2003-2004

HOUSE INSURANCE

COMMITTEE MINUTES

NORTH CAROLINA GENERAL ASSEMBLY HOUSE INSURANCE COMMITTEE 2003–2004 SESSION



Rep. Hugh Holliman Chair



Rep. Mitchell Setzer Chair



Rep. John Hall Vice-Chair



Rep. Lucy Allen



·Rep. Bobby Barbee



Rep. Robert Grady



Rep. Howard Hunter



Rep. Charles Johnson



Rep. Linda Johnson



Rep. David Lewis



Rep. David Miner



Rep. Karen Ray



Rep. Drew Saunders



Rep. William Wainwright



Rep. Connie Wilson



Rep. Tom Wright



Rep. Harold Brubaker Ex-officio



Rep. Bill Culpepper Ex-officio



Rep. Pete Cunningham Ex-officio



Rep. Rick Eddins Ex-officio

HOUSE COMMITTEE ON INSURANCE

| MEMBER | <u>ASSISTANT</u> | PHONE | | OFFICE | <u>SEAT</u> |
|-------------------------|--------------------|----------|------|---------------|-------------|
| Holliman, Hugh, Chair | Carol Bowers | 5-0873 | | 1213 | 55 |
| Setzer, Mitchell, Chair | Joanna Mills | 3-4948 | | 1204 | 42 |
| Hall. John, Vice-Chair | Delta Prince | 3-5878 | · | 611 | 60 |
| Allen, Lucy | Melissa Riddle | 3-5860 | | 1307 | 92 |
| Barbee, Bobby | Rosa Murray | 3-5908 | | 1025 | 52 |
| Grady, Robert | Peggy Murray | 5-9644 | | 302A | 4 |
| Hunter , Howard | Barbara Phillips | 3-2962 | | 613 | 68 |
| Johnson, Charles | Sally Gillis | 5-3021 | | 416A | 116 |
| Johnson, Linda | Debbie Pons | 3-5861 | | 1006 | 28 |
| Lewis, David | Marie Strickland | 5-3015 | | 509 | 73 |
| Miner, David | Susan Phillips | 3-5956 | | 2204 | 6 |
| Ray, Karen | Susan Brothers | 3-5741 | | 1315 | 75 |
| Saunders, Drew | Ruth Fish | 3-5606 | | 2217 | 48 |
| Wainwright, William | Blinda Edwards | 3-5995 | | 532 | 8 |
| Wilson, Connie | Chris Floyd | 3-5849 | | 503 | 37 |
| Wright, Tom | Clarestene Stewart | 3-5754 | | 528 | 19 |
| Ex-Officio Members: | | | | | |
| Brubaker, Harold | Cindy Coley | 5-4946 | | 1229 | 2 |
| Culpepper, Bill | Dot Crocker | 5-3028 | | 404 | 36 |
| Cunningham, Pete | Valerie Rustin | 3-5778 | | 541 | 7 |
| Eddins, Rick | Dorie Monroe | 3-5828 1 | 1002 | 26 | |

Legislative Staff:

earch – 733-2578 - Tim Hovis, Linda Attarian and Kori Goldsmith

ATTENDANCE

HOUSE INSURANCE COMMITTEE

| DATES | 2/26/03 | _ | / | 4) 08) | | | 4) | <i> </i> | | 129 | | 5/0/0 | 5/5/80 | 5/20 | 2/03 |
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| Rep. Hugh Holliman, Chair | V | v | V | V | V | 1 | r | V | V | V | V | V | ~ | / | V |
| Rep. Mitchell Setzer, Chair | V | V | V | V | V | ~ | V | V | V | V | V | V | V | \ | 1 |
| Rep. John Hall, Vice-Chair | V | r | V | V | | | V | V | | V | V | | 7 | | |
| Rep. Lucy Allen | ~ | V | V | V | V | V | V | V | ν | V | ~ | V | V | V | レ |
| Rep. Bobby Barbee | V | V | V | V | V | | V | V | V | V | V | 7 | 1 | V | V |
| Rep. Robert Grady | | | | | | V | V | V | | ノ | V | | | / | V |
| Rep. Howard Hunter | V | | | | | | ✓ | V | V | V | | V | V | | |
| Rep. Charles Johnson | 1 | V | \ | V | 1 | / | V | / | V | J | V | V | ~ | / | V |
| Rep. Linda Johnson | V | V | | | | V | V | V | | V | V | V | V | 1/ | |
| Rep. David Lewis | V | V | ~ | V | V | | V | V | V | ン | V | V | | V | V |
| Rep. David Miner | | V | V | V | | | | V | | \ | V | | | | |
| Rep. Karen Ray | | V | ~ | | V | V | ✓ | v | V | V | \ | V | | / | V |
| Rep. Drew Saunders | V | ✓ | V | V | V | V | V | ~ | V | V | > | | ~ | V | |
| Rep. William Wainwright | V | | | | | | | V | 9 ₁ | V | V | | ゝ | 1 | V |
| Rep. Connie Wilson | V | V | | | | V | \checkmark | 1 | V | \checkmark | V | ン | / | / | V |
| Rep. Tom Wright | | V | | | | | V | V | 1 | V | Y | | | V | V |
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| Rep. Bill Culpepper, Ex-officio | | | | | | | | | | | , | | | | |
| Rep. Pete Cunningham, Ex-officio | V | | V | | | | <u> </u> | | | | | | | | |
| Rep. Rick Eddins, Ex-officio | | | | | | | | V | | | | | | | |
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ATTENDANCE

HOUSE INSURANCE COMMITTEE

| DATES | 5/27/03 | 5/29/03 | 6/03/02 | 6 | 6, | | | | | | | | | | |
|----------------------------------|----------|----------|---------|----------|-----|---|----------|----------|----------|----------|----------|--------------|--|---------|--|
| Rep. Hugh Holliman, Chair | | V | V | 23 | 103 | | 1 | | | | | | ļ | | |
| Rep. Mitchell Setzer, Chair | V | V | V | V | | _ | | | | | | | | | |
| Rep. John Hall, Vice-Chair | | | V | | | | | | | - | | | | | |
| Rep. Lucy Allen | ✓ | V | V | V | V | | | | | | - | | | | |
| Rep. Bobby Barbee | V | ~ | V | V | V | | | | | | | | | | |
| Rep. Robert Grady | | V | V | | | | | | | | | | | | |
| Rep. Howard Hunter | V | 1 | V | | V | | | | | | | | | | |
| Rep. Charles Johnson | V | V | V | V | 1 | | | | | | | 1 | | | |
| Rep. Linda Johnson | | ✓ | | V | | | | | | | | 1 | | | |
| Rep. David Lewis | Y | V | V | | / | | | | | | | | | | |
| Rep. David Miner | | | V | | V | | | | | | | | | | |
| Rep. Karen Ray | V | | V | 1 | 1 | | | | | | | | | | |
| Rep. Drew Saunders | V. | V | V | V | V | | | | | | | | | | |
| Rep. William Wainwright | V | V | V | U | V | | | | | | | | | | |
| Rep. Connie Wilson | V | | V | | V | | | | | | | | | | |
| Rep. Tom Wright | | | | | | | | | | | | | | | |
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| Rep. Harold Brubaker, Ex-officio | | | | | V | | | | | | <u> </u> | | <u> </u> | | |
| Rep. Bill Culpepper, Ex-officio | | | | | | | | | | | | ļ | | <u></u> | |
| Rep. Pete Cunningham, Ex-officio | | | | | | | <u> </u> | | <u> </u> | | | | ļ | | |
| Rep. Rick Eddins, Ex-officio | | | | | | | | - | ļ | | | | | | |
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MINUTES

