2002

HOUSE INSURANCE

MINUTES

HOUSE COMMITTEE ON INSURANCE
2002 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	Lisa Brown	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	Vandella Bradley	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

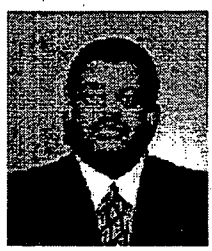
NORTH CAROLINA GENERAL ASSEMBLY

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

2002

DATES	10-01-02														
HURLEY, Bill CHAIR	X														
DOCKHAM, Jerry CHAIR	X														
BARBEE, Bobby VICE-CHAIR	X														
BLUE, Daniel															
BRUBAKER, Harold															
DEDMON, Andrew	X														
GRADY, Robert															
HALL, John VICE-CHAIR	X														
HUNTER, Howard															
JOHNSON, Linda	X														
JUSTUS, Larry T.															
REDWINE, David	X														
SAUNDERS, Drew															
SETZER, Mitchell	X														
SMITH, Ronald	X														
WAINWRIGHT, William, VICE-CHAIR															
WARNER, Alex															
WILSON, Connie	X														
Ex-Officio Members															
BADDOUR, Phil															
CUNNINGHAM, W. Pete															
EARLE, Beverly															
HACKNEY, Joe															

North Carolina General Assembly
Through House Committee on
Insurance

Date: 10/10/2002
Time: 11:42

Leg. Day: H-256/S-242

2001-2002 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
[illegible]=	Sherrill	MOTOR VEHICLE REPAIRS.	*HR	Ch. SL 2001-451	02-20-01	04-19-01
[illegible]=	Sherrill	MOTOR VEHICLE REPAIRS.	*HR	Ch. SL 2001-451	10-10-01	10-17-01
0036=	Nye	MANAGED CARE OMBUDSMAN.	HF	Postponed Indefinitely	02-01-01	10-01-02
0037=	Nye	HEALTH BENEFIT PLAN DISCLOSURE	HF	Postponed Indefinitely	02-01-01	10-01-02
0038=	Nye	DISCLOSE PAYMENT OBLIGATIONS.	HF	Postponed Indefinitely	02-01-01	10-01-02
0039=	Nye	PROVIDER DIRECTORIES.	HF	Postponed Indefinitely	02-01-01	10-01-02
0048=	Nye	CONTINUITY OF CARE.	HF	Postponed Indefinitely	02-05-01	10-01-02
0109=	Alexander	REIMBURSEMENT FOR MARRIAGE/FAMILY THERAPISTS.	HR	Ch. SL 2001-258	03-21-01	03-29-01
0164	Baker	ACCIDENT PREVENTION COURSE REDUCTION.	*HR	Ch. SL 2001-423	02-19-01	04-24-01
0181=	Adams	HMO CEASE AND DESIST.	HF	Postponed Indefinitely	02-20-01	10-01-02
0191=	Hurley	SELF-EMPLOYED DEDUCT HEALTH INS.	*HF	Postponed Indefinitely	02-22-01	04-09-01
0232=	Allen	BUDGET REVENUE PROVISIONS-2001	*HR	Ch. SL 2001-427	02-26-01	03-21-01
0346=	Hurley	INSURANCE PRODUCER LICENSING.	H	Ref To Com On Insurance	03-01-01	
0347=	Hurley	INSURANCE FINANCIAL AMENDMENTS.	H	Ref To Com On Insurance	03-01-01	
0348=	Hurley	TOBACCO ESCROW COMPLIANCE.	*HR	Ch. SL 2002-145	03-01-01	03-14-01
[illegible]=	Hurley	INSURANCE INFORMATION PRIVACY.	H	Ref To Com On Insurance	03-01-01	
0350=	Hurley	GRAMM-LEACH-BLILEY ACT REQUIREMENTS.	HR	Ch. SL 2001-215	03-01-01	04-04-01
0351=	Hurley	UTILIZATION REVIEW AND GRIEVANCE CHANGES.	*HR	Ch. SL 2001-417	03-01-01	04-23-01
0352=	Hurley	RISK SHARING PLAN SUNSET REPEAL.	HR	Ch. SL 2001-122	03-01-01	03-14-01
0353=	Dockham	WORKER'S COMP.CANCELLATIONS AND RENEWALS.	H	Ref To Com On Insurance	03-01-01	
0354=	Dockham	WORKERS' COMPENSATION AMENDMENTS.	H	Ref To Com On Insurance	03-01-01	
0355	Dockham	STATE BUILDING CODE CHANGES.	*HR	Ch. SL 2001-421	07-25-01	08-01-01
0356=	Dockham	COLLECTION AGENCY/ BAIL BOND AMENDMENTS.	*HR	Ch. SL 2001-269	03-01-01	04-10-01
0357=	Dockham	UMBRELLA INSURANCE IMPROVEMENTS.	*HR	Ch. SL 2001-236	03-01-01	03-14-01
0358=	Dockham	INSURANCE EXAM LAW AMENDMENTS.	H	Ref To Com On Insurance	03-01-01	
0359=	Dockham	VIATICAL SETTLEMENTS REWRITE.	*HR	Ch. SL 2001-436	03-01-01	06-19-01
0360=	Dockham	HEALTH INSURANCE OMNIBUS CHANGES.	*HR	Ch. SL 2001-334	03-01-01	04-24-01
0462	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.
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'=' indicates that the original bill is identical to another bill.

2001-2002 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		STUDENTS.				
3=	Alexander	HEALTH INSURANCE/ LICENSED PROF'L COUNSELOR	*HR	Ch. SL 2001-297	03-14-01	03-28-01
0760	Hurley	INSURANCE AMENDMENTS.	*H	Pres. To Gov. 10/ 3/2002	03-26-01	04-12-01
0790	Starnes	INCREASE DAMAGE LIMITS FOR MV ACCIDENTS.	HF	Postponed Indefinitely	03-26-01	10-01-02
0808	Alexander	MENTAL HEALTH/ CHEMICAL DEP. PARITY.	HF	Postponed Indefinitely	04-11-01	10-01-02
1032	Nye	HEALTH INS./UR RETROSPECTIVE REVIEW LIMIT.	HF	Postponed Indefinitely	04-09-01	10-01-02
1045=	Baddour	RESTORE WORKERS' COMP. STABILITY.	*HR	Ch. SL 2001-216	04-10-01	04-18-01
1048=	Redwine	MORATORIUM ON HEALTH INS. MANDATES.	*HR	Ch. SL 2001-453	04-10-01	04-23-01
1077	**Arnold**	**FIREFIGHTERS' AND RESCUE SQUAD WORKERS' RETIRE.**	***HF**	**Postponed Indefinitely**	**05-23-01**	**07-12-01**
1088	Saunders	ABC AMENDMENTS.	*H	Ref To Com On Commerce	04-11-01	04-24-01
1092	Rayfield	HEALTH BENEFIT PLANS/ DISCRIMINATION PROHIBITED.	HF	Postponed Indefinitely	04-11-01	10-01-02
1105	Hurley	INSURANCE REGULATORY FUND CHANGES.	*HR	Ch. SL 2002-144	04-11-01	04-24-01
9	Nye	MANAGED CARE/PATIENT ACCESS.	*H	Ref To Com On Health Care	04-11-01	04-12-01
0	Nye	BEACH AND FAIR PLAN AMENDMENTS.	*H	Pres. To Gov. 10/ 4/2002	04-12-01	04-24-01
1122	Allred	WORKERS' COMP LOSS MODIFICATIONS AND STUDY.	HF	Postponed Indefinitely	04-12-01	10-01-02
1123	Allred	CHANGE NAME OF N.C. RATE BUREAU.	HF	Postponed Indefinitely	04-12-01	10-01-02
1160	Alexander	HEALTH INS./UNIFORM PROVIDER CREDENTIALING.	*HR	Ch. SL 2001-172	04-12-01	04-24-01
1170	Wilson, C	MEDICAL TREATMENT PROTOCOL.	HF	Postponed Indefinitely	04-12-01	04-17-01
1253	Goodwin	UNINSURED MOTORIST COVERAGE.	*HF	Postponed Indefinitely	04-12-01	04-25-01
1266	Wright	SURGICAL NURSES/3RD PARTY PAYMENT.	H	Ref To Com On Rules and Operations of the Senate	04-12-01	04-25-01
1326	Blue	AUTO-COMPREHENSIVE DEDUCTIBLE NO GLASS.	HF	Postponed Indefinitely	04-12-01	10-01-02
1329	Carpenter	MV INSURERS-NO MANDATE/NONORIGINAL CRASH PARTS.	HF	Postponed Indefinitely	04-12-01	04-25-01
1586=		HOMEOWNERS' REINSURANCE FACILITY.	HF	Postponed Indefinitely	06-06-02	10-01-02
0132	Robert C. Carpen	HEALTH INSURANCE/	*HR	Ch. SL 2001-116	03-20-01	04-12-01

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2001-2002 Biennium

Bill	Introducer	Short Title	Latest Action	In Date	Out Date
		COLORECTAL CANCER SCREENING.			
0168=	Allen H. Wellons	HMO CEASE AND DESIST.	*HR Ch. SL 2001-5	02-28-01	03-07-01
0241	Walter H. Dalton	HEALTH INSURANCE TERMINATION NOTICE.	*HR Ch. SL 2001-422	04-25-01	05-16-01
0318=	Allen H. Wellons	INSURANCE PRODUCER LICENSING.	*HR Ch. SL 2001-203	04-26-01	05-29-01
0321=	Allen H. Wellons	INSURANCE EXAM LAW AMENDMENTS.	*HR Ch. SL 2001-180	04-26-01	05-29-01
0459=	Allen H. Wellons	INSURANCE FINANCIAL AMENDMENTS.	*HR Ch. SL 2001-223	04-23-01	05-31-01
0461=	Allen H. Wellons	INSURANCE INFORMATION PRIVACY.	*HR Ch. SL 2001-351	04-26-01	07-18-01
0466=	Allen H. Wellons	WORKERS COMPENSATION AMENDMENTS.	*HR Ch. SL 2001-232	04-10-01	05-29-01
0468=	Allen H. Wellons	WORKERS COMP. CANCELLATIONS AND RENEWALS.	*HR Ch. SL 2001-241	04-10-01	06-05-01
0729	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
0801	Stan Bingham	FIREMEN REPORTING.	*HR Ch. SL 2001-222	04-25-01	05-29-01
0852	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
October 1, 2002

The House Committee on Insurance met in Room 1228 of the Legislative Building on October 1, 2002, at 12:00 p.m. Representative Hurley called the meeting to order. The following Committee members were present: Representative Dockham, Co-Chair, and Representatives Barbee, Dedmon, Hall, Johnson, Redwine, Setzer, Smith, and C. Wilson. Linda Attarian and Frank Folger, Staff Counsels, were in attendance. A list of visitors attending is attached.

Representative Hurley indicated the following bills were to be considered with HB 760 being taken up for discussion purposes only:

HB 760, entitled, AN ACT TO CLARIFY THE MOTOR VEHICLE REINSURANCE FACILITY AND BEACH AND FAIR PLAN LAWS; AMEND LAWS REGARDING DEPARTMENT OF INSURANCE OVERSIGHT OF INSURANCE COMPANY SOLVENCY; AMEND THE MANAGED CARE EXTERNAL REVIEW LAW TO PROVIDE FOR CLARITY IN MAILING NOTICES, THE SAME IMMUNITY TO MEDICAL PROFESSIONALS ADVISING THE COMMISSIONER AS PROVIDED TO EXTERNAL REVIEWERS, AND CONFIDENTIALITY OF CREDENTIALING INFORMATION IN THE POSSESSION OF THE COMMISSIONER; EXTEND THE RATE HEARING TIMETABLES FOR HOMEOWNERS' AND WORKERS' COMPENSATION INSURANCE; CLARIFY THE NORTH CAROLINA HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT; EXTEND THE TIME FOR PREMIUM FINANCE COMPANY PREMIUM REFUNDS FOR AUDITED POLICIES; AMEND THE TITLE INSURANCE RESERVE LAWS TO ENHANCE INSOLVENCY PROTECTION; AND REDUCE THE NONFORFEITURE INTEREST RATE FOR INDIVIDUAL ANNUITIES.

