coverage to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;

d. A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

e. A financing entity;

f. A special purpose entity;

g. A related provider trust; or

h. A viatical settlement purchaser.

i. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, and who purchasers a viaticated policy from a viatical settlement provider.

(14) 'Viatical settlement purchase agreement' or 'purchase agreement' means an agreement, entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, that is entered into for the purpose of deriving an economic benefit.

(15) 'Viatical settlement purchaser' or 'purchaser' means a person who gives a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit. 'Viatical settlement purchaser' does not include:

a. A licensee under this Part;

b. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;

c. A financing entity;

d. A special purpose entity; or

e. A related provider trust.

(16) 'Viaticated policy' means a policy that has been acquired by a viatical settlement provider under a viatical settlement contract.

(17) 'Viator' means the owner of a policy or a certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract. For the purposes of this Part, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. 'Viator' does not include:

a. A licensee under this Part;

b. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;

c. A financing entity;

d. A special purpose entity; or

e. A related provider trust.

§ 58-58-210. License requirements.

(a) No person shall operate as a provider or broker without first obtaining a license from the insurance regulator of the state of residence of the viator. If there is more than one viator on a single policy and the viators are residents of different states, the viatical settlement shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all viators.

(b) A person shall not operate as a investment agent in this State without first obtaining a license from the Commissioner. If there is more than one purchaser of a single policy and the purchasers are residents of different states, the purchase agreement shall be governed by the law of the state in which the purchaser having the largest percentage ownership resides or, if the purchasers hold equal ownership, the state of residence of one purchaser agreed upon in writing by all purchasers.

(c) Application for a provider, broker, or investment agent license shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner, and these applications shall be accompanied by a fee of one hundred dollars ($100).

(d) Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fee of one hundred dollars ($100). Failure to pay the fees by the renewal date results in expiration of the license.

(e) The applicant shall provide information on forms required by the Commissioner. The Commissioner may require the applicant to fully disclose the identity of all stockholders, partners, officers, members, and employees; and may refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner, or member of the legal entity who may materially influence the applicant's conduct meets the standards of this Part.

(f) A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as providers, brokers, or investment agents, as applicable, under the license; and all those persons shall be named in the application and any supplements to the application.

(g) Upon the filing of an application and the payment of the license fee, the Commissioner shall investigate each applicant and issue a license if the Commissioner finds that the applicant:

(1) If a provider, 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 legal entity, provides a certificate of good standing from the state of its domicile.

(h) The Commissioner shall not issue a license to a 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.

(i) A provider, broker, or investment agent shall provide to the Commissioner new or revised information about officers, ten percent (10%) or more stockholders, partners, directors, members, or designated employees within 20 days after the change.

§ 58-58-215. License revocation and denial.

(a) The Commissioner may refuse to issue, suspend, revoke, or refuse to renew the license of a provider, broker, or investment agent if the Commissioner finds that:

(1) There was any material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member, or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

(3) The provider demonstrates a pattern of unreasonable payments to viators;

(4) The licensee or any officer, partner, member, or key management personnel has been found guilty of, or has pleaded guilty or *nolo contendere* to, any felony, or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(5) The provider has entered into any viatical settlement contract that has not been approved pursuant to this Part;

(6) The provider has failed to honor contractual obligations set out in a viatical settlement contract or a purchase agreement;

(7) The licensee no longer meets the requirements for initial licensure;

(8) The provider has assigned, transferred, or pledged a viaticated policy to a person other than a provider licensed in this State, viatical settlement purchaser, an accredited investor, or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; or

(9) The licensee or any officer, partner, member, or key management personnel has violated any provision of this Part.

(b) If the Commissioner denies a license application or suspends, revokes, or refuses to renew the license of a provider, broker or investment agent, the Commissioner shall conduct a hearing in accordance with Chapter 150B of the General Statutes.

§ 58-58-220. Approval of viatical settlement contracts and disclosure statements.

A person shall not use a contract or provide to a viator a disclosure statement form in this State unless filed with and approved by the Commissioner. The Commissioner shall disapprove a contract form or disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained therein are unreasonable, contrary to the

interests of the public, or otherwise misleading or unfair to the viator. At the Commissioner's discretion, the Commissioner may require the submission of advertising material.

§ 58-58-225. Reporting requirements and privacy

(a) Each licensee shall file with the Commissioner on or before June 1 of each year an annual statement containing such information as the Commissioner prescribes by administrative rule.

(b) Except as otherwise allowed or required by law, a provider, broker, investment agent, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a provider and the viator and insured have provided prior written consent to the disclosure;

(2) Is necessary to effect a purchase agreement between the viatical settlement purchaser and a provider and the viator and insured have provided prior written consent to the disclosure;

(3) Is provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of G.S. 58-58-270;

(4) Is a term of or condition to the transfer of a policy by one provider to another provider;

(5) Is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a provider and the viator and insured have provided prior written consent to the disclosure;

(6) Is necessary to allow the provider or broker or their authorized representatives to make contacts for the purpose of determining health status; or

(7) Is required to purchase stop loss coverage.

§ 58-58-230. Examinations.

(a) The Commissioner may conduct an examination of a licensee as often as the Commissioner considers appropriate.

(b) An examination under this Part shall be conducted in accordance with the Examination Law.

(c) In lieu of an examination of any foreign or alien person licensed under this Part, the Commissioner may accept an examination report on the licensee prepared by the appropriate viatical settlement regulator for the licensee's state of domicile or port-of-entry state.

(d) When making an examination under this Part, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or

other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

§ 58-58-235. Record retention requirements.

(a) A person licensed under this Part shall retain copies for five years of all:

(1) Proposed, offered, or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of the contract or purchase agreement, whichever is later.

(2) Checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date the transaction.

(3) Other records and documents related to the requirements of this Part.

(b) This section does not relieve a person of the obligation to produce these documents to the Commissioner after the retention period has expired if the person has retained the documents.

(c) Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

§ 58-58-240. Investigative authority of the Commissioner.

The Commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

§ 58-58-245. Disclosure

(a) With each application for a viatical settlement, provider, or broker shall provide the viator with at least the following disclosures no later than the time the application for the contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the provider or broker, and shall provide the following information:

(1) There are possible alternatives to contracts including any accelerated death benefits or policy loans offered under the viator's policy.

(2) Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.

(3) Proceeds of the viatical settlement could be subject to the claims of creditors.

(4) Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

(5) The viator has the right to rescind a contract for 15 days after the receipt of the viatical settlement proceeds by the viator, as provided in G.S. 58-58-250(h). If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to

repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the provider or purchaser.

(6) Funds will be sent to the viator within three business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

(7) Entering into a 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. Assistance should be sought from a financial adviser.

(8) Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used unless the Commissioner develops one.

(9) The disclosure document shall contain the following language: 'All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.'

(10) The insured may be contacted by either the provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

(b) A provider shall provide the viator with at least the following disclosures no later than the date the contract is signed by all parties. The disclosures shall be conspicuously displayed in the contract or in a separate document signed by the viator and the provider or broker, and provide the following information:

(1) State the affiliation, if any, between the provider and the issuer of the insurance policy to be viaticated.

(2) The document shall include the name, address, and telephone number of the provider.

(3) A broker shall disclose to a prospective viator the amount and method of calculating the broker's compensation. The term 'compensation' includes anything of value paid or given to a broker for the placement of a policy.

(4) If an insurance 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 under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement.

(5) State the dollar amount of the current death benefit payable to the provider under the policy. If known, the 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 provider's interest in those benefits.

(6) State the name, business address, and telephone number of the independent third party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

(c) If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change in ownership or beneficiary to the insured within 20 days after the change.

(d) A provider or its investment agent shall provide the viatical settlement purchaser with at least the following disclosures before the date the purchase agreement is signed by all parties. The disclosures shall be conspicuously displayed in any purchase agreement or in a separate document signed by the viatical settlement purchaser and provider or investment agent, and shall make the following disclosure to the viatical settlement purchaser:

(1) The purchaser will receive no returns (i.e., dividends and interest)until the insured dies.

(2) The actual annual rate of return on a contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual 'guaranteed' rate of return is not determinable.

(3) The viaticated life insurance contract should not be considered a liquid purchase since it is impossible to predict the exact timing of its maturity and the funds probably are not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser.

(4) The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

(5) The purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party also shall be disclosed.

(6) If the purchaser is responsible for payment of the insurance premiums or other costs related to the policy if the insured returns to health, disclose the amount of such premiums, if applicable.

(7) State the name and address of any person providing escrow services and the relationship to the broker.

(8) The amount of any trust fees or other expenses to be charged to the viatical settlement purchaser shall be disclosed.

(9) State whether the purchaser is entitled to a refund of all or part of his or her investment under the contract if the policy is later determined to be null and void.

(10) Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage.

(11) Disclose the risks associated with policy contestability including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.

(12) Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including, but not limited to, the risk that the beneficiary may be changed or the premium may not be paid.

(13) Describe the experience and qualifications of the person who determines the life expectancy of the insured, i.e., in-house staff, independent physicians, and specialty firms that weigh medical and actuarial data; the information this projection is based on; and the relationship of the projection maker to the provider, if any.

(14) Disclosure to an investor shall include distribution of a brochure describing the process of investment in viatical settlements. The NAIC's form for the brochure shall be used unless the Commissioner develops one.

(e) A provider or its investment agent shall provide the viatical settlement purchaser with at least the following disclosures no later than at the time of the assignment, transfer or sale of all or a portion of an insurance policy. The disclosures shall be contained in a document signed by the viatical settlement purchaser and provider or investment agent, and shall make the following disclosures to the viatical settlement purchaser:

(1) Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator.

(2) State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums.

(3) State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums.

(4) Disclose the type of policy offered or sold, i.e., whole life, term life, universal life, or a group policy certificate, any additional benefits contained in the policy, and the current status of the policy.

(5) If the policy is term insurance, disclose the special risks associated with term insurance including, but not limited to, the purchaser's responsibility for additional premiums if the viator continues the term policy at the end of the current term.

(6) State whether the policy is contestable.

(7) State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the contract, what these rights are, and under what conditions these rights are activated.

(8) State the name and address of the person responsible for monitoring the insured's condition. Describe how often the monitoring of the insured's condition is done, how the date of death is determined, and how and when this information will be transmitted to the purchaser.

(f) The purchase agreement is voidable by the purchaser at any time within three days after the disclosures mandated by subsections (d) and (e) of this section are received by the purchaser.

§ 58-58-250. General rules

(a) A provider entering into a contract shall first obtain:

(1) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a contract.

(2) A document in which the insured consents to the release of his or her medical records to a provider or broker and, if the policy being viaticated has been in effect for less than five years, to the insurance company that issued the policy covering the life of the insured.

(b) Within 20 days after a viator executes documents necessary to transfer any rights under a policy or within 20 days after entering any agreement, option, promise, or any other form of understanding, expressed or implied, to viaticate the policy, the provider shall give written notice to the insurer that issued that policy that the policy has

or will become a viaticated policy. The notice shall be accompanied by the documents required by subsection (c) of this section.

(c) If the policy being viaticated has been in effect for less than five years, the viatical provider shall deliver a copy of the medical release required under subdivision (a)(2) of this section, a copy of the viator's application for the contract, the notice required under subsection (b) of this section and a request for verification of coverage to the insurer that issued the policy that is the subject of the viatical settlement. The NAIC's form for verification shall be used unless the Commissioner develops standards for verification.

(d) The insurer shall respond to a request for verification of coverage submitted on an approved form by a provider within 30 days after the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the policy.

(e) Before or at the time of execution of the contract, the provider shall obtain a witnessed document in which the viator consents to the contract, represents that the viator has a full and complete understanding of the contract, that he or she has a full and complete understanding of the benefits of the policy, acknowledges that he or she is entering into the contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness.

(f) If a broker performs any of these activities required of the provider, the provider is deemed to have fulfilled the requirements of this section.

(g) All medical information solicited or obtained by any licensee is subject to the applicable provisions of federal and North Carolina law relating to confidentiality of medical information.

(h) All contracts entered into in this State shall provide the viator with an unconditional right to rescind the contract for at least 15 days after the receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded, subject to repayment to the provider or purchaser of all viatical settlement proceeds, and any premiums, loans, and loan interest that have been paid by the provider or purchaser.

(i) The purchaser may rescind a contract within three days after the purchaser receives the disclosures required by G.S. 58-58-245(d) and G.S. 58-58-245(e).

(j) The provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment, or change in beneficiary directly to the independent escrow agent. Within three business days after the date the escrow agent receives the document, or from the date the provider receives the documents, if the viator erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally-chartered financial institution, the deposits of which are insured by the Federal Deposit Insurance Corporation (FDIC) or any successor entity. Upon payment of the settlement proceeds into the escrow account, the escrow

agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the provider or related provider trust. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

(k) Failure to tender consideration to the viator for the contract within the time required under G.S. 58-58-245(a)(6) renders the contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator.

(l) Contacts with the insured for the purpose of determining the health status of the insured by the provider or broker after the viatical settlement has occurred shall only be made by the provider or broker licensed in this State or its authorized representatives and shall be limited to once every three months for insureds with a life expectancy of more than one year, and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Providers and brokers shall be responsible for the actions of their authorized representatives.

(m) An investment agent shall not have any direct or indirect contact with the viator or have knowledge of the identity of the viator. An investment agent is deemed to represent the viatical settlement provider of whom the investment agent is an appointed or contracted agent.

§ 58-58-255. Prohibited practices

(a) It is a violation of this Part for any person to enter into a contract within a two-year period commencing with the date of issuance of the policy unless the viator certifies to the provider that one or more of the following conditions have been met within the two-year period:

(1) The policy was issued upon the viator's exercise of conversion rights arising out of a policy, provided the total time covered under the conversion policy plus the time covered under the prior policy is at least 24 months, or the contestability and suicide time periods have been waived by the insurer. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.

(2) The viator is a charitable organization exempt from taxation under 26 U.S.C. § 501 (c)(3).

(3) The viator is not a natural person (e.g., the owner is a corporation, limited liability company, partnership, etc.).

(4) The viator submits independent evidence to the provider that one or more of the following conditions have been met within the two-year period:

a. The viator or insured is terminally or chronically ill.

b. The viator's spouse dies.
c. The viator divorces his or her spouse.
d. The viator retires from full-time employment.
e. The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment.
f. The viator was the insured's employer at the time the policy was issued and the employment relationship terminated.
g. A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets.
h. The viator experiences a significant decrease in income that is unexpected and that impairs the viator's reasonable ability to pay the policy premium.
i. The viator or insured disposes of his or her ownership interests in a closely held corporation.

(b) Copies of the independent evidence described in subdivision (a)(4) of this subsection and documents required by G.S. 58-58-250(a) shall be submitted to the insurer when the provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider.

(c) If the provider submits to the insurer a copy of the owner or insured's certification described in subdivision (a)(4) and subsection (b) of this section when the provider submits a request to the insurer to effect the transfer of the policy to the provider, the copy shall be deemed to conclusively establish that the contract satisfies the requirements of this section and the insurer shall timely respond to the request.

§ 58-58-260. Advertising for viatical settlements and viatical settlements purchase agreements.

(a) The purpose of this section is to provide prospective viators and viatical settlement purchasers with clear and unambiguous statements in the advertisement of viatical settlements and to assure the clear, truthful, and adequate disclosure of the benefits, risks, limitations, and exclusions of any contract or purchase agreement bought or sold. This purpose is intended to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of viatical settlements to assure that product descriptions are presented in a manner that prevents unfair, deceptive, or misleading advertising and is conducive to accurate presentation and description of viatical settlements through the advertising media and material used by viatical settlement licensees.

(b) This section shall apply to any advertising of contracts, viatical purchase agreements or related products or services intended for dissemination in this State,

including Internet advertising viewed by persons located in this State. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

(c) Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its contracts, products, and services. All advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the viatical settlement licensee, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval before the use of any advertisements not furnished by the viatical settlement licensee.

(d) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a contract or purchase agreement, product or service shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(e) Certain viatical settlement advertisements are deemed false and misleading on their face and are prohibited. False and misleading viatical settlement advertisements include, but are not limited to, the following representations:

(1) 'Guaranteed,' 'fully secured,' '100 percent secured,' 'fully insured,' 'secure,' 'safe,' 'backed by rated insurance companies,' 'backed by federal law,' 'backed by state law,' or 'state guaranty funds,' or similar representations;

(2) 'No risk,' 'minimal risk,' 'low risk,' 'no speculation,' 'no fluctuation,' or similar representations;

(3) 'Qualified or approved for individual retirement accounts (IRAs), Roth IRAs, 401(k) plans, simplified employee pensions (SEP), 403(b), Keogh plans, TSA, other retirement account rollovers,' 'tax deferred,' or similar representations;

(4) Utilization of the word 'guaranteed' to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations;

(5) 'No sales charges or fees' or similar representations;

(6) 'High yield,' 'superior return,' 'excellent return,' 'high return,' 'quick profit,' or similar representations;

(7) Purported favorable representations or testimonials about the benefits of contracts or purchase agreements as an investment, taken out of

context from newspapers, trade papers, journals, radio and television programs, and all other forms of print and electronic media.

(f) The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(g) An advertisement shall not:

(1) Omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving viators, purchasers, or prospective purchasers as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax consequence. The fact that the contract or purchase agreement offered is made available for inspection before consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied or that the contract or purchase agreement includes a 'free look' period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(2) Use the name or title of a life insurance company or a policy unless the insurer has approved the advertisement.

(3) Represent that premium payments will not be required to be paid on the policy that is the subject of a contract or purchase agreement in order to maintain that policy, unless that is the fact.

(4) State or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

(5) State or imply that a contract or purchase agreement, benefit, or service has been approved or endorsed by a group of individuals, society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(6) Contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

(7) Disparage insurers, providers, brokers, investment agents, insurance producers, policies, services, or methods of marketing.

(8) Use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to

mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a contractor purchase agreement.

(9) Use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators or purchasers into believing that the solicitation is in some manner connected with a government program or agency.

(10) Create the impression that the provider, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its contracts or purchase agreement forms are recommended or endorsed by any government entity.

(h) The words 'free,' 'no cost,' 'without cost,' 'no additional cost,' at no extra cost,' or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(i) Testimonials, appraisals, or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the contract or purchase agreement, product, or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators or purchasers as to the nature or scope of the testimonials, appraisal, analysis, or endorsement. In using testimonials, appraisals, or analysis, the viatical settlement licensee makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

(j) If the individual making a testimonial, appraisal, analysis, or an endorsement has a financial interest in the provider or related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(k) When an endorsement refers to benefits received under a contract or purchase agreement all pertinent information shall be retained for a period of five years after its use.

(l) The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its contract or purchase agreements, products, or services, and if any specific contract or purchase agreement is advertised, the contract or purchase agreement shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the provider or broker shall be shown on the application.

(m) An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that competing viatical settlement licensee may not be so licensed. The

advertisement may ask the audience to consult the licensee's web site or contact the department of insurance to find out if the state requires licensing and, if so, whether the provider, broker, or investment agent is licensed.

(n) The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

(o) An advertisement shall not directly or indirectly create the impression that any state or federal governmental agency endorses, approves, or favors:

(1) Any viatical settlement licensee or its business practices or methods of operation;

(2) The merits, desirability, or advisability of any contract or purchase agreement;

(3) Any contract or purchase agreement; or

(4) Any policy or life insurance company.

(p) If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(q) If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six months.

§ 58-58-265. Fraudulent viatical settlement acts, interference, and participation of convicted felons prohibited.

(a) A person who commits a fraudulent viatical settlement act is guilty of a Class H felony.

(b) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this Part or investigations of suspected or actual violations of this Part.

(c) A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

§ 58-58-270. Report to Commissioner.

Whenever any person licensed under this Part knows or has reasonable cause to believe that any other person has violated any provision of this Part, it is the duty of that person, upon acquiring the knowledge, to notify the Commissioner and provide the Commissioner with a complete statement of all of the relevant facts and circumstances. The report is a privileged communication, and when made without actual malice does not subject the person making the report to any liability whatsoever. The Commissioner may suspend, revoke, or refuse to renew the license of any person who willfully fails to comply with this section.

§ 58-58-275. Reporting and investigation of suspected viatical settlement fraudulent acts; 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 any known or suspected viatical settlement fraudulent act.

(b) The Commissioner, acting without actual malice, is not subject to civil liability for libel or slander by virtue of an investigation of any known or suspected viatical settlement fraudulent act; 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.

(c) During the course of an investigation of a known or suspected viatical settlement fraudulent act, the Commissioner may request any person to furnish copies of any information relative to the known or suspected viatical settlement fraudulent act. The person shall release the information requested and cooperate with the Commissioner under this section.

§ 58-58-280. Confidentiality.

(a) Information and evidence provided under G.S. 58-58-270 or G.S. 58-58-275 or obtained by the Commissioner in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential, is not a public record, and is not subject to discovery or subpoena in a civil or criminal action.

(b) Subsection (a) of this section does not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(1) In administrative or judicial proceedings to enforce laws administered by the Commissioner;

(2) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the NAIC; or

(3) At the discretion of the Commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(c) Release of documents and evidence under subsection (b) of this section does not abrogate or modify the privilege granted in subsection (a) of this section.

§ 58-58-285. Other law enforcement or regulatory authority.

This Part does not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law.

(2) Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the Commissioner.

(3) Limit the powers granted elsewhere by the laws of this State to the Commissioner to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

§ 58-58-290. Injunctions; civil remedies; cease and desist orders.

(a) In addition to the penalties and other enforcement provisions of this Part, if any person violates this Part or any rule implementing this Part, the Commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the Commissioner determines are necessary to restrain the person from committing the violation.

(b) Any person damaged by the acts of a person in violation of this Part may bring a civil action against the person committing the violation in a court of competent jurisdiction.

(c) A violation of this Part attendant to the execution of a purchase agreement renders the purchase agreement voidable and subject to rescission by the viatical settlement purchaser, upon return of the policy received to the provider. Suit for rescission may be brought in a court of competent jurisdiction or where the alleged violator resides or has a principal place of business or where the alleged violation occurred.

(d) The Commissioner may issue, in accordance with G.S. 58-63-32, a cease and desist order upon a person that violates any provision of this Part, any rule or order adopted by the Commissioner, or any written agreement entered into with the Commissioner. The cease and desist order may be subject to judicial review under G.S. 58-63-35.

(e) When the Commissioner finds that an activity in violation of this Part presents an immediate danger to the public that requires an immediate final order, the Commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for 90 days. If the Commissioner begins non-emergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction in accordance with G.S. 58-63-35.

(f) In addition to the penalties and other enforcement provisions of this Part, any person who violates this Part is subject to G.S. 58-2-70.

§ 58-58-295. Unfair trade practices.

A violation of this Part is an unfair trade practice under Article 63 of this Chapter.

§ 58-58-300. Authority to adopt rules.

The Commissioner may:

(1) Adopt rules implementing this Part.

(2) Establish standards for evaluating reasonableness of payments under contracts for persons who are terminally or chronically ill, including

standards for the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy.

(3) Establish appropriate licensing requirements, fees, and standards for continued licensure for providers, and investment agents.

(4) Require a bond or other mechanism for financial accountability for providers and brokers.

(5) Adopt rules governing the relationship and responsibilities of insurers and providers, brokers, and investment agents during the viatication of a policy.

§ 58-58-305. Disclaimer.

Nothing in this Part affects the North Carolina Securities Act or the jurisdiction of the North Carolina Secretary of State.

§ 58-58-310. Effective date.

A provider, broker, or investment agent transacting business in this State on the effective date of this Part may continue to do so pending approval of the provider, broker, or investment agent's application for a license as long as the application is filed with the Commissioner no later than three months from the effective date of this Part. If the application is disapproved then the provider, broker, or investment agent shall cease transacting viatical business in this State."

SECTION 4. G.S. 58-33-32(e) reads as rewritten:

"(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),~~ G.S. 58-58-205, 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.~~ Part 5 of Article 58 of this Chapter."

SECTION 5. G.S. 58-58-42 is repealed.

SECTION 6. This act becomes effective October 1, 2001.

HOUSE BILL 359*

Short Title:	Viatical Settlements Rewrite-AB.	(Public)
Sponsors:	Representatives Dockham and Hurley (Primary Sponsors).	
Referred to:	Insurance.	

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REVISE NORTH CAROLINA'S LAW REGULATING VIATICAL SETTLEMENTS IN ACCORDANCE WITH A MODEL ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

The General Assembly of North Carolina enacts:

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

"Article 58.

~~General Regulations of Business - Life Insurance.~~Life Insurance and Viatical Settlements."

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

(1) By designating G.S. 58-58-1 through G.S. 58-58-40 as Part 1 with the heading "General Provisions."

(2) By designating G.S. 58-58-45 through G.S. 58-58-65 as Part 2 with the heading "Financial Provisions."

(3) By designating G.S. 58-58-70 through G.S. 58-58-120 as Part 3 with the heading "Insurable Interests and Other Rights."

(4) By designating G.S. 58-58-125 through G.S. 58-58-170 as Part 4 with the heading "Miscellaneous Provisions."

(5) By reserving G.S. 58-58-175 through G.S. 58-58-195 for future codification.

SECTION 3. Article 58 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 5. Viatical Settlements.

"**§ 58-58-200. Short title.**

This Part may be cited as the Viatical Settlements Act.

"**§ 58-58-205. Definitions.**

(1) 'Advertising' means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to purchase or sell a life insurance policy or an interest in a life insurance policy under a viatical settlement contract or a viatical settlement purchase agreement.

(2) 'Business of viatical settlements' means an activity involved in, but not limited to, the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating, or in any other manner, of viatical settlement contracts or purchase agreements.

(3) 'Chronically ill' means:

a. Being unable to perform at least two activities of daily living (i.e., eating, toileting, transferring, bathing, dressing, or continence);

b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

c. Having a level of disability similar to that described in sub-subdivision a. of this subdivision as determined by the Secretary of Health and Human Services;

(4) '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 entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but:

a. Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and

b. Who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. Financing entity does not include a nonaccredited investor or viatical settlement purchaser.

(5) 'Fraudulent viatical settlement act' includes:

a. Acts or omissions committed by any person who, knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including:

1. Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by a

viatical settlement provider, viatical settlement broker, viatical settlement purchaser, viatical settlement investment agent, financing entity, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of or concerning a fact material to one or more of the following:

I. An application for the issuance of a viatical settlement contract or insurance policy.

II. The underwriting of a viatical settlement contract or insurance policy.

III. A claim for payment or benefit under a viatical settlement contract or insurance policy.

IV. Premiums paid on an insurance policy or as a result of a viatical settlement purchase agreement.

V. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract, viatical settlement purchase agreement, or insurance policy.

VI. The reinstatement or conversion of an insurance policy.

VII. In the solicitation, offer, effectuation, or sale of a viatical settlement contract, insurance policy, or viatical settlement purchase agreement.

VIII. The issuance of written evidence of viatical settlement contract, viatical settlement purchase agreement or insurance.

IX. A financing transaction.

2. Employing any device, scheme, or artifice to defraud related to viaticated policies;

b. In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to:

1. Remove, conceal, alter, destroy, or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

2. Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

3. Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

4. File with the Commissioner or the insurance regulator of another jurisdiction a document containing false

information or otherwise conceals information about a material fact from the Commissioner.

c. Embezzlement, theft, misappropriation, or conversion of monies, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policy owner or any other person engaged in the business of viatical settlements or insurance; or

d. Recklessly entering into, brokering, otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator's agent intended to defraud the policy's issuer. 'Recklessly' means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct;

e. Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

(6) 'Policy' means an individual or group policy, group certificate, contract or arrangement of life insurance affecting the rights of a resident of this State or bearing a reasonable relation to this State, regardless of whether delivered or issued for delivery in this State.

(7) 'Related provider trust' means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the Commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

(8) 'Special purpose entity' means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or licensed viatical settlement provider.

(9) 'Terminally ill' means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

(10) 'Viatical settlement investment agent' means a person who is an appointed or contracted agent of a licensed viatical settlement provider

who solicits or arranges the funding for the purchase of a viatical settlement by a viatical settlement purchaser and who is acting on behalf of a viatical settlement provider.

a. A viatical settlement investment agent shall not have any contact directly or indirectly with the viator or have knowledge of the identity of the viator.

b. A viatical settlement investment agent is deemed to represent the viatical settlement provider of whom the viatical settlement investment agent is an appointed or contracted agent.

(11) '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 contracts between a viator and one or more viatical settlement providers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent 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. The term does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

(12) 'Viatical settlement contract' means a written agreement establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. A viatical settlement contract also includes a contract for a loan or other financing transaction with a viator secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company under the terms of the life insurance contract, or a loan secured by the cash value of a policy. A viatical settlement contract includes an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator.

(13) 'Viatical settlement provider' means a person, other than a viator, that enters into or effectuates a viatical settlement contract. Viatical settlement provider does not include:

a. A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

b. The issuer of a life insurance policy providing accelerated benefits under rules adopted by the Commissioner and under the contract;

c. An authorized or eligible insurer that provides stop loss coverage to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;
d. A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;
e. A financing entity;
f. A special purpose entity;
g. A related provider trust;
h. A viatical settlement purchaser; or
i. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, and who purchases a viaticated policy from a viatical settlement provider.

(14) 'Viatical settlement purchase agreement' means a contract or agreement, entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, that is entered into for the purpose of deriving an economic benefit.

(15) 'Viatical settlement purchaser means' a person who gives a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit. Viatical settlement purchaser does not include:
a. A licensee under this Part;
b. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;
c. A financing entity;
d. A special purpose entity; or
e. A related provider trust.

(16) 'Viaticated policy' means a life insurance policy or certificate that has been acquired by a viatical settlement provider under a viatical settlement contract.

(17) 'Viator' means the owner of a life insurance policy or a certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract. For the purposes of this Part, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal

or chronic illness or condition except where specifically addressed. Viator does not include:

a. A licensee under this Part;

b. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;

c. A financing entity;

d. A special purpose entity; or

e. A related provider trust.

"**§ 58-58-210. License requirements.**

(a) No person shall operate as a viatical settlement provider or viatical settlement broker without first obtaining a license from the insurance regulator of the state of residence of the viator. If there is more than one viator on a single policy and the viators are residents of different states, the viatical settlement shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all viators.

(b) A person shall not operate as a viatical settlement investment agent without first obtaining a license from the Commissioner of the state of residence of the viatical settlement purchaser. If there is more than one purchaser of a single policy and the purchasers are residents of different states, the viatical settlement purchase agreement shall be governed by the law of the state in which the purchaser having the largest percentage ownership resides or, if the purchasers hold equal ownership, the state of residence of one purchaser agreed upon in writing by all purchasers.

(c) Application for a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent license shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner, and these applications shall be accompanied by a fee of one hundred dollars ($100.00).

(d) Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fee of one hundred dollars ($100.00). Failure to pay the fees by the renewal date results in expiration of the license.

(e) The applicant shall provide information on forms required by the Commissioner. The Commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members, and employees, and the Commissioner may, in the exercise of the Commissioner's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner, or member thereof who may materially influence the applicant's conduct meets the standards of this Part.

(f) A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers, viatical settlement brokers, or viatical settlement investment agents, as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

(g) Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and issue a license if the Commissioner finds that the applicant:

(1) If a viatical settlement provider, 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 legal entity, provides a certificate of good standing from the state of its domicile; and

(5) If a viatical settlement provider or viatical settlement broker, has provided an antifraud plan that meets the requirements of G.S. 58-58-275.

(h) The Commissioner shall not issue a license to a 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.

(i) A viatical settlement provider, viatical settlement broker, or viatical settlement investment agent shall provide to the Commissioner new or revised information about officers, ten percent (10%) or more stockholders, partners, directors, members, or designated employees within 10 days after the change.

"**§ 58-58-215. License revocation and denial.**

(a) The Commissioner may refuse to issue, suspend, revoke, or refuse to renew the license of a viatical settlement provider, viatical settlement broker or viatical settlement investment agent if the Commissioner finds that:

(1) There was any material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member, or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

(4) The licensee or any officer, partner, member, or key management personnel has been found guilty of, or has pleaded guilty or *nolo contendere* to, any felony, or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(5) The viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to this Part;

(6) The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract or a viatical settlement purchase agreement;

(7) The licensee no longer meets the requirements for initial licensure;

(8) The viatical settlement provider has assigned, transferred, or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this State, viatical settlement purchaser, an accredited investor, or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; or

(9) The licensee or any officer, partner, member, or key management personnel has violated any provision of this Part.

(b) If the Commissioner denies a license application or suspends, revokes, or refuses to renew the license of a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent the Commissioner shall conduct a hearing in accordance with Chapter 150B of the General Statutes.

"**§ 58-58-220. Approval of viatical settlement contracts and disclosure statements.**

A person shall not use a viatical settlement contract or provide to a viator a disclosure statement form in this State unless filed with and approved by the Commissioner. The Commissioner shall disapprove a viatical settlement contract form or disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained therein are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the viator. At the Commissioner's discretion, the Commissioner may require the submission of advertising material.

"**§ 58-58-225. Reporting requirements and privacy.**

(a) Each licensee shall file with the Commissioner on or before June 1 of each year an annual statement containing such information as the Commissioner may prescribe by regulation.

(b) Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, viatical settlement investment agent, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information 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 and insured have provided prior written consent to the disclosure;

(2) Is necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(3) Is provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of G.S. 58-58-269;

(4) Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

(5) Is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(6) Is necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status; or

(7) Is required to purchase stop loss coverage.

"**§ 58-58-230. Authority, scope and scheduling of examinations.**

(a) The Commissioner may conduct an examination under this Part of a licensee as often as the Commissioner in his or her sole discretion deems appropriate.

(b) For purposes of completing an examination of a licensee under this Part, the Commissioner may examine or investigate any person, or the business of any person, in so far as the examination or investigation is, in the sole discretion of the Commissioner, necessary or material to the examination of the licensee.

(c) In lieu of an examination under this Part of any foreign or alien licensee licensed in this State, the Commissioner may, at the Commissioner's discretion, accept an examination report on the licensee as prepared by the Commissioner for the licensee's state of domicile or port-of-entry state.

"**§ 58-58-232. Record retention requirements.**

(a) A person required to be licensed by this Part shall for five years retain copies of all:

(1) Proposed, offered, or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of the contract or purchase agreement, whichever is later;

(2) Checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the transaction; and

(3) Other records and documents related to the requirements of this Part.

(b) This section does not relieve a person of the obligation to produce these documents to the Commissioner after the retention period has expired if the person has retained the documents.

(c) Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

"**§ 58-58-234. Conduct of examinations.**

(a) Upon determining that an examination should be conducted, the Commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the *Examiners' Handbook* adopted by the NAIC. The Commissioner may also employ such other guidelines or procedures as the Commissioner may deem appropriate.

(b) Every licensee or person from whom information is sought, its officers, directors, and agents shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Commissioner shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to G.S. 58-2-50.