HOUSE COMMITTEE ON INSURANCE

FEBRUARY 26, 2003

The House Committee on Insurance met at 1:05PM on February 26, 2003. The following Representatives attended: Hugh Holliman, Mitchell Setzer, John Hall, Lucy Allen, Bobby Barbee, Howard Hunter, Charles Johnson, Linda Johnson, David Lewis, Drew Saunders, William Wainwright, Connie Wilson, Pete Cunningham.

Chair Hugh Holliman called the meeting to order. Introduced Senator Kerr to speak on SB 8. He spoke on the urgency of passing SB 8

Rep. Saunders spoke to who determines what is a major disaster.

Franklin Freeman encouraged the committee to do whatever is needed to get this bill to the Governor and the Gov. is prepared to sign it.

Rep. LaRoque thanked everyone for his or her assistance and support for the people in his district.

Former Commissioner Harry Payne expressed his appreciation for the timely manner on moving SB 8.

Rep. Hall and Rep. Saunders moved for a favorable report. Rep. Hunter seconded the motion.

SB 8 was sent to the clerk's office with a favorable report.

Meeting adjourned at 1:25PM.

Rep. L. Hugh Holliman, Chair

Rep. Mitchell Setzer, Chair

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

February 26, 2003 1:00 P.M. ROOM 1228 LB

<u>Chairs</u> Representative Hugh Holliman Representative Mitchell Setzer

<u>Vice Chair</u> Representative John Hall

AGENDA

Senate Bill 8: Industrial Disaster Unemployment Benefits

Sponsors: Senators Kerr; and Purcell

1

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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SENATE BILL 8

| | Short Title: | Industrial Disaster Unemployment Benefits. (Pu | ıblic) |
|----|--------------|--|--------|
| | Sponsors: | Senators Kerr; and Purcell. | |
| | Referred to: | Finance. | |
| | | February 10, 2003 | |
| 1 | | A BILL TO BE ENTITLED | |
| 1 | ANI ACT D | PROVIDING IMMEDIATE ELIGIBILITY FOR UNEMPLOYM | ENT |
| 2 | BENEFIT | TO A DEAL PROPERTY OF THE PROP | JOR |
| 3 | | RIAL DISASTER. | 13010 |
| 4 | | | |
| 5 | ine General | Assembly of North Carolina enacts: CCTION 1. G.S. 96-13 is amended by adding a new subsection to read | 1. |
| 6 | SE UK 1) A T | to claims filed on or after January 29, 2003, the waiting period | for a |
| 7 | "(c1) As | to claims filed oil of after January 25, 2005, the waiting period | met: |
| 8 | | shall not be required of a claimant if all of the following conditions are | maior |
| 9 | <u>(1)</u> | The benefits are to be paid for unemployment due directly to a reindustrial disaster that destroys substantially all of the phy | |
| 10 | | | ysicai |
| 11 | (2) | facilities of a manufacturing plant. The Governor has acknowledged the disaster through the creation. | on of |
| 12 | (2) | | |
| 13 | | such task forces as are needed to coordinate State assistance to | o uic |
| 14 | (2) | manufacturer and its employees. | rizina |
| 15 | (3) | The Governor has issued an Executive Order directing and author | de for |
| 16 | *. | the Employment Security Commission to waive the waiting wee | K 101 |
| 17 | | employees of the manufacturer. | |
| 18 | <u>(4)</u> | The Employment Security Commission shall implement regular | |
| 19 | | prescribing the procedure for the waiver of the waiting period we | ek in |
| 20 | | accordance with G.S. 96-4(b)." | |
| 21 | SE | ECTION 2. This act is effective when it becomes law. | |

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: SB 8

(First Edition)

SHORT TITLE: Industrial Disaster Unemployment Benefits.

SPONSOR(S):

Senators Kerr, Purcell

FISCAL IMPACT

Yes (X)

No ()

No Estimate Available ()

FY 2003-04 FY 2004-05 FY 2005-06 FY 2006-07 FY 2007-08

REVENUES

EXPENDITURES

Unemployment Insurance

Trust Fund

** See Assumptions and Methodology**

POSITIONS: None

PRINCIPAL DEPARTMENT(S) &

PROGRAM(S) AFFECTED: Employment Security Commission, Unemployment

Insurance Division

EFFECTIVE DATE: This Act is effective when it becomes law.

BILL SUMMARY: The Act removes the one-week waiting period for unemployment insurance (UI) benefit claimants who are unemployed due directly to a major industrial disaster that destroys substantially all of the physical facilities of a manufacturing plant. Under current statute, an unemployed person seeking UI benefits from the Employment Security Commission (ESC) must wait one week after an initial claim is filed before receiving benefits.

ASSUMPTIONS AND METHODOLOGY:

Risk of Overpayment

The primary purpose of the one-week waiting period is to allow ESC to confirm the validity of an individual's benefit claim. Waiving the waiting period for UI benefits in situations where there is uncertainty regarding the validity of a claim, would increase the risk of overpayment of benefits due to fraudulent or otherwise ineligible claims. This overpayment would increase costs to the Unemployment Insurance Trust Fund. In situations where there is no uncertainty regarding the validity of a claim, there is virtually no risk of overpayment. This analysis assumes that any claims filed pursuant to the Act will be clearly valid (i.e., the reason for separation from employment will be well established) and will, thus, pose no risk of overpayment. The Act will, therefore, impose no cost on the UI Trust Fund as a result of overpayment.