Representative Hurley recognized Bill Hale, NC Department of Insurance, to explain the bill and the changes made by the Senate. HB 760 would amend various insurance laws governing: (1) the Motor Vehicle Reinsurance Facility and Beach and FAIR Plans; (2) Department of Insurance oversight of insurance solvency; (3) managed care external reviews: (4) rate filings for homeowners and workers' compensation insurance; (5) North Carolina's HIPAA; (6) premium finance company premium refunds for audited policies; (7) title insurance reserve laws; and (8) guaranteed annuity interest rates. The provisions regarding guaranteed annuity interest rates are effective when they become law and apply to policies issued on or after that date. The remainder of the act is effective when it becomes law. Much discussion ensued pertaining to this bill.

HB 36, entitled, AN ACT TO ESTABLISH A MANAGED CARE OMBUDSMAN PROGRAM WITHIN THE DEPARTMENT OF INSURANCE.

HB 37, entitled, AN ACT TO PROVIDE FOR HEALTH BENEFIT PLAN DISCLOSURE TO AND SUMMARY PLAN INFORMATION FOR PROSPECTIVE INSUREDS.

HB 38, entitled, AN ACT TO REQUIRE INSURERS TO DISCLOSE PAYMENT OBLIGATIONS FOR COVERED SERVICES.

HB 39, entitled, AN ACT TO ESTABLISH STANDARDS FOR MANAGED CARE PROVIDER DIRECTORIES.

HB 48, entitled, AN ACT TO PROVIDE FOR CONTINUITY OF CARE IN HMO PLANS.

HB 181, entitled, AN ACT TO UPDATE THE CEASE AND DESIST PROVISIONS IN THE HMO LAWS.

HB 790, entitled, AN ACT TO INCREASE THE DAMAGE AMOUNTS ON DEFINED MOTOR VEHICLE ACCIDENTS.

HB 808, entitled, AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY.

HB 1032, entitled, AN ACT LIMITING RETROSPECTIVE REVIEWS UNDER UTILIZATION REVIEW IN HEALTH BENEFIT PLANS.

HB 1092, entitled, AN ACT TO PROHIBIT HEALTH BENEFIT PLANS FROM DISCRIMINATING WITH RESPECT TO PARTICIPATION, REIMBURSEMENT, OR INDEMNIFICATION AS TO ANY HEALTH CARE PROVIDER ACTING WITHIN THE SCOPE OF THE PROVIDER'S LICENSE OR CERTIFICATION UNDER APPLICABLE STATE LAW, SOLELY ON THE BASIS OF THE LICENSE OR CERTIFICATION.

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.

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.

HB 1326, entitled, AN ACT TO ELIMINATE THE COMPREHENSIVE INSURANCE DEDUCTIBLE ON MOTOR VEHICLE WINDSHIELD GLASS.

HB 1586, entitled, AN ACT TO ESTABLISH A REINSURANCE FACILITY FOR HOMEOWNER'S INSURANCE IN NORTH CAROLINA.

Representative Dedmon moved that the fourteen House bills listed above (HB 36, 37, 38, 39, 48, 181, 790, 808, 1032, 1092, 1122, 1123, 1326, and 1586) be given an indefinite postponement report. The motion passed.

Representative Dockham addressed the committee and expressed his appreciation for the work the committee has done over the past two years. Representative Hurley also thanked the committee for their efforts.

There being no further business, the Presiding Chair adjourned the meeting at 12:44 p.m.

Respectfully submitted,

Representative John W. "Bill" Hurley
Presiding Chair

Melissa M. Riddle
Assistant to the Committee

ATTACHMENTS:

Visitor Registration Form
HB 36, 37, 38, 39, 48, 181, 790, 808, 1032, 1092, 1122, 1123, 1326, 1586.
HB 790 Bill Analysis & Summary by Bill Hale (Department of Insurance)

VISITOR REGISTRATION SHEET

INSURANCE — October 01, 2002

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NCRA
Jim Long	NCDOI
Frank Gray	ANCLIC
Howard Kramer	N.C. B.O.N.
D. Propes	NC DOI
	NCAHP
	[illegible]
Cam Cevee	BPMHL
RH Partin	Edenton
Ken Kinion	A.I.G.
Barbara Cansler	NFSS

VISITOR REGISTRATION SHEET

INSURANCE — October 01, 2002

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Starla Mchenry	NCDOT
Michelle Frazier	NC Bar Ass'n
Mari Hunt	GSK
Robt Rashel	Young, Moore
John Rumgay	NCSOS
R. Paul Wilms	NCHBA
Stephanie M. Simpson	NCAR
Angela Horne	NCMS
Bill Scoggin	KCLH
John McMillan	MFLS
	NCAPP

VISITOR REGISTRATION SHEET

INSURANCE — October 01, 2002

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
William Potter	NYDS & NCPTA
Bode Call	Bode Call & Strong

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

H 2

HOUSE BILL 760

Senate Insurance and Consumer Protection Committee Substitute Adopted 9/30/02

Short Title: Insurance Amendments. (Public)

Sponsors:

Referred to:

March 26, 2001

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE MOTOR VEHICLE REINSURANCE FACILITY AND BEACH AND FAIR PLAN LAWS; AMEND LAWS REGARDING DEPARTMENT OF INSURANCE OVERSIGHT OF INSURANCE COMPANY SOLVENCY; AMEND THE MANAGED CARE EXTERNAL REVIEW LAW TO PROVIDE FOR CLARITY IN MAILING NOTICES, THE SAME IMMUNITY TO MEDICAL PROFESSIONALS ADVISING THE COMMISSIONER AS PROVIDED TO EXTERNAL REVIEWERS, AND CONFIDENTIALITY OF CREDENTIALING INFORMATION IN THE POSSESSION OF THE COMMISSIONER; EXTEND THE RATE HEARING TIMETABLES FOR HOMEOWNERS' AND WORKERS' COMPENSATION INSURANCE; CLARIFY THE NORTH CAROLINA HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT; EXTEND THE TIME FOR PREMIUM FINANCE COMPANY PREMIUM REFUNDS FOR AUDITED POLICIES; AMEND THE TITLE INSURANCE RESERVE LAWS TO ENHANCE INSOLVENCY PROTECTION; AND REDUCE THE NONFORFEITURE INTEREST RATE FOR INDIVIDUAL ANNUITIES.

The General Assembly of North Carolina enacts:

PART I. REINSURANCE FACILITY AND FAIR AND BEACH PLAN DEFINITION CLARIFICATIONS AND TECHNICAL AND SUBSTANTIVE CORRECTIONS.

SECTION 1.1. G.S. 58-37-1(8) reads as rewritten:

"(8) 'Person' means every natural person, firm, partnership, association, trust, limited liability company, firm, corporation, ~~or government or agency thereof.~~ government, or governmental agency."

SECTION 1.2. G.S. 58-37-35(b)(2) reads as rewritten:

"(2) Additional ceding privileges for motor vehicle insurance shall be provided by the Board of Governors up to the following:

a. Bodily injury liability: one hundred thousand dollars ($100,000) each person, three hundred thousand dollars ($300,000) each accident;
b. Property damage liability: fifty thousand dollars ($50,000) each accident;
c. Medical payments: two thousand dollars ($2,000) each person; except that this coverage shall not be available for motorcycles;
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) each accident for property damage (one hundred dollars ($100.00) deductible)."

SECTION 1.3. G.S. 58-37-35(b)(2a) reads as rewritten:

"(2a) For persons who must maintain liability coverage limits above those available under subdivision (2) of this subsection in order to obtain or continue coverage under personal excess liability or personal 'umbrella' insurance policies, additional ceding privileges for motor vehicle insurance shall be provided by the Board of Governors up to the following:

a. Bodily injury liability: two hundred fifty thousand dollars ($250,000) each person, five hundred thousand dollars ($500,000) each accident.
b. Property damage liability: one hundred thousand dollars ($100,000) each accident.
c. Medical payments: five thousand dollars ($5,000) each ~~person.~~ person; except that this coverage shall not be available for motorcycles.
d. Uninsured motorist: one hundred thousand dollars ($100,000) each accident for property damage (one hundred dollars ($100.00) deductible)."

SECTION 1.4. G.S. 58-45-6 reads as rewritten:

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

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

SECTION 1.5. G.S. 58-46-2 reads as rewritten:

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

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

PART II. FINANCIAL EVALUATION AND SOLVENCY PROTECTION.

SECTION 2.1. G.S. 58-2-131(d) reads as rewritten:

"(d) The Commissioner may conduct an examination of any insurer whenever the Commissioner deems it to be prudent for the protection of policyholders but shall at a minimum conduct a ~~regular~~ financial 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 2.2. G.S. 58-2-131(i) reads as rewritten:

"(i) Every person from whom information is sought and its officers, directors, and agents must provide to the Commissioner timely, convenient, and free access, at all reasonable hours at its offices, to all data relating to the property, assets, business, and affairs of the ~~insurer~~ entity being examined. The officers, directors, employees, and agents of the ~~person~~ entity must facilitate and aid in the examination. The refusal of any ~~insurer,~~ entity, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Commissioner or to knowingly or willfully make any false statement in regard to the examination or written request, is grounds for revocation, suspension, refusal, or nonrenewal of any license or authority held by the ~~insurer~~ entity to engage in an insurance or other business subject to the Commissioner's jurisdiction."

SECTION 2.3. G.S. 58-2-134 reads as rewritten:

"**§ 58-2-134. Cost of certain examinations.**

(a) An insurer shall reimburse the State Treasurer for the actual expenses incurred by the Department in any examination of those records or assets conducted under G.S. 58-2-131, 58-2-132, or 58-2-133 ~~when:~~ under any of the following circumstances:

(1) The insurer maintains part of its records or assets outside this State under G.S. 58-7-50 or G.S. 58-7-55 and the examination is of the records or assets outside this State.

(2) The insurer requests an examination of its records or assets.

(3) The Commissioner examines an insurer that is impaired or insolvent or is unlikely to be able to meet obligations with respect to known or anticipated claims or to pay other obligations in the normal course of business.

(4) The examination involves analysis of the company's investment portfolio, a material portion of which comprises a sophisticated derivatives program, material holdings of collateralized mortgage obligations with high flux scores, unusual real estate or limited partnership holdings, high or unusual portfolio turnover, material asset movement between related parties, or unusual securities lending activities.

(b) The amount paid by an insurer for an examination of records or assets under this section shall not exceed one hundred thousand dollars ($100,000), unless the insurer and the Commissioner agree on a higher amount. The State Treasurer shall deposit all funds received under this section in the Insurance Regulatory Fund established under G.S. 58-6-25. Funds received under this section shall be used by the Department for

offsetting the actual expenses incurred by the Department for examinations under this section."

SECTION 2.4. Article 7 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-7-73. Dissolutions of insurers.**

Upon reaching a determination of intent to dissolve and before filing articles of dissolution with the Office of the Secretary of State, a domestic insurer organized under this Chapter shall file a plan of dissolution for approval by the Commissioner. At such time the Commissioner may restrict the license of the insurer. In order to proceed with a dissolution, the plan must be approved by the Commissioner."

SECTION 2.5. G.S. 58-7-130(b) reads as rewritten:

"(b) No domestic stock insurance company shall declare or pay 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."

SECTION 2.6. G.S. 58-7-178(b) reads as rewritten:

"(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~~ cost 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 pursuant to this subsection shall not exceed three percent (3%) of the insurer's admitted assets."

SECTION 2.7. G.S. 58-9-2(a)(9) reads as rewritten:

"(9) 'Reinsurer' means any ~~licensed~~ insurer that is licensed by the Commissioner and that is authorized to assume reinsurance."

SECTION 2.8. 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 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 2.9. G.S. 58-13-25(a) reads as rewritten:

"(a) Every insurer subject to this Article shall at all times have and maintain free and unencumbered reserve assets equal to an amount that is ~~at least ten percent (10%) more than~~ the total of its policyholder-related liabilities and its required minimum

capital and minimum surplus and shall not pledge, hypothecate, or otherwise encumber those reserve assets. The Commissioner, upon application made to the Commissioner, may issue a written order approving the pledging, hypothecation, or encumbrance of any of the assets of an insurer not otherwise prohibited upon a finding that the pledging, hypothecation, or encumbrance will not adversely affect the insurer's solvency."