(c) The Commissioner may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the Commissioner may petition the Wake County Superior Court, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

(d) When making an examination under this Part, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(e) Nothing in this Part limits the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action under this Chapter. Findings of fact and conclusions made under any examination shall be *prima facie* evidence in any legal or regulatory action.

(f) Nothing contained in this Part shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee working papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

"**§ 58-58-235. Examination reports.**

(a) Examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the licensee, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined

concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(b) No later than 60 days after completion of the examination, the examiner in charge shall file with the Commissioner a verified written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(c) If the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

"**§ 58-58-237. Confidentiality of examination information.**

(a) Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the Commissioner, unless required by law.

(b) Except as otherwise provided in this Part, all examination reports, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an examination made under this Part, or in the course of analysis or investigation by the Commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to Chapter 132 of the General Statutes or G.S. 58-2-100, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

(c) Documents, materials, or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the NAIC and its affiliates and subsidiaries are confidential and privileged, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action if they are:

(1) Created, produced, or obtained by or disclosed to the NAIC and its affiliates and subsidiaries in the course of assisting an examination made under this Part, or assisting a Commissioner in the analysis or investigation of the financial condition or market conduct of a licensee; or

(2) Disclosed to the NAIC and its affiliates and subsidiaries under subsection (d) of this section by a Commissioner;

(3) For the purposes of subsection (b) of this section, 'Part' includes the law of another state or jurisdiction that is substantially similar to this Part.

(d) Neither the Commissioner nor any person that received the documents, material, or other information while acting under the authority of the Commissioner, including the NAIC and its affiliates and subsidiaries, shall be permitted to testify in any

private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(e) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (a) of this section, with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(2) May receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) May enter into agreements governing sharing and use of information consistent with this subsection.

(f) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (d) of this section.

(g) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this State.

(h) Nothing contained in this Part shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the Commissioner of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time or to the NAIC, as long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this Part.

"**§ 58-58-239. Conflict of interest.**

(a) The Commissioner may not appoint an examiner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Part. This section shall not be construed to automatically preclude an examiner from being:

(1) A viator;

(2) An insured in a viaticated insurance policy; or

(3) A beneficiary in an insurance policy that is proposed to be viaticated.

(b) Notwithstanding the requirements of this subsection, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this Part.

"**§ 58-58-241. Immunity from liability.**

(a) No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives, or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Part.

(b) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this Part, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This subsection does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (a) of this section.

(c) A person identified in subsection (a) or (b) of this section shall be entitled to an award of attorneys' fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this Part and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is 'substantially justified' if it had a reasonable basis in law or fact at the time that it was initiated.

"**§ 58-58-243. Investigative authority of the Commissioner.**

The Commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

"**§ 58-58-245. Disclosure.**

(a) With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosures no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker and shall provide the following information:

(1) There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.

(2) Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and State franchise and income taxes, and assistance should be sought from a professional tax advisor.

(3) Proceeds of the viatical settlement could be subject to the claims of creditors.

(4) Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

(5) The viator has the right to rescind a viatical settlement contract for 15 days after the receipt of the viatical settlement proceeds by the viator, as provided in G.S. 58-58-250(h). If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement provider or purchaser.

(6) Funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

(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 or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser.

(8) Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used unless the Commissioner develops one.

(9) The disclosure document shall contain the following language: 'All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.'

(10) The insured may be contacted by either the viatical settlement provider or viatical settlement broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

(b) A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement

contract or in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker, and provide the following information:

(1) State the affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated.

(2) The document shall include the name, address, and telephone number of the viatical settlement provider.

(3) A viatical settlement broker shall disclose to a prospective viator the amount and method of calculating the broker's compensation. The term 'compensation' includes anything of value paid or given to a viatical settlement broker for the placement of a policy.

(4) If an insurance 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 under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy, and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement.

(5) State the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, 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 or certificate, and the viatical settlement provider's interest in those benefits.

(6) State the name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

(c) If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change in ownership or beneficiary to the insured within 20 days after the change.

(d) A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures before the date the viatical settlement purchase agreement is signed by all parties. The disclosures shall be conspicuously displayed in any viatical purchase contract or in a separate document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent and shall make the following disclosure to the viatical settlement purchaser:

(1) The purchaser will receive no returns (i.e., dividends and interest) until the insured dies.

(2) The actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual 'guaranteed' rate of return is not determinable.

(3) The viaticated life insurance contract should not be considered a liquid purchase since it is impossible to predict the exact timing of its maturity and the funds probably are not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser.

(4) The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

(5) The purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party also shall be disclosed.

(6) If the purchaser is responsible for payment of the insurance premiums or other costs related to the policy or if the insured returns to health, the amount of the premiums, if applicable.

(7) State the name and address of any person providing escrow services and the relationship to the broker.

(8) The amount of any trust fees or other expenses to be charged to the viatical settlement purchaser shall be disclosed.

(9) State whether the purchaser is entitled to a refund of all or part of his or her investment under the settlement contract if the policy is later determined to be null and void.

(10) Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage.

(11) Disclose the risks associated with policy contestability including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.

(12) Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including, but not limited to, the risk that the beneficiary may be changed or the premium may not be paid.

(13) Describe the experience and qualifications of the person who determines the life expectancy of the insured, i.e., in-house staff, independent physicians, and specialty firms that weigh medical and actuarial data; the information this projection is based on; and the relationship of the projection maker to the viatical settlement provider, if any.

(14) Disclosure to an investor shall include distribution of a brochure describing the process of investment in viatical settlements. The NAIC's form for the brochure shall be used unless the Commissioner develops one.

(e) A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures no later than at the time of the assignment, transfer, or sale of all or a portion of an insurance policy. The disclosures shall be contained in a document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent and shall make the following disclosures to the viatical settlement purchaser:

(1) Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator.

(2) State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums.

(3) State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums.

(4) Disclose the type of policy offered or sold, i.e., whole life, term life, universal life, or a group policy certificate, any additional benefits contained in the policy, and the current status of the policy.

(5) If the policy is term insurance, disclose the special risks associated with term insurance including, but not limited to, the purchaser's responsibility for additional premiums if the viator continues the term policy at the end of the current term.

(6) State whether the policy is contestable.

(7) State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are, and under what conditions these rights are activated.

(8) State the name and address of the person responsible for monitoring the insured's condition. Describe how often the monitoring of the insured's condition is done, how the date of death is determined, and how and when this information will be transmitted to the purchaser.

(f) The viatical settlement purchase agreement is voidable by the purchaser at any time within three days after the disclosures mandated by subsections (d) and (e) of this section are received by the purchaser.

"**§ 58-58-250. General rules.**

(a) A viatical settlement provider entering into a viatical settlement contract shall first obtain:

(1) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

(2) A document in which the insured consents to the release of his or her medical records to a viatical settlement provider or viatical settlement broker and the insurance company that issued the life insurance policy covering the life of the insured.

(b) Within 20 days after a viator executes documents necessary to transfer any rights under an insurance policy or within 20 days after entering any agreement, option, promise, or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by subsection (c) of this section.

(c) The viatical provider shall deliver a copy of the medical release required under subdivision (a)(2) of this section, a copy of the viator's application for the viatical settlement contract, the notice required under subsection (b) of this section, and a request for verification of coverage to the insurer that issued the life insurance policy that is the subject of the viatical transaction. The NAIC's form for verification shall be used unless the Commissioner develops standards for verification.

(d) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider within 30 days after the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(e) Before or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract which:

(1) Represents that the viator has a full and complete understanding of the viatical settlement contract;

(2) Represents that the viator has a full and complete understanding of the benefits of the life insurance policy;

(3) Acknowledges that the viator is entering into the viatical settlement freely and voluntarily; and

(4) For persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness or condition and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(f) If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

(g) All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of State law relating to confidentiality of medical information.

(h) All viatical settlement contracts entered into in this State shall provide the viator with an unconditional right to rescind the contract for at least 15 days after the receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans, and loan interest that have been paid by the viatical settlement provider or purchaser.

(i) The purchaser may rescind a viatical settlement contract within three days after the purchaser receives the disclosures required by G.S. 58-58-245(d) and G.S. 58-58-245(e).

(j) The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment, or change in beneficiary directly to the independent escrow agent. Within three business days after the date the escrow agent receives the document (or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider), the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the viatical settlement provider or related provider trust. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

(k) Failure to tender consideration to the viator for the viatical settlement contract within the time disclosed under G.S. 58-58-245(a)(6) renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator.

(l) Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider, or viatical settlement broker after the viatical settlement has occurred shall only be made by the viatical settlement provider or broker licensed in this State or its authorized representatives and shall be limited to once every three months for insureds with a life expectancy of more than one year, and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

"**§ 58-58-255. Prohibited practices.**

(a) It is a violation of this Part for any person to enter into a viatical settlement contract within a two-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement

provider that one or more of the following conditions have been met within the two-year period:

(1) The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

(2) The viator is a charitable organization exempt from taxation under 26 U.S.C. § 501 (c)(3);

(3) The viator is not a natural person (e.g., the owner is a corporation, limited liability company, partnership, etc.);

(4) The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the two-year period:

a. The viator or insured is terminally or chronically ill;

b. The viator's spouse dies;

c. The viator divorces his or her spouse;

d. The viator retires from full-time employment;

e. The viator becomes physically or mentally disabled, and a physician determines that the disability prevents the viator from maintaining full-time employment;

f. The viator was the insured's employer at the time the policy or certificate was issued, and the employment relationship terminated;

g. A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets;

h. The viator experiences a significant decrease in income that is unexpected and that impairs the viator's reasonable ability to pay the policy premium; or

i. The viator or insured disposes of his or her ownership interests in a closely held corporation.

(b) Copies of the independent evidence described in subdivision (a)(4) of this subsection and documents required by G.S. 58-58-250(a) shall be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(c) If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification described in subdivision (a)(4) and subsection (b) of this section when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

"**§ 58-58-260. Advertising for viatical settlements and viatical settlements purchase agreements.**

(a) The purpose of this section is to provide prospective viators and viatical settlement purchasers with clear and unambiguous statements in the advertisement of viatical settlements and to assure the clear, truthful, and adequate disclosure of the benefits, risks, limitations, and exclusions of any viatical settlement contract or viatical settlement purchase agreement bought or sold. This purpose is intended to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of viatical settlements to assure that product descriptions are presented in a manner that prevents unfair, deceptive, or misleading advertising and is conducive to accurate presentation and description of viatical settlements through the advertising media and material used by viatical settlement licensees.

(b) This section shall apply to any advertising of viatical settlement contracts, viatical purchase agreements or related products or services intended for dissemination in this State, including Internet advertising viewed by persons located in this State. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

(c) Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its contracts, products, and services. All advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the viatical settlement licensee, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval before the use of any advertisements not furnished by the viatical settlement licensee.

(d) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract or viatical settlement purchase agreement, product, or service shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(e) Certain viatical settlement advertisements are deemed false and misleading on their face and are prohibited. False and misleading viatical settlement advertisements include, but are not limited to, the following representations:

(1) 'Guaranteed', 'fully secured', '100 percent secured', 'fully insured', 'secure', 'safe', 'backed by rated insurance companies', 'backed by federal law', 'backed by state law', or state guaranty funds, or similar representations;

(2) 'No risk', 'minimal risk', 'low risk', 'no speculation', 'no fluctuation', or similar representations;

(3) 'Qualified or approved for individual retirement accounts (IRAs), Roth IRAs, 401(k) plans, simplified employee pensions (SEP), 403(b), Keogh plans, TSA, other retirement account rollovers,' 'tax deferred,' or similar representations;

(4) Utilization of the word 'guaranteed' to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations;

(5) 'No sales charges or fees' or similar representations;

(6) 'High yield', 'superior return', 'excellent return', 'high return', 'quick profit', or similar representations;

(7) Purported favorable representations or testimonials about the benefits of viatical settlement contracts or viatical settlement purchase agreements as an investment, taken out of context from newspapers, trade papers, journals, radio and television programs, and all other forms of print and electronic media.

(f) The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(g) An advertisement shall not:

(1) Omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving viators, purchasers, or prospective purchasers as to the nature or extent of any benefit, loss covered, premium payable, or State or federal tax consequence. The fact that the viatical settlement contract or viatical settlement purchase agreement offered is made available for inspection before consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied or that the viatical settlement contract or viatical settlement purchase agreement includes a 'free look' period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(2) Use the name or title of a life insurance company or a life insurance policy unless the insurer has approved the advertisement.

(3) Represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a viatical settlement

contract or viatical settlement purchase agreement in order to maintain that policy, unless that is the fact.

(4) State or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

(5) State or imply that a viatical settlement contract or viatical settlement purchase agreement, benefit, or service has been approved or endorsed by a group of individuals, society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(6) Contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

(7) Disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services, or methods of marketing.

(8) Use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contractor viatical settlement purchase agreement.

(9) Use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators or purchasers into believing that the solicitation is in some manner connected with a government program or agency.

(10) Create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its viatical settlement contracts or viatical settlement purchase agreement forms are recommended or endorsed by any government entity.

(h) The words 'free', 'no cost', 'without cost', 'no additional cost', 'at no extra cost' or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(i) Testimonials, appraisals, or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the viatical settlement contract or viatical settlement purchase agreement, product, or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators or purchasers as to the nature or scope of the testimonials, appraisal, analysis, or endorsement. In using testimonials, appraisals, or analysis, the viatical settlement licensee makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

(j) If the individual making a testimonial, appraisal, analysis, or an endorsement has a financial interest in the viatical settlement provider or related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(k) When an endorsement refers to benefits received under a viatical settlement contract or viatical settlement purchase agreement all pertinent information shall be retained for a period of five years after its use.

(l) The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contract or viatical settlement purchase agreements, products, or services, and if any specific viatical settlement contract or viatical settlement purchase agreement is advertised, the viatical settlement contract or viatical settlement purchase agreement shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

(m) An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that competing viatical settlement licensee may not be so licensed. The advertisement may ask the audience to consult the licensee's web site or contact the department of insurance to find out if the state requires licensing and, if so, whether the viatical settlement provider, viatical settlement broker, or viatical settlement investment agent is licensed.

(n) The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

(o) An advertisement shall not directly or indirectly create the impression that any division or agency of the State or of the U. S. government endorses, approves, or favors:

(1) Any viatical settlement licensee or its business practices or methods of operation;

(2) The merits, desirability, or advisability of any viatical settlement contract or viatical settlement purchase agreement;

(3) Any viatical settlement contract or viatical settlement purchase agreement; or

(4) Any life insurance policy or life insurance company.

(p) If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(q) If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six months.

"**§ 58-58-265. Fraudulent viatical settlement acts, interference, and participation of convicted felons prohibited.**

(a) A person shall not commit a fraudulent viatical settlement act.

(b) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this Part or investigations of suspected or actual violations of this Part.

(c) A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

"**§ 58-58-267. Fraud warning required.**

(a) Viatical settlements contracts and purchase agreement forms and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

'Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a crime and may be subject to fines and confinement in prison.'

(b) The lack of a statement as required in subsection (a) of this section does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

"**§ 58-58-269. Mandatory reporting of fraudulent viatical settlement acts.**

(a) Any person engaged in the business of viatical settlements having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

(b) Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

"**§ 58-58-270. Immunity from liability.**

(a) No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(1) The Commissioner or the Commissioner's employees, agents, or representatives;

(2) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(3) A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees, or representatives;

(4) The NAIC, National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents, or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities, or investment fraud; or

(5) The life insurer that issued the life insurance policy covering the life of the insured.

(b) Subsection (a) of this section does not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that subsection (a) of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

(c) A person identified in subsection (a) of this section shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this Part, and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is 'substantially justified' if it had a reasonable basis in law or fact at the time that it was initiated.

(d) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subsection (a) of this section.

"**§ 58-58-272. Confidentiality.**

(a) The documents and evidence provided under G.S. 58-58-270 or obtained by the Commissioner in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential, is not a public record, and is not subject to discovery or subpoena in a civil or criminal action.

(b) Subsection (a) of this section does not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(1) In administrative or judicial proceedings to enforce laws administered by the Commissioner;

(2) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the NAIC; or

(3) At the discretion of the Commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(c) Release of documents and evidence under subsection (b) of this section does not abrogate or modify the privilege granted in subsection (a) of this section.

"**§ 58-58-274. Other law enforcement or regulatory authority.**

This Part does not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(2) Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the insurance department; or

(3) Limit the powers granted elsewhere by the laws of this State to the Commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

"**§ 58-58-275. Viatical settlement antifraud initiatives.**

(a) Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts. At the discretion of the Commissioner, the Commissioner may order, or a licensee may request and the Commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section.

(b) Antifraud initiatives shall include:

(1) Fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors; and

(2) An antifraud plan, which shall be submitted to the Commissioner. The antifraud plan shall include, but not be limited to:

a. A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

b. A description of the procedures for reporting possible fraudulent viatical settlement acts to the Commissioner;

c. A description of the plan for antifraud education and training of underwriters and other personnel; and

d. A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the

investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(c) Antifraud plans submitted to the Commissioner are privileged and confidential, are not public records, and are not subject to discovery or subpoena in a civil or criminal action.

"**§ 58-58-280. Injunctions; civil remedies; cease and desist.**

(a) In addition to the penalties and other enforcement provisions of this Part, if any person violates this Part or any rule implementing this Part, the Commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the Commissioner determines are necessary to restrain the person from committing the violation.

(b) Any person damaged by the acts of a person in violation of this Part may bring a civil action against the person committing the violation in a court of competent jurisdiction.

(c) A violation of this Part attendant to the execution of a viatical settlement purchase agreement renders the viatical settlement purchase agreement voidable and subject to rescission by the viatical settlement purchaser, upon return of the policy received to the viatical settlement provider. Suit for rescission may be brought in a court of competent jurisdiction or where the alleged violator resides or has a principal place of business or where the alleged violation occurred.

(d) The Commissioner may issue, in accordance with Chapter 150B of the General Statutes, a cease and desist order upon a person that violates any provision of this Part, any rule or order adopted by the Commissioner, or any written agreement entered into with the Commissioner.

(e) When the Commissioner finds that an activity in violation of this Part presents an immediate danger to the public that requires an immediate final order, the Commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for 90 days. If the Commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction in accordance with Chapter 150B of the General Statutes.

(f) In addition to the penalties and other enforcement provisions of this Part, any person who violates this Part is subject to G.S. 58-2-70.

(g) A person convicted of a violation of this Part by a court of competent jurisdiction is guilty of a Class H felony. A person convicted of a violation of this Part shall be ordered to pay restitution to persons aggrieved by the violation of this Part. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

"**§ 58-58-285. Unfair trade practices.**

A violation of this Part is an unfair trade practice under Article 63 of this Chapter.

"**§ 58-58-290. Authority to adopt rules.**

The Commissioner may:

(1) Adopt rules implementing this Part;

(2) Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons who are terminally or chronically ill. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy;

(3) Establish appropriate licensing requirements, fees, and standards for continued licensure for viatical settlement providers and investment agents;

(4) Require a bond or other mechanism for financial accountability for viatical settlement providers and brokers; and

(5) Adopt rules governing the relationship and responsibilities of insurers and viatical settlement providers, viatical settlement brokers, and viatical settlement investment agents during the viatication of a life insurance policy or certificate.

"**§ 58-58-295. Effective date.**

A viatical settlement provider, viatical settlement broker, or viatical settlement investment agent transacting business in this State on the effective date of this act may continue to do so pending approval of the provider's, broker's, or investment agent's application for a license as long as the application is filed with the Commissioner no later than three months from the effective date of this act. If such application is disapproved then the viatical settlement provider, viatical settlement broker, or viatical settlement investment agent shall cease transacting viatical business in this State.

"**§ 58-58-300. Disclaimer.**

Notwithstanding any provision of this Part, nothing in this Part affects the jurisdiction of the North Carolina Secretary of State or the North Carolina Securities Act."

SECTION 4. This act becomes effective October 1, 2001.

HOUSE BILL 359:
Viatical Settlements Rewrite

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representatives Dockham and Hurley
Date:	June 13, 2001		
Version:	H359-CSSO-46	**Summary by:**	Frank W. Folger Committee Counsel

SUMMARY: ***This bill would create the Viatical Settlements Act, a new Part to Article 58 of Chapter 58 of the General Statutes. The Act, based on the NAIC model act, would comprehensively govern viatical settlements and the business of entering into viatical settlements in this State.***

CURRENT LAW: Viatical Settlements are currently governed by the N.C.G.S. § 58-55-42; Title 11, Chapter 12, Section .1700 of the North Carolina Administrative Code; and other generally applicable laws regarding insurance and civil matters.

BILL ANALYSIS: Section 1. would rewrite the title of Article 58 of Chapter 58 of the General Statutes as "Life Insurance and Viatical Settlements"

Section 2. would reorganize Article 58 of Chapter 58 of the General Statutes with Part designations and titles.

Section 3. contains the substantive content of the bill. It would:

- Establish the Viatical Settlements Act in a newly created Part 5 of Article 58 of Chapter 58 of the General Statutes; define key players in the viatical settlements business context: viatical settlement provider, viatical settlement broker, viatical settlement purchaser, viatical settlements investment agent, and viator; and define other important provisions including: fraudulent viatical settlement act, viatical settlement contract, viatical settlement purchase agreement, viaticated policy, chronically ill and terminally ill.

- Prohibit operation as a viatical settlement provider, broker, or investment agent without proper State licensure, establish standards for the issuance of a license, and grant the Commissioner of Insurance authority to revoke or refuse to issue or renew a license; require prior Commissioner approval of viatical settlement contracts and disclosure statements required by the Act; and impose annual reporting by viatical settlement licensees and prohibit disclosure of an insured's identity, financial information or medical information except as provided.

- Grant the Commissioner authority to examine a licensee in accordance with the Examination Law whenever the Commissioner deemed appropriate and to accept an examination report from another jurisdiction in lieu of the in-state examination; require persons required to be licensed under the Act to keep its records for five (5) years in a legible and complete manner; and require the subject licensee to bear the expense of the examination; and grant the Commissioner authority to investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

- Require certain disclosures to be made to the viator no later than the signing of the viatical settlement contract and to the viatical settlement purchaser at the viatical settlement agreement signing and at the policy assignment, transfer or sale; require the viatical settlement provider,

prior to the contract execution, to obtain a written statement that the viator, if the insured, is competent to enter the contract, and the insured's consent to release of medical records; require notice of the proposed viatication of the policy to the insurer within 20 days of the execution of transfer documents; provide the insurer 30 days to respond and give notice of intent, if any, to investigate the validity of the insurance contract; require the viatical settlement provider to obtain a witnessed document from the viator when the contract is executed and provide certain disclosures and information; and validate a broker performing any of these activities.

- Provide the viator a 15-day right of rescission of the viatical settlement contract and would deem the contract rescinded if the insured died within the rescission period; provide a viatical settlement purchaser a 3-day right of rescission following the required disclosures. Deem a contract voidable until consideration is tendered upon failure to tender the viator's money to the viator within three (3) days of the escrow agent's receipt of acknowledgements of the complete transfer of the policy; and prohibit entering into a viatical settlement contract within 2 years of the issuance of the policy except under four (4) specified situations.

- Prohibit false, deceptive and misleading advertising regarding the business of viatical settlements in whatever medium is used, require a system of controls over advertising by each licensee, and would grant the Commissioner authority to determine whether advertising has the capacity or tendency to mislead or deceive based on an "average education and intelligence of the targeted public" standard; deem the use of certain statements and advertising as false and misleading; and prohibit the use in advertising of certain statements of opinion, disparaging commentary, and inferences. It would require certain disclosures by endorsers.

- Make it a Class H felony to commit a fraudulent viatical settlement act and prohibit a knowing and intentional interference with enforcement of or investigation conducted pursuant to the Act, or knowing or intentional allowance of a person with felony involving dishonesty or breach of trust to participate in the business of viatical settlements; require persons in the business of viatical settlements to provide information to the Commissioner when that person has knowledge or reasonable belief that a fraudulent act has been, is, or will be committed, and would allow any other person with that knowledge or reasonable belief to provide the Commissioner with the information; and provide civil immunity to the Commissioner (and agents of the Commissioner) and to persons providing information, except in the case of statements made in actual malice, and allow for attorneys' fees under certain circumstances.

- Provide for confidentiality and privilege for documents and evidence obtained by the Commissioner in an investigation of fraud, but would not prohibit release by the Commissioner for administrative or judicial proceedings, to State and federal agencies to detect and prevent fraud, or to a person in the business of viatical settlements who is aggrieved by a fraudulent act; provide that it does not preempt other law enforcement or regulatory authority from carrying out their duties; and allow the Commissioner to enforce the Act via injunction, a cease and desist order (which may be stayed) and/or an emergency cease and desist order; allow for a private right of action for a violation; in the case of violation of provisions regarding a viatical settlement purchase agreement, it would render the agreement voidable; make a violation of the Act an unfair and deceptive trade practice under Article 63 of Chapter 58 of the General Statutes; and grant the Commissioner authority to adopt rules to carry out the provisions of the Act.

- Not affect the jurisdiction of the North Carolina Secretary of State or the North Carolina Securities Act; and allow persons required to be licensed under the Act three (3) months from the effective date of the Act to apply for a license, while being able to continue business.

Section 4. would make a conforming technical change.

Section 5. would repeal the existing statutory provisions dealing with viatical settlements

EFFECTIVE DATE: October 1, 2001

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

June 13, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 359 -- Viatical Settlements Rewrite

The following are highlights of this bill:

- Requires viatical settlement providers, brokers, and investment agents to be licensed and sets forth licensing requirements and fees.
- Prohibits persons convicted of a felony involving dishonesty or breach of trust from participating in the business of viatical settlements.
- Requires viatical settlement contracts and disclosure statement forms to be filed with and approved by the Commissioner of Insurance.
- Requires viatical settlement providers, brokers, and investment agents to keep confidential the identity of insureds and their financial and medical information except in specified circumstances.

(Continued on other side.)

- Specifies disclosures viatical settlement providers and brokers must make to viators (persons entering viatical settlement contracts), including disclosures pertaining to alternatives to viatical settlement contracts, the right to rescind the contract within 15 days, and potential adverse consequences of the settlement.

- Sets forth general rules for viatical settlements that include, among other things, requirements to ensure that a viator consents to the contract, is of sound mind and under no constraint or undue influence.

- Prohibits any person from entering into a viatical settlement contract within a two-year period after an insurance policy or certificate is issued unless certain conditions are met. Requires advertising for viatical settlements to be truthful and not misleading or deceptive, as determined by the Commissioner.

- Deems specified representations in advertising as false and misleading and prohibits them. Sets forth additional detailed requirements for advertising.

- Defines and prohibits fraudulent viatical settlement acts and authorizes Commissioner to investigate when such acts are suspected. Requires those licensed in the viatical settlement business to report to the Commissioner when they know or reasonably believe that a fraudulent viatical settlement act has been or will be committed, and immunizes those reporting from liability, unless they acted with actual malice.

- Provides that a person convicted of a fraudulent viatical settlement act is guilty of a Class H felony and may be ordered to pay restitution in addition to a fine or imprisonment.

- Makes a violation of the Act an unfair trade practice under the insurance law.

- Authorizes Commissioner to adopt rules implementing the Act.

NORTH CAROLINA DEPARTMENT OF INSURANCE
MEMORANDUM

June 13, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 359 – Viatical Settlements Rewrite

This bill would expand North Carolina's current viatical settlement law, which presently regulates the purchase of a life insurance policy by a third party (the viatical settlement provider) from an insured who has a life threatening or terminal illness, to regulating the purchase of a life insurance policy by a third party, without regard to the insured's health.

This bill requires licensing of viatical settlement providers, viatical settlement brokers, and viatical settlement investment agents.

§58-58-205- Definitions
Viatical Settlement Provider is the person who enters into the viatical settlement contract with the viator (the insured).

Viatical Settlement Broker is the person, on behalf of the viator and for a fee, attempts to negotiate a viatical settlement contract between a viator and one or more viatical settlement providers.

Viatical Settlement Investment Agent is the person who is a contracted agent of a licensed viatical settlement provider who solicits or arranges the funding for the purchase of a viatical settlement for the viatical settlement purchaser and who is acting on behalf of the viatical settlement provider.

Viatical Settlement Purchaser is the person who gives a sum of money to purchase (or invest) in a life insurance policy for the purpose of deriving an economic benefit.

Financing entity is an entity whose principal activity is providing funds to effect the viatical settlement or purchase of one or more viaticated policies. The financing entity has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. It does not include the viatical settlement purchaser.

§58-58-210- License requirements
Viatical settlement provider, broker, and investment agent licenses must be renewed

annually, and there is a $100 licensing and renewal fee. An applicant must provide information on forms provided by the Commissioner. An applicant can be required to fully disclose the identity of all stockholders, partners, officers, members, and employees. The Commissioner shall investigate each applicant before issuing a license. A nonresident applicant must file and maintain a written designation of an agent for service of process.

§58-58-215 - License sanctions
The Commissioner may refuse to issue, suspend, revoke, or refuse to renew a license for various reasons. If the license is denied or revoked the Commissioner shall conduct a hearing in accordance with the Administrative Procedure Act.

§58-58-220 – Approval of viatical settlement contracts and disclosure statements
Every viatical settlement contract must be filed with and approved by the Commissioner. The Commissioner may require the submission of advertising material.

§58-58-225 – Reporting requirements and privacy
Annual reports must be filed each year before June 1. The identity or financial or medical information of the insured may not be disclosed except for specific stated reasons.

§58-58-230 – Authority, scope and scheduling of examinations
The Commissioner may conduct an examination of any licensee under the existing Examination Law.

§58-58-235 – Record retention requirements
Records must be maintained for five years. This would include proposed, offered, or executed contracts, purchase agreements, underwriting documents, policy forms, applications, and evidence relating to payment.

§58-58-240 – Investigative authority of the Commissioner
Authorizes the Commissioner to investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

§58-58-245 – Disclosure
Requires that certain disclosures be made to the viator at the time of application. Examples are possible alternatives to viatical settlement, possible penalties, possible taxation of proceeds, claims of creditors on proceeds, and viator's rights. Requires certain disclosures to the viatical purchaser as to rights, expectations, and risks. The viator has the right to rescind the viatical settlement contract within 15 days after receipt of the

viatical settlement proceeds. The viatical settlement purchase agreement is voidable by the purchaser within three days after the purchaser receives the disclosures.

§58-58-250 – General rules
Specifies specific steps the viatical settlement provider and insurer must follow, some of which are:

- Requires the viator to provide a statement from a licensed attending physician that the viator is of sound mind and not under undue influence.
- Requires a document in which the insured consents to release of his or her medical records to the viatical settlement provider.
- Requires the viatical settlement provider to give notice to the insurer within 20 days after entering into the agreement that the policy has or will become viaticated.
- Requires the insurer to respond to request for verification of coverage within 30 days after the inquiry is received from the viatical settlement provider.
- Contacts with the insured to determine health status limited to once every three months for life expectancy over one year and once every month for a life expectancy of less than one year.

§58-58-255 – Prohibited practices
Prohibits entering into a viatical settlement contract within the two-year contestability period, unless certain stated circumstances are met.

§58-58-260 – Advertising for viatical settlements and viatical settlements purchase agreements
Requires advertisements to be truthful and not misleading. No one may use false or misleading representations with regard to the investment into a viatical settlement. Representations such as, 'guaranteed', 'fully secured', '100 percent', backed by state guaranty funds', are prohibited.

§58-58-265 – Fraudulent viatical settlement acts, interference, and participation of convicted felons prohibited
Provides that a person who commits a fraudulent viatical settlement act is guilty of a Class H felony. Prohibits persons from knowingly or intentionally (i) interfering with the enforcement of the law or investigations of violations of the law or (ii) permitting a person convicted of a felony from participating in the business of viatical settlements.

§58-58-270 and §58-58-275 – Reporting of fraudulent viatical settlement acts and immunity from liability
Requires licensees having knowledge of a fraudulent viatical settlement act to provide

this information to the Commissioner. No civil liability will be imposed on and no cause of action will arise from a licensee's furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts. Also provides immunity to others who report and act on violations of the law. These provisions are substantively similar to provisions for insurance companies in G.S. 58-2-160 and G.S. 58-2-163.

§58-58-280 – Confidentiality
Documents and evidence obtained under G.S. 58-58-270 or G.S. 58-58-275 or obtained in an investigation of suspected fraudulent viatical settlement act are privileged and confidential and are not public records.

§58-58 285 – Other law enforcement or regulatory authority
Provides that this law does not preclude any other law enforcement or regulatory action against anyone in the business of viatical settlements for a violation of any law.

§58-58-290 – Injunctions; civil remedies; cease and desist
Authorizes the Commissioner to seek an injunction in a court and apply for temporary and permanent orders that the Commissioner may determine necessary to restrain the person from committing a violation. Provides that the Commissioner may issue a cease and desist order, subject to court review, upon a person that violates any provision of the Act.

§58-58-295 – Unfair trade practices
Makes a violation of the law an insurance unfair trade practice under the insurance law.

§58-58-300 – Authority to adopt rules
Commissioner may adopt rules to implement the Act.

§58-58-305 – Disclaimer
Nothing in the Act affects the jurisdiction of the N.C. Secretary of State or affects the N.C. Securities Act.

§58-58-310 – Effective date
Requires a viatical settlement provider, viatical settlement broker, and viatical settlement investment agent currently doing business in North Carolina to file an application no later than three months from the effective date of the Act, which is October 1, 2001.

HOUSE BILL 1077:
Firefighters' and Rescue Squad Workers' Retire.

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Arnold
Date:	June 13, 2001	**Summary by:**	Frank W. Folger
Version:	First Edition		Committee Counsel

SUMMARY:

House Bill 1077 amends the law to provide retirement benefits from the Supplemental Retirement Income Plan (401K Plan) to all eligible career firefighters and career rescue squad workers. The bill also provides that career firefighters and career rescue squad workers who are members of the Local Governmental Employees' Retirement System (Local System) will be eligible for the same deferred, early, and service retirement benefits as are now available to law enforcement officers. It further raises the gross premiums tax rate on insurance contracts from 1.9% to 2.0319%, and makes an appropriation from the General Fund to the Local System for fiscal years 2001-2002 and 2002-2003.

CURRENT LAW:

Under current law, all local law enforcement officers are participating members of the Supplemental Retirement Income Plan for Local Governmental Law Enforcement Officers. Local government employers contribute five percent of each officer's monthly compensation to the individual account of the member. Some local governments currently provide this benefit to all employees; however, the law only requires it for law enforcement officers.

The service retirement provisions of the Local Governmental Employees' Retirement System allow law enforcement officers to retire with full benefits at age 55 with five years of service or at any age with 30 years. Other members may retire at age 65 with five years or at any age with 30 years. The Local System is funded, in part, by each participating local employer. Each employer's contribution rate is determined when it elects to enter the System.

BILL ANALYSIS:

This bill amends the law to give all career firefighters and career rescue squad workers the same benefit in the Supplemental Retirement Income Plan as is currently available to law enforcement officers. In addition, the bill also amends several provisions in the Local Governmental Employees' Retirement System to provide the same deferred, early and service retirement benefits as are now available to law enforcement officers to career firefighters and career rescue squad workers.