Effect on Weeks of Benefits Paid

The Act does not affect the total number of weeks of State unemployment insurance benefits for which targeted workers are eligible. No individual may receive greater than 26 weeks of benefits per benefit year. By waiving the one-week waiting period required by current statute, however, the Act does ensure that individuals receive benefit payments sooner than they would under current statute. Assuming an individual does not use the maximum number of weeks of benefits for which she is eligible, this expedited receipt of benefits will increase the number of weeks of benefits received by the individual prior to returning to work. Regardless of how long the individual receives benefits (short of the maximum for which the individual is eligible) before returning to work, they will have received one more week of benefits than they would have in the absence of the Act. This payout of "additional" benefits will have some fiscal impact on the UI Trust Fund. Based on the assumptions described below, this analysis estimates that impact to be up to approximately \$40,800 for FY 2002-03.

The effects on the UI Trust Fund in a given fiscal year will depend primarily upon several factors: (1) number of qualifying disaster events, (2) number of workers eligible for waiver of the waiting period pursuant to the Act, and (3) number of workers who file claims for benefits for fewer than the maximum for which they are eligible. According to staff at ESC, an industrial disaster at a plant that causes 225 workers to be unemployed and eligible for UI benefits is likely to produce approximately 100 workers who file claims for fewer than the maximum weeks of benefits for which they are eligible. If each of these workers were to receive the State maximum weekly benefit each week, the total impact of their "additional" week would be \$40,800. The following calculation illustrates how this amount is reached:

100 workers X \$408 (maximum weekly benefit) = \$40,800 in "additional" benefits paid

It is unlikely that all 100 workers would receive the maximum weekly benefit. Therefore, assuming only one qualifying industrial disaster in FY 2002-03, the total payout may well be less than \$40,800.

Since it is not possible to predict accurately the number of qualifying industrial disasters that will occur in future years, an estimate of fiscal impact on the UI Trust Fund going forward is not available.

SOURCES OF DATA: Employment Security Commission

FISCAL RESEARCH DIVISION: (919) 733-4910 PREPARED BY: Adam Levinson, Fiscal Analyst

Orlam Fri

APPROVED BY: James D. Johnson, Director, Fiscal Research Division

DATE: February 11, 2003



INDUSTRIAL DISASTER UNEMPLOYMENT **BENEFITS:** Senate Bill 8

Committee: House Insurance

Date:

February 26, 2003

Version:

1st Edition

Introduced by: Sen. Kerr

Summary by:

Cindy Avrette

Staff Attorney

SUMMARY: Senate Bill 8 removes the one-week waiting period for claimants who are unemployed due directly to a major industrial disaster that destroys substantially all of the physical facilities of a manufacturing plant. The bill is effective when it becomes law.

An unemployed person seeking unemployment benefits from the Employment **CURRENT LAW:** Security Commission must wait one week after a claim is filed before receiving benefits. This period is known as the "wait week period". Since 1977, the wait week period has served as an investigation period for ESC to verify with the claimant's employer the circumstances surrounding the unemployment to prevent fraudulent claims.

BILL ANALYSIS: Senate Bill 8 removes the wait week period for claims filed on or after January 29. 2003, if all of the following conditions are met:

- ✓ The unemployment is due directly to a major industrial disaster that destroys substantially all of the physical facilities of a manufacturing plant.
- ✓ The Governor has acknowledged the disaster through the creation of a task force to coordinate State assistance to the manufacturer and its employees.
- ✓ The Governor has issued an Executive Order directing and authorizing ESC to waive the waiting week for employees of the manufacturer.

The bill is effective when it becomes law.

Only one fact circumstance meets these conditions at this time and that circumstance is the explosion of the West Pharmaceutical plant in Kinston, North Carolina. The explosion on January 29, 2003, substantially destroyed the physical facilities of the West Pharmaceutical plant. The Governor has created a Disaster Task Force consisting of Crime Control and Public Safety, the Department of Health and Human Services, the Employment Security Commission, the Industrial Commission, and the Department of Labor. Finally, if the General Assembly enacts this legislation, the Governor will be able to direct ESC to waive the wait week period for the employees of West Pharmaceutical.

The General Assembly enacted similar legislation in 1999 for individuals unemployed due directly to a major natural disaster as part of the Hurricane Floyd Recovery Act of 1999. Under that legislation, the President of the United States must declare a disaster under the Disaster Relief Act of 1970 for ESC to waive the wait week period. In these disaster circumstances, the need for the wait week period is diminished because the circumstances surrounding the unemployment are undisputed.

INDUSTRIAL DISASTER UNEMPLOYMENT BENEFITS

Page 2

BACKGROUND: The severely damaged West Pharmaceutical facility in Kinston hosts the Automated Compounding System where bulk rubber materials are mixed into formulations for molding into medical device components as well as a molding and finishing area where finished components are produced. The Kinston facility is the largest of West's five US rubber compounding facilities and one of the worldwide. The facility employs 255 people. Four people have died as a result of the explosion and many others were injured.

West Pharmaceutical plans to pay its employees of the Kinston facility through the end of February. Therefore, the employees will not be eligible to file for unemployment insurance benefits until March 1st. If this legislation is enacted before March 1st, the employees will be able to receive up to 26 weeks of unemployment insurance benefits without an interruption. If the legislation is not enacted before March 1st, the employees will have to wait a week from the time they file their claim for unemployment benefits until they receive a payment.²

² Unemployment benefits are subject to federal and State individual income tax. G.S. 96-12(g). IRC 104(a)(1) excludes workers' compensation benefits from gross income.

¹.Employees injured or killed by the industrial disaster of the West Pharmaceutical facility are eligible for workers' compensation benefits. An employee is not eligible for both workers' compensation and unemployment benefits for the same time period.

VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

February 26, 2003

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| FIRM OR AGENCY AND ADDRESS |
|----------------------------|
| NC Justice Conter |
| Morros Van Allan |
| Young, Moone |
| DRDAN PRICE LAW FIRM |
| House Marker |
| Gov. office |
| EC |
| |
| NC Statewatch |
| NC DOI |
| Ne DOS |
| |

VISITOR REGISTRATION SHEET

February 26, 2003

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| | NAME | FIRM OR AGENCY AND ADDRESS |
|--------------|-----------------|----------------------------|
| | Jerry Dockham | Member NCGA- |
| gers. | Man Toplan | NESJL |
| \ <i>U</i> ; | Paul Pully | NCATL |
| - | Mike Okun | NU Str DELSCO |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representative(s) Holliman and Setzer (Chair/Chairs) for the Committee on INSURANCE. Committee Substitute for A BILL TO BE ENTITLED AN ACT PROVIDING IMMEDIATE ELIGIBILITY FOR UNEMPLOYMENT BENEFITS TO INDIVIDUALS UNEMPLOYED DUE TO A MAJOR INDUSTRIAL DISASTER. 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 # 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) 1/29/03

MINUTES

HOUSE COMMITTEE ON INSURANCE

MARCH 27, 2003

The House Committee on Insurance met at 10:00 AM on March 27, 2003. The following Representatives attended: Mitchell Setzer, Hugh Holliman, John Hall, Lucy Allen, Bobby Barbee, Robert Grady, Charles Johnson, Linda Johnson, David Lewis, David Miner, Karen Ray, Drew Saunders, Connie Wilson and Tom Wright.