SECTION 2.10. G.S. 58-30-62(a) reads as rewritten:

"(a) As used in this section, an insurer has 'exceeded its powers' when it: has refused to permit examination of its books, papers, accounts, records or affairs by the Commissioner; has in violation of G.S. 58-7-50 removed from this State books, papers, accounts or records necessary for an examination of the insurer; has failed to comply promptly with applicable financial reporting statutes or rules and related Department requests; continues to transact the business of insurance after its license has been revoked, suspended, or not renewed by the Commissioner; by contract or otherwise, has unlawfully, or has in violation of an order of the Commissioner, or has without first having obtained any legally required written approval of the Commissioner, totally reinsured its entire outstanding business or merged or consolidated substantially its entire property or business with another insurer; has engaged in any transaction in which it is not authorized to engage under the laws of this State; has not complied with G.S. 58-7-73; or has refused to comply with a lawful order of the Commissioner. As used in this section, 'Commissioner' includes an authorized representative or designee of the Commissioner."

PART III. EXTERNAL REVIEW CLARIFICATIONS.

SECTION 3.1. G.S. 58-50-80(b)(3) reads as rewritten:

"(3) Notify in writing the covered person and the covered person's provider who performed or requested the service whether the request is complete and whether the request has been accepted for external review. If the request is complete and accepted for external review, the notice shall include a copy of the information that the insurer provided to the Commissioner pursuant to subdivision (b)(1) of this section, and inform the covered person that the covered person may submit to the assigned independent review organization in writing, within seven days after the ~~date~~ receipt of the notice, additional information and supporting documentation relevant to the initial denial for the organization to consider when conducting the external review. If the covered person chooses to send additional information to the assigned independent review organization, then the covered person shall at the same time and by the same means, send a copy of that information to the insurer."

SECTION 3.2. G.S. 58-50-80 is amended by adding a new subsection to read:

"(m) For the purposes of this section, a person is presumed to have received a written notice two days after the notice has been placed, first-class postage prepaid, in the United States mail addressed to the person. The presumption may be rebutted by sufficient evidence that the notice was received on another day or not received at all."

SECTION 3.3. G.S. 58-50-89 reads as rewritten:

"**§ 58-50-89. Hold harmless for ~~Commissioner~~ Commissioner, medical professionals, and independent review organizations.**

~~The Commissioner or~~ Neither the Commissioner, a medical professional rendering advice to the Commissioner under G.S. 58-50-82(b)(2), an independent review ~~organization or~~ organization, nor a clinical peer reviewer working on behalf of an organization shall ~~not~~ be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence."

SECTION 3.4. G.S. 58-2-105 reads as rewritten:

"**§ 58-2-105. Confidentiality of medical and credentialing records.**

(a) All patient medical records in the possession of the Department are confidential and are not public records pursuant to G.S. 58-2-100 or G.S. 132-1. As used in this section, "patient medical records" includes personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, and that has been obtained from the individual patient, a health care provider, or from the patient's spouse, parent, or legal guardian.

(b) Under Part 4 of Article 50 of this Chapter, the Department may disclose patient medical records to an independent review organization, and the organization shall maintain the confidentiality of those records as required by this section, except as allowed by G.S. 58-39-75 and G.S. 58-39-76.

(c) Under Part 4 of Article 50 of this Chapter, all information related to the credentialing of medical professionals that is in the possession of the Commissioner is confidential and is a public record neither under this section nor under Chapter 132 of the General Statutes."

PART IV. HOMEOWNERS' AND WORKERS' COMPENSATION INSURANCE RATE FILINGS.

SECTION 4.1. G.S. 58-36-15(a) reads as rewritten:

"(a) The Bureau shall file with the Commissioner copies of the rates, loss costs, classification plans, rating plans and rating systems used by its members. Each rate or loss costs filing shall become effective on the date specified in the filing, but not earlier than ~~105~~ 210 days from the date the filing is received by the Commissioner: Provided that (1) rate or loss costs filings for workers' compensation insurance and employers' liability insurance written in connection therewith shall not become effective earlier than ~~120~~ 210 days from the date the filing is received by the Commissioner or on the date as provided in G.S. 58-36-100, whichever is earlier; and (2) any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the Bureau."

SECTION 4.2. G.S. 58-36-20(a) reads as rewritten:

"(a) At any time within 50 days ~~from and~~ after the date of any filing, the Commissioner may give written notice to the Bureau specifying in what respect and to what extent ~~he~~ the Commissioner contends ~~such~~ the filing fails to comply with the requirements of this Article and fixing a date for hearing not less than 30 days from the date of mailing of such notice. At ~~such~~ the hearing the factors specified in G.S.

58-36-10 shall be considered. If the Commissioner after hearing finds that the filing does not comply with the provisions of this Article, he may issue his order determining wherein and to what extent such filing is deemed to be improper and fixing a date thereafter, within a reasonable time, after which ~~such~~ the filing shall no longer be effective. Any order of disapproval under this section must be entered within ~~105~~ 210 days ~~of~~ after the date the filing is received by the ~~Commissioner: Provided that any order of disapproval under this section with respect to workers' compensation insurance and employers' liability insurance written in connection therewith shall be entered within 150 days of the date the filing is received by the~~ Commissioner."

SECTION 4.3. G.S. 58-36-65(c) reads as rewritten:

"(c) The classifications and Plan filed by the Bureau shall be subject to the filing, hearing, modification, approval, disapproval, review, and appeal procedures provided by law; provided that the ~~105-day~~ 210-day disapproval period in G.S. 58-36-20(a) and the 50-day deemer period in G.S. 58-36-20(b) do not apply to filings or modifications made under this section. The classifications or Plan filed by the Bureau and promulgated by the Commissioner shall of itself not be designed to bring about any increase or decrease in the overall rate level."

PART V. HIPAA CLARIFICATIONS.

SECTION 5.1. G.S. 58-68-25(b)(1) reads as rewritten:

"(1) Benefits not subject to requirements. –

a. Coverage only for accident or disability income insurance or any combination of these.

b. Coverage issued as a supplement to liability insurance.

c. Liability insurance, including general liability insurance and automobile liability insurance.

d. Workers' compensation or similar insurance.

e. Automobile medical payment insurance.

f. Credit-only insurance.

g. Coverage for on-site medical clinics.

h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

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

SECTION 5.2. G.S. 58-51-15(h) reads as rewritten:

"(h) Preexisting Condition Exclusion Clarification. – Sub-subdivision (a)(2)b. of this section does not apply to:

(1) Policies issued to eligible individuals under G.S. 58-68-60.

(2) Excepted benefits as described in ~~G.S. 58-68-25(b)(1), (2), and (4).~~ G.S. 58-68-25(b)."

PART VI. PREMIUM FINANCE COMPANY PREMIUM REFUNDS FOR AUDITED POLICIES.

SECTION 6. G.S. 58-35-85(5) reads as rewritten:

"(5) ~~Whenever~~ When an insurance contract is cancelled in accordance with this section, the insurer shall promptly return ~~whatever~~ the gross unearned premiums that are due under the contract to the insurance premium finance company effecting the ~~cancellation~~ cancellation, for the benefit of the insured or insureds, no later than 30 days after the effective date of cancellation. ~~Whenever~~ When the return premium is ~~in excess of~~ more than the amount ~~due~~ the insured owes the insurance premium finance company ~~by the insured~~ under the agreement, the excess shall be promptly remitted ~~promptly~~ to the order of the insured, as provided in subdivision (8) of this section, subject to the minimum service charge provided for in this Article. ~~In the event that~~ If a premium is subject to an audit to determine the final premium amount, the amount to be refunded to the premium finance company shall be calculated upon the deposit ~~premium~~ premium, and the insurer shall return that amount to the premium finance company no later than ~~30~~ 90 days after the effective date of cancellation. This ~~provision shall~~ subdivision does not limit any other remedies the insurer may have against the insured for additional premiums."

PART VII. AMEND TITLE INSURANCE RESERVE LAWS.

SECTION 7.1. G.S. 58-26-1(b) is repealed.

SECTION 7.2. G.S. 58-26-1 is amended by adding a new subsection to read:

"(b1) Domestic and foreign title insurance companies are subject to the same capital, surplus, and investment requirements that govern the formation and operation of domestic stock casualty companies. Domestic title insurance companies are subject to the same deposit requirements that govern the operation of other domestic casualty companies in this State. Foreign or alien title insurance companies are subject to an initial deposit pursuant to G.S. 58-26-31(b), based on the forecasted statutory premium reserve and the supplemental reserve for the first full year of operation in this State, but not less than two hundred thousand dollars ($200,000)."

SECTION 7.3. G.S. 58-26-20 reads as rewritten:

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

Every domestic title insurance company shall, in addition to other reserves, establish and maintain a reserve to be known as the '~~unearned~~ statutory premium reserve' for title insurance, which shall at all times and for all purposes be considered and constitute ~~unearned portions of the original risk premiums and shall be charged as~~ a reserve liability of ~~such~~ the title insurance company in determining its financial ~~conditions. The unearned premium reserve shall be withdrawn from the use of the insurer for its general purposes and placed in a trust account, as approved by the Commissioner, in favor of the holders of title policies and held available for reinsurance of the title policies in the event of insolvency of the insurer. Nothing herein contained shall preclude such an insurer from investing said reserve in investments authorized by law for such an insurer, and the income from such invested reserve shall be included in the general income of the insurer to be used by such insurer for any lawful purpose.~~condition."

SECTION 7.4. G.S. 58-26-25(a) reads as rewritten:

"(a) The ~~unearned~~statutory premium reserve of every domestic title insurance company shall consist of the aggregate of:

(1) The amount of the unearned premium reserve held as of December 31, 1998.

(2) The amount of all additions required to be made to such reserve by this section, less the reduction of ~~such~~the aggregate amount required ~~hereby.~~ by this section."

SECTION 7.5. G.S. 58-26-25(b) reads as rewritten:

"(b) A domestic title insurance company on and after January 1, 1999, shall reserve initially as ~~an unearned~~a statutory premium reserve a sum equal to ten ~~per centum~~percent (10%) of the following items set forth in the title insurer's most recent annual statement on file with the Commissioner:

(1) Direct premiums ~~written; and~~written.

(2) Premiums for reinsurance assumed less premiums for reinsurance ceded during the year."

SECTION 7.6. G.S. 58-26-25(c) reads as rewritten:

"(c) The aggregate of the amounts set aside in ~~unearned~~statutory premium reserves in any calendar year, ~~pursuant to~~under subsection (b) of this section, shall be reduced annually at the end of each calendar year following the year in which the policy is issued, over a period of 20 years, pursuant to the following: twenty percent (20%) the first year; ten percent (10%) for years two and three; five percent (5%) for years four through 10; three percent (3%) for years 11 through 15; and two percent (2%) for years 16 through 20."

SECTION 7.7. G.S. 58-26-30 is repealed.

SECTION 7.8. Article 26 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-26-31. Statutory premium reserve held in trust or as a deposit.**

(a) Each domestic title insurance company shall withdraw from use funds to be used by the Commissioner in the event of the insurer's insolvency, the funds being equal to the statutory premium reserve and the supplemental reserve pursuant to G.S. 58-26-25. The amount shall be held in a trust account, as approved by the Commissioner. The trust account will be held in favor of the holders of title policies in the event of the insolvency of the insurer. Nothing in this section precludes the insurer from investing the reserve in investments authorized by law for that insurer, and the income from the invested reserve shall be included in the general income of the insurer to be used by the insurer for any lawful purpose.

(b) Each foreign or alien title insurance company shall withdraw from use funds to be used by the Commissioner in the event of the insurer's insolvency, the funds being equal to the statutory premium reserve and the supplemental reserve as calculated under G.S. 58-26-25 for North Carolina risks. The Commissioner shall hold the funds as a deposit in accordance with G.S. 58-5-20. Annually, the company shall file a statement of actuarial opinion consistent with the annual statement instructions for North Carolina risks, issued by a qualified actuary, in support of this deposit.

(c) A title insurance company shall have 30 days after notification by the Commissioner to increase the amounts held on deposit. If the amount held on deposit is greater than the amount required under subsection (b) of this section, the Commissioner shall release the excess within 30 days after a request by the insurer."

SECTION 7.9. G.S. 58-26-35 reads as rewritten:

"**§ 58-26-35. Maintenance of the ~~unearned~~ statutory premium reserve.**

If ~~by reason of any cause, other than depreciation in the market value of investments,~~ the amount of the assets of a title insurance company held ~~as investments of its unearned premium reserve~~ in trust or held by the Commissioner under G.S. 58-26-31 should on any date be less than the amount required to be ~~maintained by law in such reserve,~~ maintained, and the deficiency ~~shall~~ is not ~~be~~ promptly cured, ~~such~~ the title insurance company shall ~~forthwith~~ immediately give written notice ~~thereof~~ of the deficiency to the Commissioner and shall ~~make no further policies, contracts of title insurance or reinsurance agreements of title insurance~~ not write or assume any title insurance until the deficiency ~~shall have~~ has been eliminated and until it ~~shall have~~ has received written approval from the Commissioner authorizing it to again ~~issue such policies, contracts of title insurance or agreements.~~ write and assume title insurance."