The bill also amends the tax law to increase the tax rate for gross premiums on certain insurance contracts from 1.9% to 2.0319%. It also authorizes an appropriation of $6,500,000 for fiscal year 2001-2002, and $13,000,000 for fiscal year 2002-2003 to implement the provisions of the act. The appropriation will help to offset the additional cost to local government employers imposed by this act.

EFFECTIVE DATE:

The tax increase would become effective for taxable years beginning on or after January 1, 2001. The appropriation would become effective July 1, 2001. The remainder of the act would become effective January 1, 2002, but would not affect the rights of members vested in the Local Governmental Employees' Retirement System to any disability benefits for which the person might otherwise be eligible.

Karen Cochrane-Brown, counsel to the House Committee on Pensions and Retirement, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1077

Short Title:	Firefighters' and Rescue Squad Workers' Retire.	(Public)
Sponsors:	Representatives Arnold; Baddour and Russell.	
Referred to:	Pensions and Retirement.	

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR CAREER FIREFIGHTERS' AND RESCUE SQUAD WORKERS' BENEFITS IN THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. Article 12E of Chapter 143 of the General Statutes reads as rewritten:

"Article 12E.

"Retirement Benefits for Local Governmental Law-Enforcement ~~Officers.~~ Officers and Career Firefighters and Rescue Squad Workers.

"**§ 143-166.50. Retirement benefits for local governmental law-enforcement ~~officers.~~ officers and career firefighters and rescue squad workers.**

(a) Definitions. – The following words and phrases as used in this Article, unless a different meaning is plainly required by the context, have the following meaning:

(1) "Beneficiary" means any person in receipt of a retirement allowance or other benefit from a Retirement System.

(1a) "Career firefighter" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a fire department certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the prevention, detection, and suppression of fire.

(1b) "Career rescue squad worker" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a rescue squad or emergency medical services team certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the

alleviation of human suffering and assistance to persons who are in difficulty, who are injured, or who become suddenly ill, by providing proper and efficient care or emergency medical services.

(2) "Employer" means a county, city, town or other political subdivision of the State.

(3) "Law-enforcement officer" means a full-time paid employee of an employer, who possesses the power of arrest, who has taken the law enforcement oath administered under the authority of the State as prescribed by G.S. 11-11, and who is certified as a law enforcement officer under the provisions of Chapter 17C of the General Statutes or certified as a deputy sheriff under the provisions of Chapter 17E of the General Statutes. "Law enforcement officer" also means the sheriff of the county. The number of paid personnel employed as law enforcement officers by a law enforcement agency may not exceed the number of law enforcement positions approved by the applicable local governing board.

(4) "Law-Enforcement Officers' Retirement System" means the system provided for under Article 12 of Chapter 143 of the General Statutes, as it existed prior to January 1, 1986.

(5) "Local Governmental Employees' Retirement System" means the Local Governmental Employees' Retirement System of North Carolina provided for under Article 3 of Chapter 128 of the General Statutes.

(6) "Member" means an ~~officer~~ officer, firefighter, or rescue squad worker included in the membership of a retirement system, including former ~~officers~~ officers, firefighters, or rescue squad workers no longer employed who also elected to leave their accumulated contributions on deposit with a Retirement System.

(7) "Officer" means a "law-enforcement officer."

(8) "State" means the State of North Carolina.

(b) Basic Retirement System. – On and after January 1, 1986, law-enforcement officers employed by an employer shall be members of the Local Government Employees' Retirement System, and beneficiaries who were last employed as officers by an employer, or who are surviving beneficiaries of officers last employed by an employer, are beneficiaries of the Local Governmental Employees' Retirement System and paid in benefit amounts then in effect. All members of the Law-Enforcement Officers' Retirement System last employed and paid by an employer are members of the Local Retirement System.

(c) Rights. – Notwithstanding any other provisions of law, any accrued or inchoate rights of a member of the Law-Enforcement Officers' Retirement System as of his transfer to the Local Governmental Employees' Retirement System on January 1, 1986, including the rights to a vested deferred retirement allowance and to commence retirement at certain ages with required years of service as a law-enforcement officer, may in no way be diminished; provided, however, in no event may a member

commence retirement and continue membership service with the same Retirement System after January 1, 1986.

(d) Court Cost Receipts. – Of the sum derived from the cost of court provided for in G.S. 7A-304(a)(3), the amount designated for this Article, except for the amount designated for the provisions of G.S. 143-166.50(e), shall be paid over to the pension accumulation fund of the Local Governmental Employees' Retirement System and shall offset, to the extent of these receipts, the employers' normal contribution rate required in G.S. 128-30(d)(2) as it pertains to law enforcement officers.

(e) Supplemental Retirement Income Plan for Local Governmental Law-Enforcement Officers. – As of January 1, 1986, all law-enforcement officers employed by a local government employer, are participating members of the Supplemental Retirement Income Plan as provided by Article 5 of Chapter 135 of the General Statutes. In addition to the contributions transferred from the Law-Enforcement Officers' Retirement System, participants may make voluntary contributions to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participants; provided, in no instance shall the total contributions by a participant exceed ten percent (10%) of a participant's compensation within any calendar year. From July 1, 1987, until July 1, 1988, local government employers of law enforcement officers shall contribute an amount equal to at least two percent (2%) of participating local officers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating local officers; and on and after July 1, 1988, local government employers of law enforcement officers shall contribute an amount equal to five percent (5%) of participating local officers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating local officers.

Additional contributions shall also be made to the individual accounts of all participants in the Plan, except for Sheriffs, on a per capita equal-share basis from the sum of one dollar and twenty-five cents ($1.25) for each cost of court collected under G.S. 7A-304.

(e1) Rights of Participants under the Uniformed Services Employment and Reemployment Rights Act. – A participant whose employment is interrupted by reason of service in the Uniformed Services, as that term is defined in section 4303(16) of the Uniformed Services Employment and Reemployment Rights Act, Public Law 103-353, hereafter referred to as "USERRA", shall be entitled to all rights and benefits that the participant would have been entitled to under this section had the participant's employment not been interrupted, provided that the participant returns to service as a law enforcement officer while the participant's reemployment rights are protected under the provisions of USERRA.

(e2) Supplemental Retirement Income Plan for Full-Time Local Career Firefighters and Rescue Squad Workers. – As of January 1, 2002, all career firefighters and career rescue squad workers employed by a local government employer are participating members of the Supplemental Retirement Income Plan as provided by Article 5 of Chapter 135 of the General Statutes. Participants may make voluntary contributions to the Supplemental Retirement Income Plan to be credited to the designated individual

accounts of participants; however, in no instance shall the total contributions by a participant exceed ten percent (10%) of a participant's compensation within any calendar year. On and after January 1, 2002, local government employers of career firefighters or career rescue squad workers shall contribute an amount equal to five percent (5%) of participating firefighters' or rescue squad workers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating firefighters or rescue squad workers."

SECTION 2. G.S. 128-21 is amended by adding two new subdivisions to read:

"(17a) "Career firefighter" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a fire department certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the prevention, detection, and suppression of fire.

(17b) "Career rescue squad worker" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a rescue squad or emergency medical services team certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the alleviation of human suffering and assistance to persons who are in difficulty, who are injured, or who become suddenly ill, by providing proper and efficient care or emergency medical services."

SECTION 3. G.S. 128-24(5) reads as rewritten:

"(5) The provisions of this subdivision (5) shall apply to any member whose membership is terminated on or after July 1, 1965, and who becomes entitled to benefits hereunder in accordance with the provisions hereof.

a. Notwithstanding any other provision of this Chapter, any member who separates from service prior to the attainment of the age of 60 years for any reason other than death or retirement for disability as provided in G.S. 128-27(c), after completing 15 or more years of creditable service, and who leaves his total accumulated contributions in said System shall have the right to retire on a deferred retirement allowance upon attaining the age of 60 years; provided that such member may retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired; and further provided that in the case of a member who so separates from service on or after July 1, 1967, the aforestated requirement of 15 or more years of creditable service shall be reduced to 12 or more years of creditable service; and further

provided that in the case of a member who so separates from service on or after July 1, 1971, or whose account is active on July 1, 1971, the aforestated requirement of 12 or more years of creditable service shall be reduced to five or more years of creditable service. Such deferred retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to a member who is not a law enforcement officer or eligible former law enforcement officer.

b. In lieu of the benefits provided in paragraph a of this subdivision, any member who separates from service prior to the attainment of the age of 60 years, for any reason other than death or retirement for disability as provided in G.S. 128-27(c), after completing 20 or more years of creditable service, and who leaves his total accumulated contributions in said System may elect to retire on an early retirement allowance upon attaining the age of 50 years or at any time thereafter; provided that such member may so retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired. Such early retirement allowance so elected shall be equal to the deferred retirement allowance otherwise payable at the attainment of the age of 60 years reduced by the percentage thereof indicated below.

Age at Retirement	Percentage Reduction
59	7
58	14
57	20
56	25
55	30
54	35
53	39
52	43
51	46
50	50

b1. In lieu of the benefits provided in paragraphs a and b of this subdivision, any member who is a law enforcement ~~officer~~ officer, career firefighter, or career rescue squad worker at the time of separation from service prior to the attainment of the age of 50 years, for any reason other than death or disability as provided in this Article, after completing 15 or more years of creditable service in this capacity immediately prior to separation from service, and who leaves his total accumulated contributions in this System, may elect to retire on a deferred

early retirement allowance upon attaining the age of 50 years or at any time thereafter; provided, that the member may commence retirement only upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to commence retirement. The deferred early retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to law enforcement ~~officers.~~ officers, career firefighters, or career rescue squad workers.

b2. In lieu of the benefits provided in paragraphs a and b of this subdivision, any member who is a law enforcement officer at the time of separation from service prior to the attainment of the age of 55 years, for any reason other than death or disability as provided in this Article, after completing five or more years of creditable service in this capacity immediately prior to separation from service, and who leaves his total accumulated contributions in this System may elect to retire on a deferred service retirement allowance upon attaining the age of 55 years or at any time thereafter; provided, that the member may commence retirement only upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to commence retirement. The deferred service retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to law enforcement ~~officers.~~ officers, career firefighters, or career rescue squad workers.

b3. Deferred retirement allowance of members retiring on or after July 1, 1995. – In lieu of the benefits provided in paragraphs a. and b. of this subdivision, any member who separates from service prior to attainment of age 60 years, after completing 20 or more years of creditable service, and who leaves his total accumulated contributions in said System, may elect to retire on a deferred retirement allowance upon attaining the age of 50 years or any time thereafter; provided that such member may so retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired. Such deferred retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to a member who is not a

law enforcement ~~officer or~~ officer, an eligible former law enforcement ~~officer.~~ officer, a career firefighter, an eligible former career firefighter, a career rescue squad worker, or an eligible former career rescue squad worker.

c. Should a beneficiary who retired on an early or service retirement allowance be reemployed, or otherwise engaged to perform services, by an employer participating in the Retirement System on a part-time, temporary, interim, or on fee-for-service basis, whether contractual or otherwise, and if such beneficiary earns an amount in any calendar year which exceeds fifty percent (50%) of the reported compensation, excluding terminal payments, during the 12 months of service preceding the effective date of retirement, or twenty thousand dollars ($20,000), whichever is greater, as hereinafter indexed, then the retirement allowance shall be suspended as of the first day of the month following the month in which the reemployment earnings exceed the amount above, for the balance of the calendar year. The retirement allowance of the beneficiary shall be reinstated as of January 1 of each year following suspension. The amount that may be earned before suspension shall be increased on January 1 of each year by the ratio of the Consumer Price Index to the Index one year earlier, calculated to the nearest tenth of a percent (1/10 of 1%).

d. Should a beneficiary who retired on an early or service retirement allowance be restored to service as an employee, then the retirement allowance shall cease as of the first day of the month following the month in which the beneficiary is restored to service and the beneficiary shall become a member of the Retirement System and shall contribute thereafter as allowed by law at the uniform contribution payable by all members.

Upon his subsequent retirement, he shall be paid a retirement allowance determined as follows:

1. For a member who earns at least three years' membership service after restoration to service, the retirement allowance shall be computed on the basis of his compensation and service before and after the period of prior retirement without restriction; provided, that if the prior allowance was based on a social security leveling payment option, the allowance shall be adjusted actuarially for the difference between the amount received under the optional payment and what would have been paid if the retirement allowance had been paid without optional modification.

2. For a member who does not earn three years' membership service after restoration to service, the retirement allowance shall be equal to the sum of the retirement allowance to which he would have been entitled had he not been restored to service, without modification of the election of an optional allowance previously made, and the retirement allowance that results from service earned since being restored to service; provided, that if the prior retirement allowance was based on a social security leveling payment option, the prior allowance shall be adjusted actuarially for the difference between the amount that would have been paid for each month had the payment not been suspended and what would have been paid if the retirement allowance had been paid without optional modification."

SECTION 4. G.S. 128-27(a) reads as rewritten:

"(a) Service Retirement Benefits. –

(1) Any member may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired: Provided, that the said member at the time so specified for his retirement shall have attained the age of 60 years and have at least five years of creditable service or shall have completed 30 years of creditable service, or if a ~~fireman, he~~ career firefighter or career rescue squad worker, the member shall have attained the age of 55 years and have at least five years of creditable service.

(2) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1019, s. 1.

(3) Repealed by Session Laws 1971, c. 325, s. 12.

(4) Any member who was in service October 8, 1981, who had attained 60 years of age, may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired.

(5) Any member who is a law enforcement ~~officer,~~ officer, career firefighter, or career rescue squad worker and who attains age 50 and completes 15 or more years of creditable service in this capacity or who attains age 55 and completes five or more years of creditable service in this capacity, may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, ~~he~~ the member desires to be retired; provided, also, any member who has met the conditions required by this ~~subdivision~~ section but does not retire, and later

becomes an employee other than as a law enforcement ~~officer,~~ officer, career firefighter, or career rescue squad worker continues to have the right to commence retirement."

SECTION 5. G.S. 128-27(b18) reads as rewritten:

"(b18) Service Retirement Allowance of Member Retiring on or After July 1, ~~2000.~~2000, but Before January 1, 2002. – Upon retirement from service in accordance with subsection (a) or (a1) above, on or after July 1, 2000, but before January 1, 2002, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday and completion of five years of creditable service as a law enforcement officer, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 128-27(b18)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b18)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th birthday and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 128-27(b18)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 128-27(b18)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or
2. The service retirement allowance as computed under G.S. 128-27(b18)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or
3. If the member's creditable service commenced prior to July 1, 1995, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 128-27(b18)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1965, shall not receive less than the benefit provided by G.S. 128-27(b)."

SECTION 6. G.S. 128-27 is amended by adding a new subsection to read:

"(b19) Service Retirement Allowance of Member Retiring on or After January 1, 2002. – Upon retirement from service in accordance with subsection (a) or (a1) above, on or after January 1, 2002, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer, an eligible former law enforcement officer, a career firefighter, an eligible former career firefighter, a career rescue squad worker, or an eligible former career rescue squad worker shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday and completion of five years of creditable service as a law enforcement officer, career firefighter, or career rescue squad worker, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer, career firefighter, or career rescue squad worker and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 128-27(b19)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b19)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer, an eligible former law enforcement officer, a career firefighter, an eligible former career firefighter, a career rescue worker, or an eligible former career rescue squad worker shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th birthday and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 128-27(b19)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 128-27(b19)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b19)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or

3. If the member's creditable service commenced prior to July 1, 1995, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 128-27(b19)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1965, shall not receive less than the benefit provided by G.S. 128-27(b)."

SECTION 7. G.S. 128-27(m) reads as rewritten:

"(m) Survivor's Alternate Benefit. – Upon the death of a member in service, the principal beneficiary designated to receive a return of accumulated contributions shall have the right to elect to receive in lieu thereof the reduced retirement allowance provided by Option two of subsection (g) above computed by assuming that the member had retired on the first day of the month following the date of his death, provided that all three of the following conditions apply:

(1) a. The member had attained such age and/or creditable service to be eligible to commence retirement with an early or service retirement allowance, or

b. The member had obtained 20 years of creditable service in which case the retirement allowance shall be computed in accordance with ~~G.S. 128-27(b18)(1)b. or G.S. 128-27(b18)(2)c.,~~ G.S. 128-27(b19)(1)b. or G.S. 128-27(b19)(2)c., notwithstanding the requirement of obtaining age 50.

(2) The member had designated as the principal beneficiary to receive a return of his accumulated contributions one and only one person who is living at the time of his death.

(3) The member had not instructed the Board of Trustees in writing that he did not wish the provisions of this subsection apply.

For the purpose of this benefit, a member is considered to be in service at the date of his death if his death occurs within 180 days from the last day of his actual service. The last day of actual service shall be determined as provided in subsection (l) of this section. Upon the death of a member in service, the surviving spouse may make all purchases for creditable service as provided for under this Chapter for which the member had made application in writing prior to the date of death, provided that the date of death occurred prior to or within 60 days after notification of the cost to make the purchase."

SECTION 8. G.S. 105-228.5(d)(2) reads as rewritten:

"(2) Other Insurance Contracts. – The tax rate to be applied to gross premiums on all other insurance contracts issued by insurers shall be ~~one-and-nine-tenths percent (1.9%).~~ two and three hundred nineteen ten-thousandths percent (2.0319%). The net proceeds shall be credited to the General Fund."

SECTION 9. There is appropriated from the General Fund to the Local Governmental Employees' Retirement System the sum of six million five hundred thousand dollars ($6,500,000) for the 2001-2002 fiscal year and the sum of thirteen million dollars ($13,000,000) for the 2002-2003 fiscal year to implement the provisions of this act.

SECTION 10. Section 8 of this act is effective for taxable years beginning on or after January 1, 2001. Section 9 of this act becomes effective July 1, 2001. The remainder of this act becomes effective January 1, 2002, but shall not affect the rights of a person who is a vested member of the Local Governmental Employees' Retirement System on that date to any disability benefits for which that person is otherwise eligible on that date.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 20, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 20, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Ashley Bass and Lindsay Creech (Cumberland County – Representative Hurley) and Megan Varsamis (Guilford County - Representative Jeffus). The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Barbee, Brubaker, Dedmon, Grady, Hall, Hunter, Justus, Saunders, Setzer, Smith, Wainwright, Warner, and C. Wilson. Linda Attarian and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

SB 461, entitled, AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102. Senator Wellons, bill sponsor, was recognized and he presented a proposed committee substitute. Representative Barbee moved for adoption of the committee substitute for discussion. The motion passed. This committee substitute would amend the General Statutes to conform to the consumer information privacy requirements of the federal Gramm-Leach-Bliley Act, and would enhance certain consumer protections and remove certain industry burdens without consumer impact. Bill Hale, NC Department of Insurance, was recognized to further explain the committee substitute. North Carolina law provides that no insured's personal information can be further disclosed by an insurance company or agent without that insured's written consent. This is known as an "opt in" standard. There are some exceptions to this. SB 461 provides that no sharing of a consumer's medical record information for marketing purposes may occur unless the insurer or agent obtains the consumer's permission ("opt in"). The law requires insurance companies once every two years to give insureds a written notice about how the companies collect and share information about the insureds and the rights of the insureds under the law. SB 461 changes this to once every year.

SB 461 extends the notice protection to persons insured under a group insurance plan (usually employees insured under an employer's group health policy), who currently have no right to notice unless their policies are individually underwritten. SB 461 extends the protections of the law to the homeowner who pays for mortgage guaranty insurance even though the lender is the insured under the policy.

The Chair indicated at this time that a vote would not be taken on SB 461 at this meeting to give everyone a chance to look at this bill in more detail and iron out a few minor changes. It will be taken up again for a vote at a future Insurance Committee meeting.

HB 1077, entitled, AN ACT TO PROVIDE FOR CAREER FIREFIGHTERS' AND RESCUE SQUAD WORKERS' BENEFITS IN THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM. Representative Arnold, bill sponsor, was recognized to explain the bill. This bill amends the law to give all career firefighters and career rescue squad workers the same benefit in the Supplemental Retirement Income Plan as is currently available to law enforcement officers. In addition, the bill also amends several provisions in the Local Governmental Employees' Retirement System to provide the same deferred, early and service retirement benefits as are now available to law enforcement officers to career firefighters and career rescue squad workers. The bill also amends the tax law to increase the tax rate for gross premiums on certain insurance contracts from 1.9% to 2.0319%. It also authorizes an appropriation of $6,500,000 for fiscal year 2001-2002, and $13,000,000 for fiscal year 2002-2003 to implement the provisions of the act. The appropriations will help to offset the additional cost to local government employers imposed by this act.

Mr. Paul Brooks, with the Greensboro Fire Department, spoke in favor of the bill, and brought up the topic of the retaliatory tax. Much discussion ensued regarding who would ultimately pay the retaliatory tax – individuals in other states, the insurers, or the insured. Bob Price, Association of NC Life Insurance Companies, spoke in opposition to the bill. Dorothy Austell, Jefferson Pilot Life Underwriters Association, spoke in opposition to the bill. Representative Smith raised the question as to why local governments state we should not send them a mandate, yet the General Assembly is expected to solve the situation, and feels the situation should be solved at the local level, which would allow it to be handled in the same manner as the law enforcement officer's retirement. Jim Phillips, Jefferson Pilot, spoke in opposition to the bill. Paul Miller, NC State Firemen's Association spoke in favor of the bill. The consensus of the committee members is that the intent of the bill is good; however, the means of funding the retirement is the topic of controversy. A vote was not taken on this bill

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

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
Senate Bill 461 and House Bill 1077
Bill Summaries
Handout

VISITOR REGISTRATION SHEET

INSURANCE — June 20, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sheila McKinney	NC Dept. of Insurance
Spencer Tetterton	Angier + Black River Fire PO Box 389 27501
Austin F. Tew	Dunn F.D. / Harnett Co. Chiefs Assoc, 102 N. Powell Ave. Dunn NC 28334
Andy Romanet	NCLM,
Mark Benson	Capitol Group
Rick O'Brien	PFFPNC
B E Scarbro	WSPFFA
Jim Phillips	BPMH L
[illegible]	Morningstar Allen
[illegible]	NCDOI
[illegible]	Boone + Assoc

VISITOR REGISTRATION SHEET

INSURANCE — June 20, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Keith P Kirton	RPFFA
Danny Poole	Ral Professional Fri Fighters assoc
DON CARTER	RALEIGH PROFESSIONAL FIRE FIGHTERS ASSO.
Henry L. Pierce	Rocky Mount Fire Dept.
Steve Carr	Rocky MT. Fire Dept.
Walter E Jones	Rocky Mount Fire Dept.
Lonnie M Hedgepeth	Rocky Mount, Fire Dept.
Todd D Dettman	Rocky Mount Fire Dept.
Cam Cox	BPOE
Frank Sutherland	Jefferson Pilot Broadcasting
ANThony W. Slater	Goldsboro Fire Fighter Assoc. (President)

VISITOR REGISTRATION SHEET

INSURANCE — June 20, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Dilday	NC State Firemen Association P.O. 186 Farmville
Glenn P. Brown Jr.	Ahoskie Volunteer Fire Dept.
Dorothy B. Austell	N.C. State Board of Eye and Health Care Specialists Association
Robert Pasquel	Young, Moore
Brad Price	Jordan Price
Steve Woodson	NC Farm Bureau Federation
DERICK CAUTHREN	Raleigh Fire Dept.
JIM PARKER	RALEIGH PROFESSIONAL FIREFIGHTERS
Andy Holliman	Williamston Fire/Rescue 901 Washington St. Williamston, NC 27892
Paul Brooks	NC State Firemens Assoc. Greensboro Fire Dept.
Barbara Carsten	MFSPA

VISITOR REGISTRATION SHEET

INSURANCE — June 20, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
James Dean	MGM
Amy Fulbright	Hunton & Williams
Tom Daniel	NCAHP
Dan Dunn	NCAHP
Joyce Rakes	MAMSI
David Kelly	R.P.I.F.A
Don Lampe	Smith Helms
Paul Stark	NC Bankers Assn.
Angie Yeakes	NCRPC
Stephen W. Keene	NCMS
Keith Wilder	Raleigh Fire Dept.

VISITOR REGISTRATION SHEET

INSURANCE — June 20, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tim BRADLEY	NC DEPT OF INSURANCE
Paul Miller	NC State Firemen's Assoc.
Crissy Porter	Bone & Associates
Susan Palami	Nationwide
John McMillan	MFDS P.A.
Mike Causey	NC Glass Assn.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 461*

Insurance and Consumer Protection Committee Substitute Adopted 4/24/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S461-CSSO-48 [v.3]

6/20/2001 11:00:45 AM

Short Title: Insurance Information Privacy-AB. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-39-10 reads as rewritten:

"**§ 58-39-10. Scope.**

(a) The obligations imposed by this Article shall apply to those insurance institutions, agents, or insurance-support organizations ~~that, on or after July 1, 1982:~~that:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance:

a. Collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this State; or

b. Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this State; and

(2) In the case of property or casualty insurance:

a. Collect, receive, or maintain information in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; ~~or~~

b. Engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~State; or

c. Engage in transactions involving mortgage guaranty insurance where the mortgage guaranty policies, contracts, or certificates

of insurance are delivered, issued for delivery, or renewed in this State.

(b) The rights granted by this Article shall extend to:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance, the following persons who are residents of this State:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions;

(2) In the case of property or casualty insurance, the following persons:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in (i) insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~ State; or (ii) mortgage guaranty insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State.

(c) For purposes of this section, a person shall be considered a resident of this State if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance-support organization, is located in this State.

(d) Notwithstanding subsections (a) and (b) of this section, this Article shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this State.

(e) This article applies to credit insurance that is subject to Article 57 of this Chapter."

SECTION 2. G.S. 58-39-15(1) reads as rewritten:

"(1) "Adverse underwriting decision" means:

a. Any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

1. A declination of insurance coverage;

2. A termination of insurance coverage;

3. Failure of an agent to apply for insurance coverage with a specific insurance institution that an agent represents and that is requested by an applicant;

4. In the case of a property or casualty insurance coverage:
   I. Placement by an insurance institution or agent of a risk with a residual market ~~mechanism or~~ mechanism, an unauthorized insurer, or an insurance institution that specializes in substandard risks; or
   II. The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished; or
5. In the case of a ~~life or accident and health~~ life, health, or disability insurance coverage, an offer to insure at higher than standard rates.

b. Notwithstanding subdivision (1)a of this section, the following actions shall not be considered adverse underwriting decisions, but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:
1. The termination of an individual policy form on a class or statewide basis;
2. A declination of insurance coverage solely because such coverage is not available on a class or statewide basis; or
3. The rescission of a policy."

SECTION 3. G.S. 58-39-15(9) reads as rewritten:

"(9) "Individual" means any natural person who:
a. In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder;
b. In the case of life or accident and health insurance, is a past, present, or proposed principal insured or certificate holder;
c. Is a past, present or proposed policy owner;
d. Is a past or present applicant;
e. Is a past or present claimant; ~~or~~
f. Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this ~~Article.~~Article; or
g. Is the subject of personal information collected or maintained by an insurance institution, agent, or insurance-support organization in connection with mortgage guaranty insurance."

SECTION 4. G.S. 58-39-25 reads as rewritten:

"**§ 58-39-25. Notice of insurance information practices.**

(a) An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided in this section:

(1) In the case of an application for insurance a notice shall be provided no later than:

a. At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records; ~~or~~

b. At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records; or

c. Before the initial disclosure of personal information under G.S. 58-39-75(11).

(2) In the case of a policy ~~renewal,~~ that has been issued, a notice shall be provided ~~no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:~~

~~a. Personal information is collected only from the policyholder or from public records; or~~

~~b. A notice meeting the requirements of this section has been given within the previous 24 months; or~~ not less than annually while the policy is in force. As used in this subdivision, 'annually' means at least once in any period of 12 consecutive months during which the policy is in effect.

(2a) In the case of new policies issued after January 1, 2002, and policy renewals occurring after January 1, 2002, a notice shall be provided at the time of issuance or renewal, and thereafter provided not less than annually during the continuation of the policy. As used in this subdivision, 'annually' means at least once in any period of 12 consecutive months during which the policy is in effect.

(3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance ~~institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.~~ institution.

(b) The notice required by ~~subsection (a)~~ sub-subdivision (a)(1)a. and (a)(1)b. and subdivisions (a)(2a) and (a)(3)of this section shall be in writing and shall state:

(1) Whether personal information may be collected from persons other than the individual or individuals proposed for ~~coverage;~~ coverage.

(2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such ~~information;~~ information.

(3) The types of disclosures identified in subsections (2), (3), (4), (5), (6), (9), (11), (12), and (14) of G.S. 58-39-75 and the circumstances under which such disclosures may be made without prior authorization: Provided, however, only those circumstances need be described that occur with such frequency as to indicate a general business ~~practice;~~practice.

(4) A description of the rights established under G.S. 58-39-45 and 58-39-50 and the manner in which such rights may be ~~exercised; and~~ exercised.

(5) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(b1) The notice required by sub-subdivisions (a)(1)a and (a)(1)c and subdivisions (a)(2) and (a)(2a) of this section shall include information relating to:

(1) The policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the insurance institution or agent, consistent with Title V of P.L. 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided pursuant to Title V of P.L. 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(2) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with Title V of P.L. 106-102.

(3) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In lieu of the notice prescribed in ~~subsection (b)~~ subdivisions (b)(1) through (b)(5) of this section, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that:

(1) Personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) Such information, as well as other personal or privileged information subsequently collected by the insurance institution or agent, in certain circumstances, may be disclosed to third parties without authorization;

(3) A right of access and correction exists with respect to all personal information collected; and

(4) The notice prescribed in ~~subsection (b)~~ subdivisions (b)(1) through (b)(5) of this section will be furnished to the applicant or policyholder upon request.

(d) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

(e) An insurance institution or agent may provide a joint notice from the insurance institution or agent and one or more of its affiliates or other financial institutions, as defined in the notice, as long as the notice is accurate with respect to the insurance institution or agent and the other institutions.

(f) The notice requirements of this section may be satisfied by providing a single notice if two or more applicants or policyholders jointly obtain or apply for an insurance product.

(g) An insurance institution or agent may satisfy the notice requirements of this section and Title V of P.L. 106-102 through the use of separate or combined notices.

(h) An insurance institution or agent is not required to provide the notices required by this section to:

(1) Any applicant or policyholder whose last known address, according to the insurance institution's or agent's records is deemed invalid. The applicant's or policyholder's last known address shall be deemed invalid if mail sent to that address has been returned by the postal authorities as undeliverable and if subsequent reasonable attempts to obtain a current valid address for the applicant or policyholder have been unsuccessful; or

(2) Any policyholder whose policy is lapsed, expired, or otherwise inactive or dormant under the insurance institution's business practices, and the insurance institution has not communicated with the policyholder about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, or promotional materials.

(i) If an agent does not share information with any person other than the agent's principal or an affiliate of the prinicipal, and if the principal provides all notices required by this section, the agent is not required to provide the notices required by this section. G.S. 58-39-75 applies to the sharing of information with an affiliate under this subsection.

(j) When an agent discloses a policyholder's personal information, other than medical information, to an insurance institution solely for the purposes of renewal, transfer, replacement, reinstatement, or modification of an existing policy, the agent is not required to provide the notices required by this section.

(k) For the purposes of this section only, the terms 'applicant' or 'policyholder' include respectively a person who applies for, or a certificate holder who obtains, insurance coverage under a group or blanket insurance contract, employee benefit plan, or group annuity contract, regardless of whether the coverage is individually

underwritten. An insurance institution or agent that does not disclose personal information about an applicant or policyholder under a group or blanket insurance contract, employee benefit plan, or group annuity contract, except as permitted under G.S. 58-39-75(1) through (10) and G.S. 58-39-75(12) through (21), may satisfy any notice requirement that otherwise exists under this section with respect to that applicant or policyholder by providing a notice of information practices to the holder of the group or blanket insurance or annuity contract or the employee benefit plan sponsor. If an insurance institution or agent discloses personal information about an applicant or policyholder as permitted by G.S. 58-39-75(11), it shall provide the notice required by sub-subdivision (a)(1)c of this section to the applicant or policyholder not less than 30 days before the information is disclosed; and it may satisfy any other notice requirement that otherwise exists under this section with respect to that applicant or policyholder by providing a notice of information practices to the holder of the group or blanket insurance or annuity contract or employee benefit plan sponsor.

(l) An insurance institution or agent that does not disclose and does not wish to reserve the right to disclose nonpublic personal information about policyholders or former policyholders to affiliates or nonaffiliates, except as authorized in G.S. 58-39-75(1) through (10) and G.S. 58-39-75(12) through 58-39-75(21), satisifes the requirements of G.S. 58-39-25 by providing a notice that:

(1) States the foregoing information regarding that insurance institution or agent.

(2) Describes the types of personal information that may be collected under G.S. 58-39-25(b)(1).

(3) Describes the policies to protect the confidentiality and security of nonpublic personal information under G.S. 58-39-25(b)(7).

(4) States that the insurance institution or agent makes disclosure to other affiliated or nonaffiliated third parties, as applicable, as permitted by law."

SECTION 5. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-26. Exception for title and mortgage guaranty insurance.**

(a) A title insurance company shall give notice of its insurance information practices under G.S. 58-39-25 only at the time the final policy of title insurance is issued and is not subject to any annual notice requirement thereafter.

(b) In the case of mortgage guaranty insurance, a notice shall be provided at the time a master policy is issued and thereafter only if there is a material change in the insurer's policies and practices regarding the use or disclosure of personal information."

SECTION 6. G.S. 58-39-75(1) reads as rewritten:

"(1) With the written authorization of the individual, provided:

a. If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35; or

b. If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35 and is:

1. Dated;
2. Signed by the individual; and
3. Obtained one year or less ~~prior to~~ before the date a disclosure is sought pursuant to this paragraph; or".

SECTION 7. G.S. 58-39-75(18) reads as rewritten:

"(18) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of ~~insurance; provided that~~ insurance only if:

a. No medical record information is disclosed unless the disclosure would otherwise be permitted by this section; and

b. ~~the~~ The information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy; or."

SECTION 8. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-76. Limits on sharing account number information for marketing purposes.**

(a) General Prohibition on Disclosure of Account Numbers. – An insurance institution, insurance agent, or insurance-support organization shall not disclose, other than to a consumer reporting agency, an account number or similar form of access number or access code for a credit card account, deposit account, or transaction account of a consumer to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) Definitions. – As used in this section:

(1) 'Account number' means an account number, or similar form of access number or access code, but does not include a number or code in an encrypted form, as long as the insurance institution, insurance agent, or insurance-support organization does not provide the recipient with a means to decode the number or code.

(2) 'Transaction account' means an account other than a deposit account or credit card account. A transaction account does not include an account to which third parties cannot initiate charges.