Chair Mitchell Setzer called the meeting to order. He introduced the page, Heaven Gouch from Harnett Co. who was sponsored by Rep. Lewis. He also introduced the Sgt.-At-Arms, Walter Spell and Brian Doherty. Rep. Setzer then turned the meeting over to Representative Holliman in order to present his bill-House Bill 270-INSURANCE TECHNICAL CORRECTIONS/AB.

Representative Setzer called on Frank Folger, Legislative Counsel for the Department of Insurance to explain the bill section-by-section. See attachment #3. Rep. Saunders made motion for a favorable report and it was sent to the clerk's office.

The Chair was turned back to Representative Setzer who called on Representative Edgar Starnes to explain the PROPOSED COMMITTEE SUBSTITUTE FOR HOUSE BILL 358. See attachment 6 for explanation of the committee substitute. Representative Connie Wilson made the motion for a favorable report. It passed and was sent to the clerk's office with a favorable report.

The Meeting was adjourned at 10:30 AM

Rep. Mitchell Setzer, Chair

Rep. L. Hugh Holliman, Chair

Joanna Mills, Committee Clerk

HOUSE INSURANCE COMMITTEE March 27, 2003 ROOM 425 LOB

Chairs:

Representative Hugh Holliman Representative Mitchell Setzer

Vice Chair:

Representative John Hall

AGENDA

House Bill-270-AN ACT TO MAKE TECHNICAL CORRECTIONS TO THE INSURANCE LAWS.

Sponsor: Representative Mitchell Setzer

House Bill-358- AN ACT TO INCREASE THE DAMAGE AMOUNTS ON DEFINED MOTOR VEHICLE ACCIDENTS.

Sponsors: Representatives Starnes and Saunders

| Hou | ise Pages | | |
|-----|---------------|-------|---|
| 1. | Name: HEAVEN | GOUCH | • |
| | County: HACKY | - + | |

Sponsof Pavis Lews

2. Name:

County:

Sponsor:

Name:

County:

Sponsor:____

5. Name:____

County:

Sponsor:

Sgt-At-Arms

1.

- 1. Name: WALTER SPELL
- 2. Name: BRIAN DONERTH
- 3.\ Name:_____
- 4. Name:_____

| USE PAG | ES: | | |
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| Name: | Jeaven | Couch | |
| Town: | Harne | it Co | |
| Sponsor: | ep D. | Lewis | · |
| Name: | | | |
| Town: | | | |
| Sponsor | • | | |





DEPARTMENT OF INSURANCE

State of North Carolina

P. O. Box 26387 RALEIGH, N. C. 27611

LEGISLATIVE COUNSEL

COMMISSIONER OF INSURANCE

JIM LONG

MEMORANDUM

TO:

House Committee on Insurance

FROM:

Frank W. Folger, Legislative Counsel

DATE:

March 27, 2003

HOUSE BILL 270 – INSURANCE TECHNICAL CORRECTIONS/AB Section-by-Section Bill Summary

Section 1. Corrects an erroneous statutory reference in S.L. 2002-144 (HB 1105 – Insurance Regulatory Fund Changes. Section 4 of the bill incorrectly stated that "G.S. 143-10(a) reads as rewritten" in making changes regarding fees collected by the North Carolina Manufactured Housing Board. The amended statute should have been G.S. 143-143.10(a). This corrects it.

Section 2. Clarifies that, under the newly created G.S. 58-26-31, which requires premium reserves of real estate title insurance companies be held in trust to protect title policyholders in case of insolvency, the trust account is not subject to the statutory rule against perpetuities, which invalidates property interests that do not vest within certain time periods.

Sections 3. and 4. Corrects an antiquated reference to Article 17A the former article in Chapter 58 governing insurer supervision, rehabilitation and liquidation. This section changes the reference to Article 30, the current article governing insurer supervision, rehabilitation and liquidation.



- **Sections 5. through 10.** Corrects various references to "the Department of Insurance Fund" under G.S. 58-6-25 to reflect its current name "the Insurance Regulatory Fund".
- Section 11. Corrects an inconsistency in percentages used for funding the North Carolina State Volunteer Firemen's Association. G.S. 58-84-25 directs the Commissioner of Insurance to remit 3% of the fire tax (imposed pursuant to G.S. 105-228.5(d)(4) to the treasurer of the State Firemen's Association. G.S. 58-85-30 incorrectly refers to this remittance as 5%. This section corrects this inconsistent percentage to reflect "3% ". This section also amends 58-85-30: by deleting the unnecessary word "Insurance" before "Commissioner", clarifying to which treasurer the 3% is remitted, rewording for clarity and brevity, and organizing the statute into two subsections.
- **Section 12**. Codifies existing uncodified law by placing in the statute, G.S. 58-51-80, which defines group accident and health insurance and establishes limitations on those policies, that the 90 day deadline for adding employees to group coverage does not apply with regards to disability income coverage.
- **Section 13.** Corrects an incorrect reference to "Commission" in G.S. 58-33-83 to make it "Commissioner".
- **Section 14.** Corrects an incorrect reference in 58-30-200. The reference, which is to the recommendations to the Court by the liquidator, incorrectly cites G.S. 58-30-125 (Notice to creditors and others). The corrected reference is to G.S. 58-30-225 (Liquidator's recommendations to the Court.)
- **Section 15.** Repeals G.S. 97-195(b)(4) as a basis for revocation of a workers' compensation license because it cites as a basis for revocation the failure of a self-insurer to pay the maintenance fund tax ("assessment under G.S. 97-100" specifically 97-100(j)). This maintenance fund tax provision G.S. 97-100(j) was repealed in 1995 by S.L. 1995-360, s.1.
- **Section 16.** Makes the act effective when it becomes law.

Attachnent

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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1 2

HOUSE BILL 270

Short Title: Insurance Technical Corrections.-AB (Public)

Sponsors: Representative Setzer.

Referred to: Insurance.

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CORRECTIONS TO THE INSURANCE LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. The introductory clause of Section 4 of S.L. 2002-144 reads as rewritten:

"SECTION 4. G.S. 143-10(a) G.S. 143-143.10(a) reads as rewritten:"

SECTION 2. G.S. 58-26-31(a) reads as rewritten:

"(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, insurer, and is not subject to G.S. 41-15. 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."

SECTION 3. G.S. 1-507.7 reads as rewritten:

"§ 1-507.7. Report on claims to court; exceptions and jury trial.