SECTION 7.10. G.S. 58-26-40 is repealed.

PART VIII. ANNUITY NONFORFEITURE RATE CHANGE.

SECTION 8. G.S. 58-58-60(d) reads as rewritten:

"(d) The minimum values as specified in subsections (e), (f), (g), (h) and (j) of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(1) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of ~~three percent (3%)~~ one and one-half percent (1½%) per annum of percentages of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of:

(i) Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of ~~three percent (3%)~~ one and one-half percent (1½%) per annum; and

(ii) The amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract.

The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars ($30.00) and less a collection charge of one dollar and twenty-five cents ($1.25) per consideration credited to the contract during that contract

year. The percentages of net considerations shall be sixty-five percent (65%) of the net consideration for the first contract year and eighty-seven and one-half (87 1/2%) of the net considerations for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent (65%) of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent (65%).

(2) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations which are paid annually with two exceptions:

(i) The portion of the net consideration for the first contract year to be accumulated shall be the sum of sixty-five percent (65%) of the net consideration for the first contract year plus twenty-two and one-half percent (22 1/2%) of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.

(ii) The annual contract charge shall be the lesser of (i) thirty dollars ($30.00) or (ii) ten percent (10%) of the gross annual considerations.

(3) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to ninety percent (90%) and the net consideration shall be the gross consideration less a contract charge of seventy-five dollars ($75.00)."

SECTION 9. Section 8 of this act is effective when it becomes law and applies to policies issued on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 760:
Insurance Amendments

BILL ANALYSIS

Committee:	House Insurance	**Introduced by:**	
Date:	October 1, 2002	**Summary by:**	Frank W. Folger
Version:	2nd Edition		Committee Counsel

SUMMARY: ***This bill would amend various insurance laws governing: (1) the Motor Vehicle Reinsurance Facility and Beach and FAIR Plans; (2) Department of Insurance oversight of insurer solvency; (3) managed care external review; (4) rate filings for homeowners and workers' compensation insurance; (5) North Carolina's HIPAA; (6) premium finance company premium refunds for audited policies; (7) title insurance reserve laws; and (8) guaranteed annuity interest rates. The provisions regarding guaranteed annuity interest rates are effective when they become law and apply to policies issued on or after that date. The remainder of the act is effective when it becomes law.***

BILL ANALYSIS and BACKGROUND:

Bill Part	Insurance Area(s) [Article in G.S.Chapter 58]	Effect of Provision	Background
I	Motor Vehicle Reinsurance Facility [Article 37]	§1.1 modernizes definition of "person" in the Reinsurance Facility Law to specifically show inclusion of trusts, LLCs, and firms and reword reference to "agency". §1.2 Section 1.2 conforms the additional available coverages provisions of the Reinsurance Facility Law to conform to the basic coverage provisions in subsection (a) of the same statute. §1.3 conforms provisions added last session in S.L. 2001-236 (HB 357) which allow for ceding of additional coverage to the Facility for the purpose of obtaining or continuing umbrella coverage with the rest of the Reinsurance Facility Law.	

	Beach Plan (NCIUA) and FAIR Plans (NCJUA) [Articles 45 & 46]	§§1.4 and 1.5 clarify that the State is a "person" eligible for coverage under the Beach and FAIR Plans.	
II	Department of Insurance Oversight of Insurer Solvency [Articles 2, 7, 9, 13, & 30]	Amends various provisions to address current concerns about corporate finance: §2.1 clarifies that the requirement that the Commissioner of Insurance (Commissioner) examine each insurer at least once every five years refers to an examination of a insurer's financial records rather than to an examination of the insurer's market conduct. §2.2 makes a change to 58-2-131(i) to conform it with changes made in the Examination Law in S.L. 2001-180 (S.B. 321) clarifying that it applies to "entities" regulated by the Department of Insurance (Department) rather than just "insurers". §2.3 adds a fourth basis on which the costs of examining an insurer under the Examination Law shall be reimbursed by the subject insurer: when the Department must examine an insurer's investments so complex that it requires outside expertise to properly conduct the examination. §2.4 requires an insurer that has decided to file articles of dissolution with the Secretary of State's Office to file a plan of dissolution for approval by the Commissioner prior to proceeding with the dissolution. §2.5 clarifies that a domestic stock insurance	

		company can neither declare nor pay dividends but from unassigned surplus reflected in financial statements filed with the Commissioner. §2.6 corrects an error created by S.L. 2001-233 (S.B. 459, §8.11) in the laws governing foreign investment by domestic insurers. §2.7 clarifies, in Article 9 - Reinsurance Intermediaries, that "reinsurer" refers to those licensed by North Carolina's Commissioner rather than just "licensed". §2.8 adds back into the scope provision for the Asset Protection Act (Article 13) the modifier "Articles 1 through 68 of" which was inadvertently omitted from that provisions in S.L. 2001-233 (S.B. 459, §8.11). §2.9 reduces the unencumbered reserve assets requirements imposed by the Asset Protection Act from a minimum of 110% of the total of policyholder-related liabilities and mimium capital and surplus requirements to 100% of that amount. §2.10 adds noncompliance with the new dissolution requirements imposed in Section 2.4 of this bill as another basis for placing an insurer under administrative supervision (under G.S. § 58-30-62).	
III	Managed Care External Review [Articles 50 and 2]	§3.1 clarifies that the 7-day deadline for an insured to provide the independent review organization (IRO) with supplemental information on the matter runs from the date of receipt of the notice of acceptance for external review rather than the date of the notice. §3.2 adds a rebuttable presumption that notice of acceptance for external review is received two days after the notice has been mailed. §3.3 provides immunity to a medical professional rendering advice to the Commissioner regarding eligibility for an expedited external review. Under existing law, the Commissioner and the IRO each enjoy such immunity.	

		§3.4 provides confidentiality for credentialing information provided to the Commissioner by medical professionals contracting with the Department pursuant to the external review provisions.	
IV	Rate Filings for Homeowners' and Workers' Compensation Insurance [Article 36]	Amends the laws governing the timetable for the Commissioner to respond to filings of homeowners and workers compensation rate documents to provide that the Commissioner will havc 210 days following the filing of homeowners' insurance rate documents (rather than the current 105 days) and workers' compensation insurance rate documents (rather than the current 150 days) to issue an order disapproving the filing, if any, in cases where the 50-day deemer provision has not applied.	
V	North Carolina's HIPAA [Articles 68 and 51]	Amends G.S. 58-68-25(b)(1) to conform North Carolina's law to federal law and returns the law to its 1997 status such that insurers will again be encouraged to issue specified disease and hospital indemnity policies. This second change in this section addresses portability and pre-existing conditions for specified disease policies and hospital indemnity policies.	North Carolina passed legislation in 1997 to comply with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The legislation included this provision to make it compatible with federal law. However, specified disease and hospital indemnity policies were taken out of the exclusion in 1999, resulting in the requirement that specified disease and hospital indemnity insurers give credit for medical conditions existing under prior coverages. Practically, the change threatened the availability of these policies for individuals with pre-existing conditions, because, unlike other individual

			health insurance coverage, insurers are not required to issue specified disease and hospital indemnity policies to all applicants.
VI	Insurance Premium Financing [Article 35]	Extends the time in which insurers must refund unearned premiums to premium financing companies after termination of certain policies, from 30 days to 90 days.	This provision is called for because in the workers' compensation context, workers' compensation insurers must conduct an audit of employers' payrolls to determine the premiums to be paid for the coverages furnished and these insurers are having difficulty conducting the audits and refunding the money within the 30 day deadline. Workers' compensation insurers and premium finance companies doing business in North Carolina agree to this provision.
VII	Title Insurance [Article 26]	Amends the laws governing how and how much title insurers, primarily foreign title insurers, must keep in reserve. The change would base the reserves for foreign title insurers on NC premiums and risks, instead of on all premiums and risks, and require deposits with the DOI for the amount of NC exposure. The other changes to the provisions on title insurance reserves are structural and conforming	Though for years, foreign title insurers have been subject to the same reserve requirements for domestic title insurers, until the last two years, these requirements have been essentially unenforceable, which resulted in complaints from domestic insurers. When the Department of Insurance instituted a certification requirement last year, many foreign title insurers could not certify because they did not maintain enough

			reserves to meet the requirements. After negotiations, the Department and industry agreed on the changes proffered by these provisions. The failure to enact this legislation may result in foreign title insurers withdrawing from the market to the detriment of North Carolina's policyholders.
VIII	Annuity Interest Rates [Article 58]	Reduces the interest rate guaranteed for annuities from 3% to 1 1/2%.	This change addresses the drastic change in interest rates since the 3% interest rate "floor" was put in place. With the prime interest rate below 3% and expected not to change much for several years to come, this reduction is intended to encourage insurers to offer more annuity products which are currently cost-prohibitive with the current rates.

NORTH CAROLINA DEPARTMENT OF INSURANCE

MEMORANDUM

October 1, 2002

TO: Members of the House Insurance Committee

FROM: William K. Hale
Deputy Commissioner

SUBJECT: Senate Committee Substitute for HB 760 – Insurance Amendments

The following is a section-by-section summary of the bill:

PART I. REINSURANCE FACILITY AND FAIR AND BEACH PLAN DEFINITION CLARIFICATIONS AND TECHNICAL AND SUBSTANTIVE CORRECTIONS.

SECTION 1.1. This amendment modernizes the definition of "person" in the Motor Vehicle Reinsurance Facility law.

SECTION 1.2. This is a technical correction that makes the additional available coverages provision in the Motor Vehicle Reinsurance Facility law conform to the provisions on basic coverages.

SECTION 1.3. In 2001 the General Assembly amended in the Motor Vehicle Reinsurance Facility law (S.L. 2001-236, H.B. 357) to provide for higher coverages for persons who needed those amounts to obtain personal umbrella liability policies. This is a technical amendment that conforms that law with the rest of in the Motor Vehicle Reinsurance Facility law.

SECTIONS 1.4 AND 1.5. These sections clarify the Beach and FAIR Plan laws to include the State as any person that can obtain fire insurance or wind coverage from the Plans.

SECTION 1.6. In 1989 the General Assembly provided for windstorm policies to be issued by the Beach Plan in the beach area (since 1997 also in 18 coastal counties). There was and still is a requirement that the underlying coverage (whether a standard fire policy or, if the insured is lucky, a homeowner's policy) be issued by a licensed insurer. This requirement

excludes the possibility that a surplus lines insurer could fill a gap by providing that same coverage. Surplus lines insurers generally write hard-to-get property and liability coverages, and they must be authorized to do so in North Carolina by the Commissioner.

This amendment would allow surplus lines insurers to write the underlying coverages. In order to go to the surplus lines market, the insured must swear by affidavit that he or she is unable to obtain coverage in the regular market after making a diligent search. This change is fair to consumers who live in areas in which the licensed insurers prefer not to write.

PART II. FINANCIAL EVALUATION AND SOLVENCY PROTECTION.

SECTION 2.1. There are two kinds of examinations that the Department makes on insurance companies. One is financial, in which the Department examines the financial records of the company to determine the company's financial shape. The other is market conduct, in which the Department examines the claims and other records of the company to determine how the company has conducted itself in the marketplace. This amendment makes it clear that the type of exam the Department must conduct on every domestic insurer is an examination of the company's financial status.

SECTION 2.2. This is a follow-up to legislation enacted last year (S.L. 2001-180, S.B. 321), in which the term, "insurer" was changed to the term, "entity" to reflect that a number of entities regulated by the Department are covered by the examination laws.

SECTION 2.3. Before 1995, the Department billed insurers for the costs of examinations. Since then, examinations have been funded out of the Department's budget. This statute sets out situations in which the Department may bill an insurer for an examination. This amendment adds another situation, which is when the Department must examine complex investments and requires outside expertise in order to conduct a proper examination.

SECTION 2.4. Insurers that are formed in this State incorporate under the corporation laws, which are administered by the Secretary of State. When corporations decide to go out of business, they are dissolved under the corporation laws. This requires a domestic insurance

company to file a plan of dissolution with the Department before it files a plan of dissolution with the Secretary of State. The purpose is to give the Department notice of the company's plan to wind down its affairs and give the Department an opportunity to limit the company's writings if necessary while the company is winding down.