(c) Exceptions. – Subsection (a) of this section does not apply if an insurance institution, insurance agent, or insurance-support organization discloses an account number or similar form of access number or access code:

(1) To the insurance institution's, insurance agent's, or insurance-support organization's agent or service provider solely in order to perform

marketing for the insurance institution's, insurance agent's, or insurance-support organization's own products or services, as long as the agent or service provider is not authorized to directly initiate charges to the account; or

(2) To a participant in a private label credit card program or an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program."

SECTION 9. G.S. 58-39-75(12) reads as rewritten:

"(12) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated ~~persons; or~~ persons, and further provided that no medical record information may be disclosed to the affiliate for the marketing of an insurance product or service; or".

SECTION 10. G.S. 58-39-75(2) reads as rewritten:

"(2) To a person other than an insurance institution, agent, or insurance-support organization, provided such disclosure is reasonably necessary:

a. To enable ~~such~~ that person to perform a business, professional, or insurance function for the disclosing insurance institution, agent, or insurance-support organization, including, but not limited to, performing marketing functions and other functions regarding the provision of information concerning the disclosing institution's own products, services, and programs, and ~~such~~ that person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

1. Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or
2. s reasonably necessary for ~~such~~ that person to perform its function for the disclosing insurance institution, agent, or insurance-support organization; or

b. To enable ~~such~~ that person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

1. Determining an individual's eligibility for an insurance benefit or payment; or
2. Detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction; or"

SECTION 11. G.S. 58-39-75 is amended by adding a new subdivision to read:

"(21) To a person whose only use of an applicant's or policyholder's personal information, but not including medical record information, will be in connection with the marketing of a financial product or service intended to be provided by participants in a marketing program where the program participants and the types of information to be shared are identified to the applicant or policyholder when the applicant or policyholder is first offered the financial product or service. As used in this subdivision:

a. 'Financial institution' means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. §1843(k)).

b. 'Financial product or service' means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. §1843(k)).

c. 'Marketing program' includes only those programs established by written agreement by the insurance institution and one or more financial institutions under which they jointly offer, endorse, or sponsor a financial product or service."

SECTION 12. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 13. This act becomes effective January 1, 2002, and applies to policies and contracts newly issued or renewed on and after that date. For purposes of application of this act to policies or contracts renewed on or after January 1, 2002, the renewal of a policy or contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the policy or contract.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 461*

Insurance and Consumer Protection Committee Substitute Adopted 4/24/01

Short Title: Insurance Information Privacy-AB. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-39-10 reads as rewritten:

"**§ 58-39-10. Scope.**

(a) The obligations imposed by this Article shall apply to those insurance institutions, agents, or insurance-support organizations that, on or after July 1, 1982:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance:

a. Collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this State; or

b. Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this State; and

(2) In the case of property or casualty insurance:

a. Collect, receive, or maintain information in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; ~~or~~

b. Engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~State; or

c. Engage in transactions involving mortgage guaranty insurance where the mortgage guaranty policies, contracts, or certificates of insurance are delivered, issued for delivery, or renewed in this State.

(b) The rights granted by this Article shall extend to:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance, the following persons who are residents of this State:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions;

(2) In the case of property or casualty insurance, the following persons:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in (i) insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~ State; or (ii) mortgage guaranty insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State.

(c) For purposes of this section, a person shall be considered a resident of this State if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance-support organization, is located in this State.

(d) Notwithstanding subsections (a) and (b) of this section, this Article shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this State."

SECTION 2. G.S. 58-39-15(1) reads as rewritten:

"(1) "Adverse underwriting decision" means:

a. Any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

1. A declination of insurance coverage;

2. A termination of insurance coverage;

3. Failure of an agent to apply for insurance coverage with a specific insurance institution that an agent represents and that is requested by an applicant;

4. In the case of a property or casualty insurance coverage:

I. Placement by an insurance institution or agent of a risk with a residual market ~~mechanism or~~ mechanism, an unauthorized insurer, or an

insurance institution that specializes in substandard risks; or

II. The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished; or

5. In the case of a ~~life or accident and health~~ life, health, or disability insurance coverage, an offer to insure at higher than standard rates.

b. Notwithstanding subdivision (1)a of this section, the following actions shall not be considered adverse underwriting decisions, but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

1. The termination of an individual policy form on a class or statewide basis;
2. A declination of insurance coverage solely because such coverage is not available on a class or statewide basis; or
3. The rescission of a policy."

SECTION 3. G.S. 58-39-15(9) reads as rewritten:

"(9) "Individual" means any natural person who:

a. In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder;
b. In the case of life or accident and health insurance, is a past, present, or proposed principal insured or certificate holder;
c. Is a past, present or proposed policy owner;
d. Is a past or present applicant;
e. Is a past or present claimant; ~~or~~
f. Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this ~~Article.~~Article; or
g. Is the subject of personal information collected or maintained by an insurance institution, agent, or insurance-support organization in connection with mortgage guaranty insurance."

SECTION 4. G.S. 58-39-25 reads as rewritten:

"**§ 58-39-25. Notice of insurance information practices.**

(a) An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided in this section:

(1) In the case of an application for insurance a notice shall be provided no later than:

a. At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records; ~~or~~

b. At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records; or

c. Before the initial disclosure of personal information under G.S. 58-39-75(11).

(2) In the case of a policy ~~renewal,~~ that has been issued, a notice shall be provided ~~no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:~~

~~a. Personal information is collected only from the policyholder or from public records; or~~

~~b.~~ ~~A notice meeting the requirements of this section has been given within the previous 24 months;~~ not less than annually while the policy is in force; or

(3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance ~~institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.~~ institution.

(b) The notice required by sub-subdivision (a)(1)a. and (a)(1)b. and subdivision (a)(3)of this section shall be in writing and shall state:

(1) Whether personal information may be collected from persons other than the individual or individuals proposed for ~~coverage;~~ coverage.

(2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such ~~information;~~ information.

(3) The types of disclosures identified in subsections (2), (3), (4), (5), (6), (9), (11), (12), and (14) of G.S. 58-39-75 and the circumstances under which such disclosures may be made without prior authorization: Provided, however, only those circumstances need be described that occur with such frequency as to indicate a general business ~~practice;~~practice.

(4) A description of the rights established under G.S. 58-39-45 and 58-39-50 and the manner in which such rights may be ~~exercised; and~~ exercised.

(5) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(6) The notice required by sub-subdivisions (a)(1)a and (a)(1)c and subdivision (a)(2) of this section shall include information relating to the policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the insurance institution or agent, consistent with Title V of P.L. 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided pursuant to Title V of P.L. 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(7) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with Title V of P.L. 106-102.

(8) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In lieu of the notice prescribed in ~~subsection (b)~~ subdivisions (b)(1) through (b)(5) of this section, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that:

(1) Personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) Such information, as well as other personal or privileged information subsequently collected by the insurance institution or agent, in certain circumstances, may be disclosed to third parties without authorization;

(3) A right of access and correction exists with respect to all personal information collected; and

(4) The notice prescribed in subsection (b) of this section will be furnished to the applicant or policyholder upon request.

For the purposes of this section only, the terms 'applicant' or 'policyholder' include respectively a person who applies for or obtains coverage under a group insurance contract, regardless of whether that person's coverage is individually underwritten. An insurance institution or agent that does not disclose personal information about an applicant or policyholder under a group insurance contract, as permitted by G.S. 58-39-75(11), may satisfy any notice requirement that otherwise exists under this section with respect to the applicant or policyholder by providing a notice of information practices to the holder of the group insurance contract.

(d) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

(e) An insurance institution may provide a joint notice from the insurance institution and one or more of its affiliates or other financial institutions, as defined in

the notice, as long as the notice is accurate with respect to the insurance institution and the other institutions.

(f) The notice requirements of this section may be satisfied by providing a single notice if two or more applicants or policyholders jointly obtain or apply for an insurance product.

(g) An insurance institution or agent may satisfy the notice requirements of this section and Title V of P.L. 106-102 through the use of separate or combined notices.

(h) An insurance institution or agent is not required to provide the notices required by this section to:

(1) Any applicant or policyholder whose last known address, according to the insurance institution's or agent's records is deemed invalid. The applicant's or policyholder's last known address shall be deemed invalid if mail sent to that address has been returned by the postal authorities as undeliverable and if subsequent reasonable attempts to obtain a current valid address for the applicant or policyholder have been unsuccessful; or

(2) Any policyholder whose policy is lapsed, expired, or otherwise inactive or dormant under the insurance institution's business practices, and the insurance institution has not communicated with the policyholder about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, or promotional materials.

(i) If an insurance agent does not share information with any person other than the agent's principal, and if the principal provides all notices required by this section, the insurance agent is not required to provide the notices required by this section."

SECTION 5. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-26. Exception for title and mortgage guaranty insurance.**

(a) A title insurance company shall give notice of its insurance information practices under G.S. 58-39-25 only at the time the final policy of title insurance is issued and is not subject to any annual notice requirement thereafter.

(b) In the case of mortgage guaranty insurance, a notice shall be provided at the time a master policy is issued and thereafter only if there is a material change in the insurer's policies and practices regarding the use or disclosure of personal information."

SECTION 6. G.S. 58-39-75(1) reads as rewritten:

"(1) With the written authorization of the individual, provided:

a. If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35; or

b. If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization,

the authorization meets the requirements of G.S. 58-39-35 and is:

1. Dated;
2. Signed by the individual; and
3. Obtained one year or less ~~prior to~~ before the date a disclosure is sought pursuant to this paragraph; or".

SECTION 7. G.S. 58-39-75(18) reads as rewritten:

"(18) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of ~~insurance; provided that~~ insurance only if:

a. No medical record information is disclosed unless the disclosure would otherwise be permitted by this section; and

b. ~~the~~ The information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy; or."

SECTION 8. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-76. Limits on sharing account number information for marketing purposes.**

(a) General Prohibition on Disclosure of Account Numbers. – An insurance institution, insurance agent, or insurance-support organization shall not disclose, other than to a consumer reporting agency, an account number or similar form of access number or access code for a credit card account, deposit account, or transaction account of a consumer to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) Definitions. – As used in this section:

(1) 'Account number' means an account number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the insurance institution, insurance agent, or insurance-support organization does not provide the recipient with a means to decode the number or code.

(2) 'Transaction account' means an account other than a deposit account or credit card account. A transaction account does not include an account to which third parties cannot initiate charges.

(c) Exceptions. – Subsection (a) of this section does not apply if an insurance institution, insurance agent, or insurance-support organization discloses an account number or similar form of access number or access code:

(1) To the insurance institution's, insurance agent's, or insurance-support organization's agent or service provider solely in order to perform marketing for the insurance institution's, insurance agent's, or insurance-support organization's own products or services, as long as

the agent or service provider is not authorized to directly initiate charges to the account; or

(2) To a participant in a private label credit card program or an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program."

SECTION 9. G.S. 58-39-75(12) reads as rewritten:

"(12) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated ~~persons; or~~ persons, provided that no medical record information may be disclosed to the affiliate; or".

SECTION 10. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 11. This act becomes effective January 1, 2002.

SENATE BILL 461:
Insurance Information Privacy- AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Wellons
Date:	May 30, 2001	**Summary by:**	Frank W. Folger
Version:	Second Edition		Committee Counsel

SUMMARY: This bill would amend Article 39 of Chapter 58 of the General Statutes, the North Carolina Insurance Information and Privacy Protection Act (the Act) to conform it to the consumer information privacy requirements of the federal Gramm-Leach-Bliley Act, Public Law 106-102, enhance certain consumer protections, and remove certain industry burdens without consumer impact.

CURRENT LAW: The Act governs the collection, use and disclosure of information gathered in connection with insurance transactions. Provisions which would be affected by the legislation include:

Notice of Insurance Information Practices Notice must be provided to applicants or policyholders no later than at delivery of the policy or certificate when information is gathered only from the applicant or public sources, and no later than beginning collection of information when information is collected from another source. For a policy renewal, notice is not required if personal information is only collected from the policyholder or public records; but if required, it must be provided by the renewal date unless given in the last 24 months. For policy reinstatement or change in benefits, notice is not required if personal information is collected only from the policyholder or from public records; but if required, it must be given no later than the time the insurance institution receives the policy reinstatement or change in benefits request.

Contents of Notice The notice must state: whether personal information may be collected from persons other than those proposed for coverage; the types of, sources of, and investigative techniques used in obtaining personal information; disclosures which may be made pursuant to G.S. 58-39-75 and how they may be disclosed without prior authorization, but only when such disclosure would be deemed a general business practice by its frequency; a description of the policyholders and/or applicants rights regarding personal information access, correction, amendment, and deletion; the fact that insurance-support organization report information may be kept by the insurance support organization and disclosed to others. It provides for an alternative abbreviated notice to be given in lieu of that just described.

Disclosure of Individual's Personal or Privileged Information An insurance institution, agent or insurance-support organization seeking to disclose an individual's privileged or personal information collected or received in connection with an insurance transaction must meet certain requirements to be able to do so. When disclosure is sought with written authorization of the individual but the authorization is submitted by a person other than the policyholder or insurance institution, insurance-support organization or agent, the authorization must be dated, signed by the individual, and obtained one year or less before disclosure is sought. The section provides for disclosure to lienholders and others with a legal or beneficial interest in a policy as long as it is limited to that reasonably necessary to permit protection of that party's interest.

BILL ANALYSIS: Section 1 would amend reference to "life or accident and health insurance" to "life, health, or disability insurance" to conform the language to the model act, incorporate mortgage guaranty insurance expressly into its scope, and make consistent conforming changes throughout the bill.

Section 2 would redefine "adverse underwriting decision" to include risk placement by an insurance institution with an insurance institution specializing in substandard risks.

Section 3 would provide protection under the Act (limited notice) to people whose mortgages are the subject of a mortgage guaranty insurance transaction or proposed transaction, even though these mortgagors are not the insured under such policies.

Section 4 would require, for policies already issued and in force, that notice be provided at least annually. For policy reinstatement or change in benefits situations, the exception to the notice requirement would be removed. *These change are required by the Gramm-Leach-Bliley Act.* It would also require notice be given before an insurance institution or agent makes initial disclosure of personal information to a person for marketing of a product or services, if notice had not already been required. It would also make technical and conforming changes.

It would add to the notice contents requirements to applicants or policyholders:

- The insurance institution or agent's policies and practices regarding disclosure of nonpublic personal information to nonaffiliated third parties, other than their agents, consistent with Title V, Privacy, of the Gramm-Leach Bliley Act, including the categories of persons to whom disclosure may be made and the policies and practices regarding disclosure about persons who are no longer customers.
- The insurance institution or agent's policies for protecting confidentiality and security of nonpublic personal information in accordance with Title V.
- Any required disclosures under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

This change is required by the Gramm-Leach-Bliley Act.

It would require notice be given to persons applying for or obtaining coverage under a group insurance contract whether individually underwritten or not, except an insurance institution that does not disclose personal information about an applicant or policyholder as permitted by G.S. 58-39-75(11) can satisfy the notice requirement with notice to the holder of the group contract.

Section 5 would create a new section, N.C.G.S. §58-39-26, to require a title insurance company to only provide notice at the time the final policy is issued, and to require, in the case of mortgage guaranty insurance, that notice need only be provided at the time the master policy is issued and whenever there is a material change in the insurer's disclosure policies and practices.

Section 6 would require that disclosure based on a person's written authorization submitted by a person other than the institution agent or insurance-support organization be based on an authorization meeting the requirements for content in N.C.G.S. §58-39-35.

Section 7 would further limit disclosure to lienholders and other persons having a legal or beneficial interest in an insurance policy to prohibit disclosure of medical record information not otherwise permitted by N.C.G.S. §58-39-75.

Section 8 would create a new section, N.C.G.S. §58-39-76, placing limits on the sharing of account number information for marketing purposes. *This change is required by the Gramm-Leach-Bliley Act.*

Section 9 would prohibit disclosure of medical record information to an affiliate for auditing or marketing of an insurance product or service.

Section 10 is a severability clause.

EFFECTIVE DATE: January 1, 2002

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

June 20, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 461 -- Insurance Information Privacy

The Department of Insurance is proposing to amend the current Insurance Information and Privacy Protection Act ("the Act") in three general ways. First, certain amendments are necessary to bring the Act into compliance with the privacy protection mandates of the federal Gramm-Leach-Bliley Act, P.L. 106-102. Second, the Department is proposing to enhance insurance consumer protections currently found in the Act. Third, where doing so does not reduce consumer protections, certain burdens can be lifted off of the industry.

G.S. 58-39-10(a)(2)(c) and (b)(2)(b). Clarifies that mortgage guaranty insurers are subject to the Act. This amendment is supported by the mortgage guaranty insurance industry.

G.S. 58-39-10(e). Clarifies that credit insurers are subject to the Act.

G.S. 58-39-15(9)(g). Extends the protections of G.S. 58-39-75 (limitations on insurer disclosure of personal information) to the homeowner who pays for mortgage guaranty insurance even though that person is not an applicant or insured under the policy. This amendment is supported by the mortgage guaranty insurance industry.

G.S. 58-39-25(a)(2) and (a)(2a). Requires insurers or agents to send notices of their information practices to insureds every 12 months. Current law says every 24 months. The proposed annual notice requirement is required by Section 503(a) of the Gramm-Leach-Bliley Act.

G.S. 58-39-25(a)(3). Strikeouts are required by the Gramm-Leach- Bliley Act because that federal Act requires notices be sent to all insurance customers.

G.S. 58-39-25(b)(6), (7), and (8). These are additions to what must be included in the notice of information practices, as required by Sections 502 and 503 of the Gramm-Leach-Bliley Act.

G.S. 58-39-25(c). The strikeouts delete the abbreviated notice of information practices allowed under current law. An abbreviated notice does not comply with the notice requirements required by Sections 502 and 503 of the Gramm-Leach-Bliley Act.

G.S. 58-39-25(e). Allows a holding company to provide a joint notice of information practices on behalf of all of its subsidiaries. Included at industry's request.

G.S. 58-39-25(f). Allows an insurer or agent to provide one notice to co-policyholders, such as a husband and wife insured under the same auto policy. Included at industry's request.

G.S. 58-39-25(g). Allows an insurer or agent to send out notices required by G.S. 58-39-25 and Title V of the federal Gramm-Leach-Bliley Act as either two separate notices or one combined notice. Included at industry's request.

G.S. 58-39-25(h). Relieves an insurer or agent of providing notices to persons who do not keep their addresses current or whose policies have lapsed. Included at industry's request.

G.S. 58-39-25(i). Relieves an agent of notice requirements when (1) the agent is not sharing the insured's information with anyone but his or her principal (the insurer) and (2) where that principal gives the insured the notice required by G.S. 58-39-25. Included at industry's request.

G.S. 58-39-25(j). Requires an insurer or agent to give any notices required by the Gramm-Leach-Bliley Act in addition to the notice required by G.S. 58-39-25. This amendment is required by Title V of the Gramm-Leach-Bliley Act. This amendment has industry support.

G.S. 58-39-25(k). Extends the notice protections to group certificate holders, who currently have no right to notice unless their policies are individually underwritten. However, notice only need be given certificate holders if the insurer or agent intends to share their personal information. Otherwise, an insurer can comply with the notice requirements of G.S. 58-39-25 by giving notice to the group master policyholder (typically an employer). This proposed amendment has wide industry backing, and gives something to group certificate holders that they do not have under current law.

G.S. 58-39-25(l). Allows for an abbreviated notice where insurers or agents will not be sharing information with anyone else.

G.S. 58-39-26. Relieves title insurers and mortgage guaranty insurers of the annual notices required by G.S. 58-39-25(a)(2). The rationale is that in the title insurance context, the insured's only contact with the company is when the policy is purchased with a single premium payment at the closing. The only information held by the title insurer comes from public records. Thus, an annual notice seems expensive and does not appear to offer the insured any protections. In the mortgage insurance context, the homeowner paying the mortgage insurance premium is not the insured and is not entitled to any notice under current law. The lending institution is the insured. Requiring annual notices to sophisticated lending institutions seems burdensome and does nothing for the individual paying for the policy. The title insurers and mortgage guaranty insurers support this amendment.

G.S. 58-39-76(a). Limits the sharing of an individual's account number information. This is required by Section 502(d) of the Gramm-Leach-Bliley Act.

G.S. 58-39-76(b). Creates limited exceptions to the restrictions imposed on account sharing information by G.S. 58-39-76(a). These exceptions are taken verbatim from rules promulgated by the federal banking regulatory agencies in addressing Section 502(d) of the Gramm-Leach-Bliley Act. Included at industry's request.

G.S. 58-39-75(12). Current law imposes a general requirement that no individual's personal information can be shared by an insurer or agent without that individual's written consent. This is known as an "opt in" standard. There are two marketing exceptions to the basic "opt in" standard. G.S. 58-39-75(11) currently allows an insurer or agent to share a consumer's personal information with others, both affiliates and non-affiliates, for general marketing purposes if the insured is given notice of the proposed sharing and an opportunity to say "no". This is known as the "opt out" standard. G.S. 58-39-75(12) currently allows an insurer or agent to share a consumer's personal information with affiliates for insurance marketing purposes without the consumer's permission and even if the consumer does not want his or her information shared. This amendment would prohibit the sharing of the consumer's medical record information under G.S. 58-39-75(12).

G.S. 58-39-75(21). Addresses joint marketing programs, which are allowed by the Gramm-Leach-Bliley Act. Allows information to be shared where the program participants and the type of information to be shared are identified to the insured when the insured is first offered the financial product or service in the program.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

June 20, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 461 -- Insurance Information Privacy

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PREMIUM TAX RATE BY LINE

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The rate in the first box is the rate generally charged insurers. The following boxes are used to indicate specific rates by type of insurance. A # sign in the box indicates the generally charged rate is in effect. A zero indicates that type of insurance premium is not taxed. A blank indicates that information is not available. These figures do not indicate in any way credits or other effects on premium tax rates, nor are additional assessments indicated.

	ALABAMA	ALASKA	ARIZONA	ARKANSAS	CALIFORNIA	COLORADO
INSURERS GENERALLY		2.7%	2%	2.5%	2.35%	2.05% (99); 2% (00); 1% with CO home or regional office
A/H	1.6%	#	# Note	#	#	#
LIFE	2.3%	# Note	#	#	#	# Note
ANNUITY	0%	0%	0%	0%	# .5% for qualified retirement plans	0%
P/C	3.6%	#	# Note	# +.5% on property	#	#
FIRE	3.6% Low value dwelling classes 9 & 10: 1%	#	2.2% or .66% private fire co.	# +.5% on property	#	#
RRG	3.6%	#	#	4%	#	#
BC/BS	1.6%	6% Note	#	#	0%	5 cents per enrollee
PREPAID LINES	Dental: 1.6% Legal: 3.6%		Dental 2% Legal 2%	#		
TITLE	3.6%	1%	0%	#	#	#
INDEPENDENT PROCUREMENT	4%	3% .75% gross Marine profit		2%	3%	2.25%
HMOS	1.6%	#	2% net charges	# Note	0% Note	0% Note
SURPLUS LINES	6%	# or .75% +1% fee	3%	4%	3%	3%
MARINE	3.6%	.75% gross profit	#	.75% gross profit	5% gross profit	#
NOTES	Tax rates may be reduced based on AL office facilities credit. Some small life premiums are taxed at 1% & .5%	BC/BS Gross premium less claims paid Life: if yearly premium exceeds $100,000, rate is .1%	Small employer health 0% Additional .4312% on premiums covering vehicles	Foreign Trade: .75% HMO credit for home office and some salaries/wages	BC/BS - No provision HMO - No provision	Captives: 1% Premiums for qualified retirement plans not taxed. HMO - No provision

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PREMIUM TAX RATE BY LINE

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	CONNECTICUT	DELAWARE	DISTRICT OF COLUMBIA	FLORIDA	GEORGIA	HAWAII
INSURERS GENERALLY	1.75%	1.75% additional .25%	1.7%	1.75%	2.25%	4.265%
A/H	#	#	#	#	#	#
LIFE	#	# COLI & TOLI graduated rates based on net premiums per case	#	#	#	2.75%
ANNUITY	0%	0%	0%	1% with exceptions	0%	0%
P/C	#	#	#	#	#	#
FIRE	#	#	#	#	# + additional 1%	#
RRG	4%	#	#	Foreign: 5% Domestic: 1.75%	4%	1%
BC/BS	#	0% Note	1%	#	#	0% Note
PREPAID LINES	2% nonprofit legal			#		
TITLE	#	#	#	#	#	#
INDEPENDENT PROCUREMENT	4%			5%	4%	4.68%
HMOS	0% Note	0% Note	0% Note	0%	# Note	0% Note
SURPLUS LINES	4%	#	2%	5%	4%	4.68%
MARINE	0% Foreign Co.	5% gross profit	#	.75% gross profit	#	.8775% gross profit
NOTES	HMO - No provision	Captives: Graduated rate up to 1% HMO and BC/BS - No provision	HMO - No provision	MEWA; Self-Ins. Fund and Prof. Liab. Trust Fund: 1.6% Med. Mal. Self-Ins. Fund: 1.3%		Pure Captives: .25% HMO and BC/BS: No provision

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PREMIUM TAX RATE BY LINE

1/00

	IDAHO	ILLINOIS	INDIANA	IOWA
INSURERS GENERALLY	2.75% or 1.4% for insurers investing over 25% in ID investments.	Insurers subject to income tax, privilege tax and retaliatory tax	2% Domestics may pay 1.2% on gross income instead.	2%
A/H	#	#	#	#
LIFE	# Note	#	#	# Note
ANNUITY	0%	0%	0%	2% if issued prior to 7/1/88; 0% if issued after 7/1/88
P/C	#	#	#	#
FIRE	#	# + additional 1%; # + 2% Foreign	#	#
RRGS	#	#	#	#
BC/BS	# (mutuals)	.4% of net taxable premium	0% Note	# gross payments
PREPAID LINES				#
TITLE	1.5%	#		#
INDEPENDENT PROCUREMENT	2.75%; 1.5% Title			
HMOS	Note	.4% of net taxable premium	0% Note	# Note
SURPLUS LINES	2.75%	3%	2.5%	2%
MARINE	#	#	#	6.5% average profit 3 yrs
NOTES	Life insurance used to fund qualified retirement plan not taxed.		HMO and BC/BS - No provision	County Mutuals: 2% HMO - 1-5 years: tax exempt; 6+ years: 2%; Life insurance used to fund qualified retirement program not taxed.

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PREMIUM TAX RATE BY LINE

1/00

	KANSAS	KENTUCKY	LOUISIANA	MAINE
INSURERS GENERALLY	2%	2% (1999); 1.9% (2000)	Based on volume; see Notes	2%
A/H	#	# Note	#	# Note
LIFE	# Note	# Foreign Domestic pay tax based on capital and reserves in 1999 (may elect foreign rate in 2000)	#	# Note
ANNUITY	0%	# Foreign Note	0%	# Note
P/C	#	#	#	#
FIRE	# Additional 1.25% and 2%	# + additional .75%	Based on vol. + 2%; see Notes	# + additional 1.4%
RRG	Foreign: 6% Domestic: 1%	#	#	#
BC/BS	#	# Note	#	0%
PREPAID LINES				
TITLE	#	#	#	#
INDEPENDENT PROCUREMENT	6%			3%
HMOS	.5% / 1% Note	# Note	#	0% Note
SURPLUS LINES	6%	3%	5%	3%
MARINE	#	#	Based on volume; *see* Notes	#
NOTES	Captives: 1% HMO - 1-5 years Privilege fee of .5% year; 6+ yrs. privilege fee of 1% all premiums.	Insurers, HMOs, BC/BS pay $.25 per outpatient prescription they reimburse if tax not paid by pharmacy. Single premium deferred annuities and wholly employer sponsored annuities may pay tax at annuitization.	$140 for $7,000 or less in premiums received. Add $225 for each additional $10,000 or part. Fire, marine, transportation, casualty, surety, workers' comp.: $180 for $6,000 or less in premiums. Add $300 for each additional $10,000 or part. Fire: .25% fireman training, 1.25% fire damage	Long-Term Care: 1%; 1% group disability income; 2.55% group disability income written by large insurers. Premiums for qualified retirement plans not taxed HMO - No provision

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PREMIUM TAX RATE BY LINE

1/00

	MARYLAND	MASSACHUSETTS	MICHIGAN	MINNESOTA	MISSISSIPPI
INSURERS GENERALLY	2%;	2.28%	Greater of Single Business Tax or Retaliatory tax	2%	3%
A/H	#	#	#	#	#
LIFE	#	2%	#	#	# Note
ANNUITY	0%	0% except retaliatory	0%	0%	0%
P/C	#	#	#	#	#
FIRE	#	# + additional. .25% on gross premiums	#	# + additional .5%	# + 1% additional
RRG	#	#	2% + additional. .5% regulatory fee for nonadmitted RRG	#	#
BC/BS	0% Note	Excise tax: 1% of subscription dues	0%	1%	0% except for privilege tax based on no. of contracts
PREPAID LINES					
TITLE			#	#	#
INDEPENDENT PROCUREMENT	3% except Marine		2%		3%
HMOS	Note	0% Note	0% Note	1%	0% Note
SURPLUS LINES	3%	4%	2% + .5% regulatory fee	3%	4%
MARINE	5% profit (retaliatory)	5.7% net profit	#	5% average profit	#
NOTES	HMO - Tax exempt except where HMO benefits are offered by an insurer. If insurer nonprofit - HMO benefits exempt. BC/BS - No provision	PPOs: 2.28% HMO - No provision	HMO - No provision	1% for town & farmers' mutuals & mutuals not writing life and with assets <$5 million, 1.26% if assets >$5 million	HMO - No provision

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PREMIUM TAX RATE BY LINE

1/00

	MISSOURI	MONTANA	NEBRASKA	NEVADA	NEW HAMPSHIRE
INSURERS GENERALLY	2%	2.75% Note	1%	3.5%	2% Note
A/H	#	#	# .5% group		#
LIFE	# Note	#	# Note	# Note	#
ANNUITY	0%	0%	0%	# Note	0%
P/C	#	#	#		#
FIRE	#	# + additional 2.5%	# + additional Domestic: .375% Foreign: .75%		#
RRG	#	#	#	#	#
BC/BS	0%	0%	#	#	# net premiums
PREPAID LINES,					
TITLE	#	#	#	#	#
INDEPENDENT PROCUREMENT	5%	#		#	4% Marine: 2%
HMOS	0% Note	0% Note	#	0% Note,	#
SURPLUS LINES	5%	#	3%, fire taxes apply	#	2%
MARINE	#	#	#	#	5% of underwriting profit
NOTES	HMO - No provision Premiums for qualified retirement plans not taxed	HMO - No provision	Premiums for qualified retirement plans not taxed	Premiums for qualified retirement plans not taxed HMO - No provision	Minimum payment $200 Business Profit tax: 7.5%, premium tax paid is allowed as a credit against this tax

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PREMIUM TAX RATE BY LINE

1/00

	NEW JERSEY	NEW MEXICO	NEW YORK	NORTH CAROLINA	NORTH DAKOTA
INSURERS GENERALLY	2.1%	3%	1.3%	1.9%	1.75%
A/H	1.05% group	#	1%	#	#
LIFE	# Note	#	.7%	#	2%
ANNUITY	0%	0%	0%	0%	0%
P/C	#	#	#	#	#
FIRE	#	#	# + additional 2% foreign	# + additional 1.33% additional. .5% for local fire & lightening policies	#
RRG	# Note	#	#	5%	#
BC/BS	2% taxable premiums + 2 cents per subscriber	#	0%	.5%	#
PREPAID LINES	1% legal	#			
TITLE	#	#	#	#	#
INDEPENDENT PROCUREMENT	3%	#	3.6%		
HMOS	0% Note	#	0% Note	0%	# Note
SURPLUS LINES	3%	#	3.6%	5%	1.75% Life: 2%
MARINE	5.25% average profit 3 yrs.	#	#	#	#
NOTES	Premiums for qualified retirement plans not taxed RRG taxed at same rate as surplus lines if not chartered in NJ; same rate as foreign admitted insurers if chartered in NJ HMO - No provision		Also subject to franchise tax or retaliatory tax. HMO - Comp. Health plans pursuant to art. 44 of Public Health Law (HMO Law) are exempt	2.5% workers' compensation	HMO - Tax credits for exam fees and home office.

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PREMIUM TAX RATE BY LINE

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	OHIO	OKLAHOMA	OREGON	PENNSYLVANIA	RHODE ISLAND
INSURERS GENERALLY	Domestic: 2.3% (1999); 2.09% (2000) Note	2.25%	Corporate excise tax and retaliatory taxes	2%	2%
A/H	.21% Note	#	#	#	#
LIFE	#	#	#	#	#
ANNUITY	0%	0%	0%	0%	0%
P/C	#	#	#	#	#
FIRE	# + .75% additional	# + .3125% additional	# + 1% additional	#	#
RRG	Foreign: 5% Domestic: Note	#	#	#	#
BC/BS	.21% (98) .42% (99)	#	0%	0%	Domestics shall pay assessment; min. $1,000
PREPAID LINES					
TITLE	#	#	#	Domestic: Note Foreign: #	#
INDEPENDENT PROCUREMENT	5%	6%		3%	
HMOS	.21% (98) .42% (99)	# Note	0% Note	Note	0% Note
SURPLUS LINES	5%	6%	2% + 1% for fire	3%	3%
MARINE	#	#	5% average profit 3 yrs.	5% average profits 3 yrs.	# - inland 0% - ocean
NOTES	Health insuring corp. (HIC) rate is .21% for 1999, .42% for 2000	HMO - Payments from Sec. HHS are exempt. Credits for investments & home office	HMO - No provision MEWAs taxed same as insurer	Domestic title insurers pay tax based on stock, 1.25% HMO - pay corporate income tax	Captives: 1% HMO and BC/BS - No provision

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PREMIUM TAX RATE BY LINE

	SOUTH CAROLINA	SOUTH DAKOTA	TENNESSEE
INSURERS GENERALLY	1.25%	2.5%	2.5% Note
A/H	#	#	#
LIFE	.75%	#	Domestic: 1.75% Foreign: 1.8% (99); 1.75% thereafter Note
ANNUITY	0%	1.25%	0%
P/C	#	#	#
FIRE	# + additional 2%	# + additional .5%	# + additional .75%
RRG	#	#	#
BC/BS	#	#	#
PREPAID LINES			
TITLE	#	#	#
INDEPENDENT PROCUREMENT		2.5%	2.5%
HMOS	0% Note	# Note	2%
SURPLUS LINES	4%	#	2.5% Other than fire 3.25% Fire Workers' Compensation: 4.4%
MARINE	#	#	#
NOTES	HMO - No provision	HMO - Credit for home office	$150 minimum tax due Captives: 1%

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PREMIUM TAX RATE BY LINE

1/00

	TEXAS	UTAH	VERMONT	VIRGINIA
INSURERS GENERALLY	3.5%; 2.4% (85-90% in Texas qualified investments); 1.6% (over 90% in Texas qualified investments); beginning in 2000, 1.6% applies	2.25%	2%	2.25%
A/H	1.75% Note	0%	#	#
LIFE	1.75% Note	#	#	#
ANNUITY	0%	0%	0% Note	0%
P/C	#	# except .0175% auto liability	#	#
FIRE	#	#	#	# + 1% to fund fire program fund
RRG	#	#	#	#
BC/BS	0% Note	0% Note	0%	.75% of subscription fees 2.25% of subscription fees if no open enrollment
PREPAID LINES				.75%
TITLE	2% 1.3% if Texas qualified investment is greater than 90%	.45%	#	#
INDEPENDENT PROCUREMENT	4.85%	4.25% gross less return premium, except ocean marine and annuities	3%	
HMOS	1.75% Note	0%	0% Note	0%
SURPLUS LINES	4.85%	4.25%	3%	2.25% + up to .1% assessment
MARINE	#	0%	#	
NOTES	Reduced rates for investments HMO - Credit for Texas investments per capita maintenance assessment not to exceed $2 per enrollee For life, health, HMOs: For first $450,000 of gross revenues or premiums collected, rate shall be 50% of rate above BC/BS - no provision		If annuities taxed by state of incorporation, VT taxes HMO - No provision Captive insurers taxed based on reinsurance premium volume	Domestic Nonprofit Mutuals: 1% Industrial Sick Benefit Cos.: 1% 2.5% Workers' Compensation

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GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1077

Short Title:	Firefighters' and Rescue Squad Workers' Retire.	(Public)
Sponsors:	Representatives Arnold; Baddour and Russell.	
Referred to:	Pensions and Retirement.	