It is the duty of the receiver to report to the session of the superior court subsequent to a finding by him as to any claim against the corporation, and exceptions thereto may be filed by any person interested, within 10 days after notice of the finding by the receiver, and not later than within the first three days of the said term; and, if, on an exception so filed, a jury trial is demanded, it is the duty of the court to prepare a proper issue and submit it to a jury; and if the demand is not made in the exceptions to the report the right to a jury trial is waived. The judge may, in his discretion, extend the time for filing such exceptions. Provided, that no court shall issue any order of distribution or order of discharge of a receiver until said receiver has proved to the satisfaction of the court that written notice has been mailed to the last known address of

every claimant who has properly filed claim with the receiver, to the effect that such orders will be applied for at a certain time and place therein set forth and by producing a receipt issued by the United States post office, showing that such notice has been mailed to each of such claimant's last known address at least 20 days prior to the time set for hearing and passing upon such application to the court for said orders of distribution and/or discharge.

As to delinquency proceedings for insurance companies under Article 17A 30 of General Statutes Chapter 58, such prior notice need be given only to those claimants whose presented claims have been denied or have not been adjudicated; and notice is satisfied by mailing either a general notice of application for distribution showing disposition of the claims or a copy of the application to such claimants. Proof of mailing with the United States Postal Service may be made by the receiver's certificate of service without either the necessity of postal receipt or the listing of individual claimants names and addresses."

SECTION 4. G.S. 1-339.1(8) reads as rewritten:

"(8) A sale made in the course of liquidation of an insurance company pursuant to Article 17A 30 of Chapter 58 of the General Statutes, or".

SECTION 5. G.S. 58-33-133(c) reads as rewritten:

"(c) Fees collected by the Commissioner under this section shall be credited to the Department of Insurance Regulatory Fund created under G.S. 58-6-25."

SECTION 6. G.S. 143-138(g) reads as rewritten:

"(g) (Effective until June 30, 2003) Publication and Distribution of Code. – The Building Code Council shall cause to be printed, after adoption by the Council, the North Carolina State Building Code and each amendment thereto. It shall, at the State's expense, distribute copies of the Code and each amendment to State and local governmental officials, departments, agencies, and educational institutions, as is set out in the table below. (Those marked by an asterisk will receive copies only on written request to the Council.)

2930 OFFICIAL OR AGENCY

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NUMBER OF COPIES

| 31 | | |
|----|---|---|
| 32 | Governor | 1 |
| 33 | Lieutenant Governor | 1 |
| 34 | Auditor | 1 |
| 35 | Treasurer | 1 |
| 36 | Secretary of State | |
| 37 | Superintendent of Public Instruction | |
| 38 | Attorney General (Library) | |
| 39 | Commissioner of Agriculture | |
| 40 | Commissioner of Labor | |
| 41 | Commissioner of Insurance | |
| 42 | Department of Environment and Natural Resources | |
| 43 | Department of Health and Human Services | |
| 44 | Department of Juvenile Justice and Delinquency Prevention | |
| | | |

GENERAL ASSEMBLY OF NORTH CAROLINA

| 1 | Board of Transportationl |
|----|---|
| 2 | Utilities Commission1 |
| 3 | Department of Administration1 |
| 4 | Clerk of the Supreme Court1 |
| 5 | Clerk of the Court of Appeals1 |
| 6 | Department of Cultural Resources [State Library]1 |
| 7 | Supreme Court Library1 |
| 8 | Legislative Library1 |
| 9 | Office of Administrative Hearings1 |
| 10 | Rules Review Commission1 |
| 11 | Schools |
| 12 | All state-supported colleges and universities in the State of North |
| 13 | Carolina*1 each |
| 14 | Local Officials |
| 15 | Clerks of the Superior Courts |
| 16 | Chief Building Inspector of each incorporated |
| 17 | municipality or county1 |
| 10 | |

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43 44 In addition, the Building Code Council shall make additional copies available at such price as it shall deem reasonable to members of the general public. The proceeds from sales of the Building Code shall be credited to the Department of Insurance Regulatory Fund under G.S. 58-6-25."

SECTION 7. G.S. 58-69-40 reads as rewritten:

"§ 58-69-40. Disposition of fees.

All fees collected by the Commissioner under this Article shall be credited to the Department of Insurance Regulatory Fund created under G.S. 58-6-25."

SECTION 8. G.S. 58-70-45 reads as rewritten:

"§ 58-70-45. Disposition of permit fees.

All permit fees collected under this Article shall be credited to the Department of Insurance Regulatory Fund created under G.S. 58-6-25."

SECTION 9. G.S. 58-71-180 reads as rewritten:

"§ 58-71-180. Disposition of fees.

Fees collected by the Commissioner pursuant to this Article shall be credited to the Department of Insurance Regulatory Fund created under G.S. 58-6-25."

SECTION 10. G.S. 143-151.21 reads as rewritten:

"§ 143-151.21. Disposition of fees.

Fees collected by the Commissioner under this Article shall be credited to the Department of Insurance Regulatory Fund created under G.S. 58-6-25."

SECTION 11. G.S. 58-85-30 reads as rewritten:

"§ 58-85-30. Treasurer to pay fund to Volunteer Firemen's Association.

(a) The treasurer of the North Carolina State Firemen's Association shall pay to the treasurer of the North Carolina State Volunteer Firemen's Association one sixth of the funds arising from the five percent (5%) three percent (3%) paid him the treasurer of the North Carolina State Firemen's Association by the Insurance Commissioner each

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year to be used by said-the North Carolina State Volunteer Firemen's Association for the purposes set forth in G.S. 58-84-35.

(b) Local units of the North Carolina State Volunteer Firemen's Association shall maintain records and report to the North Carolina State Firemen's Association in the same manner and to the same extent as provided for in accordance with G.S. 58-84-40, and shall be subject to the sanctions as set forth therein in G.S. 58-84-40."

SECTION 12. G.S. 58-51-80(c) reads as rewritten:

"(c) The term "employees" as used in this section shall be deemed to include, for the purposes of insurance hereunder, employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. Employees-With the exception of disability income insurance, employees shall be added to the group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. The term "employer" as used herein may be deemed to include the State of North Carolina, any county, municipality or corporation, or the proper officers, as such, of any unincorporated municipality or any department or subdivision of the State, county, such corporation, or municipality determined by conditions pertaining to the employment."

SECTION 13. G.S. 58-33-83 reads as rewritten: "§ **58-33-83**. Assumed names.

An insurance producer doing business under any name other than the producer's legal name shall notify the Commission-Commissioner before using the assumed name."