SECTION 2.5. This is a clarification of the law regarding domestic stock insurer dividends. The intent of the law is to address not only the declaration of dividends but also the payment of dividends.

SECTION 2.6. This corrects a mistake made in 2001 (S.L. 2001-223, S.B. 459, § 8.11).

SECTION 2.7. This amendment clarifies the language in the definition of "reinsurer" in the law dealing with reinsurance intermediaries.

SECTION 2.8. This amendment puts a reference back into the statute that was inadvertently omitted in 2001 (S.L. 2001-223, S.B. 459, § 8.11).

SECTION 2.9. This amendment reduces the amount of reserve assets an insurer must have. The change does not have any effect on insurer solvency protection.

SECTION 2.10. This makes a corresponding amendment to the insurer receivership laws to reflect the dissolution notice requirement in Section 2.4 of this bill.

PART III. EXTERNAL REVIEW CLARIFICATIONS.

SECTION 3.1. This clarifies the managed care external review law by stating the insured has seven days to submit additional information to the independent review organization after the insured receives the notice, instead of seven days after the date of the notice. An insured would be at a disadvantage when the notice gets delayed in transit if the date of the notice is the trigger for the seven-day period to run. The intent of this provision was to give the insured seven days to get information together for the organization.

SECTION 3.2. This addition to the managed care external review law provides for a rebuttable presumption that it takes two days for a mailed notice to reach the addressee.

SECTION 3.3. This is a very important amendment to the managed care external review law. Current law provides qualified civil immunity to everyone involved in the independent external review process except for the medical professional who advises the Commissioner as to whether an insured is entitled to an expedited external review. This is a critical role because the medical professional's advice could have a profound effect on the insured's condition. Also, the Commissioner will either not be able to retain medical professionals without this change; or medical professionals that are retained will take the safest approach and allow every insured expedited review.

SECTION 3.4. This is also a very important amendment to the external review law. Medical professionals who contract with the Department provide their credentialing information to the Department as a part of the contacting process. Presently, there is no provision for the Department maintaining the confidentiality of this information like there is for hospitals. This amendment would provide for that confidentiality.

PART IV. HOMEOWNERS' AND WORKERS' COMPENSATION INSURANCE RATE FILINGS.

The provisions of this Part of the bill accomplish one thing: They lengthen the timetables on homeowners' and workers' compensation insurance rate filings.

Currently, when a homeowners' insurance rate filing is made by the Rate Bureau with the Commissioner, the Commissioner must issue an order within 105 days after the filing was made. In workers' compensation insurance rate filings, the Commissioner has 150 days from the date of the filing to issue an order. If the Commissioner does not issue a notice of hearing within 50 days after the filing is made, the filing is deemed to be approved by law.

These amendments would extend both of those periods to 210 days.

This extra time is needed in order for the Commissioner to adequately analyze homeowners' and workers' compensation insurance rate filings. These filings are much more complex than they were in 1985, when these timetables were established. Homeowners' insurance rate filings involve complicated computer models of weather patterns, the analyses of which are

time consuming. Although this is not the case with workers' compensation insurance, it makes sense to have the same timetable for these Rate Bureau coverages.

PART V. HIPAA CLARIFICATIONS.

SECTION 5.1. This amendment conforms North Carolina law to federal law.

SECTION 5.2. This amendment deals with portability and pre-existing conditions for specified disease policies, such as cancer insurance, and hospital indemnity policies, which pay a flat per day amount for hospital stays. In 1997, when North Carolina enacted legislation to comply with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), this provision was added to existing law to make it compatible with federal law. In 1999, specified disease and hospital indemnity policies [described in G.S. 58-68-25(b)(3)] were taken out of the exclusion. The effect of that change was to require specified disease and hospital indemnity insurers to give credit for medical conditions existing under prior coverages. However, the practical effect of the change was also to jeopardize the availability of specified disease and hospital indemnity policies for individuals with pre-existing conditions, because, unlike other individual health insurance coverage, there is no requirement that insurers issue specified disease and hospital indemnity policies to all applicants.

PART VI. PREMIUM FINANCE COMPANY PREMIUM REFUNDS FOR AUDITED POLICIES.

SECTION 6. This provision addresses the maximum length of time an insurer has to refund unearned premiums to a premium finance company when certain policies are canceled. This mainly affects workers' compensation insurance policies. Those policies are subject to audits by insurers, which are surveys of employers' payroll records to determine the premiums that should be paid for the coverages furnished. The present 30-day limit does not give workers' compensation insurers enough time to conduct audits and refund the proper amounts. Workers' compensation insurers and premium finance companies doing business in North Carolina have agreed to the proposed 90-day period.

PART VII. AMEND TITLE INSURANCE RESERVE LAWS

For years, foreign title insurers have been required to maintain reserves at least as great as those required of domestic title insurers. However, this requirement is virtually impossible for the Department of Insurance to enforce and provides no real insolvency protection to policyholders. Our domestic title insurer has complained that its foreign competition has been allowed to carry lower reserves for years, thus putting it at an unfair disadvantage. But the Department was unable to substantiate these claims because of the lack of information contained in the financial statements filed with the Department.

In an effort to enforce the law, last year the Department developed an affidavit in which foreign title insurers certified that their reserves were in compliance with North Carolina's laws. Most insurers were unable to make such a certification. The provisions in Part VII would base the reserves on with North Carolina premiums and risks, instead of on all premiums and risks, and require deposits with the Department for the amount of North Carolina exposure. This would provide foreign companies with some relief from the higher reserve requirements while providing North Carolina policyholders with much better insolvency protection. Because there is no guaranty fund protection for title policies, the proposed deposit requirement is doubly important. The industry supports to the amended language.

Without these changes, the Department would have to require all foreign title insurers to increase their reserves to the required levels or prohibit them from doing business in North Carolina. This would cause a huge problem for the Department and the industry and ultimately the policyholders. The Department would have to spend a tremendous amount time (which it does not have) evaluating company reserves, ensuring adequacy, and taking action against those companies that fail to comply. The industry would be faced with booking potentially large reserve increases, which could significantly affect company surplus levels. And ultimately, policyholders may have fewer title companies from which to choose. The industry is fully aware of the consequences if the proposed legislation is not passed.

PART VIII. ANNUITY NONFORFEITURE RATE CHANGE.

SECTION 8. A deferred annuity is a contract that accumulates a sum of money over time, with the intent of providing installment payments at some point in the future. A person can buy this contract by making a lump sum payment up front, by making payments over time, or through some combination of these two methods of payment. In return, the insurance company invests the money and credits interest to this contract.

Current law provides a minimum value to the policyholder. It was enacted in 1979 when interest rates were relatively high and expected to remain so (one year rates were between 9.6% and 12.44%). Interest rates throughout the economy have declined significantly in recent years and will probably remain low for many years to come. The Federal Reserve Board lowered interest rates eleven times in one year.

During 1979, the year in which North Carolina's 3% nonforfeiture rate was enacted, the Five-Year Constant Treasury Rate ranged from 9.06 to 10.21%. The "One Year Constant Treasury Rate" ranged from 9.57 to 12.44%. Thus, a 3% minimum, which was never envisioned to be reached, let alone breached, was considered a fair "floor" for rates, especially considering that insurer expenses require additional margin over earned rates. During 2000, rates for the Five-Year Constant Treasury Rate began at 6.58%; in late 2001 they fell to 3.91%; in March 2002, the rate was 4.74%. The One-Year Constant Treasury Rate was 6.12% in January 2000, and fell to 2.16% in January 2002. In March, it was 2.57%.

The minimum guaranteed interest rate of 3% under current law is high in light of very low interest rates in the current economy. Insurers believe it may become possible that they simply cannot obtain high enough yields on their own investments, pay for selling and administrative expenses, and still guarantee to pay consumers at least 3%.

Reducing the statutory minimum guaranteed rate from 3% to 1 ½% could result in insurers offering more deferred annuity products to consumers because insurers could be able to more closely match reduced payments to consumers with their own reduced returns on investments.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 36 A BILL TO BE ENTITLED AN ACT TO ESTABLISH A MANAGED CARE OMBUDSMAN PROGRAM WITHIN THE DEPARTMENT OF INSURANCE.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

H

HOUSE BILL 36

Short Title:	Managed Care Ombudsman.	(Public)
Sponsors:	Representatives Nye, Nesbitt, Cunningham, Edwards, Insko; Barefoot, Justus, Luebke, Wainwright, Weiss, and Womble.	
Referred to:	Insurance.	

February 1, 2001

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A MANAGED CARE OMBUDSMAN PROGRAM WITHIN THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

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

"**§ 58-2-27. Managed Care Ombudsman in the Department of Insurance.**

(a) The Commissioner shall appoint a Managed Care Ombudsman and hire other staff necessary and appropriate to carry out the duties and responsibilities set out in subsection (b) of this section. The Managed Care Ombudsman shall have expertise and experience in both health care and advocacy.

(b) The duties and responsibilities of the Managed Care Ombudsman are as follows:

(1) Develop and distribute educational and informational materials for consumers explaining their rights and responsibilities as HMO enrollees.

(2) Assist HMO enrollees in filing appeals and grievances pertaining to insurance matters, and to assist HMO enrollees in utilizing internal review procedures remedies on behalf of HMO enrollees.

(3) Publicize the Office of the Managed Care Ombudsman.

(4) Answer inquiries posed by HMO enrollees.

(5) Compile data on the activities of the Office, and evaluate such data to make recommendations as to the needed activities of the Office.

(6) Refer those complaints that appear to be of a regulatory nature to regulatory staff within the Department of Insurance.

(c) The Commissioner shall annually report the activities of the Managed Care Ombudsman, including the types of appeals, grievances, and complaints received and the outcome of these cases. The report shall be submitted to the General Assembly,

upon its convening, and shall make recommendations as to efforts that could be implemented to assist HMO consumers."

SECTION 2. There is appropriated from the General Fund the sum of two hundred fifty thousand ($250,000) for the 2001-2002 fiscal year and five hundred thousand dollars ($500,000) for the 2002-2003 fiscal year for the Office of the Managed Care Ombudsman established under this act.

SECTION 3. This act becomes effective January 1, 2002.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 37 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR HEALTH BENEFIT PLAN DISCLOSURE TO AND SUMMARY PLAN INFORMATION FOR PROSPECTIVE INSUREDS.

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

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
_____ the House amendment (s).
_____the House committee substitute bill.
____ 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 37

Short Title:	Health Benefit Plan Disclosure.	(Public)
Sponsors:	Representatives Nye, Nesbitt, Cunningham, Edwards, Insko; Justus, Luebke, Wainwright, Weiss, and Womble.	
Referred to:	Insurance.	

February 1, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR HEALTH BENEFIT PLAN DISCLOSURE TO AND SUMMARY PLAN INFORMATION FOR PROSPECTIVE INSUREDS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-240. Health benefit plan disclosure and summary plan information.**

An insurer shall provide every prospective applicant and prospective enrollee with a clear and concise description of the coverage provided by the insurer's health benefit plan. The description shall be printed on a form prescribed by the Commissioner. The description shall specify:

(1) Definitions of terms used in the health benefit plan.

(2) A brief description of the principal benefits and coverage provided, including any coverage exclusions or limitations.

(3) A brief description of how coverage determinations are made, including whether factors other than medical necessity and coverage exclusions and limitations are considered.

(4) A brief explanation of insurer and insured payment responsibilities, including how plan allowances, such as 'usual and customary charges', are developed.

(5) A brief explanation of provider network limitations and requirements, including requirements for the use of sub-networks, prior authorization or precertification, and the arrangements of tertiary and quaternary care.

(6) Tax and health plan accreditation status of the insurer.

(7) A statement that the outline is a summary of the health benefit plan and that the health benefit plan should be examined to determine specific health benefit plan provisions."

SECTION 2. This act is effective when it becomes law. This act applies to all health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2003.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 38 A BILL TO BE ENTITLED AN ACT TO REQUIRE INSURERS TO DISCLOSE PAYMENT OBLIGATIONS FOR COVERED SERVICES.

☐ With a favorable report.

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

☐ With a favorable report, as amended.