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR CAREER FIREFIGHTERS' AND RESCUE SQUAD WORKERS' BENEFITS IN THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. Article 12E of Chapter 143 of the General Statutes reads as rewritten:

"Article 12E.

"Retirement Benefits for Local Governmental Law-Enforcement ~~Officers.~~ Officers and Career Firefighters and Rescue Squad Workers.

"**§ 143-166.50. Retirement benefits for local governmental law-enforcement ~~officers.~~ officers and career firefighters and rescue squad workers.**

(a) Definitions. – The following words and phrases as used in this Article, unless a different meaning is plainly required by the context, have the following meaning:

(1) "Beneficiary" means any person in receipt of a retirement allowance or other benefit from a Retirement System.

(1a) "Career firefighter" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a fire department certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the prevention, detection, and suppression of fire.

(1b) "Career rescue squad worker" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a rescue squad or emergency medical services team certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the

alleviation of human suffering and assistance to persons who are in difficulty, who are injured, or who become suddenly ill, by providing proper and efficient care or emergency medical services.

(2) "Employer" means a county, city, town or other political subdivision of the State.

(3) "Law-enforcement officer" means a full-time paid employee of an employer, who possesses the power of arrest, who has taken the law enforcement oath administered under the authority of the State as prescribed by G.S. 11-11, and who is certified as a law enforcement officer under the provisions of Chapter 17C of the General Statutes or certified as a deputy sheriff under the provisions of Chapter 17E of the General Statutes. "Law enforcement officer" also means the sheriff of the county. The number of paid personnel employed as law enforcement officers by a law enforcement agency may not exceed the number of law enforcement positions approved by the applicable local governing board.

(4) "Law-Enforcement Officers' Retirement System" means the system provided for under Article 12 of Chapter 143 of the General Statutes, as it existed prior to January 1, 1986.

(5) "Local Governmental Employees' Retirement System" means the Local Governmental Employees' Retirement System of North Carolina provided for under Article 3 of Chapter 128 of the General Statutes.

(6) "Member" means an ~~officer~~ officer, firefighter, or rescue squad worker included in the membership of a retirement system, including former ~~officers~~ officers, firefighters, or rescue squad workers no longer employed who also elected to leave their accumulated contributions on deposit with a Retirement System.

(7) "Officer" means a "law-enforcement officer."

(8) "State" means the State of North Carolina.

(b) Basic Retirement System. – On and after January 1, 1986, law-enforcement officers employed by an employer shall be members of the Local Government Employees' Retirement System, and beneficiaries who were last employed as officers by an employer, or who are surviving beneficiaries of officers last employed by an employer, are beneficiaries of the Local Governmental Employees' Retirement System and paid in benefit amounts then in effect. All members of the Law-Enforcement Officers' Retirement System last employed and paid by an employer are members of the Local Retirement System.

(c) Rights. – Notwithstanding any other provisions of law, any accrued or inchoate rights of a member of the Law-Enforcement Officers' Retirement System as of his transfer to the Local Governmental Employees' Retirement System on January 1, 1986, including the rights to a vested deferred retirement allowance and to commence retirement at certain ages with required years of service as a law-enforcement officer, may in no way be diminished; provided, however, in no event may a member

commence retirement and continue membership service with the same Retirement System after January 1, 1986.

(d) Court Cost Receipts. – Of the sum derived from the cost of court provided for in G.S. 7A-304(a)(3), the amount designated for this Article, except for the amount designated for the provisions of G.S. 143-166.50(e), shall be paid over to the pension accumulation fund of the Local Governmental Employees' Retirement System and shall offset, to the extent of these receipts, the employers' normal contribution rate required in G.S. 128-30(d)(2) as it pertains to law enforcement officers.

(e) Supplemental Retirement Income Plan for Local Governmental Law-Enforcement Officers. – As of January 1, 1986, all law-enforcement officers employed by a local government employer, are participating members of the Supplemental Retirement Income Plan as provided by Article 5 of Chapter 135 of the General Statutes. In addition to the contributions transferred from the Law-Enforcement Officers' Retirement System, participants may make voluntary contributions to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participants; provided, in no instance shall the total contributions by a participant exceed ten percent (10%) of a participant's compensation within any calendar year. From July 1, 1987, until July 1, 1988, local government employers of law enforcement officers shall contribute an amount equal to at least two percent (2%) of participating local officers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating local officers; and on and after July 1, 1988, local government employers of law enforcement officers shall contribute an amount equal to five percent (5%) of participating local officers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating local officers.

Additional contributions shall also be made to the individual accounts of all participants in the Plan, except for Sheriffs, on a per capita equal-share basis from the sum of one dollar and twenty-five cents ($1.25) for each cost of court collected under G.S. 7A-304.

(e1) Rights of Participants under the Uniformed Services Employment and Reemployment Rights Act. – A participant whose employment is interrupted by reason of service in the Uniformed Services, as that term is defined in section 4303(16) of the Uniformed Services Employment and Reemployment Rights Act, Public Law 103-353, hereafter referred to as "USERRA", shall be entitled to all rights and benefits that the participant would have been entitled to under this section had the participant's employment not been interrupted, provided that the participant returns to service as a law enforcement officer while the participant's reemployment rights are protected under the provisions of USERRA.

(e2) Supplemental Retirement Income Plan for Full-Time Local Career Firefighters and Rescue Squad Workers. – As of January 1, 2002, all career firefighters and career rescue squad workers employed by a local government employer are participating members of the Supplemental Retirement Income Plan as provided by Article 5 of Chapter 135 of the General Statutes. Participants may make voluntary contributions to the Supplemental Retirement Income Plan to be credited to the designated individual

accounts of participants; however, in no instance shall the total contributions by a participant exceed ten percent (10%) of a participant's compensation within any calendar year. On and after January 1, 2002, local government employers of career firefighters or career rescue squad workers shall contribute an amount equal to five percent (5%) of participating firefighters' or rescue squad workers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating firefighters or rescue squad workers."

SECTION 2. G.S. 128-21 is amended by adding two new subdivisions to read:

"(17a) "Career firefighter" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a fire department certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the prevention, detection, and suppression of fire.

(17b) "Career rescue squad worker" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a rescue squad or emergency medical services team certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the alleviation of human suffering and assistance to persons who are in difficulty, who are injured, or who become suddenly ill, by providing proper and efficient care or emergency medical services."

SECTION 3. G.S. 128-24(5) reads as rewritten:

"(5) The provisions of this subdivision (5) shall apply to any member whose membership is terminated on or after July 1, 1965, and who becomes entitled to benefits hereunder in accordance with the provisions hereof.

a. Notwithstanding any other provision of this Chapter, any member who separates from service prior to the attainment of the age of 60 years for any reason other than death or retirement for disability as provided in G.S. 128-27(c), after completing 15 or more years of creditable service, and who leaves his total accumulated contributions in said System shall have the right to retire on a deferred retirement allowance upon attaining the age of 60 years; provided that such member may retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired; and further provided that in the case of a member who so separates from service on or after July 1, 1967, the aforestated requirement of 15 or more years of creditable service shall be reduced to 12 or more years of creditable service; and further

provided that in the case of a member who so separates from service on or after July 1, 1971, or whose account is active on July 1, 1971, the aforestated requirement of 12 or more years of creditable service shall be reduced to five or more years of creditable service. Such deferred retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to a member who is not a law enforcement officer or eligible former law enforcement officer.

b. In lieu of the benefits provided in paragraph a of this subdivision, any member who separates from service prior to the attainment of the age of 60 years, for any reason other than death or retirement for disability as provided in G.S. 128-27(c), after completing 20 or more years of creditable service, and who leaves his total accumulated contributions in said System may elect to retire on an early retirement allowance upon attaining the age of 50 years or at any time thereafter; provided that such member may so retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired. Such early retirement allowance so elected shall be equal to the deferred retirement allowance otherwise payable at the attainment of the age of 60 years reduced by the percentage thereof indicated below.

Age at Retirement	Percentage Reduction
59	7
58	14
57	20
56	25
55	30
54	35
53	39
52	43
51	46
50	50

b1. In lieu of the benefits provided in paragraphs a and b of this subdivision, any member who is a law enforcement ~~officer~~ officer, career firefighter, or career rescue squad worker at the time of separation from service prior to the attainment of the age of 50 years, for any reason other than death or disability as provided in this Article, after completing 15 or more years of creditable service in this capacity immediately prior to separation from service, and who leaves his total accumulated contributions in this System, may elect to retire on a deferred

early retirement allowance upon attaining the age of 50 years or at any time thereafter; provided, that the member may commence retirement only upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to commence retirement. The deferred early retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to law enforcement ~~officers.~~ officers, career firefighters, or career rescue squad workers.

b2. In lieu of the benefits provided in paragraphs a and b of this subdivision, any member who is a law enforcement officer at the time of separation from service prior to the attainment of the age of 55 years, for any reason other than death or disability as provided in this Article, after completing five or more years of creditable service in this capacity immediately prior to separation from service, and who leaves his total accumulated contributions in this System may elect to retire on a deferred service retirement allowance upon attaining the age of 55 years or at any time thereafter; provided, that the member may commence retirement only upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to commence retirement. The deferred service retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to law enforcement ~~officers.~~ officers, career firefighters, or career rescue squad workers.

b3. Deferred retirement allowance of members retiring on or after July 1, 1995. – In lieu of the benefits provided in paragraphs a. and b. of this subdivision, any member who separates from service prior to attainment of age 60 years, after completing 20 or more years of creditable service, and who leaves his total accumulated contributions in said System, may elect to retire on a deferred retirement allowance upon attaining the age of 50 years or any time thereafter; provided that such member may so retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired. Such deferred retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to a member who is not a

law enforcement ~~officer or~~ officer, an eligible former law enforcement ~~officer.~~ officer, a career firefighter, an eligible former career firefighter, a career rescue squad worker, or an eligible former career rescue squad worker.

c. Should a beneficiary who retired on an early or service retirement allowance be reemployed, or otherwise engaged to perform services, by an employer participating in the Retirement System on a part-time, temporary, interim, or on fee-for-service basis, whether contractual or otherwise, and if such beneficiary earns an amount in any calendar year which exceeds fifty percent (50%) of the reported compensation, excluding terminal payments, during the 12 months of service preceding the effective date of retirement, or twenty thousand dollars ($20,000), whichever is greater, as hereinafter indexed, then the retirement allowance shall be suspended as of the first day of the month following the month in which the reemployment earnings exceed the amount above, for the balance of the calendar year. The retirement allowance of the beneficiary shall be reinstated as of January 1 of each year following suspension. The amount that may be earned before suspension shall be increased on January 1 of each year by the ratio of the Consumer Price Index to the Index one year earlier, calculated to the nearest tenth of a percent (1/10 of 1%).

d. Should a beneficiary who retired on an early or service retirement allowance be restored to service as an employee, then the retirement allowance shall cease as of the first day of the month following the month in which the beneficiary is restored to service and the beneficiary shall become a member of the Retirement System and shall contribute thereafter as allowed by law at the uniform contribution payable by all members.

Upon his subsequent retirement, he shall be paid a retirement allowance determined as follows:

1. For a member who earns at least three years' membership service after restoration to service, the retirement allowance shall be computed on the basis of his compensation and service before and after the period of prior retirement without restriction; provided, that if the prior allowance was based on a social security leveling payment option, the allowance shall be adjusted actuarially for the difference between the amount received under the optional payment and what would have been paid if the retirement allowance had been paid without optional modification.

2. For a member who does not earn three years' membership service after restoration to service, the retirement allowance shall be equal to the sum of the retirement allowance to which he would have been entitled had he not been restored to service, without modification of the election of an optional allowance previously made, and the retirement allowance that results from service earned since being restored to service; provided, that if the prior retirement allowance was based on a social security leveling payment option, the prior allowance shall be adjusted actuarially for the difference between the amount that would have been paid for each month had the payment not been suspended and what would have been paid if the retirement allowance had been paid without optional modification."

SECTION 4. G.S. 128-27(a) reads as rewritten:

"(a) Service Retirement Benefits. –

(1) Any member may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired: Provided, that the said member at the time so specified for his retirement shall have attained the age of 60 years and have at least five years of creditable service or shall have completed 30 years of creditable service, or if a ~~fireman, he~~ career firefighter or career rescue squad worker, the member shall have attained the age of 55 years and have at least five years of creditable service.

(2) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1019, s. 1.

(3) Repealed by Session Laws 1971, c. 325, s. 12.

(4) Any member who was in service October 8, 1981, who had attained 60 years of age, may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired.

(5) Any member who is a law enforcement ~~officer,~~ officer, career firefighter, or career rescue squad worker and who attains age 50 and completes 15 or more years of creditable service in this capacity or who attains age 55 and completes five or more years of creditable service in this capacity, may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, ~~he~~ the member desires to be retired; provided, also, any member who has met the conditions required by this ~~subdivision~~ section but does not retire, and later

becomes an employee other than as a law enforcement ~~officer,~~ officer, career firefighter, or career rescue squad worker continues to have the right to commence retirement."

SECTION 5. G.S. 128-27(b18) reads as rewritten:

"(b18) Service Retirement Allowance of Member Retiring on or After July 1, ~~2000.~~2000, but Before January 1, 2002. – Upon retirement from service in accordance with subsection (a) or (a1) above, on or after July 1, 2000, but before January 1, 2002, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday and completion of five years of creditable service as a law enforcement officer, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 128-27(b18)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b18)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th birthday and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 128-27(b18)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 128-27(b18)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or
2. The service retirement allowance as computed under G.S. 128-27(b18)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or
3. If the member's creditable service commenced prior to July 1, 1995, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 128-27(b18)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1965, shall not receive less than the benefit provided by G.S. 128-27(b)."

SECTION 6. G.S. 128-27 is amended by adding a new subsection to read:

"(b19) Service Retirement Allowance of Member Retiring on or After January 1, 2002. – Upon retirement from service in accordance with subsection (a) or (a1) above, on or after January 1, 2002, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer, an eligible former law enforcement officer, a career firefighter, an eligible former career firefighter, a career rescue squad worker, or an eligible former career rescue squad worker shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday and completion of five years of creditable service as a law enforcement officer, career firefighter, or career rescue squad worker, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer, career firefighter, or career rescue squad worker and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 128-27(b19)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b19)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer, an eligible former law enforcement officer, a career firefighter, an eligible former career firefighter, a career rescue worker, or an eligible former career rescue squad worker shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th birthday and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 128-27(b19)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 128-27(b19)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b19)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or

3. If the member's creditable service commenced prior to July 1, 1995, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 128-27(b19)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1965, shall not receive less than the benefit provided by G.S. 128-27(b)."

SECTION 7. G.S. 128-27(m) reads as rewritten:

"(m) Survivor's Alternate Benefit. – Upon the death of a member in service, the principal beneficiary designated to receive a return of accumulated contributions shall have the right to elect to receive in lieu thereof the reduced retirement allowance provided by Option two of subsection (g) above computed by assuming that the member had retired on the first day of the month following the date of his death, provided that all three of the following conditions apply:

(1) a. The member had attained such age and/or creditable service to be eligible to commence retirement with an early or service retirement allowance, or

b. The member had obtained 20 years of creditable service in which case the retirement allowance shall be computed in accordance with ~~G.S. 128-27(b18)(1)b. or G.S. 128-27(b18)(2)c.,~~ G.S. 128-27(b19)(1)b. or G.S. 128-27(b19)(2)c., notwithstanding the requirement of obtaining age 50.

(2) The member had designated as the principal beneficiary to receive a return of his accumulated contributions one and only one person who is living at the time of his death.

(3) The member had not instructed the Board of Trustees in writing that he did not wish the provisions of this subsection apply.

For the purpose of this benefit, a member is considered to be in service at the date of his death if his death occurs within 180 days from the last day of his actual service. The last day of actual service shall be determined as provided in subsection (l) of this section. Upon the death of a member in service, the surviving spouse may make all purchases for creditable service as provided for under this Chapter for which the member had made application in writing prior to the date of death, provided that the date of death occurred prior to or within 60 days after notification of the cost to make the purchase."

SECTION 8. G.S. 105-228.5(d)(2) reads as rewritten:

"(2) Other Insurance Contracts. – The tax rate to be applied to gross premiums on all other insurance contracts issued by insurers shall be ~~one and nine tenths percent (1.9%).~~ two and three hundred nineteen ten-thousandths percent (2.0319%). The net proceeds shall be credited to the General Fund."

SECTION 9. There is appropriated from the General Fund to the Local Governmental Employees' Retirement System the sum of six million five hundred thousand dollars ($6,500,000) for the 2001-2002 fiscal year and the sum of thirteen million dollars ($13,000,000) for the 2002-2003 fiscal year to implement the provisions of this act.

SECTION 10. Section 8 of this act is effective for taxable years beginning on or after January 1, 2001. Section 9 of this act becomes effective July 1, 2001. The remainder of this act becomes effective January 1, 2002, but shall not affect the rights of a person who is a vested member of the Local Governmental Employees' Retirement System on that date to any disability benefits for which that person is otherwise eligible on that date.

HOUSE BILL 1077:
Firefighters' and Rescue Squad Workers' Retire.

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Arnold
Date:	June 13, 2001	**Summary by:**	Frank W. Folger
Version:	First Edition		Committee Counsel

SUMMARY:

House Bill 1077 amends the law to provide retirement benefits from the Supplemental Retirement Income Plan (401K Plan) to all eligible career firefighters and career rescue squad workers. The bill also provides that career firefighters and career rescue squad workers who are members of the Local Governmental Employees' Retirement System (Local System) will be eligible for the same deferred, early, and service retirement benefits as are now available to law enforcement officers. It further raises the gross premiums tax rate on insurance contracts from 1.9% to 2.0319%, and makes an appropriation from the General Fund to the Local System for fiscal years 2001-2002 and 2002-2003.

CURRENT LAW:

Under current law, all local law enforcement officers are participating members of the Supplemental Retirement Income Plan for Local Governmental Law Enforcement Officers. Local government employers contribute five percent of each officer's monthly compensation to the individual account of the member. Some local governments currently provide this benefit to all employees; however, the law only requires it for law enforcement officers.

The service retirement provisions of the Local Governmental Employees' Retirement System allow law enforcement officers to retire with full benefits at age 55 with five years of service or at any age with 30 years. Other members may retire at age 65 with five years or at any age with 30 years. The Local System is funded, in part, by each participating local employer. Each employer's contribution rate is determined when it elects to enter the System.

BILL ANALYSIS:

This bill amends the law to give all career firefighters and career rescue squad workers the same benefit in the Supplemental Retirement Income Plan as is currently available to law enforcement officers. In addition, the bill also amends several provisions in the Local Governmental Employees' Retirement System to provide the same deferred, early and service retirement benefits as are now available to law enforcement officers to career firefighters and career rescue squad workers.

The bill also amends the tax law to increase the tax rate for gross premiums on certain insurance contracts from 1.9% to 2.0319%. It also authorizes an appropriation of $6,500,000 for fiscal year 2001-2002, and $13,000,000 for fiscal year 2002-2003 to implement the provisions of the act. The appropriation will help to offset the additional cost to local government employers imposed by this act.

EFFECTIVE DATE:

The tax increase would become effective for taxable years beginning on or after January 1, 2001. The appropriation would become effective July 1, 2001. The remainder of the act would become effective January 1, 2002, but would not affect the rights of members vested in the Local Governmental Employees' Retirement System to any disability benefits for which the person might otherwise be eligible.

Karen Cochrane-Brown, counsel to the House Committee on Pensions and Retirement, contributed to this summary.

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 11, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on July 11, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Heather Leiber (Randolph County – Representative Brubaker) and Chad Walker (Wilkes County - Representative Walker). The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Barbee, Dedmon, Grady, Hall, Justus, Saunders, Setzer, Smith, Warner, and C. Wilson. Linda Attarian and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bills were considered:

HB 1077, entitled, AN ACT TO PROVIDE FOR CAREER FIREFIGHTERS' AND RESCUE SQUAD WORKERS' BENEFITS IN THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM. Representative Saunders was recognized, and he presented a proposed committee substitute and he moved for adoption of the committee substitute for discussion. The motion passed. Representative Saunders thanked the bill sponsor, Representative Gene Arnold, for bringing this bill before the General Assembly, and indicated the committee substitute bill would allow this bill to be studied in an interim study committee. The general consensus of the committee was that this bill would be defeated if it were to continue through the General Assembly during this session, and the passage of the committee substitute would be the best approach for the bill and would allow it not to die at this time. It was also felt a study committee would be able to provide a thorough comprehensive approach to funding for retirement benefits for firefighters. The bill sponsor, Representative Arnold, explained the bill process, what a study committee does, and indicated he was in favor of this approach. Representative Dockham moved for a favorable report to the committee substitute, unfavorable to the original bill and be re-referred to the Committee on Rules, Calendar and Operations of the House. The motion passed.

SB 461, entitled, AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102. Senator Wellons, bill sponsor, was recognized and he presented a proposed committee substitute. Representative Saunders moved for adoption of the committee substitute for discussion. The motion passed. Bill Hale, NC Department of Insurance, was recognized to explain the committee substitute. This committee substitute would amend the General Statutes to conform to the consumer information privacy requirements of the federal Gramm-Leach-Bliley Act, and would enhance certain consumer protections and remove certain industry burdens without consumer impact. North Carolina law provides that no insured's personal information can be further disclosed by an insurance company or agent without that insured's written consent. This is known as an "opt in" standard. There are some exceptions to this. SB 461 provides that no sharing of a consumer's medical record information for marketing purposes may occur unless the insurer or agent obtains the consumer's permission ("opt in"). The law requires insurance companies once every two

years to give insureds a written notice about how the companies collect and share information about the insureds and the rights of the insureds under the law. SB 461 changes this to once every year. SB 461 extends the notice protection to persons insured under a group insurance plan (usually employees insured under an employer's group health policy), who currently have no right to notice unless their policies are individually underwritten. SB 461 extends the protections of the law to the homeowner who pays for mortgage guaranty insurance even though the lender is the insured under the policy. Representative C. Wilson moved for a favorable report to the House committee substitute, unfavorable to the Senate committee substitute. The motion passed.

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

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
House Bill 1077 and Senate Bill 461
Bill Summaries
Handouts

VISITOR REGISTRATION SHEET

INSURANCE — July 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jimmy Fullbright	Hunton & Williams
Bill Scoggin	Kennedy Covington
Paul Meyer	NCACC
Paul Owen	NCSFA
Gordon A Joyner	NCARK EMS
Jim Phillips	Brooks Pierce
Cam Cook	B Powell
John Cyrus	N.C. State Grange
Larry Heckner	Household Financial Group
John Palumbo	AT&T
Nicole Dusenberry	NC Equity

VISITOR REGISTRATION SHEET

INSURANCE — July 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gary Salamido	GSK
Carol Duncan	NCAHP
Ann Bradley	NC DOI
Mark W. Rice	Callahan & Rice Ins. Group
Cissy Porter	Bone & Associates
Amy Jo Bain	NCMS
Barbara Canales	MFS, PA
Tracy Jackson	Pres. Elect, N.C. Assoc of Insur. & Fin. Advisors
Ellis Hankins	NCLM
Steve Woodson	NC Farm Bureau
Julie Campbell	NCCBI

VISITOR REGISTRATION SHEET

INSURANCE — July 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paul Stock	NC Bankers Assn.
Don Lampe	Smith Helms
BOB PAGE	NCIFA FOUNDATION
Dorothy Hunsucker	Jefferson P.L.T Ins Co.
Bob Price	Jordan Price
Robert Pasichof	Young, Moore
[illegible]	Moore & Van Allen
[illegible]	HR Assoc/Manist
[illegible]	Bone & Assoc.
Susan Valauri	Nationwide
Marie Smith	GSK

VISITOR REGISTRATION SHEET

INSURANCE — July 11, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
PAUL MAHONEY	NCAHP
[signature]	NCAHP
[signature]	NCAHP

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Committee Substitute for
S.B. 461 A BILL TO BE ENTITLED AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 461*

Insurance and Consumer Protection Committee Substitute Adopted 4/24/01
PROPOSED HOUSE COMMITTEE SUBSTITUTE S461-CSSO-54 [v.3]

7/11/2001 10:42:03 AM

Short Title: Insurance Information Privacy-AB. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-39-10 reads as rewritten:

"**§ 58-39-10. Scope.**

(a)The obligations imposed by this Article shall apply to those insurance institutions, agents, or insurance-support organizations ~~that, on or after July 1, 1982:~~ that:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance:

a. Collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this State; or

b. Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this State; and

(2) In the case of property or casualty insurance:

a. Collect, receive, or maintain information in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; ~~or~~

b. Engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~ State; or

c. Engage in transactions involving mortgage guaranty insurance where the mortgage guaranty policies, contracts, or

certificates of insurance are delivered, issued for delivery, or renewed in this State.

(b) The rights granted by this Article shall extend to:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance, the following persons who are residents of this State:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions;

(2) In the case of property or casualty insurance, the following persons:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in (i) insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~ State; or (ii) mortgage guaranty insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State.

(c) For purposes of this section, a person shall be considered a resident of this State if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance-support organization, is located in this State.

(d) Notwithstanding subsections (a) and (b) of this section, this Article shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this State.

(e) This Article applies to credit insurance that is subject to Article 57 of this Chapter."

SECTION 2. G.S. 58-39-15(1) reads as rewritten:

"(1) "Adverse underwriting decision" means:

a. Any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

1. A declination of insurance coverage;

2. A termination of insurance coverage;

3. Failure of an agent to apply for insurance coverage with a specific insurance institution that an agent represents and that is requested by an applicant;

4. In the case of a property or casualty insurance coverage:

I. Placement by an insurance institution or agent of a risk with a residual market ~~mechanism or~~ mechanism, an unauthorized insurer, or an insurance institution that specializes in substandard risks; or

II. The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished; or

5. In the case of a ~~life or accident and health~~ life, health, or disability insurance coverage, an offer to insure at higher than standard rates.

b. Notwithstanding subdivision (1)a of this section, the following actions shall not be considered adverse underwriting decisions, but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

1. The termination of an individual policy form on a class or statewide basis;

2. A declination of insurance coverage solely because such coverage is not available on a class or statewide basis; or

3. The rescission of a policy."

SECTION 3. G.S. 58-39-15(9) reads as rewritten:

"(9) "Individual" means any natural person who:

a. In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder;

b. In the case of life or accident and health insurance, is a past, present, or proposed principal insured or certificate holder;

c. Is a past, present or proposed policy owner;

d. Is a past or present applicant;

e. Is a past or present claimant; ~~or~~

f. Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this ~~Article.~~Article; or

g. Is the subject of personal information collected or maintained by an insurance institution, agent, or insurance-support organization in connection with mortgage guaranty insurance."

SECTION 4. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-26. Federal privacy disclosure notice requirements.**

(a) Disclosure Required – In addition to the notice requirements of G.S. 58-39-25, an insurance institution or agent shall provide to all applicants and policyholders no later than (i) before the initial disclosure of personal information under G.S. 58-39-75(11) or (ii) the time of the delivery of the insurance policy or certificate, a clear and conspicuous notice, in written or electronic form, of the insurance institution or agent's policies and practices with respect to:

(1) Disclosing nonpublic personal information to affiliates and nonaffiliated third parties, consistent with section 502 of Public Law 106-102, including the categories of information that may be disclosed.

(2) Disclosing nonpublic personal information of persons who have ceased to be customers of the financial institution.

(3) Protecting the nonpublic personal information of consumers.

These disclosures shall be made in accordance with the regulations prescribed under section 504 of Public Law 106-102.

(b) Information to be Included -- The disclosure required by subsection (a) of this section shall include:

(1) The policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the insurance institution or agent, consistent with section 502 of Public Law 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided under section 502(e) Public Law 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(2) The categories of nonpublic personal information that are collected by the insurance institution or agent.

(3) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with section 501 of Public Law 106-102.

(4) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In the case of a policyholder, the notice required by this section shall be provided not less than annually during the continuation of the policy. As used in this subsection, 'annually' means at least once in any period of 12 consecutive months during which the policy is in effect."

SECTION 5. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-27. Privacy notice and disclosure requirement exceptions.**

(a) Under G.S. 58-39-25 and G.S. 58-39-26, an insurance institution or agent may provide a joint notice from the insurance institution or agent and one or more of its affiliates or other financial institutions, as defined in the notice, as long as the notice is accurate with respect to the insurance institution or agent and the other institutions.

(b) An insurance institution or agent may satisfy the notice requirements of G.S. 58-39-25 and G.S. 58-39-26 by providing a single notice if two or more applicants or policyholders jointly obtain or apply for an insurance product.

(c) An insurance institution or agent may satisfy the notice requirements of G.S. 58-39-25 and G.S. 58-39-26 through the use of separate or combined notices.

(d) An insurance institution or agent is not required to provide the notices required by G.S. 58-39-25 and G.S. 58-39-26 to:

(1) Any applicant or policyholder whose last known address, according to the insurance institution's or agent's records is deemed invalid. The applicant's or policyholder's last known address shall be deemed invalid if mail sent to that address has been returned by the postal authorities as undeliverable and if subsequent reasonable attempts to obtain a current valid address for the applicant or policyholder have been unsuccessful; or

(2) Any policyholder whose policy is lapsed, expired, or otherwise inactive or dormant under the insurance institution's business practices, and the insurance institution has not communicated with the policyholder about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, or promotional materials.

(e) If an agent does not share information with any person other than the agent's principal or an affiliate of the principal, and if the principal provides all notices required by G.S. 58-39-25 and G.S. 58-39-26, the agent is not required to provide the notices required by G.S. 58-39-25 and G.S. 58-39-26. G.S. 58-39-75 applies to the sharing of information with an affiliate under this subsection.

(f) When an agent discloses a policyholder's personal information, other than medical information, to an insurance institution solely for the purposes of renewal, transfer, replacement, reinstatement, or modification of an existing policy, the agent is not required to provide the notices required by G.S. 58-39-25 and G.S. 58-39-26.

(g) For the purposes of G.S. 58-39-26 only, the terms 'applicant' or 'policyholder' include respectively a person who applies for, or a certificate holder who obtains, insurance coverage under a group or blanket insurance contract, employee benefit plan, or group annuity contract, regardless of whether the coverage is individually underwritten. An insurance institution or agent that does not disclose personal information about an applicant or policyholder under a group or blanket insurance

contract, employee benefit plan, or group annuity contract, except as permitted under G.S. 58-39-75(1) through (10) and G.S. 58-39-75(12) through (21), may satisfy any notice requirement that otherwise exists under G.S. 58-39-26 with respect to that applicant or policyholder by providing a notice of information practices to the holder of the group or blanket insurance or annuity contract or the employee benefit plan sponsor. If an insurance institution or agent discloses personal information about an applicant or policyholder as permitted by G.S. 58-39-75(11), it shall provide the notice required G.S. 58-39-26 to the applicant or policyholder not less than 30 days before the information is disclosed; and it may satisfy any other notice requirement that otherwise exists under this section with respect to that applicant or policyholder by providing a notice of information practices to the holder of the group or blanket insurance or annuity contract or employee benefit plan sponsor."

SECTION 6. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-28. Exception for title and mortgage guaranty insurance.**

(a) A title insurance company shall give notice of its insurance information practices under G.S. 58-39-25 and G.S. 58-39-26 only at the time the final policy of title insurance is issued and is not subject to any annual notice requirement thereafter.

(b) In the case of mortgage guaranty insurance, the notice required by G.S. 58-39-25 and G.S. 58-39-26 shall be provided at the time a master policy is issued and thereafter only if there is a material change in the insurer's policies and practices regarding the use or disclosure of personal information."

SECTION 7. G.S. 58-39-75(1) reads as rewritten:

"(1) With the written authorization of the individual, provided:

a. If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35; or

b. If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35 and is:

1. Dated;

2. Signed by the individual; and

3. Obtained one year or less ~~prior to~~ before the date a disclosure is sought pursuant to this paragraph; or".

SECTION 8. G.S. 58-39-75(18) reads as rewritten:

"(18) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of ~~insurance; provided that~~ insurance only if:

a. No medical record information is disclosed unless the disclosure would otherwise be permitted by this section; and

b. ~~the~~ The information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy; or."

SECTION 9. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-76. Limits on sharing account number information for marketing purposes.**

(a) General Prohibition on Disclosure of Account Numbers. – An insurance institution, insurance agent, or insurance-support organization shall not disclose, other than to a consumer reporting agency, an account number or similar form of access number or access code for a credit card account, deposit account, or transaction account of a consumer to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) Definitions. – As used in this section:

(1) 'Account number' means an account number, or similar form of access number or access code, but does not include a number or code in an encrypted form, as long as the insurance institution, insurance agent, or insurance-support organization does not provide the recipient with a means to decode the number or code.

(2) 'Transaction account' means an account other than a deposit account or credit card account. A transaction account does not include an account to which third parties cannot initiate charges.

(c) Exceptions. – Subsection (a) of this section does not apply if an insurance institution, insurance agent, or insurance-support organization discloses an account number or similar form of access number or access code:

(1) To the insurance institution's, insurance agent's, or insurance-support organization's agent or service provider solely in order to perform marketing for the insurance institution's, insurance agent's, or insurance-support organization's own products or services, as long as the agent or service provider is not authorized to directly initiate charges to the account; or

(2) To a participant in a private label credit card program or an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program."

SECTION 10. G.S. 58-39-75(12) reads as rewritten:

"(12) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated ~~persons; or~~ persons; and further provided that no medical record information may be disclosed to the affiliate for the marketing of an insurance product or service; or".