SECTION 14. G.S. 58-30-200(c) reads as rewritten:

"(c) The liquidator shall make his recommendations to the Court under G.S. 58-30-125, G.S. 58-30-225 for the allowance of an insured's claim under subsection (b) of this section after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. After allowance by the Court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he shall reconsider the claim on the basis of additional information and amend his recommendations to the Court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The Court may amend its allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of (i) the amount actually recovered from the insured by action or

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| paid by agreement plus the reasonable costs and expense of defense, or (ii) the amount |
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| allowed on the claims by the Court. After all claims are settled or barred, any sum |
| remaining from the amount withheld shall revert to the undistributed assets of the |
| insurer. Delay in final payment under this subsection shall not be a reason for |
| unreasonable delay of final distribution and discharge of the liquidator." |
| |

SECTION 15. G.S. 97-195(b)(4) is repealed. SECTION 16. This act is effective when it becomes law.



HOUSE BILL 270: Insurance Technical Changes/AB



Committee: House Insurance

Date:

March 26, 2003

Version:

First Edition

Introduced by: Representative Setzer

Summary by:

Tim Hovis

Committee Counsel

SUMMARY: House Bill 270 makes various technical changes and corrections to the laws governing insurance.

Section 1 of the bill amends S.L. 2002-144 (HB 1105-Insurance Regulatory Fund Changes) to correct the introductory clause. The clause incorrectly reads "G.S. 143-10(a) reads as rewritten." The correct statute is G.S. 143-143.10(a).

Section 2 of the bill clarifies G.S. 58-26-3. This statute creates a trust account from premium reserves of real estate title companies to be held in favor of title policy holders in case of insolvency. Section 2 provides that this trust account is **not** subject to the statutory rule against perpetuities as provided in G.S. 41-15.

The rule against perpetuities provides that a nonvested property interest (such as the trust account) is invalid unless, at the time of creation, it is certain to vest or terminate no later than 21 years after the death of an individual then alive, or terminates within 90 years of creation.

Sections 3 and 4 of the bill delete references to Article 17A of Chapter 58 of the General Statutes, which formerly governed insurance supervision, rehabilitation and changes these references to Article 30. Article 17 has been repealed. Article 30 is the current article governing insurance supervision. rehabilitation, and liquidation.

Sections 5 through 10 replace various statutory references to the "Department of Insurance Fund" with the fund's correct name, the "Insurance Regulatory Fund."

Section 11 corrects a reference to the percentage of funds to be paid by the Commissioner of Insurance to the North Carolina State Firemen's Association. G.S. 58-85-30 incorrectly refers to a percentage of 5% of the fire tax to be remitted by the Commissioner of Insurance to the Firemen's Association (of which an amount is forwarded to the Volunteer Firemen's Association. G.S. 58-85-25 directs the Commissioner to remit, not 5%, but 3% of the tax.

Section 12 clarifies that the 90-day deadline for adding employees to group accident and health insurance coverage does not apply to disability income insurance.

Section 13 corrects an incorrect reference to "Commission" in G.S. 58-33-83. The word should be "Commissioner."

HOUSE BILL 270

Page 2

Section 14 corrects a reference in Article 30 of Chapter 58 governing recommendations to a court upon liquidation of an insurer. G.S. 58-30-200, Special provisions for third party claims, incorrectly refers to G.S. 58-30-125, Notice to creditors and others. This reference should be to G.S. 58-30-225, Liquidator's recommendations to the court.

Section 15 repeals G.S. 97-195(b)(4). This subsection authorizes the revocation of a workers compensation license if a self-insurer fails to pay the maintenance fund tax under G.S.97-100(j). The maintenance fund tax was repealed in 1995 (S.L. 1995-360).

EFFECTIVE DATE: House Bill 270 is effective when it becomes law.

This summary was contributed to by the N.C. Department of Insurance.



HOUSE BILL 358: Increase Damage Limits for MV Accidents

Committee: House Insurance

Date:

March 26, 2003

Version:

H358-CSRC-4[v.1]

Introduced by: Rep. Starnes

Summary by:

Kory J. Goldsmith

Committee Counsel

SUMMARY: HB 358 would increase the property damage amounts that determine whether and how many insurance points a driver will be charged under the Safe Driver Incentive Plan.

CURRENT LAW: G.S. 58-36-75(a) sets monetary property damage limits and defines the types of atfault accidents. They are:

- Major accident \$2,500 dollars or more.
- Intermediate accident Less than \$2,500, but more than \$1,500.
- Minor accident \$1,500 or less.

Under the plan, the accident classification determines the number of points assessed and therefore the percentage increase for insurance premiums. They are:

- Major accident = 3 points = 65% rate of increase.
- Intermediate accident = 2 points = 45% rate of increase.
- Minor accident = 1 point = 25% rate of increase.

The increases may be charged for at-fault accidents occurring during the experience period. The experience period is the three years immediately preceding the date of the application or the preparation of the renewal.

The Proposed Committee Substitute to HB 358 increases the property damage limits that define the types of at-fault accidents. Under the bill, the categories would be:

- Major accident \$3,000 dollars or more.
- Intermediate accident Less than \$3,000, but more than \$1,800.
- Minor accident \$1,800 or less.

BACKGROUND: In 1987, the statutory rates were:

- Major accident \$2,000 dollars or more.
- Intermediate accident Less than \$2,000, but more than \$1,000.
- Minor accident \$1,000 or less.

These limits were increased to the current levels in 1997.

H358-SMRC-001(H358-CSRC-4)

attachnest

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 358

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| Short Title: | Increase Damage Limits for MV Accidents. | (Public) |
|--------------|---|----------|
| Sponsors: | Representatives Starnes, Saunders (Primary Sponsors); and Culp. | |
| Referred to: | Insurance. | |

March 10, 2003

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:

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, 2003.

Ottachment 8

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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only property damage."

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(Public)

HOUSE BILL 358-CSLT-2 House Proposed Committee Substitute PROPOSED COMMITTEE SUBSTITUTE H358-CSLT-2-CSRC-4 [v.1]

3/26/2003 5:14:07 PM

Short Title: Increase Damage Limits for MV Accidents.

| Sponsors: |
|---|
| Referred to: |
| March 10, 2003 |
| |
| 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) three thousand |
| dollars (\$3,000) 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) one |
| thousand eight hundred dollars (\$1.800) but less than two thousand five hundred dollars |

(\$2,500). three thousand dollars (\$3,000). A "minor accident" is an at-fault accident that

results in only property damage of one thousand five hundred dollars (\$1.500) one

thousand eight hundred dollars (\$1,800) 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

SECTION 2. This act becomes effective October 1, 2003.

VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

03-27-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|----------------------------|
| David Soller | STATE FARM. Naleigh |
| Joyan Lus | Marane |
| Robert Paschel | Young, Moone |
| KanWajli | BUSAL |
| AND SALLY | MARP |
| Maci Juin | NESA |
| Janes | MGM |
| Barbare Canalu | Mris |
| PAUL MAHONEY | NCANP |
| Tord PERERSON | NCINS |
| Chris Wich. 15 | Hunter & Williams |

VISITOR REGISTRATION SHEET

| Name of Committee | Data |
|---------------------------|---------------|
| HOUSE INSURANCE COMMITTEE | March 27 2003 |

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|-------------------------|----------------------------|
| Stephen Alan Woodson VI | NC FB |
| B14 Scob61N | KECH |
| SUSON VALAGRI | NATIONWIDE |
| Invergo | Morre q Van Alla |
| Steveltoffman | NCSBA |
| Mike Causy | NC Hlass assay |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| | following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
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| | ommittee Substitute for |
| H.B. | |
| | |
| ⊠ v | Vith a favorable report. |
| | With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations Finance . |
| □ v | Vith 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 . |
| ti | With a favorable report as to the committee substitute bill (#), \(\subseteq \) which changes the itle, unfavorable as to (the original bill) (Committee Substitute Bill #), (and ecommendation that the committee substitute bill #) be re-referred to the Committee in .) |
| | With a favorable report as to House committee substitute bill (#), which changes he title, unfavorable as to Senate committee substitute bill. |
| □ v | Vith an unfavorable report. |
| □ v | Vith recommendation that the House concur. |
| □ v | Vith recommendation that the House do not concur. |
| □ v | Vith recommendation that the House do not concur; request conferees. |
| □ V | Vith recommendation that the House concur; committee believes bill to be material. |
| □ v | Vith an unfavorable report, with a Minority Report attached. |
| □ v | Vithout prejudice. |
| □ W | Vith an indefinite postponement report. |
| □ ¼ | Vith an indefinite postponement report, with a Minority Report attached. |
| □ W | Vith recommendation that it be adopted. (HOUSE RESOLUTION ONLY) |

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 1, 2003

The House Committee on Insurance met at 10:00 AM on April 1, 2003. The following Representatives attended: Mitchell Setzer, Hugh Holliman, John Hall, Lucy Allen, Bobby Barbee, Charles Johnson, David Lewis, David Miner, Karen Ray, Drew Saunders, and Ex-officio Pete Cunningham.

Chair Hugh Holliman called the meeting to order. He introduced the page; Sarah Robertson form Danbury in Stokes County who was sponsored by Rep. Rex Baker. He then called on the bill sponsor to introduce the bill. Chairman Mitchell Setzer presented HB-253-AN ACT TO MAKE TECHNICAL AND RELATED SUBSTANTIVE CHANGES TO THE CONTINUING CARE RETIREMENT (CCR) LAWS TO ELIMINATE THE UNNECESSARY PROVISION ALLOWING FOR ACCREDITED BUT UNLICENSED PROVIDERS OF CCR SERVICES; CHAN REFERENCES FROM "FACILITY" TO "PROVIDER" WHERE APPROPRIATE TO ACCOMMODATE THE SITUATION WHERE AN ENTITY OPERATES MORE THAN ONE FACILITY; CHANGE "FORECAST" TO "FORECASTED" WHERE FOUND; CHANGE THE OPERATING RESERVES STATUTE BY REWORDING SOME PROVISIONS TECHNICALLY; CHANGE REFERENCES TO "REGISTRATION" OF A FACILITY TO "LICENSURE"; MAKE GENDER NEUTRAL CHANGES TO THE CCR LAWS: CLARIFY THAT A PROVIDER MUST HOLD SEMI-ANNUAL MEETINGS WITH THE RESIDENTS OF EACH FACILITY OPERATED BY THE PROVIDER; AND MAKE OTHER TECHNICAL AND CONFORMING CHANGES TO ARTICLE 64.

Representative Setzer called on Frank Folger, Legislative Counsel for the Department of Insurance to explain the bill section-by-section. See attachment #1. Rep. Saunders made motion for a favorable report and it was sent to the clerk's office.

Chairman Holliman called on Chairman Setzer to explain HB-276- AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMENTS IN THE LAWS CONCERNING INSURANCE COMPANY SOLVENCY. Frank Folger explained the bill section by section. See attachment #2 for explanation. Co-Chair Hall made a motion to postpone the voting on this bill until the next Insurance Committee Meeting.

The Meeting was adjourned at 10:35 AM

Rep. Mitchell Setzer, Chair

1. Hugh Holliman, Chair

Joanna Mills, Committee Clerk

HOUSE INSURANCE COMMITTEE

April 1, 2003 10:00 AM Room 425 LOB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

House Bill 253- Continuing Care Ret./Tech. Changes.-AB Sponsor: Rep. Setzer

House Bill 276 – Insurance Financial Amendments Omnibus.-AB

Sponsor: Rep. Setzer



attachment

DEPARTMENT OF INSURANCE

State of North Carolina

P. O. Box 26387 RALEIGH, N. C. 27611

LEGISLATIVE COUNSEL (919) 733-4529

JIM LONG COMMISSIONER OF INSURANCE

MEMORANDUM

TO: Members of House Committee on Insurance

FROM: Frank W. Folger, Legislative Counsel

DATE: April 1, 2003

HOUSE BILL 253 – CONTINUING CARE RETIREMENT/TECHINICAL CHANGES/AB

Section-by-Section Bill Summary

Section 1. Repeals an unused, and likely unusable, provision (G.S. 58-64-5(e)) allowing for a continuing care retirement facility that is accredited under a process approved by the Commissioner to be issued a license based on that accreditation.

Sections 2. through 4. Replaces the word "facility" with "provider" to clarify that it is the provider that operates the facility that is responsible for meeting these various statutory requirements.

Section 5. Changes the word "forecast" to "forecasted" when it appears and replaces the word "facility" with "provider" consistent with the changes and rationale for Sections 2. through 4.

Sections 6 and 7. Changes the word "forecast" to "forecasted" in G.S. 58-64-20(a)(14) b. and 58-64-30(a) whenever it appears.

Section 8. Rewords for clarity language in G.S. 58-64-33, governing operating reserves for continuing care retirement facilities and providers, including:



- Changing the wording in subsection (a) to reflect the fact that a provider is to calculate and maintain a separate operating reserve for each continuing care facility operated by the provider.
- Changing the words "annual statement" to "disclosure statement" in subsection (a).
- Changing the words "invested cash" to "cash equivalents" in subsection (a).

Section 9. Makes the following changes to G.S. 58-64-40 governing the rights of residents of continuing care retirement facilities to organize:

- Changes "registered under this Article" to "operated by a provider licensed under this Article" in G.S. 58-64-40(a). No entity is "registered" under G.S. 58-64.
- Makes gender neutral corrections.
- Changes the word "facility" to "provider" where appropriate.
- Clarifies that the governing body of a provider must hold semi-annual meetings with the residents of each facility operated by the provider.