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

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

HOUSE BILL 38

Short Title:	Disclose Payment Obligations.	(Public)
Sponsors:	Representatives Nye, Nesbitt, Cunningham, Edwards, Insko; Justus, Luebke, Wainwright, Weiss, and Womble.	
Referred to:	Insurance.	

February 1, 2001

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURERS TO DISCLOSE PAYMENT OBLIGATIONS FOR COVERED SERVICES.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-235. Payment obligations for covered services.**

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a method other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage, plan summaries, and explanation of benefits, how it determines its payment obligations and the payment obligations of the insured. The explanation shall include and clearly indicate:

(1) The steps the insurer has taken in calculating the benefit amount, and the payment obligations of each party.

(2) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service.

(3) Which party is responsible for filing a claim or bill with the insurer.

(4) Whether the insured may be liable for paying any excess amount.

(b) If an insured is liable for an amount that differs from a stated fixed dollar co-payment or from a stated coinsurance percentage because the coinsurance amount is based on a plan allowance or other such amount rather than the actual charges, the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: 'NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges are not used to

determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations'."

SECTION 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 3. This act is effective when it becomes law. This act applies to all health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 39 A BILL TO BE ENTITLED AN ACT TO ESTABLISH STANDARDS FOR MANAGED CARE PROVIDER DIRECTORIES.

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

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
_____ the House amendment (s).
_____the House committee substitute bill.
____ 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 39

Short Title:	Provider Directories.	(Public)
Sponsors:	Representatives Nye, Nesbitt, Cunningham, Edwards, Insko; Justus, Luebke, Wainwright, Weiss, and Womble.	
Referred to:	Insurance.	

February 1, 2001

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH STANDARDS FOR MANAGED CARE PROVIDER DIRECTORIES.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-245. Provider directories.**

(a) As used in this section, 'updated directory information' means:

(1) The current participation status of a provider.

(2) Information known to the insurer indicating that a provider is not currently accepting new patients.

(3) The date, if known to the insurer, of a provider's voluntary or involuntary termination from the network.

(4) Other information included in a printed provider directory.

(b) An insurer that uses a network of contracting health care providers for its health benefit plans shall provide a copy of its current provider directory, including any specialty directories, to all insureds on the effective date of initial coverage and shall make these directories available to current and prospective insureds upon request. Updated directory information reflecting the most current information available to the insurer shall be available to insureds by telephone and may also be made available by other media.

(c) Each directory shall include:

(1) The name, address, telephone number, and area of specialty for each health care provider and facility in its provider network.

(2) An indication of whether the provider:

a. May be selected as a primary care provider.

b. Is or is not currently accepting new patients.

c. Has any other restrictions that would limit an insured's access to that provider.

(3) Date of publication.

(4) Instructions on how a current or prospective insured can obtain information about changes in the provider network or a provider's ability to accept new patients that may have occurred since the most recent printing of the directory.

(d) If the insurer expects a provider's participation will terminate within 60 days after the next publication of the directory because the insurer has notified the provider that it will terminate or nonrenew the contract or because the provider has given notice of termination or nonrenewal, the insurer shall indicate in the next directory that the provider's participation may not continue, and that the insurer or provider should be contacted for updated directory information of that provider.

(e) The directory shall include all of the types of health care providers with whom the insurer contracts directly or to whom the insurer has access through a contract with an intermediary organization. At a contracting provider's request, the insurer shall also list in the directory the names of any allied health professionals who provide primary care services under the supervision of the contracting provider and whose services are covered by virtue of the carrier's contract with the supervising provider and whose credentials have been verified by the contracting provider. These allied health professionals shall be listed as part of the directory listing for the contracting provider upon receipt of a certification by the contracting provider that the credentials of the allied health professional have been verified.

(f) An insurer may maintain separate directories for specialty services, such as mental health, substance abuse, or centers of excellence, but shall make each of its directories available to current and prospective insureds in accordance with this section."

SECTION 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 3. This act is effective when it becomes law. This act applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after July 1, 2002.

2002 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 48 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR CONTINUITY OF CARE IN HMO 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 the committee substitute bill (#), ☐ which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

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
_____ the House amendment (s).
_____the House committee substitute bill.
____ 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 48

Short Title:	Continuity of Care.	(Public)
Sponsors:	Representatives Nye, Nesbitt, Cunningham, Edwards, Insko; Barnhart, Goodwin, Justus, Underhill, and Wainwright.	
Referred to:	Insurance.	

February 5, 2001

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR CONTINUITY OF CARE IN HMO PLANS.

The General Assembly of North Carolina enacts:

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

"**§ 58-67-88. Continuity of care.**

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

(1) Ongoing special condition. –

a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, disabling; and requires medical care or treatment over a prolonged period of time.

c. Pregnancy.

d. Terminal illness.

(2) Terminal illness. – An individual is considered to have a terminal illness if the individual has a medical prognosis that the individual's life expectancy is six months or less.

(3) Terminated or termination. – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO that is not a point-of-service plan and a health care provider is terminated, or benefits or coverage provided by a health care provider are terminated because of a change in the terms of

provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual who is covered by the plan and is terminally ill or undergoing treatment from the provider for an ongoing special condition at the time of the termination, the HMO shall:

(1) Notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (g) of this section, permit the individual to elect to continue to be covered with respect to treatment by the provider of the condition during a transitional period provided under this section.

(c) Transitional Period: In General. – Except as otherwise provided in subsections (d), (e), and (f) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the date of the notice described in subdivision (b)(1) of this section of the provider's termination.

(d) Transitional Period: Scheduled Surgery, Organ Transplantation, or Institutional Care. – If surgery, organ transplantation, or institutional care was scheduled for an individual before the date of the announcement of the termination of the provider status under subdivision (b)(1) of this section or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or institutional care, the transitional period under this subsection with respect to the surgery, transplantation, or institutional care shall extend beyond the period under subsection (c) of this section through the date of discharge of the individual after completion of the surgery, transplantation, or institutional care, and through postdischarge follow-up care related to the surgery, transplantation, or institutional care occurring within 90 days after the date of discharge.

(e) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the announcement of the termination of the provider status under subdivision (b)(1) of this section and the provider was treating the pregnancy before the date of the announcement of the termination, the transitional period with respect to provider's treatment of the pregnancy shall extend through the provision of postpartum care directly related to the delivery.

(f) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of a provider's termination of participation and the provider was treating the terminal illness before the date of termination, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(g) Permissible Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) of this section upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

(1) The provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full.

(2) The provider agrees to adhere to the quality assurance standards of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.

(4) The insured notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section.

(h) Construction. – Nothing in this section:

(1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-60-62.

(3) Prohibits an HMO from extending any transitional period beyond that specified in this section.

(i) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

SECTION 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 3. This act is effective when it becomes law. This act applies to all health benefit plans that are delivered, issued for delivery, or renewed on or after January 1, 2002.

2002 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. 181 A BILL TO BE ENTITLED AN ACT TO UPDATE THE CEASE AND DESIST 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 the committee substitute bill (#), ☐ which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

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
_____ the House amendment (s).
_____the House committee substitute bill.
____ 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 181

Short Title:	HMO Cease and Desist.	(Public)
Sponsors:	Representatives Adams; Capps, Davis, Fitch, Hall, McAllister, Michaux, and Womble.	
Referred to:	Insurance.	

February 20, 2001

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE CEASE AND DESIST 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 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 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 provisions of this Chapter that are applicable 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 provisions of this Chapter that are applicable to health maintenance organizations. ~~Such~~ The hearing shall be conducted pursuant to Chapter 150B of the General Statutes, and judicial review shall be available as provided by ~~the said Chapter 150B.~~Chapter 150B of the General Statutes.

(e) In the case of any violation of the provisions of this Article, 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), 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 provisions of this Chapter that are applicable 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.

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. 790 A BILL TO BE ENTITLED AN ACT TO INCREASE THE DAMAGE AMOUNTS OF DEFINED 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) (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 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.

2002 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. 808 A BILL TO BE ENTITLED AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS 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 the committee substitute bill (#), ☐ which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

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
_____ the House amendment (s).
_____the House committee substitute bill.
____ 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 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.

2002 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. 1032 A BILL TO BE ENTITLED AN ACT LIMITING RETROSPECTIVE REVIEWS UNDER UTILIZATION REVIEW IN HEALTH BENEFIT 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 the committee substitute bill (#), ☐ which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

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
_____ the House amendment (s).
_____the House committee substitute bill.
____ 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 1032

Short Title:	Health Ins./UR Retrospective Review Limit.	(Public)
Sponsors:	Representatives Nye; and Smith.	
Referred to:	Insurance.	

April 9, 2001

A BILL TO BE ENTITLED

AN ACT LIMITING RETROSPECTIVE REVIEWS UNDER UTILIZATION REVIEW IN HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-61(g) reads as rewritten:

"(g) Retrospective Reviews. – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, an insurer shall make the determination within 30 days after receiving all necessary information. For a certification, the insurer may give written notification to the covered person's provider. For a noncertification, the insurer shall give written notification to the covered person and the covered person's provider within five business days after making the noncertification. An insurer may use retrospective review for the certification or noncertification of coverage only if the covered person or provider acting on behalf of the covered person fails to comply with the applicable notification requirements for prospective or concurrent review, or, after meeting the requirements for timely notification, fails to modify care as required by applicable standards or protocols communicated to the provider."

SECTION 2. 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. 1092 A BILL TO BE ENTITLED AN ACT TO PROHIBIT HEALTH BENEFIT PLANS FROM DISCRIMINATING WITH RESPECT TO PARTICIPATION, REIMBURSEMENT, OR INDEMNIFICATION AS TO ANY HEALTH CARE PROVIDER ACTING WITHIN THE SCOPE OF THE PROVIDER'S LICENSE OR CERTIFICATION UNDER APPLICABLE STATE LAW, SOLELY ON THE BASIS OF THE LICENSE OR CERTIFICATION.

☐ 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 1092

Short Title:	Health Benefit Plans/Discrimination Prohibited.	(Public)
Sponsors:	Representatives Rayfield; (By Request), Culp, Hiatt, and G. Wilson.	
Referred to:	Insurance.	

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT HEALTH BENEFIT PLANS FROM DISCRIMINATING WITH RESPECT TO PARTICIPATION, REIMBURSEMENT, OR INDEMNIFICATION AS TO ANY HEALTH CARE PROVIDER ACTING WITHIN THE SCOPE OF THE PROVIDER'S LICENSE OR CERTIFICATION UNDER APPLICABLE STATE LAW, SOLELY ON THE BASIS OF THE LICENSE OR CERTIFICATION.

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:

"**§ 58-3-205. Discrimination based solely on licensure or certification prohibited.**

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

(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.

(b) Scope. – The requirements of this section are in addition to others applicable under this Chapter. If any of the provisions of this section are in conflict with other provisions of this Chapter, this section controls to the extent of the conflict.

(c) Discrimination Prohibited. – A health benefit plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider acting within the scope of the provider's license or certification under applicable State law, solely on the basis of the provider's license or certification. This subsection shall not be construed to prohibit a health benefit plan from:

(1) Granting participation to health care providers only to the extent necessary to meet the needs of a health benefit plan's enrollees;

(2) Using different reimbursement amounts for different specialties; or

(3) Establishing measures designed to maintain quality and control costs."

SECTION 2. This act is effective when it becomes law and applies to health benefit plans delivered, issued for delivery, renewed, extended, or modified on or after October 1, 2001.

2001 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
H.B. 1122 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 COMMISSOIN TO STUDY WORKERS' COMPENSATION INSURANCE CLASSIFICATIONS, INCLUDING THE DEVELOPMENT AND IMPLEMENTATION OF LOSS MODIFICATIONS.

☐ 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 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.

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. 1123 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.

☐ 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 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.

2002 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. 1326 A BILL TO BE ENTITLED AN ACT TO ELMINATE THE COMPREHENSIVE INSURANCE DEDUCTIBLE ON MOTOR VEHICLE WINDSHIELD GLASS.

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

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
_____ the House amendment (s).
_____the House committee substitute bill.
____ 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 1326

Short Title:	Auto-Comprehensive Deductible No Glass.	(Public)
Sponsors:	Representatives Blue, Hensley, Teague, and G. Wilson.	
Referred to:	Insurance.	