SECTION 11. G.S. 58-39-75(2) reads as rewritten:

"(2) To a person other than an insurance institution, agent, or insurance-support organization, provided such disclosure is reasonably necessary:

a. To enable ~~such~~ that person to perform a business, professional, or insurance function for the disclosing insurance institution, agent, or insurance-support organization, including, but not limited to, performing marketing functions and other functions regarding the provision of information concerning the disclosing institution's own products, services, and programs, and ~~such~~ that person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

1. Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or
2. Is reasonably necessary for ~~such~~ that person to perform its function for the disclosing insurance institution, agent, or insurance-support organization; or

b. To enable ~~such~~ that person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

1. Determining an individual's eligibility for an insurance benefit or payment; or
2. Detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction; or"

SECTION 12. G.S. 58-39-75 is amended by adding a new subdivision to read:

"(21) To a person whose only use of an applicant's or policyholder's personal information, but not including medical record information, will be in connection with the marketing of a financial product or service intended to be provided by participants in a marketing program where the program participants and the types of information to be shared are identified to the applicant or policyholder when the applicant or policyholder is first offered the financial product or service. As used in this subdivision:

a. 'Financial institution' means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. §1843(k)).

b. 'Financial product or service' means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. §1843(k)).

c. 'Marketing program' includes only those programs established by written agreement by the insurance institution and one or more financial institutions under which they jointly offer, endorse, or sponsor a financial product or service."

SECTION 13 If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 14. This act becomes effective January 1, 2002, and applies to policies and contracts newly issued or renewed on and after that date. For the purposes of the application of this act to policies or contracts renewed on and after January 1, 2002, the renewal of a policy or contract is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the policy or contract.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S 2

SENATE BILL 461*

Insurance and Consumer Protection Committee Substitute Adopted 4/24/01

Short Title: Insurance Information Privacy-AB. (Public)

Sponsors:

Referred to:

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE THE NORTH CAROLINA INSURANCE INFORMATION AND PRIVACY PROTECTION ACT COMPLY WITH THE CONSUMER INFORMATION PRIVACY REQUIREMENTS IN THE FEDERAL GRAMM-LEACH-BLILEY ACT, PUBLIC LAW 106-102.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-39-10 reads as rewritten:

"**§ 58-39-10. Scope.**

(a) The obligations imposed by this Article shall apply to those insurance institutions, agents, or insurance-support organizations that, on or after July 1, 1982:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance:

a. Collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this State; or

b. Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this State; and

(2) In the case of property or casualty insurance:

a. Collect, receive, or maintain information in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; ~~or~~

b. Engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~State; or

c. Engage in transactions involving mortgage guaranty insurance where the mortgage guaranty policies, contracts, or certificates of insurance are delivered, issued for delivery, or renewed in this State.

(b) The rights granted by this Article shall extend to:

(1) In the case of ~~life or accident and health~~ life, health, or disability insurance, the following persons who are residents of this State:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions;

(2) In the case of property or casualty insurance, the following persons:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in (i) insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this ~~State.~~ State; or (ii) mortgage guaranty insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State.

(c) For purposes of this section, a person shall be considered a resident of this State if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance-support organization, is located in this State.

(d) Notwithstanding subsections (a) and (b) of this section, this Article shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this State."

SECTION 2. G.S. 58-39-15(1) reads as rewritten:

"(1) "Adverse underwriting decision" means:

a. Any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

1. A declination of insurance coverage;

2. A termination of insurance coverage;

3. Failure of an agent to apply for insurance coverage with a specific insurance institution that an agent represents and that is requested by an applicant;

4. In the case of a property or casualty insurance coverage:

I. Placement by an insurance institution or agent of a risk with a residual market ~~mechanism or~~ mechanism, an unauthorized insurer, or an

insurance institution that specializes in substandard risks; or

II. The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished; or

5. In the case of a ~~life or accident and health~~ life, health, or disability insurance coverage, an offer to insure at higher than standard rates.

b. Notwithstanding subdivision (1)a of this section, the following actions shall not be considered adverse underwriting decisions, but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

1. The termination of an individual policy form on a class or statewide basis;

2. A declination of insurance coverage solely because such coverage is not available on a class or statewide basis; or

3. The rescission of a policy."

SECTION 3. G.S. 58-39-15(9) reads as rewritten:

"(9) "Individual" means any natural person who:

a. In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder;

b. In the case of life or accident and health insurance, is a past, present, or proposed principal insured or certificate holder;

c. Is a past, present or proposed policy owner;

d. Is a past or present applicant;

e. Is a past or present claimant; ~~or~~

f. Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this ~~Article.~~Article; or

g. Is the subject of personal information collected or maintained by an insurance institution, agent, or insurance-support organization in connection with mortgage guaranty insurance."

SECTION 4. G.S. 58-39-25 reads as rewritten:

"**§ 58-39-25. Notice of insurance information practices.**

(a) An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided in this section:

(1) In the case of an application for insurance a notice shall be provided no later than:

a. At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records; ~~or~~

b. At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records; or

c. Before the initial disclosure of personal information under G.S. 58-39-75(11).

(2) In the case of a policy ~~renewal,~~ that has been issued, a notice shall be provided ~~no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:~~

~~a. Personal information is collected only from the policyholder or from public records; or~~

~~b.~~ ~~A notice meeting the requirements of this section has been given within the previous 24 months;~~ not less than annually while the policy is in force; or

(3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance ~~institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.~~ institution.

(b) The notice required by sub-subdivision (a)(1)a. and (a)(1)b. and subdivision (a)(3)of this section shall be in writing and shall state:

(1) Whether personal information may be collected from persons other than the individual or individuals proposed for ~~coverage;~~ coverage.

(2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such ~~information;~~ information.

(3) The types of disclosures identified in subsections (2), (3), (4), (5), (6), (9), (11), (12), and (14) of G.S. 58-39-75 and the circumstances under which such disclosures may be made without prior authorization: Provided, however, only those circumstances need be described that occur with such frequency as to indicate a general business ~~practice;~~practice.

(4) A description of the rights established under G.S. 58-39-45 and 58-39-50 and the manner in which such rights may be ~~exercised; and~~ exercised.

(5) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(6) The notice required by sub-subdivisions (a)(1)a and (a)(1)c and subdivision (a)(2) of this section shall include information relating to the policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the insurance institution or agent, consistent with Title V of P.L. 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided pursuant to Title V of P.L. 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(7) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with Title V of P.L. 106-102.

(8) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In lieu of the notice prescribed in ~~subsection (b)~~ subdivisions (b)(1) through (b)(5) of this section, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that:

(1) Personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) Such information, as well as other personal or privileged information subsequently collected by the insurance institution or agent, in certain circumstances, may be disclosed to third parties without authorization;

(3) A right of access and correction exists with respect to all personal information collected; and

(4) The notice prescribed in subsection (b) of this section will be furnished to the applicant or policyholder upon request.

For the purposes of this section only, the terms 'applicant' or 'policyholder' include respectively a person who applies for or obtains coverage under a group insurance contract, regardless of whether that person's coverage is individually underwritten. An insurance institution or agent that does not disclose personal information about an applicant or policyholder under a group insurance contract, as permitted by G.S. 58-39-75(11), may satisfy any notice requirement that otherwise exists under this section with respect to the applicant or policyholder by providing a notice of information practices to the holder of the group insurance contract.

(d) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

(e) An insurance institution may provide a joint notice from the insurance institution and one or more of its affiliates or other financial institutions, as defined in

the notice, as long as the notice is accurate with respect to the insurance institution and the other institutions.

(f) The notice requirements of this section may be satisfied by providing a single notice if two or more applicants or policyholders jointly obtain or apply for an insurance product.

(g) An insurance institution or agent may satisfy the notice requirements of this section and Title V of P.L. 106-102 through the use of separate or combined notices.

(h) An insurance institution or agent is not required to provide the notices required by this section to:

(1) Any applicant or policyholder whose last known address, according to the insurance institution's or agent's records is deemed invalid. The applicant's or policyholder's last known address shall be deemed invalid if mail sent to that address has been returned by the postal authorities as undeliverable and if subsequent reasonable attempts to obtain a current valid address for the applicant or policyholder have been unsuccessful; or

(2) Any policyholder whose policy is lapsed, expired, or otherwise inactive or dormant under the insurance institution's business practices, and the insurance institution has not communicated with the policyholder about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, or promotional materials.

(i) If an insurance agent does not share information with any person other than the agent's principal, and if the principal provides all notices required by this section, the insurance agent is not required to provide the notices required by this section."

SECTION 5. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-26. Exception for title and mortgage guaranty insurance.**

(a) A title insurance company shall give notice of its insurance information practices under G.S. 58-39-25 only at the time the final policy of title insurance is issued and is not subject to any annual notice requirement thereafter.

(b) In the case of mortgage guaranty insurance, a notice shall be provided at the time a master policy is issued and thereafter only if there is a material change in the insurer's policies and practices regarding the use or disclosure of personal information."

SECTION 6. G.S. 58-39-75(1) reads as rewritten:

"(1) With the written authorization of the individual, provided:

a. If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35; or

b. If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization,

the authorization meets the requirements of G.S. 58-39-35 and is:

1. Dated;
2. Signed by the individual; and
3. Obtained one year or less ~~prior to~~ before the date a disclosure is sought pursuant to this paragraph; or".

SECTION 7. G.S. 58-39-75(18) reads as rewritten:

"(18) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of ~~insurance; provided that~~ insurance only if:

a. No medical record information is disclosed unless the disclosure would otherwise be permitted by this section; and

b. ~~the~~ The information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy; or."

SECTION 8. Article 39 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-39-76. Limits on sharing account number information for marketing purposes.**

(a) General Prohibition on Disclosure of Account Numbers. – An insurance institution, insurance agent, or insurance-support organization shall not disclose, other than to a consumer reporting agency, an account number or similar form of access number or access code for a credit card account, deposit account, or transaction account of a consumer to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) Definitions. – As used in this section:

(1) 'Account number' means an account number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the insurance institution, insurance agent, or insurance-support organization does not provide the recipient with a means to decode the number or code.

(2) 'Transaction account' means an account other than a deposit account or credit card account. A transaction account does not include an account to which third parties cannot initiate charges.

(c) Exceptions. – Subsection (a) of this section does not apply if an insurance institution, insurance agent, or insurance-support organization discloses an account number or similar form of access number or access code:

(1) To the insurance institution's, insurance agent's, or insurance-support organization's agent or service provider solely in order to perform marketing for the insurance institution's, insurance agent's, or insurance-support organization's own products or services, as long as

the agent or service provider is not authorized to directly initiate charges to the account; or

(2) To a participant in a private label credit card program or an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program."

SECTION 9. G.S. 58-39-75(12) reads as rewritten:

"(12) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated ~~persons; or~~ persons, provided that no medical record information may be disclosed to the affiliate; or".

SECTION 10. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 11. This act becomes effective January 1, 2002.

SENATE BILL 461:
Insurance Information Privacy- AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Wellons
Date:	July 11, 2001	**Summary by:**	Frank W. Folger
Version:	PCS for Second Edition (S461-CSSO-54		Committee Counsel

SUMMARY: This bill would amend Article 39 of Chapter 58 of the General Statutes, the North Carolina Insurance Information and Privacy Protection Act (the Act) to conform it to the consumer information privacy requirements of the federal Gramm-Leach-Bliley Act, Public Law 106-102, enhance certain consumer protections, and remove certain industry burdens without consumer impact.

CURRENT LAW: The Act governs the collection, use and disclosure of information gathered in connection with insurance transactions. Provisions, which would be affected by the legislation, include:

Notice of Insurance Information Practices Notice must be provided to applicants or policyholders no later than at delivery of the policy or certificate when information is gathered only from the applicant or public sources, and no later than beginning collection of information when information is collected from another source. For a policy renewal, notice is not required if personal information is only collected from the policyholder or public records; but if required, it must be provided by the renewal date unless given in the last 24 months. For policy reinstatement or change in benefits, notice is not required if personal information is collected only from the policyholder or from public records; but if required, it must be given no later than the time the insurance institution receives the policy reinstatement or change in benefits request.

Contents of Notice The notice must state: whether personal information may be collected from persons other than those proposed for coverage; the types of, sources of, and investigative techniques used in obtaining personal information; disclosures which may be made pursuant to G.S. 58-39-75 and how they may be disclosed without prior authorization, but only when such disclosure would be deemed a general business practice by its frequency; a description of the policyholders and/or applicants rights regarding personal information access, correction, amendment, and deletion; the fact that insurance-support organization report information may be kept by the insurance support organization and disclosed to others. It provides for an alternative abbreviated notice to be given in lieu of that just described.

Disclosure of Individual's Personal or Privileged Information An insurance institution, agent or insurance-support organization seeking to disclose an individual's privileged or personal information collected or received in connection with an insurance transaction must meet certain requirements to be able to do so. When disclosure is sought with written authorization of the individual but the authorization is submitted by a person other than the policyholder or insurance institution, insurance-support organization or agent, the authorization must be dated, signed by the individual, and obtained one year or less before disclosure is sought. The section provides for disclosure to lienholders and others with a legal or beneficial interest in a policy as long as it is limited to that reasonably necessary to permit protection of that party's interest.

BILL ANALYSIS of SECOND EDITION

Section 1 would amend reference to "life or accident and health insurance" to "life, health, or disability insurance" to conform the language to the model act, incorporate mortgage guaranty insurance expressly into its scope, and make consistent conforming changes throughout the bill.

Section 2 would redefine "adverse underwriting decision" to include risk placement by an insurance institution with an insurance institution specializing in substandard risks.

Section 3 would provide protection under the Act (limited notice) to people whose mortgages are the subject of a mortgage guaranty insurance transaction or proposed transaction, even though these mortgagors are not the insured under such policies.

Section 4 would require, for policies already issued and in force, that notice be provided at least annually. For policy reinstatement or change in benefits situations, the exception to the notice requirement would be removed. *The Gramm-Leach-Bliley Act requires these changes.* It would also require notice be given before an insurance institution or agent makes initial disclosure of personal information to a person for marketing of a product or services, if notice had not already been required. It would also make technical and conforming changes.

It would add to the notice contents requirements to applicants or policyholders:

- The insurance institution or agent's policies and practices regarding disclosure of nonpublic personal information to nonaffiliated third parties, other than their agents, consistent with Title V, Privacy, of the Gramm-Leach Bliley Act, including the categories of persons to whom disclosure may be made and the policies and practices regarding disclosure about persons who are no longer customers.
- The insurance institution or agent's policies for protecting confidentiality and security of nonpublic personal information in accordance with Title V.
- Any required disclosures under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

The Gramm-Leach-Bliley Act requires this change.

It would require notice be given to persons applying for or obtaining coverage under a group insurance contract whether individually underwritten or not, except an insurance institution that does not disclose personal information about an applicant or policyholder as permitted by G.S. 58-39-75(11) can satisfy the notice requirement with notice to the holder of the group contract.

Section 5 would create a new section, N.C.G.S. §58-39-26, to require a title insurance company to only provide notice at the time the final policy is issued, and to require, in the case of mortgage guaranty insurance, that notice need only be provided at the time the master policy is issued and whenever there is a material change in the insurer's disclosure policies and practices.

Section 6 would require that disclosure based on a person's written authorization submitted by a person other than the institution agent or insurance-support organization be based on an authorization meeting the requirements for content in N.C.G.S. §58-39-35.

Section 7 would further limit disclosure to lienholders and other persons having a legal or beneficial interest in an insurance policy to prohibit disclosure of medical record information not otherwise permitted by N.C.G.S. §58-39-75.

Section 8 would create a new section, N.C.G.S. §58-39-76, placing limits on the sharing of account number information for marketing purposes. *The Gramm-Leach-Bliley Act requires this change.*

Section 9 would prohibit disclosure of medical record information to an affiliate for auditing or marketing of an insurance product or service.

Section 10 is a severability clause.

EFFECTIVE DATE: January 1, 2002

CHANGES IN PCS

Sections 1-3 are the same.

Section 4 would create new statutory section G.S. 58-39-26, which dictates notice disclosure requirements of Gramm-Leach-Bliley Act (GLB). These provisions are substantially the same as those changes made in former Section 4 to G.S. 58-39-25(a) –(c) [p.3, l. 35 – p.5, l. 38 of 2nd Edition]. NEW: It would specifically provide for electronic notice.

Section 5 would create new statutory section G.S. 58-39-27, which provides for exceptions to the notice requirements. These provisions are substantially similar to the changes made in former Section to G.S. 58-39-25(c)- (i)[p. 5, l. 31 – p.6, l. 25 of the 2nd Edition]. NEW: It specifically provides in subsection (f) of new G.S. 58-39-27 that an agent is not required to provide the notices mandated in 58-39-25 and 58-39-26 if the agent is disclosing personal information (other than medical information) to an insurance institution solely for renewal, transfer, replacement, reinstatement or modification of an existing policy.

Section 6 is former Section 5 with conforming changes.

Sections 7-10 are substantially the same as former Sections 6-9. NEW: Section 10 is modified such that it is clear that medical information is still prohibited from being disclosed to an affiliate for marketing purposes but not for auditing purposes.

Section 11 would amend the existing statutory section on disclosure limitations and conditions to clarify that disclosure of personal or privileged information about an individual may be made to a person other than the insurance institution, agent, or insurance-support organization is permitted if it is reasonably necessary in performing a business, professional or insurance function, *which specifically includes marketing and providing information on the disclosing institutions own products, services and programs.*

Section 12 would create a new subdivision in the statutory section on disclosure limitations and conditions to specifically permit disclosure of personal information (other than medical record information) to a person for marketing a financial product or service by participants in a marketing program, with certain conditions imposed.

Section 13 is the same as former Section 10.

Section 14 The effective date remains January 1, 2002, but the section also clarifies "the anniversary date" regarding renewal of policies after the effective date.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

July 11, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Bill 461 -- Insurance Information Privacy

The Department of Insurance is proposing to amend the current Insurance Information and Privacy Protection Act ("the Act") in three general ways. First, certain amendments are necessary to bring the Act into compliance with the privacy protection mandates of the federal Gramm-Leach-Bliley Act, P.L. 106-102. Second, the Department is proposing to enhance insurance consumer protections currently found in the Act. Third, where doing so does not reduce consumer protections, certain burdens can be lifted off of the industry.

SECTION 1

G.S. 58-39-10(a)(1) and (b)(1). Conforms the North Carolina law to the NAIC Model Act.

G.S. 58-39-10(a)(2)(c) and (b)(2)(b). Clarifies that mortgage guaranty insurers are subject to the Act.

G.S. 58-39-10(e). Clarifies that credit insurers are subject to the Act.

SECTION 2

G.S. 58-39-15(9). Conforms the North Carolina law to the NAIC Model Act.

SECTION 3

G.S. 58-39-15(9)(g). Extends the protections of G.S. 58-39-75 (limitations on insurer disclosure of personal information) to the homeowner who pays for mortgage guaranty insurance even though that person is not an applicant or insured under the policy. This amendment is supported by the mortgage guaranty insurance industry.

SECTION 4

G.S. 58-39-26(a) and (b). These are additions to what must be included in the notice of information practices, as required by Sections 502 and 503 of the Gramm-Leach-Bliley Act.

G.S. 58-39-26(c). Requires insurers or agents to send notices of their information practices to insureds every 12 months. Current law says every 24 months. The proposed annual notice requirement is required by Section 503(a) of the Gramm-Leach-Bliley Act.

SECTION 5

G.S. 58-39-27(a). Allows a holding company to provide a joint notice of information practices on behalf of all of its subsidiaries.

G.S. 58-39-27(b). Allows an insurer or agent to provide one notice to co-policyholders, such as a husband and wife insured under the same auto policy.

G.S. 58-39-27(c). Allows an insurer or agent to send out notices required by G.S. 58-39-25 and Title V of the Gramm-Leach-Bliley Act as either two separate notices or one combined notice.

G.S. 58-39-27(d). Relieves an insurer or agent of providing notices to persons who do not keep their addresses current or whose policies have lapsed.

G.S. 58-39-27(e). Relieves an agent of notice requirements when (1) the agent is not sharing the insured's information with anyone but his or her principal (the insurer) and (2) where that principal gives the insured the notice required by G.S. 58-39-25.

G.S. 58-39-25(f). Relieves an agent of notice requirements when the agent is disclosing the insured's personal information, other than medical information to the insurer solely for the purpose of renewal, transfer, reinstatement, or modification of an existing policy.

G.S. 58-39-25(g). Extends the notice protections to group certificate holders, who currently have no right to notice unless their policies are individually underwritten. However, notice only need be given certificate holders if the insurer or agent intends to share their personal information. Otherwise, an insurer can comply with the notice requirements of G.S. 58-39-25 by giving notice to the group master policyholder (typically an employer). This proposed amendment gives something to group certificate holders that they do not have under current law.

SECTION 6

G.S. 58-39-28. Relieves title insurers and mortgage guaranty insurers of the annual notices required by G.S. 58-39-25(a)(2). The rationale is that in the title insurance context, the insured's

only contact with the company is when the policy is purchased with a single premium payment at the closing. The only information held by the title insurer comes from public records. Thus, an annual notice seems expensive and does not appear to offer the insured any protections. In the mortgage insurance context, the homeowner paying the mortgage insurance premium is not the insured and is not entitled to any notice under current law. The lending institution is the insured. Requiring annual notices to sophisticated lending institutions seems burdensome and does nothing for the individual paying for the policy. The title insurers and mortgage guaranty insurers support this amendment.

SECTION 7

G.S. 58-39-75(1). Amends the opt-in provision to make sure the written authorization meets the disclosure authorization form requirements in the privacy law.

SECTION 8

G.S. 58-39-75(18). Prohibits the disclosure of medical record information to anyone who has a legal or beneficial interest in the policy unless that disclosure is permitted by the privacy law.

SECTION 9

G.S. 58-39-76(a). Limits the sharing of an individual's account number information. This is required by Section 502(d) of the Gramm-Leach-Bliley Act.

G.S. 58-39-76(b). Creates limited exceptions to the restrictions imposed on account sharing information by G.S. 58-39-76(a). These exceptions are taken verbatim from rules promulgated by the federal banking regulatory agencies in addressing Section 502(d) of the Gramm-Leach-Bliley Act. Included at industry's request.

SECTION 10

G.S. 58-39-75(12). Current law imposes a general requirement that no individual's personal information can be shared by an insurer or agent without that individual's written consent. This is known as an "opt in" standard. There are two marketing exceptions to the basic "opt in" standard. G.S. 58-39-75(11) currently allows an insurer or agent to share a consumer's personal information with others, both affiliates and non-affiliates, for general marketing purposes if the

insured is given notice of the proposed sharing and an opportunity to say "no". This is known as the "opt out" standard. G.S. 58-39-75(12) currently allows an insurer or agent to share a consumer's personal information with affiliates for insurance marketing purposes without the consumer's permission and even if the consumer does not want his or her information shared. This amendment would prohibit the sharing of the consumer's medical record information under G.S. 58-39-75(12).

SECTION 11

G.S. 58-39-75(2). Allows disclosure of information to a third party to allow that third party to perform marketing functions on the provision of information about the disclosing insurer's own products, services, and programs.

SECTION 12

G.S. 58-39-75(21). Addresses joint marketing programs, which are allowed by the Gramm-Leach-Bliley Act. Allows information to be shared where the program participants and the type of information to be shared are identified to the insured when the insured is first offered the financial product or service in the program.

SECTION 12

Standard severability clause.

SECTION 13

The act becomes effective January 1, 2001, and applies to new and renewed policies issued on and after that date.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 1077 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR CAREER FIREFIGHTERS' AND RESCUE SQUAD WORKERS' BENEFITS IN THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to committee substitute bill, ☒ which changes the title, unfavorable as to original bill, and recommendation that the committee substitute bill be re-referred to the Committee on Rules, Calendar, and Operations of the House.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H D

HOUSE BILL 1077
PROPOSED COMMITTEE SUBSTITUTE H1077-PCS6325-SO-53

Short Title: Firefighters' and Rescue Squad Workers' Retire. (Public)

Sponsors:

Referred to:

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY ISSUES RELATED TO PROVIDING CAREER FIREFIGHTERS AND RESCUE SQUAD WORKERS WITH INCREASED RETIREMENT BENEFITS.

Whereas, the General Assembly recognizes the inestimable contribution which career firefighters and rescue squad workers of this State make in preserving and protecting the lives and property of citizens of this State; and

Whereas, the General Assembly recognizes the need to ensure that career firefighters, career rescue squad workers, and their families receive retirement benefits commensurate with their commitment to service and with benefits received by other emergency personnel; and

Whereas, the General Assembly recognizes the changing economic climate which has resulted in the heightened need for intense fiscal scrutiny of legislative proposals that may adversely impact the State's budget, the ability of business and industry located in this State to compete in a global marketplace, the obligations of local governments, and the citizenry of this State; and

Whereas, the General Assembly recognizes the fact that local governments will bear the responsibility of providing increased benefits and that, given the changing economic climate, there is uncertainty about the financial impact that providing increased benefits will have on local governments; and

Whereas, the General Assembly recognizes the complexity of the issues involved, the uncertainty in the State's current economic state, and the far-reaching impact of any decisions in this matter to firefighters, rescue squad workers, local governments, and citizens of this State; and

Whereas, the General Assembly recognizes the need to study the issues thoroughly and proceed prudently; Now therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The General Assembly authorizes the Legislative Research Commission to comprehensively study issues related to providing increased retirement

benefits to career firefighters and rescue squad workers. If this study is undertaken, the Commission shall examine the following issues:

(1) The nature and extent of retirement benefits that should be provided career firefighters and rescue squad workers.

(2) The mechanism(s) through which these retirement benefits should be provided.

(3) Alternatives for funding these increased retirement benefits and the impact such alternatives would have on the citizenry, business and industry, and local governments of this State.

(4) Any other issue deemed relevant to the study directive.

If this study is undertaken, the Commission shall report to the 2002 Regular Session of the 2001 General Assembly on its findings and recommendations, including legislative proposals, if appropriate.

SECTION 2. There is appropriated from the General Fund to the General Assembly the sum of twenty thousand dollars ($20,000) for the 2001-2002 fiscal year to implement this act.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 1077

Short Title:	Firefighters' and Rescue Squad Workers' Retire.	(Public)
Sponsors:	Representatives Arnold; Baddour and Russell.	
Referred to:	Pensions and Retirement.	

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR CAREER FIREFIGHTERS' AND RESCUE SQUAD WORKERS' BENEFITS IN THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. Article 12E of Chapter 143 of the General Statutes reads as rewritten:

"Article 12E.

"Retirement Benefits for Local Governmental Law-Enforcement ~~Officers.~~ Officers and Career Firefighters and Rescue Squad Workers.

"**§ 143-166.50. Retirement benefits for local governmental law-enforcement ~~officers.~~ officers and career firefighters and rescue squad workers.**

(a) Definitions. – The following words and phrases as used in this Article, unless a different meaning is plainly required by the context, have the following meaning:

(1) "Beneficiary" means any person in receipt of a retirement allowance or other benefit from a Retirement System.

(1a) "Career firefighter" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a fire department certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the prevention, detection, and suppression of fire.

(1b) "Career rescue squad worker" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a rescue squad or emergency medical services team certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the

alleviation of human suffering and assistance to persons who are in difficulty, who are injured, or who become suddenly ill, by providing proper and efficient care or emergency medical services.

(2) "Employer" means a county, city, town or other political subdivision of the State.

(3) "Law-enforcement officer" means a full-time paid employee of an employer, who possesses the power of arrest, who has taken the law enforcement oath administered under the authority of the State as prescribed by G.S. 11-11, and who is certified as a law enforcement officer under the provisions of Chapter 17C of the General Statutes or certified as a deputy sheriff under the provisions of Chapter 17E of the General Statutes. "Law enforcement officer" also means the sheriff of the county. The number of paid personnel employed as law enforcement officers by a law enforcement agency may not exceed the number of law enforcement positions approved by the applicable local governing board.

(4) "Law-Enforcement Officers' Retirement System" means the system provided for under Article 12 of Chapter 143 of the General Statutes, as it existed prior to January 1, 1986.

(5) "Local Governmental Employees' Retirement System" means the Local Governmental Employees' Retirement System of North Carolina provided for under Article 3 of Chapter 128 of the General Statutes.

(6) "Member" means an ~~officer~~ officer, firefighter, or rescue squad worker included in the membership of a retirement system, including former ~~officers~~ officers, firefighters, or rescue squad workers no longer employed who also elected to leave their accumulated contributions on deposit with a Retirement System.

(7) "Officer" means a "law-enforcement officer."

(8) "State" means the State of North Carolina.

(b) Basic Retirement System. – On and after January 1, 1986, law-enforcement officers employed by an employer shall be members of the Local Government Employees' Retirement System, and beneficiaries who were last employed as officers by an employer, or who are surviving beneficiaries of officers last employed by an employer, are beneficiaries of the Local Governmental Employees' Retirement System and paid in benefit amounts then in effect. All members of the Law-Enforcement Officers' Retirement System last employed and paid by an employer are members of the Local Retirement System.

(c) Rights. – Notwithstanding any other provisions of law, any accrued or inchoate rights of a member of the Law-Enforcement Officers' Retirement System as of his transfer to the Local Governmental Employees' Retirement System on January 1, 1986, including the rights to a vested deferred retirement allowance and to commence retirement at certain ages with required years of service as a law-enforcement officer, may in no way be diminished; provided, however, in no event may a member

commence retirement and continue membership service with the same Retirement System after January 1, 1986.

(d) Court Cost Receipts. – Of the sum derived from the cost of court provided for in G.S. 7A-304(a)(3), the amount designated for this Article, except for the amount designated for the provisions of G.S. 143-166.50(e), shall be paid over to the pension accumulation fund of the Local Governmental Employees' Retirement System and shall offset, to the extent of these receipts, the employers' normal contribution rate required in G.S. 128-30(d)(2) as it pertains to law enforcement officers.

(e) Supplemental Retirement Income Plan for Local Governmental Law-Enforcement Officers. – As of January 1, 1986, all law-enforcement officers employed by a local government employer, are participating members of the Supplemental Retirement Income Plan as provided by Article 5 of Chapter 135 of the General Statutes. In addition to the contributions transferred from the Law-Enforcement Officers' Retirement System, participants may make voluntary contributions to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participants; provided, in no instance shall the total contributions by a participant exceed ten percent (10%) of a participant's compensation within any calendar year. From July 1, 1987, until July 1, 1988, local government employers of law enforcement officers shall contribute an amount equal to at least two percent (2%) of participating local officers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating local officers; and on and after July 1, 1988, local government employers of law enforcement officers shall contribute an amount equal to five percent (5%) of participating local officers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating local officers.

Additional contributions shall also be made to the individual accounts of all participants in the Plan, except for Sheriffs, on a per capita equal-share basis from the sum of one dollar and twenty-five cents ($1.25) for each cost of court collected under G.S. 7A-304.

(e1) Rights of Participants under the Uniformed Services Employment and Reemployment Rights Act. – A participant whose employment is interrupted by reason of service in the Uniformed Services, as that term is defined in section 4303(16) of the Uniformed Services Employment and Reemployment Rights Act, Public Law 103-353, hereafter referred to as "USERRA", shall be entitled to all rights and benefits that the participant would have been entitled to under this section had the participant's employment not been interrupted, provided that the participant returns to service as a law enforcement officer while the participant's reemployment rights are protected under the provisions of USERRA.

(e2) Supplemental Retirement Income Plan for Full-Time Local Career Firefighters and Rescue Squad Workers. – As of January 1, 2002, all career firefighters and career rescue squad workers employed by a local government employer are participating members of the Supplemental Retirement Income Plan as provided by Article 5 of Chapter 135 of the General Statutes. Participants may make voluntary contributions to the Supplemental Retirement Income Plan to be credited to the designated individual

accounts of participants; however, in no instance shall the total contributions by a participant exceed ten percent (10%) of a participant's compensation within any calendar year. On and after January 1, 2002, local government employers of career firefighters or career rescue squad workers shall contribute an amount equal to five percent (5%) of participating firefighters' or rescue squad workers' monthly compensation to the Supplemental Retirement Income Plan to be credited to the designated individual accounts of participating firefighters or rescue squad workers."

SECTION 2. G.S. 128-21 is amended by adding two new subdivisions to read:

"(17a) "Career firefighter" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a fire department certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the prevention, detection, and suppression of fire.

(17b) "Career rescue squad worker" means a person (i) who is a full-time paid employee of an employer that participates in the Local Governmental Employees' Retirement System and maintains a rescue squad or emergency medical services team certified by the North Carolina Department of Insurance, and (ii) who is actively serving in a position with assigned primary duties and responsibilities for the alleviation of human suffering and assistance to persons who are in difficulty, who are injured, or who become suddenly ill, by providing proper and efficient care or emergency medical services."

SECTION 3. G.S. 128-24(5) reads as rewritten:

"(5) The provisions of this subdivision (5) shall apply to any member whose membership is terminated on or after July 1, 1965, and who becomes entitled to benefits hereunder in accordance with the provisions hereof.

a. Notwithstanding any other provision of this Chapter, any member who separates from service prior to the attainment of the age of 60 years for any reason other than death or retirement for disability as provided in G.S. 128-27(c), after completing 15 or more years of creditable service, and who leaves his total accumulated contributions in said System shall have the right to retire on a deferred retirement allowance upon attaining the age of 60 years; provided that such member may retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired; and further provided that in the case of a member who so separates from service on or after July 1, 1967, the aforestated requirement of 15 or more years of creditable service shall be reduced to 12 or more years of creditable service; and further

provided that in the case of a member who so separates from service on or after July 1, 1971, or whose account is active on July 1, 1971, the aforestated requirement of 12 or more years of creditable service shall be reduced to five or more years of creditable service. Such deferred retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to a member who is not a law enforcement officer or eligible former law enforcement officer.

b. In lieu of the benefits provided in paragraph a of this subdivision, any member who separates from service prior to the attainment of the age of 60 years, for any reason other than death or retirement for disability as provided in G.S. 128-27(c), after completing 20 or more years of creditable service, and who leaves his total accumulated contributions in said System may elect to retire on an early retirement allowance upon attaining the age of 50 years or at any time thereafter; provided that such member may so retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired. Such early retirement allowance so elected shall be equal to the deferred retirement allowance otherwise payable at the attainment of the age of 60 years reduced by the percentage thereof indicated below.

Age at Retirement	Percentage Reduction
59	7
58	14
57	20
56	25
55	30
54	35
53	39
52	43
51	46
50	50

b1. In lieu of the benefits provided in paragraphs a and b of this subdivision, any member who is a law enforcement ~~officer~~ officer, career firefighter, or career rescue squad worker at the time of separation from service prior to the attainment of the age of 50 years, for any reason other than death or disability as provided in this Article, after completing 15 or more years of creditable service in this capacity immediately prior to separation from service, and who leaves his total accumulated contributions in this System, may elect to retire on a deferred

early retirement allowance upon attaining the age of 50 years or at any time thereafter; provided, that the member may commence retirement only upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to commence retirement. The deferred early retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to law enforcement ~~officers.~~ officers, career firefighters, or career rescue squad workers.

b2. In lieu of the benefits provided in paragraphs a and b of this subdivision, any member who is a law enforcement officer at the time of separation from service prior to the attainment of the age of 55 years, for any reason other than death or disability as provided in this Article, after completing five or more years of creditable service in this capacity immediately prior to separation from service, and who leaves his total accumulated contributions in this System may elect to retire on a deferred service retirement allowance upon attaining the age of 55 years or at any time thereafter; provided, that the member may commence retirement only upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to commence retirement. The deferred service retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to law enforcement ~~officers.~~ officers, career firefighters, or career rescue squad workers.

b3. Deferred retirement allowance of members retiring on or after July 1, 1995. – In lieu of the benefits provided in paragraphs a. and b. of this subdivision, any member who separates from service prior to attainment of age 60 years, after completing 20 or more years of creditable service, and who leaves his total accumulated contributions in said System, may elect to retire on a deferred retirement allowance upon attaining the age of 50 years or any time thereafter; provided that such member may so retire only upon written application to the Board of Trustees setting forth at what time, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired. Such deferred retirement allowance shall be computed in accordance with the service retirement provisions of this Article pertaining to a member who is not a

law enforcement ~~officer or~~ officer, an eligible former law enforcement ~~officer.~~ officer, a career firefighter, an eligible former career firefighter, a career rescue squad worker, or an eligible former career rescue squad worker.

c. Should a beneficiary who retired on an early or service retirement allowance be reemployed, or otherwise engaged to perform services, by an employer participating in the Retirement System on a part-time, temporary, interim, or on fee-for-service basis, whether contractual or otherwise, and if such beneficiary earns an amount in any calendar year which exceeds fifty percent (50%) of the reported compensation, excluding terminal payments, during the 12 months of service preceding the effective date of retirement, or twenty thousand dollars ($20,000), whichever is greater, as hereinafter indexed, then the retirement allowance shall be suspended as of the first day of the month following the month in which the reemployment earnings exceed the amount above, for the balance of the calendar year. The retirement allowance of the beneficiary shall be reinstated as of January 1 of each year following suspension. The amount that may be earned before suspension shall be increased on January 1 of each year by the ratio of the Consumer Price Index to the Index one year earlier, calculated to the nearest tenth of a percent (1/10 of 1%).

d. Should a beneficiary who retired on an early or service retirement allowance be restored to service as an employee, then the retirement allowance shall cease as of the first day of the month following the month in which the beneficiary is restored to service and the beneficiary shall become a member of the Retirement System and shall contribute thereafter as allowed by law at the uniform contribution payable by all members.

Upon his subsequent retirement, he shall be paid a retirement allowance determined as follows:

1. For a member who earns at least three years' membership service after restoration to service, the retirement allowance shall be computed on the basis of his compensation and service before and after the period of prior retirement without restriction; provided, that if the prior allowance was based on a social security leveling payment option, the allowance shall be adjusted actuarially for the difference between the amount received under the optional payment and what would have been paid if the retirement allowance had been paid without optional modification.

2. For a member who does not earn three years' membership service after restoration to service, the retirement allowance shall be equal to the sum of the retirement allowance to which he would have been entitled had he not been restored to service, without modification of the election of an optional allowance previously made, and the retirement allowance that results from service earned since being restored to service; provided, that if the prior retirement allowance was based on a social security leveling payment option, the prior allowance shall be adjusted actuarially for the difference between the amount that would have been paid for each month had the payment not been suspended and what would have been paid if the retirement allowance had been paid without optional modification."

SECTION 4. G.S. 128-27(a) reads as rewritten:

"(a) Service Retirement Benefits. –

(1) Any member may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired: Provided, that the said member at the time so specified for his retirement shall have attained the age of 60 years and have at least five years of creditable service or shall have completed 30 years of creditable service, or if a ~~fireman, he~~ career firefighter or career rescue squad worker, the member shall have attained the age of 55 years and have at least five years of creditable service.

(2) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1019, s. 1.

(3) Repealed by Session Laws 1971, c. 325, s. 12.

(4) Any member who was in service October 8, 1981, who had attained 60 years of age, may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, he desires to be retired.

(5) Any member who is a law enforcement ~~officer,~~ officer, career firefighter, or career rescue squad worker and who attains age 50 and completes 15 or more years of creditable service in this capacity or who attains age 55 and completes five or more years of creditable service in this capacity, may retire upon written application to the Board of Trustees setting forth at what time, as of the first day of a calendar month, not less than one day nor more than 90 days subsequent to the execution and filing thereof, ~~he~~ the member desires to be retired; provided, also, any member who has met the conditions required by this ~~subdivision~~ section but does not retire, and later

becomes an employee other than as a law enforcement ~~officer,~~ officer, career firefighter, or career rescue squad worker continues to have the right to commence retirement."

SECTION 5. G.S. 128-27(b18) reads as rewritten:

"(b18) Service Retirement Allowance of Member Retiring on or After July 1, ~~2000.~~2000, but Before January 1, 2002. – Upon retirement from service in accordance with subsection (a) or (a1) above, on or after July 1, 2000, but before January 1, 2002, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday and completion of five years of creditable service as a law enforcement officer, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 128-27(b18)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b18)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer or an eligible former law enforcement officer shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th birthday and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 128-27(b18)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 128-27(b18)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or
2. The service retirement allowance as computed under G.S. 128-27(b18)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or
3. If the member's creditable service commenced prior to July 1, 1995, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 128-27(b18)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1965, shall not receive less than the benefit provided by G.S. 128-27(b)."

SECTION 6. G.S. 128-27 is amended by adding a new subsection to read:

"(b19) Service Retirement Allowance of Member Retiring on or After January 1, 2002. – Upon retirement from service in accordance with subsection (a) or (a1) above, on or after January 1, 2002, a member shall receive the following service retirement allowance:

(1) A member who is a law enforcement officer, an eligible former law enforcement officer, a career firefighter, an eligible former career firefighter, a career rescue squad worker, or an eligible former career rescue squad worker shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 55th birthday and completion of five years of creditable service as a law enforcement officer, career firefighter, or career rescue squad worker, or after the completion of 30 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of his average final compensation, multiplied by the number of years of his creditable service.

b. If the member's service retirement date occurs on or after his 50th birthday and before his 55th birthday with 15 or more years of creditable service as a law enforcement officer, career firefighter, or career rescue squad worker and prior to the completion of 30 years of creditable service, his retirement allowance shall be equal to the greater of:

1. The service retirement allowance payable under G.S. 128-27(b19)(1)a. reduced by one-third of one percent (1/3 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 55th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b19)(1)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement.

(2) A member who is not a law enforcement officer, an eligible former law enforcement officer, a career firefighter, an eligible former career firefighter, a career rescue worker, or an eligible former career rescue squad worker shall receive a service retirement allowance computed as follows:

a. If the member's service retirement date occurs on or after his 65th birthday upon the completion of five years of creditable service or after the completion of 30 years of creditable service or on or after his 60th birthday upon the completion of 25 years of creditable service, the allowance shall be equal to one and seventy-eight hundredths percent (1.78%) of average final compensation, multiplied by the number of years of creditable service.

b. If the member's service retirement date occurs after his 60th birthday and before his 65th birthday and prior to his completion of 25 years or more of creditable service, his retirement allowance shall be computed as in G.S. 128-27(b19)(2)a. but shall be reduced by one-quarter of one percent (1/4 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following his 65th birthday.

c. If the member's early service retirement date occurs on or after his 50th birthday and before his 60th birthday and after completion of 20 years of creditable service but prior to the completion of 30 years of creditable service, his early service retirement allowance shall be equal to the greater of:

1. The service retirement allowance as computed under G.S. 128-27(b19)(2)a. but reduced by the sum of five-twelfths of one percent (5/12 of 1%) thereof for each month by which his retirement date precedes the first day of the month coincident with or next following the month the member would have attained his 60th birthday, plus one-quarter of one percent (1/4 of 1%) thereof for each month by which his 60th birthday precedes the first day of the month coincident with or next following his 65th birthday; or

2. The service retirement allowance as computed under G.S. 128-27(b19)(2)a. reduced by five percent (5%) times the difference between 30 years and his creditable service at retirement; or

3. If the member's creditable service commenced prior to July 1, 1995, the service retirement allowance equal to the actuarial equivalent of the allowance payable at the age of 60 years as computed in G.S. 128-27(b19)(2)b.

d. Notwithstanding the foregoing provisions, any member whose creditable service commenced prior to July 1, 1965, shall not receive less than the benefit provided by G.S. 128-27(b)."

SECTION 7. G.S. 128-27(m) reads as rewritten:

"(m) Survivor's Alternate Benefit. – Upon the death of a member in service, the principal beneficiary designated to receive a return of accumulated contributions shall have the right to elect to receive in lieu thereof the reduced retirement allowance provided by Option two of subsection (g) above computed by assuming that the member had retired on the first day of the month following the date of his death, provided that all three of the following conditions apply:

(1) a. The member had attained such age and/or creditable service to be eligible to commence retirement with an early or service retirement allowance, or

b. The member had obtained 20 years of creditable service in which case the retirement allowance shall be computed in accordance with ~~G.S. 128-27(b18)(1)b. or G.S. 128-27(b18)(2)c.,~~ G.S. 128-27(b19)(1)b. or G.S. 128-27(b19)(2)c., notwithstanding the requirement of obtaining age 50.

(2) The member had designated as the principal beneficiary to receive a return of his accumulated contributions one and only one person who is living at the time of his death.

(3) The member had not instructed the Board of Trustees in writing that he did not wish the provisions of this subsection apply.

For the purpose of this benefit, a member is considered to be in service at the date of his death if his death occurs within 180 days from the last day of his actual service. The last day of actual service shall be determined as provided in subsection (l) of this section. Upon the death of a member in service, the surviving spouse may make all purchases for creditable service as provided for under this Chapter for which the member had made application in writing prior to the date of death, provided that the date of death occurred prior to or within 60 days after notification of the cost to make the purchase."

SECTION 8. G.S. 105-228.5(d)(2) reads as rewritten:

"(2) Other Insurance Contracts. – The tax rate to be applied to gross premiums on all other insurance contracts issued by insurers shall be ~~one and nine tenths percent (1.9%).~~ two and three hundred nineteen ten-thousandths percent (2.0319%). The net proceeds shall be credited to the General Fund."

SECTION 9. There is appropriated from the General Fund to the Local Governmental Employees' Retirement System the sum of six million five hundred thousand dollars ($6,500,000) for the 2001-2002 fiscal year and the sum of thirteen million dollars ($13,000,000) for the 2002-2003 fiscal year to implement the provisions of this act.

SECTION 10. Section 8 of this act is effective for taxable years beginning on or after January 1, 2001. Section 9 of this act becomes effective July 1, 2001. The remainder of this act becomes effective January 1, 2002, but shall not affect the rights of a person who is a vested member of the Local Governmental Employees' Retirement System on that date to any disability benefits for which that person is otherwise eligible on that date.

HOUSE BILL 1077:
Firefighters' and Rescue Squad Workers' Retire.

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Rep. Arnold
Date:	June 13, 2001	**Summary by:**	Frank W. Folger
Version:	First Edition		Committee Counsel

SUMMARY:

House Bill 1077 amends the law to provide retirement benefits from the Supplemental Retirement Income Plan (401K Plan) to all eligible career firefighters and career rescue squad workers. The bill also provides that career firefighters and career rescue squad workers who are members of the Local Governmental Employees' Retirement System (Local System) will be eligible for the same deferred, early, and service retirement benefits as are now available to law enforcement officers. It further raises the gross premiums tax rate on insurance contracts from 1.9% to 2.0319%, and makes an appropriation from the General Fund to the Local System for fiscal years 2001-2002 and 2002-2003.

CURRENT LAW:

Under current law, all local law enforcement officers are participating members of the Supplemental Retirement Income Plan for Local Governmental Law Enforcement Officers. Local government employers contribute five percent of each officer's monthly compensation to the individual account of the member. Some local governments currently provide this benefit to all employees; however, the law only requires it for law enforcement officers.

The service retirement provisions of the Local Governmental Employees' Retirement System allow law enforcement officers to retire with full benefits at age 55 with five years of service or at any age with 30 years. Other members may retire at age 65 with five years or at any age with 30 years. The Local System is funded, in part, by each participating local employer. Each employer's contribution rate is determined when it elects to enter the System.

BILL ANALYSIS:

This bill amends the law to give all career firefighters and career rescue squad workers the same benefit in the Supplemental Retirement Income Plan as is currently available to law enforcement officers. In addition, the bill also amends several provisions in the Local Governmental Employees' Retirement System to provide the same deferred, early and service retirement benefits as are now available to law enforcement officers to career firefighters and career rescue squad workers.

The bill also amends the tax law to increase the tax rate for gross premiums on certain insurance contracts from 1.9% to 2.0319%. It also authorizes an appropriation of $6,500,000 for fiscal year 2001-2002, and $13,000,000 for fiscal year 2002-2003 to implement the provisions of the act. The appropriation will help to offset the additional cost to local government employers imposed by this act.

EFFECTIVE DATE:

The tax increase would become effective for taxable years beginning on or after January 1, 2001. The appropriation would become effective July 1, 2001. The remainder of the act would become effective January 1, 2002, but would not affect the rights of members vested in the Local Governmental Employees' Retirement System to any disability benefits for which the person might otherwise be eligible.

Karen Cochrane-Brown, counsel to the House Committee on Pensions and Retirement, contributed to this summary.

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 25, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on July 25, 2001, at 12:00 noon. Representative Hurley called the meeting to order and introduced the pages, Rachel House (Franklin County – Representative Crawford), Thomas Wilkins (Wake County – Representative Miner) and Chris Price (Wake County - Representative Odom). Also introduced were honorary pages, Meredith, Amanda, and Ashton Hurley, Representative Hurley's granddaughters. The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Dedmon, Grady, Johnson, Justus, Setzer, and Warner. Frank Folger, Staff Counsel, was in attendance. A list of visitors attending is attached. The following bill was considered:

SB 729, entitled, AN ACT TO PROVIDE THAT RATES AND CLASSIFICATIONS FOR MOTORCYCLE THEFT AND PHYSICAL DAMAGE INSURANCE ARE TO BE ESTABLISHED BY THE CARRIERS THAT WRITE THOSE COVERAGES AND NOT BY THE NORTH CAROLINA RATE BUREAU; TO PROVIDE THAT THE RATE BUREAU RETAINS JURISDICTION OVER RATES AND CLASSIFICATIONS FOR MOTORCYCLE LIABILITY INSURANCE; AND TO PROVIDE THAT MOTORCYCLE LIABILITY INSURANCE IS STILL CEDABLE TO THE NORTH CAROLINA MOTOR VEHICLE REINSURANCE FACILITY. Representative Hurley recognized Senator Carrington, the bill sponsor, and he presented a proposed committee substitute. Representative Dockham moved to adopt the proposed committee substitute for consideration. The motion passed. Bill Hale, NC Department of Insurance, was recognized to explain the proposed committee substitute. SB 729 is designed to improve coverage for theft and physical damage insurance for motorcycles by removing these coverages from the jurisdiction of the North Carolina Rate Bureau. The current Rate Bureau classification plan for motorcycles includes just two classes of motorcycles, and these classes are based on engine size. SB 729 would permit carriers to introduce coverage for theft and physical damage insurance that are more diverse, more flexibly priced and more focused on specific motorcycle types than are currently available in the market place. The Rate Bureau would retain jurisdiction over liability insurance, which by law must be carried by all motorcycle operators. Motorcycle liability insurance, like auto liability insurance, would remain cedable to the North Carolina Motor Vehicle Reinsurance Facility. SB 729 would become effective on January 1, 2002. Joy Barbour, Concerned Biker Association, was recognized and expressed her approval of the proposed committee substitute. Representative Justus moved for a favorable report as to House committee substitute bill #2, which changes the title, unfavorable to House committee substitute bill #1. The motion passed.

There being no further business, the meeting was adjourned at 12:15 p.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
Senate Bill 729
Bill Summary

VISITOR REGISTRATION SHEET

INSURANCE — July 25, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Will Duncan	CBA/ABATE of NC (Chatham County)
Darlene Kimsey	CBA/ABATE of NC (High Point)
Tim Pyle	Rocky Mount Chapter
Jim Everhart	DAVIDSON CO. CBA/ABATE Retreads M/C, Miles of NC
Mike Causey	McDonald & Meyer, LLC
Barbara Cansler	MFS, PA
Mike Lawson	Capitol Group
Susan Valaura	Nationwide
Robert Pasha	Young, Moore
David Gore	Raleigh CBA

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☒ House Committee Substitute for
S.B. 729 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT MOTORCYCLE INSURANCE RATES ARE SET IN ACCORDANCE WITH THE LAW REGULATING INSURANCE RATES RATHER THAN ESTABLISHED BY THE NORTH CAROLINA RATE BUREAU.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

☒ With a favorable report as to House Committee Substitute Bill # 2, unfavorable as to House Committee Substitute Bill # 1.

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

S D

SENATE BILL 729
PROPOSED HOUSE COMMITTEE SUBSTITUTE S729-CSSO-52 [v.1]

6/28/2001 4:23:18 PM

Short Title: Motorcycle Insurance Rates. (Public)

Sponsors:

Referred to:

March 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT RATES AND CLASSIFICATIONS FOR MOTORCYCLE THEFT AND PHYSICAL DAMAGE INSURANCE ARE TO BE ESTABLISHED BY THE CARRIERS THAT WRITE THOSE COVERAGES AND NOT BY THE NORTH CAROLINA RATE BUREAU; TO PROVIDE THAT THE RATE BUREAU RETAINS JURISDICTION OVER RATES AND CLASSIFICATIONS FOR MOTORCYCLE LIABILITY INSURANCE; AND TO PROVIDE THAT MOTORCYCLE LIABILITY INSURANCE IS STILL CEDABLE TO THE NORTH CAROLINA MOTOR VEHICLE REINSURANCE FACILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-1(1) reads as rewritten:

"(1) To assume the functions formerly performed by the North Carolina Fire Insurance Rating Bureau, the North Carolina Automobile Rate Administrative Office, and the Compensation Rating and Inspection Bureau of North Carolina, with regard to the promulgation of rates, for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof and valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; except as provided in G.S. 58-36-3(a)(6), for theft of and physical damage to nonfleet private passenger ~~(nonfleet) motor vehicles as the same are defined under Article 40 of this Chapter;~~ motor vehicles; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and for workers' compensation and employers' liability insurance written in connection therewith except for insurance excluded from the Bureau's jurisdiction in G.S. 58- 36-1(3)."

SECTION 2. G.S. 58-36-1(3) reads as rewritten:

"(3) The Bureau shall 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 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. This subdivision 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 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.~~"

SECTION 3. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-3. Limitation of scope; motorcycle endorsements allowed.**

(a) The Bureau has no jurisdiction over:

(1) Excess workers' compensation insurance for employers qualifying as self-insurers as provided in Article 47 of this Chapter or Article 5 of Chapter 97 of the General Statutes.

(2) Farm buildings, farm dwellings, and their appurtenant structures; farm personal property or other coverages written in connection with farm real or personal property.

(3) Travel or camper trailers designed to be pulled by private passenger motor vehicles, unless insured under policies covering nonfleet private passenger motor vehicles.

(4) 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.

(5) 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.

(6) Insurance against theft of or physical damage to motorcycles, as defined in G.S. 20-4.01(27)d.

(b) Member companies writing motorcycle liability insurance under this Article and writing insurance against theft of or physical damage to motorcycles under Article 40 of this Chapter may incorporate motorcycle theft and physical damage coverage as an endorsement to the liability policy issued under this Article."

SECTION 4. G.S. 58-37-1(6) reads as rewritten:

"(6) "Motor vehicle" means every self-propelled vehicle that is designed for use upon a highway, including trailers and semitrailers designed for use with such vehicles (except traction engines, road rollers, farm tractors, tractor cranes, power shovels, and well drillers). "Motor vehicle" also means a motorcycle, as defined in G.S. 20-4.01(27)d."

SECTION 5. G.S. 58-40-15 reads as rewritten:

"§ 58-40-15. Scope of application.

The provisions of this Article shall apply to all insurance on risks or on operations in this State, except:

(1) Reinsurance, other than joint reinsurance to the extent stated in G.S. 58-40-60;

(2) Any policy of insurance against loss or damage to or legal liability in connection with property located outside this State, or any motor vehicle or aircraft principally garaged and used outside of this State, or any activity wholly carried on outside this State;

(3) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies;
(4) Accident, health, or life insurance;
(5) Annuities;
(6) Repealed by Session Laws 1985, c. 666, s. 43.
(7) Mortgage guaranty insurance;
(8) Workers' compensation and employers' liability insurance written in connection therewith;
(9) For private passenger (nonfleet) motor vehicle liability insurance, automobile medical payments insurance, uninsured motorists' coverage and other insurance coverages written in connection with the sale of such liability insurance;
(10) Theft of or physical damage to nonfleet private passenger ~~(nonfleet)~~ motor vehicles; except this Article applies to insurance against theft of or physical damage to motorcycles, as defined in G.S. 20-4.01(27)d.; and
(11) Insurance against loss to residential real property with not more than four housing units located in this State or any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance. Provided, however, that this Article shall apply to insurance against loss to farm dwellings, farm buildings and their appurtenant structures, farm personal property and 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; 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.

The provisions of this Article shall not apply to hospital service or medical service corporations, investment companies, mutual benefit associations, or fraternal beneficiary associations."

SECTION 6. This act becomes effective January 1, 2002. Rates, rating systems, territories, classifications, and policy forms lawfully in use on January 1, 2002, may continue to be used thereafter.

SENATE BILL 729:
Motorcycle Insurance Rates

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Senator Carrington
Date:	July 25, 2001	**Summary by:**	Frank W. Folger
Version:	S729-CSSO-52		Committee Counsel

SUMMARY: ***This bill would provide that rates for insurance against theft or physical damage to motorcycles would be set by insurer's filings with the Department of Insurance rather than being set by the N.C. Rate Bureau, but would leave provisions governing liability coverage for motorcycles unchanged. The goal is to allow greater flexibility in rate setting of this coverage than is being provided under the current system.***

CURRENT LAW: The N.C. Rate Bureau currently establishes rates, subject to Commissioner approval, for motorcycle insurance, both for liability coverage and coverage against theft of or physical damage to the vehicle, as it does for nonfleet private passenger motor vehicle insurance and other insurance.

FOR GUIDANCE: In Chapter 58 (Insurance):

- Article 36 governs the N.C. Rate Bureau
- Article 37 governs the N. C. Motor Vehicle Reinsurance Facility
- Article 40 governs the Regulation of Insurance Rates

BILL ANALYSIS:

Section 1 would, by reference in G.S.§58-36-1(1) to provisions in the **newly proposed G.S. §58-36-3**, "except out" insurance against theft of or physical damage to motorcycles from the types of insurance for which the Rate Bureau sets rates.

Section 2 would remove language in G.S. §58-36-1(3) that is reorganized and transferred to **proposed §58-36-3.**

Section 3 would create a new statutory section **"G.S. §58-36-3. Limitation of scope; motorcycle endorsements allowed"** which restructures, in list form, the types of insurance excluded from the Rate Bureau's jurisdiction, previously located in G.S. §58-36-1(3), and adds to that list "insurance against theft of or physical damage to motorcycles". The new section would also provide that insurers that write both liability coverage for motorcycles under Article 36 and coverage against theft of or physical damage to motorcycles under Article 40 can incorporate the coverage against theft of or physical damage to motorcycles as an endorsement to the liability policy issued.

Section 4 would amend G.S. §58-37-1(6) in Article 37 to clarify that motorcycles are included in the definition of motor vehicles for purposes of the Article.

Section 5 would amend G.S. §58-40-15 to include coverage against theft of or physical damage to motorcycles in the provisions of Article 40 (by excluding it from exceptions to coverage).

Section 6 would make the act effective January 1, 2002, but would provide that rates, rating systems, territories, classifications, and policy forms lawfully in use on that date can continue to be used past that date.

MINUTES
HOUSE COMMITTEE ON INSURANCE
August 1, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on August 1, 2001, at 12:00 noon. Representative Dockham called the meeting to order and introduced the page, Jermaine Cross (Gates County – Representative Culpepper). The following Committee members were present: Representative Hurley, Co-Chair, and Representatives Barbee, Blue, Grady, Justus, Setzer, Smith, and Wilson. Frank Folger, Staff Counsel, was in attendance. A list of visitors attending is attached. The following bills were considered:

HB 808, entitled, AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY. Rep. Dockham made a motion to appoint a sub-committee to study the bill. The Committee shall include Rep. Hall, Chair, and Members, Representatives Barbee, Dedmon, Dockham, Hurley, Redwine, and Smith. The motion passed.

Representative Dockham indicated since he is the primary sponsor of HB 355 under consideration, he requested Representative Hurley to preside over the remaining portion of the meeting.

HB 355, entitled, AN ACT TO PROVIDE THAT THE DEPARTMENT OF INSURANCE IS NOT LIABLE FOR COSTS INCURRED IN SATISFYING THE FISCAL NOTE REQUIREMENT FOR CHANGES IN THE STATE BUILDING CODE; TO UPDATE REFERENCES TO ORGANIZATIONS WHOSE STANDARDS MAY BE USED IN ADOPTING CODE PROVISIONS; TO GIVE THE BUILDING CODE COUNCIL EXPLICIT AUTHORITY TO USE STANDARDS OF INTERNATIONAL AGENCIES; TO MAKE TECHNICAL CORRECTIONS IN THE BUILDING CODE COUNCIL STATUTES; TO PROHIBIT MEMBERS OF THE MANUFACTURED HOUSING AND HOME INSPECTOR LICENSING BOARDS FROM SPONSORING OR PROVIDING CONTINUING EDUCATION COURSES WHILE SERVING ON THE BOARD; TO AUTHORIZE THE MANUFACTURING HOUSING BOARD TO ADOPT TEMPORARY RULES REGARDING CONTINUING EDUCATION REQUIREMENTS; TO CLARIFY THAT SALES MANAGERS OF MANUFACTURED HOUSING RETAIL DEALER SHALL BE LICENSED AS SALESPERSONS; TO ENSURE THAT BUILDING INSPECTORS APPLY THE MANUFACTURES HOME INSTALLATION STANDARDS; TO MAKE A TECHNICAL CORRECTION IN THE FIREMEN'S RELIEF FUND LAW; AND TO AMEND THE BEACH PLAN LAW REGARDING LOSS ADJUSTMENT EXPENSE REIMBURSEMENTS. Representative Hurley recognized Bill Hale, NC Department of Insurance, to explain the bill and the changes made by the Senate. This bill would remove Department of Insurance liability for costs incurred in fiscal note preparation by entities other than the Department or the Building Code Council; update, correct and generally enhance flexibility in Council and building code provisions; as to the manufactured housing industry, prohibit certain "interested " transactions (accompanying the same prohibition for the home inspector field), allow temporary rulemaking, clarify certain licensing requirements, and ensure building inspector application of installation standards; technically correct the Firemen's Relief Fund law; and amend certain reimbursement provisions in the Beach Plan law. The Senate committee substitute makes the following changes: Conforms bill to GS 143-138(a), as rewritten by sec. 1 of S.L. 2001-141 (making certain features of Code amendments subject to Administrative Procedure Act). Also amends GS 143-138(a) to provide that neither the Dep't of Insurance (DOI) nor the Building Code Council (BCC) is required to pay for the preparation of fiscal note by any person outside of DOI or BCC unless one of them contracts with a third-party vendor to prepare it. Amends GS 150B-21.5(d), as rewritten by sec. 5 of S.L. 2001-141, to provide that the BCC is required to publish a notice of rule-making proceeding in the North Carolina Register when it proposes to adopt a rule that concerns the Code. Makes conforming changes to that subsection, as rewritten by sec. 6 of S.L. 2001-141. Conforms

GS 143-138(d) to changes made by sec. 2 of S.L. 2001-141, eliminating references to triennial revisions to the Code. Amends GS 143-143.9(9) to provide that licensing requirements for manufactured home salespersons apply to sales managers, lot managers, general managers, or others who manage or supervise salespersons. Amends GS 143-143.11B(a) to prohibit members of the Manufactured Housing Board from sponsoring or providing continuing education courses while serving on the board. Amends GS 143-151.64(a) to prohibit the same thing with respect to members of the Home Inspector Licensure Board. Adds new GS 150B-21.1(a6) to authorize the Manufactured Housing Board to adopt temporary rules regarding continuing education requirements. Amends GS 143-151.8(2) to provide that the Code includes the North Carolina Standard for the Installation of Manufactured/Mobile Homes adopted by the Comm'r of Insurance, thus ensuring that building inspectors enforce these requirements. Makes technical correction to GS 58-84-46 (Firemen's Relief Fund). Amends GS 58-45-50 to provide for an appeal of a decision of the North Carolina Insurance Underwriting Ass'n with respect to the reimbursement to the insurer for reasonable expenses incurred by the insurer in adjusting windstorm and hail losses. Makes editorial changes to GS 58-45-35(e). Makes those sections of the bill affecting the State Building Code effective with respect to revisions made to the Code on or after Jan. 2002. One of the changes the Senate made in this bill was to give the Manufactured Housing Board authority to adopt temporary rules on continuing education course approvals. The Board already has authority to adopt rules for a continuing education program for its licensees (dealers, salespersons, and set-up contractors). The Board is currently working on these rules, and has filed a notice of intent in the NC Register (the first step). However, before the Board can require licensees to comply with any continuing education program, continuing education courses must be in place. In order to approve courses, rules must be in place. These course approval rules need to be in effect before the other rules for the program. The only way to do that given the timetable is to let the board go ahead and adopt rules on a temporary basis. Representative Connie Wilson noted the Board doesn't need this temporary rulemaking authority forever. She suggested having the authority expire (sunset) on June 30, 2002, because once the Board adopts these temporary rules, they go on to become permanent rules through the normal APA rulemaking process. Representative Wilson made the motion not to concur. With no dissenting votes, the motion passed.

There being no further business, the meeting was adjourned at 12:25 p.m.

Respectfully submitted,

Representative Jerry C. Dockham
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
House Bill 808, HB 355
Bill Summary
Handout

VISITOR REGISTRATION SHEET

INSURANCE — August 1, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
R. Paul Wilms	NCHBA
Mary Carmilia	REBIC
Jay Peters	JPAssoc/MANSE
[illegible]	NCAHP
[illegible]	Young, Moore
Margaret Westbrook	Kennedy Covington
Euphanie Mann	NCAR
Brad Lovin	NC Manufactured Housing Coal.
Dascheil Propes	NCDOI
Grant Gray	N.C. Man. Housing Inst.
[illegible]	NCAHP

VISITOR REGISTRATION SHEET

INSURANCE — August 1, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	Moore & Van Allen

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 808*

Short Title:	Mental Health/Chemical Dep. Parity.	(Public)
Sponsors:	Representatives Alexander, Baddour, Hackney, Wainwright; Adams, Barefoot, Bell, Blue, Boyd-McIntyre, Buchanan, Church, Cole, Cox, Crawford, Cunningham, Davis, Earle, Easterling, Fitch, Fox, Goodwin, Haire, Hall, Hill, Holliman, Insko, Jarrell, Jeffus, Lucas, Luebke, McAllister, Michaux, Nesbitt, Oldham, Russell, Saunders, Tolson, Warner, Weiss, G. Wilson, Womble, and Yongue.	
Referred to:	Rules, Calendar, and Operations of the House.	

March 26, 2001

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-50 reads as rewritten:

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

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

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

(2) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(3) 'Insurer' has the same meaning as in G.S. 58-3-167.

(b) Every insurer ~~that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds~~ shall provide in each group health benefit plan benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for treatment of chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles,

coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. – An insurer may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. – Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

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

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

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

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

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

a. Chemical dependency units in licensed facilities; ~~facilities licensed after October 1, 1984;~~

b. Medical units;

c. Psychiatric units; and

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

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

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

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

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

SECTION 2. G.S. 58-51-55 reads as rewritten:

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

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

(b) Coverage of Physical Illness. – No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

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

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

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

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

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

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

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires an insurer to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-51-50.~~

~~(d) Applicability. Subsection (b1) of this section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).~~"

SECTION 3. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

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

(a) Mental Health Parity Requirement. – An insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Average. – If a health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Case Management. – An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules may ensure only that case management programs are not designed to avoid the requirement of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Medical Necessity. – Nothing in this section prohibits a group health benefit plan from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary.

(e) Definitions. – As used in this section:

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(2) 'Insurer' has the same meaning as in G.S. 58-3-167.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes."

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

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

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

(b) Chemical Dependency Parity Requirement. – Every group insurance certificate or group subscriber contract under any hospital or medical plan governed by this Article and Article 66 of this Chapter ~~that is issued, renewed, or amended on or after January 1, 1985, shall offer~~ shall provide to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. ~~Except as provided in subsection (c) of this section, benefits~~Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a hospital or medical plan governed by this Article contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, then the group insurance certificate or group subscriber contract may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. – A group insurance certificate or group subscriber contract may use a case management program for chemical dependency treatment benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. – Nothing in this section prohibits a hospital or medical plan governed by this Article from managing the provision of benefits through common methods, including, but not limited, to preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

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

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

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

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

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

a. Chemical dependency units in ~~facilities licensed after October 1, 1984;~~licensed facilities;

b. Medical units;

c. Psychiatric units; and

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

a. Chemical dependency units in psychiatric hospitals;

b. Chemical dependency hospitals;

c. Residential chemical dependency treatment facilities;

d. Social setting detoxification facilities or programs;

e. Medical detoxification facilities or programs; and

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

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

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

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

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-65-75~~58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions of this manual.

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

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

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

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

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

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

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

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

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

~~(4) Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the subscriber contract,~~

~~including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.~~

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires a service corporation to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-65-75.~~

~~(d) Applicability. Subsection (b1) of this section applies only to subscriber contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

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

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

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

(b) Chemical Dependency Requirement. – ~~On and after January 1, 1985, every~~Every health maintenance organization that writes a health care plan on a group basis and that is subject to this Article shall ~~offer~~ provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits under the health care plan generally. ~~Except as provided in subsection (c) of this section, benefits~~ Benefits for chemical dependency shall be subject to the same ~~durational limits, dollar limits, deductibles, and coinsurance factors~~ limits as are benefits under the health care plan generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b1) Weighted Average. – If a group health plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, then the health maintenance organization may impose limits on the chemical dependency treatment benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(b2) Case Management. – A health maintenance organization may use a case management program for chemical dependency treatment benefits to evaluate and

determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner. These rules shall only ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for chemical dependency treatment and those for physical illness generally.

(b3) Medical Necessity. – Nothing in this section prohibits a health maintenance organization from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for chemical dependency treatment only to those that are deemed medically necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in ~~G.S. 58-67-70~~G.S. 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Disorders, DSM-IV, or subsequent editions of this manual.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c) Mental Illness or Chemical Dependency Coverage Not Required. Nothing in this section requires an HMO to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-67-70.~~

~~(d) Applicability. Subsection (b1) of this section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~"

SECTION 8. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Treatment of chemical dependency and mental illness that is at least equal to the coverage required by G.S. 58-51-50 and G.S. 58-3-220, respectively. The Plan may use a case management program in accordance with G.S. 58-51-50 and G.S. 58-3-220, respectively.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers."