April 12, 2001

A BILL TO BE ENTITLED

AN ACT TO ELIMINATE THE COMPREHENSIVE INSURANCE DEDUCTIBLE ON MOTOR VEHICLE WINDSHIELD GLASS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-65 is amended by adding a new subsection to read:

"(n) The subclassification plan shall provide that the comprehensive coverage deductible shall not apply to motor vehicle glass. The deductible provisions of any policy of motor vehicle insurance for either comprehensive property damage or any combined additional insurance delivered or issued in this State by an insurer authorized to write motor vehicle insurance in this State shall not be applicable to damage to the windshield of any motor vehicle covered under that policy."

SECTION 2. This act becomes effective October 1, 2001.

2002 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. 1586 A BILL TO BE ENTITLED AN ACT TO ESTABLISH A REINSURANCE FACILITY FOR HOMEOWNER'S INSURANCE IN NORTH CAROLINA.

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

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

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

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

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

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

☐ Without prejudice.

☒ With an indefinite postponement report.

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

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

5/13/02

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
_____ the House amendment (s).
_____ the House committee substitute bill.
____ 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 1586*

Short Title:	Homeowners' Reinsurance Facility.	(Public)
Sponsors:	Representatives Redwine; Dedmon, Hurley, McComas, Nye, Smith, Wright, and Preston.	
Referred to:	Insurance.	

June 6, 2002

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A REINSURANCE FACILITY FOR HOMEOWNER'S INSURANCE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. The heading of Article 46 of Chapter 58 of the General Statutes reads as rewritten:

"Article 46. Fair Access to Insurance Requirements.

Part 1. Insurance Underwriting Association."

SECTION 2. Article 46 of Chapter 58 of the General Statutes is amended by adding the following new Part:

"Part 2. Homeowners' Reinsurance Facility.

"**§ 58-46-60. Findings; purpose of Part.**

(a) The General Assembly of North Carolina finds that:

(1) An adequate market for homeowner's insurance is necessary to the economic welfare of the State of North Carolina and that without that insurance the orderly growth and development in the State would be severely impeded.

(2) Adequate insurance on property in the State is necessary to enable homeowners to obtain financing for the purchase and improvement of their properties.

(3) While the need for this insurance is increasing, the market for this insurance is not adequate and is likely to become less adequate in the future.

(4) The present plans to provide adequate insurance on residences in the State, while deserving praise, have not been sufficient to meet the needs of the State.

(b) The State has an obligation to provide an equitable method whereby every licensed insurer writing homeowner's insurance in North Carolina is required to meet its

public responsibility instead of shifting the burden to a few willing and public-spirited insurers. It is the purpose of this Part to accept this obligation and to provide a mandatory program to assure an adequate market for homeowner's insurance in the State of North Carolina.

"**§ 58-46-65. Definitions.**

As used in this Part:

(1) 'Board' means the Board of Directors of the Facility.

(2) 'Cede' of 'cession' means the act of transferring the risk of loss from an individual insurer to all insurers through the operation of the Facility.

(3) 'Eligible risk' means a person who has an insurable interest in insurable property located in this State; provided, however, that a person is not an eligible risk if:

a. Timely payment of premium is not tendered by the person;

b. There is a valid unsatisfied judgment of record against the person for recovery of amounts due for premiums and the person has not been discharged from paying the judgment; or

c. The person does not furnish the information necessary to effect insurance.

(4) 'Facility' means the North Carolina Homeowners' Reinsurance Facility established by this Part.

(5) 'Homeowner's insurance' means insurance against loss to residential real property located in this State comprising not more than four housing units, its contents, any valuable interest in the property, and other insurance coverages written in connection with the sale of homeowner's insurance, as governed by Article 36 of this Chapter.

(6) 'Insurable interest' includes any lawful and substantial economic interest in the safety or preservation of property from loss, destruction, or pecuniary damage.

(7) 'Insurable property' means:

a. Residential real property located in the State comprising not more than four housing units and its contents, which is determined by the member, after inspection and under criteria specified in the Plan, to be in an insurable condition.

b. A one-family or two-family dwelling built in substantial accordance with the federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards developed by the Facility and approved by the Commissioner.

c. A one-family or two-family dwelling built in substantial accordance with the North Carolina Uniform Residential Building Code and the North Carolina State Building Code, including the design-wind requirements, that is not otherwise rendered uninsurable by reason of use or occupancy.

'Insurable property' does not mean a structure begun on or after January 1, 1970, that is not built in substantial compliance with the federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards developed by the Facility and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code, including the design-wind requirements.

(8) 'Member' means an insurance company that is a member of the Facility.

(9) 'Person' means every natural person, firm, partnership, association, limited liability company, corporation, State or local government, or State or local governmental agency.

(10) 'Plan' means the plan of operation approved under this Part and includes all written rules, practices, and procedures of the Facility, except for staffing and personnel matters.

"**§ 58-46-70. North Carolina Homeowners' Reinsurance Facility created.**

There is created the North Carolina Homeowners' Reinsurance Facility, consisting of all insurers authorized to write and engage in writing within this State, on a direct basis, homeowner's insurance, except town and county mutual insurance associations and assessable mutual companies as authorized by G.S. 58-7-75(5)b., 58-7-75(5)d., and 58-7-75(7)b. and except an insurer who only writes insurance in this State on property exempted from taxation by the provisions of G.S. 105-278.1 through G.S. 105-278.8. Every such insurer shall be a member of the Facility and shall remain a member of the Facility as long as the Facility is in existence as a condition of its authority to continue to transact the business of insurance in this State.

"**§ 58-46-75. Facility functions and administration.**

(a) The operation of the Facility shall assure the availability of homeowner's insurance to any eligible risk and the Facility shall accept all placements made in accordance with this Part and the Plan, as amended.

(b) The Facility shall require each member to adjust losses for ceded business fairly and efficiently in the same manner as voluntary business losses are adjusted and to effect settlement where settlement is appropriate.

(c) A Board of Directors shall administer the Facility. The Board shall comprise 15 directors as follows:

(1) Seven members, at least two of which shall be domestic insurers.

(2) Three individuals not employed by, or otherwise affiliated with, insurers, insurance agents, insurance brokers, producers, or other entities of the insurance industry.

(3) Four individuals who are North Carolina licensed insurance agents or brokers.

(4) The Commissioner, who shall serve ex officio.

(d) The seven member directors shall be elected annually by cumulative voting by the members, whose votes shall be weighted in accordance with the proportion that each member's premium written in the State during the most recent calendar year for which data are available bear to the aggregate premiums written by all members. Voting may be in person or by proxy. Not more than one member in a group under the same management or ownership shall serve on the Board at the same time. The three individual members not affiliated with the insurance industry and the four insurance agents or brokers shall be appointed annually by the Commissioner.

(e) The Board shall elect from its membership a chair and shall meet at the call of the chair or at the request of four or more Board members. The chair shall retain the right to vote on all issues. Eight Board members shall constitute a quorum. The same Board member may not serve as chair for more than two consecutive years; provided, however, that a Board member may continue to serve as chair until a successor chair is elected and qualified.

(f) Board members shall receive reimbursement from the Facility for their actual and necessary expenses incurred on Facility business, en route to perform Facility business, and while returning from Facility business.

(g) Except as may be delegated specifically to others in the Plan or reserved to the members, power and responsibility for the establishment and operation of the Facility is vested in the Board, including the following:

(1) To sue and be sued in the name of the Facility. No judgment against the Facility creates any direct liability in the individual members.

(2) To receive and record cessions.

(3) To assess members on the basis of participation ratios established in the Plan to cover anticipated or incurred costs of operation and administration of the Facility at such intervals that are established in the Plan.

(4) To contract for goods and services from others to assure the efficient operation of the Facility.

(5) To purchase reinsurance on behalf of the members.

(6) To maintain all loss, expense, and premium data relative to all risks reinsured in the Facility, and to require each member to furnish such statistics relative to insurance reinsured by the Facility at such times and in such form and detail as may be required.

(7) To establish fair and reasonable procedures for participation by members under G.S. 58-46-85.

(8) To receive or distribute all sums required by the operation of the Facility.

(9) To accept all risks submitted in accordance with this Part.

(10) To establish procedures for reviewing claims practices of members to the end that claims to the account of the Facility will be handled fairly and efficiently.

(11) To adopt and enforce all rules and to do anything else where the Board is not elsewhere specifically authorized that is otherwise necessary to

accomplish the purpose of the Facility and is not in conflict with this Part.

(h) Each member shall authorize the Facility to audit that part of the member's business that is written subject to the Facility in a manner and time prescribed by the Board.

(i) The Facility shall furnish each member with a copy of an annual report of the operation of the Facility in the form and detail determined by the Board.

(j) Each member shall furnish statistics in connection with insurance subject to the Facility as may be required by the Facility. The statistics shall be furnished at the time and in the form and detail that the Board requires but, at a minimum, shall include premiums charged, expenses, and losses.

(k) The rates, rating plans, rating rules, and forms applicable to the insurance written by the Facility shall be in accordance with the most recent manual rates or adjusted loss costs and forms that are legally in effect in the State. No special surcharge, other than those presently in effect, may be applied to homeowner's insurance rates.

"**§ 58-46-80. Plan of operation.**

(a) Within 60 days after the initial organizational meeting, the Facility shall submit to the Commissioner, for his approval, a proposed Plan, consistent with this Part, which shall provide for economical, fair, and nondiscriminatory administration and for the prompt and efficient provision of homeowner's insurance to eligible risks. If no Plan is submitted within the 60-day period, the Commissioner shall formulate and place into effect a Plan consistent with this Part.

(b) The proposed Plan shall be reviewed by the Commissioner and approved by him if he finds that the Plan satisfies G.S. 58-46-60. In the review of the proposed Plan, the Commissioner may consult with the Board and may seek any further information that the Commissioner considers necessary for the Commissioner's decision. If the Commissioner approves the proposed Plan, the Commissioner shall certify the approval to the Board; and the Plan shall become effective 10 days after the certification. If the Commissioner disapproves all or any part of the proposed Plan, the Commissioner shall return the proposed Plan to the Board with a written statement for the reasons for disapproval and any recommendations. The Board may change the Plan in accordance with the Commissioner's recommendation or may, within 30 days after the date of disapproval, return a new Plan to the Commissioner. If the Board fails to submit a proposed Plan within 90 days after October 1, 2002, or a new Plan that is acceptable to the Commissioner, or accept the recommendations of the Commissioner within 30 days after disapproval of the Plan, the Commissioner shall develop and place a Plan into effect. Any Plan developed by the Commissioner shall become effective 10 days after certification to the Board: Provided, however, that until a Plan is in effect under this Part, the North Carolina Insurance Underwriting Association and the North Carolina Joint Underwriting Association shall be continued in effect on a mandatory basis on such terms as the Commissioner determines.

(c) The Board may, subject to the approval of the Commissioner, amend the Plan at any time. The Commissioner may review the Plan at any time the Commissioner considers expedient or prudent, but not less than once in each calendar year. After

review of the Plan the Commissioner may amend the Plan after consultation with the Board.

(d) On the effective date of the Plan, all insurance companies licensed to write homeowner's insurance in this State as a prerequisite to further engaging in writing the insurance shall formally subscribe to and participate in the Plan.

(e) In order to obtain a transfer of business to the Facility effective when the binder or policy or renewal of the policy first becomes effective, the member shall within 30 days after the binding or policy effective date notify the Facility of the identification of the insured, the coverage and limits afforded, classification data, and premium. The Facility shall accept risks at other times on receipt of necessary information, but acceptance shall not be retroactive. The Facility shall accept renewal business after the member, on underwriting review, elects to again cede the business.

(f) The Plan shall provide that all investment income from premiums on business reinsured by the Facility shall be retained by or paid over to the Facility. In determining the cost of operation of the Facility, all investment income shall be taken into consideration.

(g) The Plan shall provide for audit of the annual statement of the Facility by independent auditor approved by the Commissioner.

"**§ 58-46-85. Participation in Facility expenses, profits, and losses.**

(a) Each member shall participate in the expenses, profits, and losses of the Facility in the proportion that its written exposure in this State during the preceding calendar year for residential properties bears to the aggregate written exposure in this State during the preceding calendar year for residential properties by all members, as certified to the Facility by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Facility for this purpose. Any insurer that is authorized to write and that is engaged in writing homeowner's insurance shall become a member of the Facility on the first day of January after authorization. The determination of the member's participation in the Facility shall be made as of the date of membership in the same manner as for all other members.

(b) All members shall receive credit each year for homeowner's insurance voluntarily written in the State in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. The participation of each member in the expenses, profits, and losses of the Facility shall be reduced accordingly. The guidelines and procedures for granting credit shall encourage and assist each member to voluntarily write these coverages in the State for commercial and residential properties.