SECTION 9. This act becomes effective January 1, 2002, and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after that date. 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.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE.**

☒ Senate Committee Substitute for
H.B. 355 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THE DEPARTMENT OF INSURANCE IS NOT LIABLE FOR COSTS INCURRED IN SATISFYING THE FISCAL NOTE REQUIREMENT FOR CHANGES IN THE STATE BUILDING CODE; TO UPDATE REFERENCES TO ORGANIZATIONS WHOSE STANDARDS MAY BE USED IN ADOPTING CODE PROVISIONS; TO GIVE THE BUILDING CODE COUNCIL EXPLICIT AUTHORITY TO USE STANDARDS OF INTERNATIONAL AGENCIES; TO MAKE TECHNICAL CORRECTIONS IN THE BUILDING CODE COUNCIL STATUTES; TO PROHIBIT MEMBERS OF THE MANUFACTURED HOUSING AND HOME INSPECTOR LICENSING BOARDS FROM SPONSORING OR PROVIDING CONTINUNG EDUCATION COURSES WHILE SERVING ON THE BOARD; TO AUTHORIZE THE MANUFACTURED HOUSING BOARD TO ADOPT TEMPORARY RULES REGARDING CONTINUING EDUCATION REQUIREMENTS; TO CLARIFY THAT SALES MANAGERS OF A MANUFACTURED HOUSING RETAIL DEALER SHALL BE LICENSED AS SALESPERSONS; TO ENSURE THAT BUILDING INSPECTORS APPLY THE MANUFACTURED HOME INSTALLATION STANDARDS; TO MAKE A TECHNICAL CORRECTION IN THE FIREMEN'S RELIEF FUND LAW; AND TO AMEND THE BEACH PLAN LAW REGARDING LOSS ADJUSTMENT EXPENSE REIMBURSEMENTS.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☒ With recommendation that the House do not concur.

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

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

☐ Without prejudice.
2/15/01

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 3

HOUSE BILL 355*

Committee Substitute Favorable 4/16/01

Senate Commerce Committee Substitute Adopted 7/18/01

Short Title: State Building Code Changes-AB. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE DEPARTMENT OF INSURANCE IS NOT LIABLE FOR COSTS INCURRED IN SATISFYING THE FISCAL NOTE REQUIREMENT FOR CHANGES IN THE STATE BUILDING CODE; TO UPDATE REFERENCES TO ORGANIZATIONS WHOSE STANDARDS MAY BE USED IN ADOPTING CODE PROVISIONS; TO GIVE THE BUILDING CODE COUNCIL EXPLICIT AUTHORITY TO USE STANDARDS OF INTERNATIONAL AGENCIES; TO MAKE TECHNICAL CORRECTIONS IN THE BUILDING CODE COUNCIL STATUTES; TO PROHIBIT MEMBERS OF THE MANUFACTURED HOUSING AND HOME INSPECTOR LICENSING BOARDS FROM SPONSORING OR PROVIDING CONTINUING EDUCATION COURSES WHILE SERVING ON THE BOARD; TO AUTHORIZE THE MANUFACTURED HOUSING BOARD TO ADOPT TEMPORARY RULES REGARDING CONTINUING EDUCATION REQUIREMENTS; TO CLARIFY THAT SALES MANAGERS OF A MANUFACTURED HOUSING RETAIL DEALER SHALL BE LICENSED AS SALESPERSONS; TO ENSURE THAT BUILDING INSPECTORS APPLY THE MANUFACTURED HOME INSTALLATION STANDARDS; TO MAKE A TECHNICAL CORRECTION IN THE FIREMEN'S RELIEF FUND LAW; AND TO AMEND THE BEACH PLAN LAW REGARDING LOSS ADJUSTMENT EXPENSE REIMBURSEMENTS.

The General Assembly of North Carolina enacts:

PART I. BUILDING CODE AND BUILDING CODE COUNCIL.

SECTION 1.1. G.S. 143-138(a), as rewritten by Section 1 of S.L. 2001-141, reads as rewritten:

"(a) Preparation and Adoption. – The Building Code Council ~~is hereby empowered to~~ may prepare and adopt, in accordance with the provisions of this Article,

a North Carolina State Building Code. ~~Prior to~~ Before the adoption of ~~this~~ the Code, or any part ~~thereof~~, of the Code, the Council shall hold at least one public hearing. A notice of ~~such~~ the public hearing shall be published in the North Carolina Register at least 15 days ~~prior to~~ before the date of the hearing. Notwithstanding G.S. 150B-2(8a)h., the North Carolina State Building Code as adopted by the Building Code Council is a rule within the meaning of G.S. 150B-2(8a) and shall be adopted in accordance with the procedural requirements of Article 2A of Chapter 150B of the General Statutes.

The Council shall request the Office of State Budget, Planning, and Management to prepare a fiscal note for a proposed Code change that has a substantial economic impact, as defined in G.S. 150B-21.4(b1), or that increases the cost of residential housing by eighty dollars ($80.00) or more per housing unit. The change can become effective only in accordance with G.S. 143-138(d). Neither the Department of Insurance nor the Council shall be required to expend any monies to pay for the preparation of any fiscal note under this section by any person outside of the Department or Council unless the Department or Council contracts with a third-party vendor to prepare the fiscal note."

SECTION 1.2. G.S. 143-138(c) reads as rewritten:

"(c) Standards to Be Followed in Adopting the Code. – All regulations contained in the North Carolina State Building Code shall have a reasonable and substantial connection with the public health, safety, morals, or general welfare, and their provisions shall be construed reasonably to those ends. Requirements of the Code shall conform to good engineering practice. The Council may use as guidance, but is not required to adopt, the requirements of the ~~National Building Code of the American Insurance Association, formerly the National Board of Fire Underwriters, the Southern~~ International Building Code of the International Code Council, the Standard Building Code of the Southern Building Code ~~Congress,~~ Congress International, Inc., the Uniform Building Code of the ~~Pacific Coast Building Officials Conference,~~ International Conference of Building Officials, the ~~Basic~~ National Building Code of the Building Officials ~~Conference of America, Inc.,~~ and Code Administrators, Inc., the National Electric Code, the Life Safety ~~Code~~ Code, the National Fuel Gas Code, ~~and~~ the Fire Prevention Code of the National Fire Protection Association, the ~~American Standard~~ Safety Code for ~~Elevators, Dumbwaiters,~~ Elevators and Escalators, and the Boiler and Pressure Vessel Code of the American Society of Mechanical Engineers, ~~Standards of the American Insurance Association for the Installation of Gas Piping and Gas Appliances in Buildings,~~ and standards promulgated by the ~~United States of America~~ American National Standards Institute, ~~formerly the American Standards Association,~~ Underwriters' Laboratories, Inc., and similar national or international agencies engaged in research concerning strength of materials, safe design, and other factors bearing upon health and safety."

SECTION 1.3. G.S. 150B-21.5(d), as enacted by Section 5 of S.L. 2001-141, reads as rewritten:

"(d) State Building Code. – The Building Code Council is not required to publish a notice of text in the North Carolina Register when it proposes to adopt a rule that

concerns the North Carolina State Building Code. The Building Code Council is required to publish a notice of rule-making proceeding in the North Carolina Register when it proposes to adopt a rule that concerns the North Carolina State Building Code. The Building Code Council is required to submit to the Commission for review a rule for which notice and hearing is not required under this subsection. In adopting a rule, the Council shall comply with the procedural requirements of G.S. 150B-21.3."

SECTION 1.4. G.S. 150B-21.17(a), as rewritten by Section 6 of S.L. 2001-141, reads as rewritten:

"(a) Content. – The Codifier of Rules must publish the North Carolina Register. The North Carolina Register must be published at least two times a month and must contain the following:

(1) Temporary rules entered in the North Carolina Administrative Code.

(1a) Notices of rule-making proceedings, the text of proposed rules, and the text of permanent rules approved by the Commission. ~~This~~ Except with regard to notices of rule-making proceedings, this subdivision does not apply to the North Carolina State Building Code.

(2) Notices of receipt of a petition for municipal incorporation, as required by G.S. 120-165.

(3) Executive orders of the Governor.

(4) Final decision letters from the United States Attorney General concerning changes in laws that affect voting in a jurisdiction subject to section 5 of the Voting Rights Act of 1965, as required by G.S. 120-30.9H.

(5) Orders of the Tax Review Board issued under G.S. 105-241.2.

(6) Other information the Codifier determines to be helpful to the public."

SECTION 1.5. G.S. 143-138(d), as rewritten by Section 2 of S.L. 2001-141, reads as rewritten:

"(d) Amendments of the Code. – The Building Code Council may revise and amend the North Carolina State Building Code, either on its own motion or upon application from any citizen, State agency, or political subdivision of the State. In adopting any amendment, the Council shall comply with the same procedural requirements and the same standards set forth above for adoption of the Code.

Handbooks providing explanatory material on Code provisions shall be provided no later than January 1, 2000, and shall be updated with each ~~triennial~~ revision of the Code or, in the discretion of the Council, more frequently. The Department may charge a reasonable fee for the handbooks."

PART II. MANUFACTURED HOUSING, CODE OFFICIALS, AND HOME INSPECTOR BOARDS.

SECTION 2.1. G.S. 143-143.9(9) reads as rewritten:

"(9) Manufactured home salesperson or salesperson. – Any person employed by a manufactured home dealer to sell manufactured homes

to buyers. Manufactured home salesperson or salesperson also includes sales managers, lot managers, general managers, or others who manage or supervise salespersons."

SECTION 2.2. G.S. 143-143.11B(a) reads as rewritten:

"(a) The Board may establish programs and requirements of continuing education for licensees, but shall not require licensees to complete more than eight credit hours of continuing education. ~~Prior to~~ Before the renewal of a license, a licensee shall present evidence to the Board that ~~he or she~~ the licensee has completed the required number of continuing education hours in courses approved by the Board during the two months immediately preceding the expiration of ~~his or her~~ the licensee's license. No member of the Board shall provide or sponsor a continuing education course under this section while that person is serving on the Board."

SECTION 2.3. G.S. 150B-21.1 is amended by adding a new subsection to read:

"(a6) Notwithstanding the provisions of subsection (a) of this section, the Manufactured Housing Board may adopt temporary rules regarding continuing education course approval under G.S. 143-143.11B(c). After having the proposed temporary rule published in the North Carolina Register and at least 30 days prior to adopting a temporary rule pursuant to this subsection, the Board shall:

(1) Notify persons on its mailing list maintained pursuant to G.S. 150B-21.2(d) and any other interested parties of its intent to adopt a temporary rule;

(2) Accept oral and written comments on the proposed temporary rule; and

(3) Hold at least one public hearing on the proposed temporary rule.

When the Board adopts a temporary rule pursuant to this subsection, the Board must submit a reference to this subsection as the Board's statement of need to the Codifier of Rules.

Notwithstanding any other provision of this Chapter, the Codifer of Rules shall publish in the North Carolina Register a proposed temporary rule received from the Board in accordance with this subsection."

SECTION 2.4. G.S. 143-151.8(2) reads as rewritten:

"(2) 'Code' means the North Carolina State Building Code and related local building rules approved by the Building Code Council ~~heretofore or hereinafter~~ enacted, adopted or approved ~~pursuant to~~ under G.S. 143-138, ~~and~~ any resolution adopted by a federally recognized Indian Tribe under G.S. 153A-350.1 in which the Tribe adopts the North Carolina State Building Code and related local building ~~rules.~~ rules, and the North Carolina Standard for the Installation of Manufactured/Mobile Homes adopted by the Commissioner of Insurance under G.S. 143-146(e)."

SECTION 2.5. G.S. 143-151.64(a) reads as rewritten:

"(a) Requirements. – The Board may establish programs of continuing education for licensees under this Article. A licensee subject to a program under this section shall present evidence to the Board upon the license renewal following initial licensure, and every renewal thereafter, that during the 12 months preceding the annual license expiration date the ~~person~~ licensee has completed the required number of classroom hours of instruction in courses approved by the Board. Annual continuing education hour requirements shall be determined by the Board, but shall not be more than 12 credit hours. No member of the Board shall provide or sponsor a continuing education course under this section while that person is serving on the Board."

PART III. FIREMEN'S RELIEF FUND TECHNICAL CORRECTION.

SECTION 3. G.S. 58-84-46 reads as rewritten:

"**§ 58-84-46. Certification to Commissioner.**

On or before October 31 of each year the clerk or finance officer of each ~~fire district~~ city or county that has a local board of trustees under G.S. 58-84-30 shall file a certificate of eligibility with the Commissioner. The certificate shall contain information prescribed by administrative rule adopted by the Commissioner. If the certificate is not filed with the Commissioner on or before January 31 in the ensuing year:

(1) The ~~fire district~~ city or county that failed to file the certificate shall forfeit the payment next due to be paid to its board of trustees.

(2) The Commissioner shall pay over that amount to the treasurer of the North Carolina State Firemen's Association.

(3) That amount shall constitute a part of the Firemen's Relief Fund."

PART IV. BEACH PLAN LOSS ADJUSTMENT REIMBURSEMENTS.

SECTION 4.1. G.S. 58-45-35(e) reads as rewritten:

"(e) Policies of windstorm and hail insurance provided for in subsection (b) of this section are available only for risks in the beach and coastal areas for which essential property insurance has been written by licensed insurers. Whenever such other essential property insurance written by licensed insurers includes replacement cost coverage, the Association shall also offer replacement cost coverage. In order to be eligible for a policy of windstorm and hail insurance, the applicant shall provide the Association, along with the premium payment for the windstorm and hail insurance, a certificate that the essential property insurance is in force. The policy forms for windstorm and hail insurance shall be filed by the Association with the Commissioner for ~~his~~ the Commissioner's approval before they may be used. Catastrophic losses, as determined by the Association and approved by the Commissioner, that are covered under the windstorm and hail coverage in the beach and coastal areas shall be adjusted by the licensed insurer that issued the essential property insurance and not by the Association. ~~Expenses incurred by the licensed insurer in adjusting windstorm and hail losses shall~~

~~be reimbursed by the Association.~~ The Association shall reimburse the insurer for reasonable expenses incurred by the insurer in adjusting windstorm and hail losses."

SECTION 4.2. 58-45-50 reads as rewritten:

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

(a) Any person or any insurer who may be aggrieved by an act, ~~ruling~~ ruling, or decision of the Association other than an act, ~~ruling~~ ruling, or decision relating to (i) the cause or amount of a claimed ~~loss,~~ loss or (ii) the reasonableness of expenses incurred by an insurer in adjusting windstorm and hail losses, may, within 30 days after the ruling, appeal to the Commissioner. Any hearings held by the Commissioner under the appeal shall be in accordance with rules adopted by the Commissioner: Provided, however, the Commissioner is authorized to appoint a member of the Commissioner's staff as deputy commissioner for the purpose of hearing those appeals and a ruling based upon 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 in G.S. 58-2-75.

(b) No later than 10 days before each hearing, the appellant shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellee a written statement of the appellant's case and any evidence that the appellant intends to offer at the hearing. No later than five days before the hearing, the appellee shall file with the Commissioner or the designated hearing officer and shall serve on the appellant a written statement of the appellee's case and any evidence that the appellee intends to offer at the hearing. Each hearing shall be recorded and may be transcribed. If the matter is between an insurer and the Association, the cost of 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 the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or the designated hearing officer and serve on the other party, a proposed order. The Commissioner or the designated hearing officer shall then issue an order."

PART V. EFFECT OF HEADINGS, SEVERABILITY, AND EFFECTIVE DATE.

SECTION 5.1. 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.

SECTION 5.2. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 5.3. This act is effective when it becomes law. Sections 1.1, 1.3, 1.4, and 1.5 apply to revisions made to the North Carolina State Building Code on or after January 1, 2002.

HOUSE BILL 355:
State Building Code Changes-AB

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Dockham
Date:	July 31, 2001	**Summary by:**	Frank W. Folger
Version:	Third Edition		Committee Counsel

SUMMARY: ***This bill would remove Department of Insurance (Department) liability for costs incurred in fiscal note preparation by entities other than the Department or the Building Code Council (Council); update, correct and generally enhance flexibility in Council and building code provisions; as to the manufactured housing industry, prohibit certain "interested" transactions (accompanying the same prohibition for the home inspector field), allow temporary rulemaking, clarify certain licensing requirements, and ensure building inspector application of installation standards; technically correct the Firemen's Relief Fund law; and amend certain reimbursement provisions in the Beach Plan law.***

BILL ANALYSIS: The bill would:

(SECTION 1.1) Provide that the Department of Insurance is not liable for costs incurred in satisfying the fiscal note requirement for changes in the State Building Code.

Current law: The Council must request preparation of a fiscal note by the Office of State Budget, Planning, and Management for proposed changes to the State Building Code (Code) if the change has a "substantial economic impact".

(SECTION 1.2) Update references to organizations whose standards may be used in adopting code provisions; and expressly authorize the Council to use standards of international agencies.

Current law: The Council may use as guidance in adopting standards to the Code the requirements of a number of organizations listed in G.S. 143-138(c). The list is not current.

(SECTIONS 1.3 and 1.4) Clarify that the Council must publish notice of rule-making proceedings in the North Carolina Register.

Current law: The intent of S.L. 2001-141,which amended portions of G.S. 150B-21.5 and 150B-21.17 among other statutes, was to make the Code subject to the Administrative Procedure Act. The language needs a technical correction.

(SECTION 1.5) Technically correct to remove the reference to the periodic (triennial) revision of the Code.

Current law: The Code will be revised as provided by the APA (see above). This language needs a technical correction.

(SECTION 2.1) Clarify that sales managers of a manufactured housing retail dealer shall be licensed as salespersons;

Current law: There is no provision for licensing of a sales manager, lot manager, or general manager of salespersons of manufactured homes. The impetus for the proposal is that certain salespeople in the industry who had been stripped of their sales licenses have resurfaced as "sales managers" and "lot managers", which currently have no licensing requirements, to skirt the licensing requirement. The provision is designed to remove that loophole.

(SECTIONS 2.2 and 2.5) Prohibit members of manufactured housing and home inspector licensing boards from sponsoring or providing continuing education courses while serving on the board.

Current law: There is no statutory provision expressly prohibiting the conduct.

(SECTION 2.3) Authorize the manufactured housing board to adopt temporary rules regarding continuing education.

Current law: There is no existing provision.

(SECTION 2.4) Ensure that building inspectors apply manufactured home and mobile home installation standards.

Current law: These standards are not specifically referenced in the statute

(SECTION 3) Technically correct the Firemen's Relief Fund provision on certification to the Commissioner by allowing a "finance officer" in addition to a clerk file the certificate and to replace reference to "fire district" with "city or county".

Current law: Needs technical correction.

(SECTIONS 4.1 and 4.2) Amend the Beach Plan law regarding loss adjustment expense reimbursements to qualify that "reasonable" expenses only will be reimbursed and that "reasonableness" can be the basis of a challenge by a person or insurer to the ruling of the North Carolina Insurance Underwriting Association.

*Current law: The licensed insurer is entitled to be reimbursed by the Association for expenses incurred (*unqualified) *in adjusting windstorm and hail losses. Correspondingly, appeal from an act, ruling or decision of the Association can be based on the cause or amount of a claimed loss.*

Effective when it becomes law. Sections 1.1, 1.3, 1.4, and 1.5 apply to revisions to the Code on or after January 1, 2002.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

August 1, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 355 – Building Code, Manufactured Housing, Continuing Education, and Other Amendments

PART I. BUILDING CODE AND BUILDING CODE COUNCIL.

SECTION 1.1. Current law requires a fiscal note for any change in the State Building Code that will increase the cost of a new home by $80 or more. The Department of Insurance provides staff support for the Building Code Council. Aside from making stylistic changes, this section provides that if for some reason the job of preparing the fiscal note is contracted out, neither the Department nor the Council has to pay for the job unless the Department or Council actually contracts the job out.

SECTION 1.2. Updates references to organizations that set standards that the Council may use in making changes in the Code. Most of the references are to organizations whose names have changed over the years. Also clarifies the fact that the Council may adopt international standards.

SECTION 1.3. Clarifies that the Council is required to publish a notice of rule-making proceedings or notice of text in the North Carolina Register. This carries forward the intent of 2001 legislation making the Building Code subject to the Administrative Procedure Act (S.L. 2001-141 – S.B. 1036).

SECTION 1.4. Makes a conforming amendment necessitated by the legislation mentioned in SECTION 1.3. The law previously had the Council on a triennial cycle for Code changes. That provision was repealed when the Code was made subject to the APA.

PART II. MANUFACTURED HOUSING, CODE OFFICIALS, AND HOME INSPECTOR BOARDS.

SECTION 2.1. Closes a licensing loophole with respect to manufactured home sales persons.

SECTION 2.2. Prohibits members of the Manufactured Housing Board from providing or sponsoring continuing education courses for licensees.

SECTION 2.3. Authorizes the Manufactured Housing Board to adopt temporary rules to speed up the approval of continuing education courses, because much lead-time is needed to implement the continuing education program authorized by law.

SECTION 2.4. Ensures that building inspectors will apply the manufactured and mobile home installation standards.

SECTION 2.5. Prohibits members of the Home Inspector Licensure Board from providing or sponsoring continuing education courses for licensees.

PART III. FIREMENS' RELIEF FUND TECHNICAL CORRECTION.

SECTION 3. Corrects language from a law enacted in 2000 dealing with reports from local governments to the administrators of the Firemen's Relief Fund.

PART IV. BEACH PLAN LOSS ADJUSTMENT REIMBURSEMENTS.

SECTION 4.1. Makes a technical and clarifying change to the Beach Plan law that deals with reimbursements to insurers from the Plan for adjusting windstorm and hail losses.

SECTION 4.2. Makes a conforming amendment to the appeals provision so the Commissioner does not have to rule on disputes between the Plan and insurers on adjustment reimbursements.

MINUTES
HOUSE COMMITTEE ON INSURANCE
October 17, 2001

The House Committee on Insurance met in Room 1228 of the Legislative Building on October 17, 2001. At 12:05 p.m. Representative Hurley called the meeting to order. The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Barbee, Hall, Saunders, Setzer, and Warner. Linda Attarian and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached. The following bill was considered:

HB 13 entitled, AN ACT TO PROHIBIT INSURANCE COMPANIES FROM RECOMMENDING THAT INSURANCE CLAIMANTS OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES WITHOUT INFORMING THEM OF THEIR OPTIONS; TO AMEND THE SURPLUS LINES LAW TO CONFORM IT TO THE GRAMM-LEACH-BLILEY ACT; AND TO CORRECT AN ERROR IN AN AMENDMENT TO THE WORKERS' COMPENSATION ACT. Representative Hurley recognized Bill Hale, NC Department of Insurance, to explain the bill and the changes made by the Senate. This bill would prohibit an insurer or insurer's representative from recommending a claimant use a particular motor vehicle repair service without disclosing to the claimant the claimant's right to choose any repair service with no penalty in the amount payable for repairs under the policy; amend the surplus lines law to conform it to the Gramm-Leach-Bliley Act; and correct an omission in the amendments to the Workers' Compensation Insurance cancellation and notice provisions. Effective date: Sect.1 – Apr. 1, 2002; Sects. 2 and 2.2 – Jan.1, 2002; bill remainder – when it becomes law. The following are the changes made by the Senate at the behest of the Department of Insurance, and will be included in all auto insurance policies beginning April 1, 2002.

- Requiring business produced by nonresident brokers to be countersigned in this State.
- Requiring premium taxes to be remitted by the person countersigning the business.

This will better ensure that nonresident surplus lines brokers properly conduct business and pay premium taxes in this State. Representative Sherrill, bill sponsor, was recognized and she agreed with the changes made by the Senate. After some discussion, Representative Hall made the motion to concur. With no dissenting votes, the motion passed.

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

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Regina M. Irwin
Assistant to the Committee

ATTACHMENTS
Visitor Registration Form
House Bill 13
Bill Summary
Handout

VISITOR REGISTRATION SHEET

INSURANCE — October 17, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Causey	McDonald & Myer, PLLC
Bill Scoggin	Kennedy Covington
Susan Valauri	Nationwide
Robert Paschal	Young, Moore
Perri Morgan	NFIB
Bob Price	Jordan Price
John McMillan	MFOS P.A.
[illegible]	Moore & Van Allen
Eddie Caldwell	Hofler Caldwell & Fendel, P.A.
[illegible]	NCAHP
Emily Fulghum	Smith Anderson

VISITOR REGISTRATION SHEET

INSURANCE — October 17, 2001

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NCAHP
	Capitol Group
	NCSSA

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Hurley & Dockham** (Chair/Chairs) for the Committee on **INSURANCE**.

☒ Senate Committee Substitute for
H.B. 13 A BILL TO BE ENTITLED AN ACT TO PROHIBIT INSURANCE COMPANIES FROM RECOMMENDING THAT INSURANCE CLAIMANTS OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES WITHOUT INFORMING THEM OF THEIR OPTIONS; TO AMEND THE SURPLUS LINES LAW TO CONFORM IT TO THE GRAMM-LEACH-BLILEY ACT; AND TO CORRECT AN ERROR IN AN AMENDMENT TO THE WORKERS' COMPENSATION ACT.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☒ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☐ With an indefinite postponement report.

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

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

2/15/01

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 3

HOUSE BILL 13

Committee Substitute Favorable 4/19/01

Senate Insurance and Consumer Protection Committee Substitute Adopted 10/3/01

Short Title: Motor Vehicle Repairs. (Public)

Sponsors:

Referred to:

January 29, 2001

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT INSURANCE COMPANIES FROM RECOMMENDING THAT INSURANCE CLAIMANTS OBTAIN MOTOR VEHICLE REPAIR SERVICES FROM PARTICULAR SOURCES WITHOUT INFORMING THEM OF THEIR OPTIONS; TO AMEND THE SURPLUS LINES LAW TO CONFORM IT TO THE GRAMM-LEACH-BLILEY ACT; AND TO CORRECT AN ERROR IN AN AMENDMENT TO THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-180, as amended by S.L. 2001-203, reads as rewritten:

"**§ 58-3-180. Motor vehicle repairs; selection by claimant.**

(a) A policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage.

(b) The amount determined by the insurer to be payable under a policy covering damage to a motor vehicle shall be paid regardless of the repair service or source selected by the claimant.

(b1) No insurer or insurer representative shall recommend the use of a particular motor vehicle repair service without clearly informing the claimant that (i) the claimant is under no obligation to use the recommended repair service, (ii) the claimant may use the repair service of the claimant's choice, and (iii) the amount determined by the insurer to be payable under the policy will be paid regardless of whether or not the claimant uses the recommended repair service.

(b2) The provisions of subsection (b1) of this section shall be included in nonfleet private passenger motor vehicle insurance policy forms promulgated by the Bureau and approved by the Commissioner.

(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and G.S. 58-33-46, provided that the maximum civil penalty that can be

assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars ($2,000).

(d) As used in this section, 'insurer representative' includes an insurance agent, limited representative, broker, adjuster, and appraiser."

SECTION 2. G.S. 58-21-70 reads as rewritten:

"**§ 58-21-70. Surplus lines licensees may accept business from other agents or ~~brokers.~~ brokers; countersignatures required; remittance of premium tax.**

(a) A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other duly licensed agent or broker, and the surplus lines licensee may compensate such agent or broker therefor.

(b) Every report filed by a nonresident licensee under G.S. 58-21-35(a) shall, before being filed with the Commissioner, be countersigned by a resident licensee or by a regulatory support organization. The resident licensee or regulatory support organization may charge the nonresident licensee a countersignature fee.

(c) Every resident licensee and regulatory support organization that countersigns a report under subsection (b) of this section is responsible for remitting the premium tax for the coverage, as specified in G.S. 58-21-85, to the Commissioner."

SECTION 2.1. Section 32 of Session Law 2001-203 reads as rewritten:

"**SECTION 32.** Section 28 of this act becomes effective ~~October 1, 2001.~~ January 1, 2002. Sections 25, 30, and this section are effective when they become law. The remaining sections of this act become effective July 1, 2002."

SECTION 2.2. G.S. 58-21-40(a), as amended by Section 28 of S.L. 2001-203, reads as rewritten:

"(a) A surplus lines regulatory support organization of surplus lines licensees shall be formed to:

(1) Facilitate and encourage compliance by resident and nonresident surplus lines licensees with the laws of this State and the rules and regulations of the Commissioner relative to surplus lines insurance;

(2) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market;

(3) Receive and disseminate to surplus lines licensees information about surplus lines insurance, including, without limitation, new electronic filing procedures approved by the Commissioner, changes in the list of eligible surplus lines insurers, and modifications in coverages, procedures, and requirements as may be requested by the Commissioner; and

(4) ~~Certify satisfactory evidence of current nonresident surplus lines licensure in this State by countersigning~~ Countersign nonresident produced surplus lines coverages and remit premium taxes for those coverages under G.S. 58-21-70 by means satisfactory to the Commissioner; and charge the nonresident surplus lines licensee a fee

for the certification and countersignature as approved by the Commissioner."

SECTION 3. G.S. 58-47-125 reads as rewritten:

"**§ 58-47-125. Admission and termination of group members.**

(a) Prospective group members shall submit applications for membership to the board. The board, a designated employee of the group, or TPA shall approve an application for membership under the bylaws of the group. Members shall have bona fide offices in this State and members' employees shall be primarily engaged in business activities within this State. Members shall receive certificates of coverage from the board on a form acceptable to the Commissioner.

(b) The group shall make available to the Commissioner properly executed applications and indemnity agreements for all members, on forms prescribed by the Commissioner. If the applications and indemnity agreements are not executed properly and maintained, the Commissioner may order the group to cease writing all new business until all of the agreements are executed properly and obtained.

(c) Members may elect to terminate their participation in a group and may be ~~canceled~~ terminated by the group under ~~G.S. 97-99~~ subsection (d) of this section and the bylaws of the group.

(d) A group may terminate a member's participation in the group on 30 days' written notice to the member. A group may terminate a member's participation in the group for nonpayment of premium on 10 days' written notice to the member. A member may terminate its participation in the group on 10 days' written notice to the group. Notices under this subsection shall be given by certified mail, return receipt requested. No termination by the group is effective until the notice is received by the member."

SECTION 4. Section 1 of this act becomes effective April 1, 2002, and applies to policies issued or renewed on and after that date. Sections 2 and 2.2 of this act become effective January 1, 2002. The remainder of this act is effective when it becomes law.

HOUSE BILL 13:
Motor Vehicle Repairs

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	Representative Sherrill
Date:	October 17, 2001	**Summary by:**	Frank W. Folger
Version:	3rd Edition		Committee Counsel

SUMMARY: ***This bill would prohibit an insurer or insurer's representative from recommending a claimant use a particular motor vehicle repair service without disclosing to the claimant the claimant's right to choose any repair service with no penalty in the amount payable for repairs under the policy; amend the surplus lines law to conform it to the Gramm-Leach-Bliley Act; and correct an omission in the amendments to the workers' compensation insurance cancellation and notice provisions. Eff. date: Sect.1 – Apr. 1, 2002; Sects. 2 and 2.2 – Jan.1, 2002; bill remainder – when it becomes law.***

CURRENT LAW: G.S. §58-3-180 Insurance policies covering damage to a motor vehicle must allow a claimant to select that claimant's repair service or source for the repair. The amount determined to be payable by the insurer must be paid regardless of the repair service or source selected by the claimant. Violators of this provision are subject to civil penalties of up to $2000, licensure or certification suspension or revocation or refusal of renewal, payment of restitution to any harmed person, and payment of restitution to any State agency for extraordinary administrative expenses incurred in the investigation and hearing of the violation.

Other Related Laws

G.S. §58-33-76 Prohibits an insurance company, agent, adjuster or appraiser from:

- Recommending the use of a particular service or source to repair property damage without clearly informing the claimant that the claimant is not required to use that service or source; or
- Accepting money or a gratuity from a repair service for recommending that repair service to a claimant.

Discounts agreed to by repair services are not violations of that section. A person violating the section is subject to the civil penalties provisions of §58-2-70 ($100-$1000 penalty and restitution orders) and to possible suspension, revocation, or nonrenewal of license under G.S. §58-33-45.

G.S. §58-33-80 Prohibits an agent or representative of any company doing the business of insurance from discriminating in favor of any person.

Administrative Code: 11 N.C.A.C 04.0423 [Ethical Standards], Subsection (c) Prohibits a claims management person, agent, agency employee, limited representative, broker, or other insurer's representative from recommending the use of a particular motor vehicle repair service without clearly inform the claimant that the claimant is not required to use the recommended repair service and that the claimant can choose the repair service.

BILL ANALYSIS:

Section 1. Would, in addition to the existing prohibitions, prohibit an insurer or insurer representative from recommending a claimant use a particular motor vehicle repair service or source of repairs without clearly informing the claimant that:

1. The claimant does not have to use the recommended repair service;
2. The claimant can use the repair service chosen by the claimant; and
3. The amount the insurer determines is payable under the policy will be paid whether or not the recommended repair service is used.

These notices would have to be included in the auto insurance policy forms promulgated by the N.C. Rate Bureau and approved by the Commissioner of Insurance. ("Insurance representative" is defined to include an agent, limited representative, broker, adjuster, or appraiser.)

Sections 2. 2, 2.1 and 2.2, Would conform the surplus lines law to the Gramm-Leach-Bliley Act by requiring:

- A resident licensee or regulatory support organization to countersign reports filed by a surplus lines carrier;
- The countersigning resident licensee or regulatory support organization to remit the premium taxes owed by the surplus lines carrier.

The consequence of this change would be to better ensure that the business of surplus lines carriers is being legitimately conducted in this State and that premium taxes owed by these carriers will be collected.

Section 3. Would correct an inadvertently created gap in the notice of cancellations requirements for workers' compensation insurance. Senate Bill 468, enacted as S.L. 2001-241 rewrote the laws governing cancellation and notice for workers' compensation but mistakenly omitted provisions for self-insurers' of workers' compensation. This amendment to G.S. 58-47-125 corrects the omission.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

October 17, 2001

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: House Bill 13 (Senate changes in Italics)

This bill says that an insurance company can not recommend that you take your car to a particular auto body shop without clearly informing you that the you do not have to use the recommended body shop, you can use the body shop of your choice, and the amount payable under the policy will be paid regardless of which body shop you go to. *This information will be included in all auto insurance policies beginning next April 1st.*

This bill also conforms the surplus lines law to the federal Gramm-Leach-Bliley Act by:

- *Requiring business produced by nonresident brokers to be countersigned in this State.*
- *Requiring premium taxes to be remitted by the person countersigning the business.*

This will better ensure that nonresident surplus lines brokers properly conduct business and pay premium taxes in this State.

Finally, the bill corrects a gap in the policy termination notice requirement law for workers' compensation insurance. Senate Bill 468, enacted as S.L. 2001-241, rewrote those laws but mistakenly omitted provisions for self-insured groups.