(c) The Facility shall use the 'take-out' program, as filed with and approved by the Commissioner.

"**§ 58-46-90. Designated agents.**

(a) Upon the request of any licensed property and liability agent meeting any two of the standards set forth in subdivisions (1) through (5) of this subsection, as determined by the Commissioner within 10 days after receipt of the application, the

Facility shall contract with one or more members within 20 days after receipt of the Commissioner's determination to appoint the agent as a designated agent in accordance with reasonable rules established by the Plan. The standards shall be whether the agent's evidence establishes:

(1) The agent has been conducting insurance business in a community for at least one year.

(2) The agent had a gross premium volume during the 13 months before the date of application of at least twenty thousand dollars ($20,000) from homeowner's insurance.

(3) The number of eligible risks served by the agent during the 13 months before the date of application was 200 or more.

(4) There was a growth in eligible risks served and premium volume during the agent's years of service as an agent.

(5) The agent made available to eligible risks premium financing or any other plan for deferred payment of premiums.

(b) With respect to business produced by designated agents, adequate provision shall be made by the Facility to assure that such business is rated in accordance with this Part and the Plan. All business produced by designated agents may be ceded to the Facility. If no insurer is willing to contract with a designated agent on terms acceptable to the Board, the Facility shall license the agent to write directly on behalf of the Facility. 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 in accordance with this Part and the Plan. 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 property and liability agent meeting the requirements of this section and under rules established by the Facility.

(c) No agent may be designated under this section to any insurer that does not actively write voluntary market business.

"**§ 58-46-95. General obligations of members and agents.**

(a) Except as otherwise provided in this Part, as a prerequisite to the further engaging in this State in the writing of homeowner's insurance, all insurers shall accept and insure any otherwise unacceptable applicant who is an eligible risk if cession of the coverage applied for is authorized under this Part. Members shall equitably share the results of the business ceded to the Facility and shall be bound by the acts of their agents in accordance with this Part. No member shall impose upon any of its agents, solely on account of ceded business received from those agents, any quota or matching requirement for any other insurance as a condition for further acceptance of ceded business from those agents. Upon receipt by a member of a risk that it does not elect to retain, the member shall follow the procedures for ceding the risk as are established by the Plan.

(b) Each member shall provide the same type of service to ceded business that it provides for voluntary market business. Records provided to agents and brokers shall include an indication that the business is ceded.

(c) Except as otherwise provided in this Part, no licensed agent of an insurer authorized to solicit and accept premiums for homeowner's insurance or by the member the agent represents shall refuse on behalf of the member to accept any application from an eligible risk for the insurance and to immediately bind the coverage applied for and for a period of not less than six months if cession of the particular coverage and coverage limits applied for are permitted in the Facility, provided the application is submitted during the agent's normal business hours, at the agent's customary place of business, and in accordance with the agent's customary practices and procedures. If the agent refuses to accept an application because the property in not insurable property, the agent shall inform the applicant that the applicant may request a review by the Facility of the agent's refusal. The Facility shall review the refusal and shall accept cession of the risk if the Facility determines the property is insurable property. If the Facility determines that the property is not insurable property, the applicant may ask the Facility to reconsider its decision or appeal to the Commissioner as provided in G.S. 58-46-115.

(d) None of the following factors shall be considered in determining insurable condition: neighborhood, area, geographic location, or environmental hazards beyond the control of the applicant or owner of the property.

(e) The owner or applicant shall furnish, with the application, proof in the form of a certificate from a local building inspector, contractor, engineer, or architect that the structure is built in substantial accordance with the federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards developed by the Facility and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code; however, an individual certificate shall not be necessary where the structure is located within a political subdivision which has certified to the Facility on an annual basis that it is enforcing the North Carolina Uniform Residential Building Code or the North Carolina State Building Code and has no plans to discontinue enforcing these codes during that year.

"**§ 58-46-100. Miscellaneous.**

(a) Any member whose membership in the Facility has been terminated by withdrawal shall, with respect to its business before midnight of the effective date of the termination, continue to be governed by this Part.

(b) Any unsatisfied net liability to the Facility of any insolvent member shall be assumed by and apportioned among the remaining members in the Facility in the same manner in which assessments are apportioned by the Facility. The Facility shall have all rights allowed by law in behalf of the remaining members against the estate or funds of the insolvent for sums due the Facility in accordance with this Part. Any assessment against an insolvent insurer shall not be a charge against any special deposit fund held under the provisions of Article 5 of this Chapter for the benefit of policyholders.

(c) When a member has been merged or consolidated into another insurer, or has reinsured its entire property insurance business in the State with another insurer, the member or its successor in interest shall remain liable for all obligations under this Part; and the member, its successor in interest, and the other insurers with which it has been merged or consolidated shall continue to participate in the Facility according to the Plan.

"**§ 58-46-105. Termination of insurance.**

No member may terminate insurance to the extent that cession of a particular type of coverage and limits is available under this Part except for the following reasons:

(1) Nonpayment of premium when due to the member or producing agent.

(2) A member has terminated an agency contract for reasons other than the quality of the agent's insureds, or the agent has terminated the contract, and the agent represented the member in taking the original application for insurance.

(3) When the insurance contract has been cancelled under a power of attorney given a member licensed under G.S. 58-35-5.

(4) The named insured, at the time of renewal, fails to meet the requirements contained in the corporate charter, articles of incorporation, and/or bylaws of the member, when the member is a company organized for the sole purpose of providing members of an organization with insurance policies in North Carolina.

"**§ 58-46-110. Appeals.**

(a) Any person or any member, who may be aggrieved by an act, ruling, or decision of the Facility other than an act, ruling, or decision relating to the cause or amount of a claimed loss, 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 may 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 has the same effect as if heard by the Commissioner. Any person aggrieved by any order or decision of the Commissioner may appeal under 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 Facility, 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 the costs by the other party. If the matter is between an insured and the Facility, the cost of transcribing shall be borne equally by the appellant and appellee; provided that the Commissioner may order the Facility 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.

"**§ 58-46-115. Immunity.**

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the Facility or its agents or employees, the Board, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Part.

"**§ 58-46-120. Annual report.**

The Facility shall file in the office of the Commissioner on an annual basis, on or before January 1, a statement that summarizes the transactions, conditions, operations and affairs of the Facility during the preceding year. The statement shall contain such matters and information as are prescribed by the Commissioner and shall be in such form as is approved by him. The Commissioner may at any time require the Facility to furnish to him any additional information with respect to its transactions or any other matter which the Commissioner deems to be material to assist him in evaluating the operation and experience of the Facility.

"**§ 58-46-125. Examinations.**

The Commissioner may from time to time make an examination into the affairs of the Facility under the Examination Law. The expenses of the examination shall be borne and paid by the Facility.

"**§ 58-46-130. Penalty for abuse of procedure.**

An insurer or agent that cedes uninsurable property to the Facility with such frequency as to indicate a general business practice is subject to G.S. 58-2-70.

"**§ 58-46-135. Open meetings.**

The Board is subject to the Open Meetings Act, Article 33C of Chapter 143 of the General Statutes, as amended.

"**§ 58-46-140. Rules.**

The Commissioner may adopt rules, not inconsistent with law, to enforce, carry out and make effective this Part. The Commissioner shall not be liable for any act or omission in connection with the administration of the duties imposed upon him by this Part."

SECTION 3. G.S. 58-2-52(a) reads as rewritten:

"(a) The Commissioner may adopt rules for the hearing of appeals by the Commissioner or the Commissioner's designated hearing officer under G.S. 58-36-35, 58-37-65, 58-45-50, 58-46-30, 58-46-110, 58-48-40(c)(7), 58-48-42, and 58-62-51(c). These rules may provide for prefiled evidence and testimony of the parties, prehearing statements and conferences, settlement conferences, discovery, subpoenas, sanctions, motions, intervention, consolidation of cases, continuances, rights and responsibilities of parties, witnesses, and evidence."

SECTION 4. 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. Section 3 of this act becomes effective on the date the Plan of Operation of the North Carolina Homeowners' Reinsurance Facility becomes effective under Section 2 of this act. The remainder of this act is effective when it becomes law.

MEMORANDUM

DATE: **September 26, 2002**

TO: **Representatives Bill Hurley & Jerry Dockham**

FROM: **Representatives Bill Hurley & Jerry Dockham**

SUBJECT: **Bills Pending in the Committee on INSURANCE**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

If you would like to request that the Committee on INSURANCE not consider your bill; for your convenience, a printed form is included at the bottom of this page. Please complete, sign and return the form to Room 2215. This form may **not** be e-mailed because it requires the sponsor's signature.

MEMORANDUM

TO: **Representatives Bill Hurley & Jerry Dockham**

FROM: **Representatives Bill Hurley & Jerry Dockham**
Bill Sponsors

SUBJECT: **HB 346, Insurance Producer Licensing.** (Short Title)

I request that the Committee on INSURANCE not consider HB 346.

Rep. Bill Hurley
(Sponsor's Signature)

Jerry C. Dockham
(Sponsor's Signature)

September 26, 2002 Date

MEMORANDUM

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MEMORANDUM

TO: **Representatives Bill Hurley & Jerry Dockham**

FROM: **Representatives Bill Hurley & Jerry Dockham**
Bill Sponsors

SUBJECT: **HB 347, Insurance Financial Amendments.** (Short Title)

I request that the Committee on INSURANCE not consider HB 347.

(Sponsor's Signature)

(Sponsor's Signature)

September 26, 2002 Date

MEMORANDUM

DATE: **September 26, 2002**

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FROM: **Representatives Bill Hurley & Jerry Dockham**

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MEMORANDUM

TO: **Representatives Bill Hurley & Jerry Dockham**

FROM: **Representatives Bill Hurley & Jerry Dockham**
Bill Sponsors

SUBJECT: **HB 349, Insurance Information Privacy-AB.** (Short Title)

I request that the Committee on INSURANCE not consider HB 349.

(Sponsor's Signature)

(Sponsor's Signature)

September 26, 2002 Date

MEMORANDUM

DATE: **September 26, 2002**

TO: **Representatives Jerry Dockham & Bill Hurley**

FROM: **Representatives Jerry Dockham & Bill Hurley**

SUBJECT: **Bills Pending in the Committee on INSURANCE**

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MEMORANDUM

TO: **Representatives Bill Hurley & Jerry Dockham**

FROM: **Representatives Jerry Dockham & Bill Hurley**
Bill Sponsors

SUBJECT: **HB 353, Workers' Comp. Cancellations and Renewals-AB.** (Short Title)

I request that the Committee on INSURANCE not consider HB 353.

Jerry C. Dockham
(Sponsor's Signature)

Bill Hurley
(Sponsor's Signature)

September 26 2002 Date

MEMORANDUM

DATE: **September 26, 2002**

TO: **Representatives Jerry Dockham & Bill Hurley**

FROM: **Representatives Jerry Dockham & Bill Hurley**

SUBJECT: **Bills Pending in the Committee on INSURANCE**

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MEMORANDUM

TO: **Representatives Bill Hurley & Jerry Dockham**

FROM: **Representatives Jerry Dockham & Bill Hurley**
Bill Sponsors

SUBJECT: **HB 354, Workers' Compensation Amendments-AB.** (Short Title)

I request that the Committee on INSURANCE not consider HB 354.

(Sponsor's Signature)

(Sponsor's Signature)

September 26, 2002 Date

MEMORANDUM

DATE: **September 26, 2002**

TO: **Representatives Jerry Dockham & Bill Hurley**

FROM: **Representatives Jerry Dockham & Bill Hurley**

SUBJECT: **Bills Pending in the Committee on INSURANCE**

Pursuant to House Rule 36(a) all House bills and resolutions shall be reported from the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair(s) of the standing committee or permanent subcommittee that the bill not be considered.**

If you would like to request that the Committee on INSURANCE not consider your bill; for your convenience, a printed form is included at the bottom of this page. Please complete, sign and return the form to Room 2215. This form may **not** be e-mailed because it requires the sponsor's signature.

MEMORANDUM

TO: **Representatives Bill Hurley & Jerry Dockham**

FROM: **Representatives Jerry Dockham & Bill Hurley**
Bill Sponsors

SUBJECT: **HB 358, Insurnce Exam Law Amendments.** (Short Title)

I request that the Committee on INSURANCE not consider HB 358.

(Sponsor's Signature)

(Sponsor's Signature)

September 26, 2002 Date