Section 10. Makes various changes to G.S. 58-64-45, governing supervision, rehabilitation and liquidation of continuing care retirement providers including:

- Replacing the word "projected" with "forecasted" in subsection (a).
- Changing the words "facility" and "facilities" to "provider" and "providers", respectively, throughout the statute, where appropriate.
- Adding the words "or facilities owned by, or operated by, the provider" or otherwise amending the statute as necessary to accommodate the fact that a provider can own or operate more than one facility.

Section 11. Amends G.S. 58-64-46, on receiverships, to reflect the fact that the Commissioner would be appointed as receiver for a provider not a facility.

Section 12. Replaces twice the word "facility" with "provider" in G.S. 58-64-55, governing examinations and financial statements.

Section 13. Replaces the word "agreements" with "contracts" for consistency of wording within Article 64.

Section 14. Removes unnecessary language from G.S. 58-64-65 to conform with the removal of the "accredited facility" provision in Section 1. of the bill.

Section 15. Amends G.S. 58-64-70, governing civil liability, to:

- Remove the misleading words "facility, or person violating this Article" in subsection (a) because the provider is the entity entering into a contract for continuing care, not the facility or other person.
- Remove the words "or person liable" because the provider is the only entity that is required to deliver a disclosure statement to the contracting party.
- Remove the words "facility, or person" since payment is made to the provider, and the provider is the entity responsible for the dissemination of the disclosure statement.

Section 16. Is a severability clause to protect the remaining provisions of the bill if a portion is declared unconstitutional, unenforceable, or otherwise invalid.

Section 17. Makes the act effective when it becomes law.

Joanna Mills (Rep. Setzer)

From: Carol Bowers (Rep. Holliman)

Sent: Tuesday, March 25, 2003 10:20 AM

To: Joanna Mills (Rep. Setzer)

Subject: Summary HB 253 Continuing Care Retirement Tech. Changes.doc

HOUSE BILL 253 – CONTINUING CARE RETIREMENT/TECHINICAL CHANGES/AB

Section-by-Section Bill Summary

Section 1. repeals an unused, and likely unusable, provision (G.S. 58-64-5(e)) allowing for a continuing care retirement facility that is accredited under a process approved by the Commissioner to be issued a license based on that accreditation.

Sections 2. through 4. Replace the word "facility" with "provider" to clarify that it is the provider that operates the facility that is responsible for meeting these various statutory requirements.

Section 5. changes the word "forecast" to "forecasted" when it appears and replaces the word "facility" with "provider" consistent with the changes and rationale for Sections 2. through 4.

Sections 6 and 7. change the word "forecast" to "forecasted" in G.S. 58-64-20(a)(14) b. and 58-64-30(a) whenever it appears.

Section 8. rewords for clarity language in G.S. 58-64-33, governing operating reserves for continuing care retirement facilities and providers, including.

- Changing the wording in subsection(a) to reflect the fact that a provider is to calculate and maintain a separate operating reserve for each continuing care facility operated by the provider.
- Changing the words "annual statement" to "disclosure statement" subsection (a).
- Changing the words "invested cash" to "cash equivalents" in subsection (a).

Section 9. makes the following changes to G.S. 58-64-40 governing the rights of residents of continuing care retirement facilities to organize:

- Changed "registered under this Article" to "operated by a provider licensed under this Article" in G.S. 58-64-40(a). No entity is "registered" under G.S. 58-64.
- Made gender neutral corrections.
- Changed the word "facility" to "provider" where appropriate.
- Clarified that the governing body of a provider must hold semi-annual meetings with the residents of each facility operated by the provider.

Section 10. makes various changes to G.S. 58-64-45, governing supervision, rehabilitation and liquidation of continuing care retirement providers including:

- Replacing the word "projected" with "forecasted" in subsection (a).
- Changing the words "facility" and "facilities" to "provider" and "providers", respectively,

throughout the statute, where appropriate.

Adding the words "or facilities owned by, or operated by, the provider" or otherwise amending the statute as necessary to accommodate the fact that a provider can own or operate more than one facility.

Section 11. amends G.S. 58-64-46, on receiverships, to reflect the fact that the Commissioner would be appointed as receiver for a provider not a facility.

Section 12. replaces twice the word "facility" with "provider" in G.S. 58-64-55, governing examinations and financial statements.

Section 13. replaces the word "agreements" with "contracts" for consistency of wording within Article 64.

Section 14. removes unnecessary language from G.S. 58-64-65 to conform with the removal of the "accredited facility" provision in Section 1. of the bill.

Section 15. amends G.S. 58-64-70, governing civil liability, to:

- Remove the misleading words "facility, or person violating this Article" in subsection (a) because the provider is the entity entering into a contract for continuing care, not the facility or other person.
- Remove the words "or person liable" because the provider is the only entity that is required to deliver a disclosure statement to the contracting party.
- Remove the words "facility, or person" since payment is made to the provider, and the provider is the entity responsible for the dissemination of the disclosure statement.

Section 16. is a severability clause to protect the remaining provisions of the bill if a portion is declared unconstitutional, unenforceable, or otherwise invalid.

Section 17. makes the act effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

H HOUSE DRH70078-LN-51 (2/27)

D

Short Title: Continuing Care Ret./Tech. Changes.-AB (Public)

Sponsors: Representative Setzer.

Referred to:

A BILL TO BE ENTITLED

2 AN ACT TO MAKE TECHNICAL AND RELATED SUBSTANTIVE CHANGES TO THE CONTINUING CARE RETIREMENT (CCR) LAWS TO ELIMINATE THE 3 PROVISION ALLOWING FOR ACCREDITED 4 UNNECESSARY UNLICENSED PROVIDERS OF CCR SERVICES; CHANGE REFERENCES 5 "FACILITY" "PROVIDER" WHERE **APPROPRIATE** 6 TO 7 ACCOMMODATE THE SITUATION WHERE AN ENTITY OPERATES MORE 8 THAN ONE FACILITY; CHANGE "FORECAST" TO "FORECASTED" WHERE 9 **CHANGE** THE **OPERATING** RESERVES **STATUTE** FOUND: REWORDING SOME PROVISIONS TECHNICALLY; CHANGE REFERENCES 10 TO "REGISTRATION" OF A FACILITY TO "LICENSURE"; MAKE GENDER 11 NEUTRAL CHANGES TO THE CCR LAWS; CLARIFY THAT A PROVIDER 12 MUST HOLD SEMI-ANNUAL MEETINGS WITH THE RESIDENTS OF EACH 13 FACILITY OPERATED BY THE PROVIDER; AND MAKE OTHER 14 TECHNICAL AND CONFORMING CHANGES TO ARTICLE 64. 15

The General Assembly of North Carolina enacts:

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SECTION 1. G.S. 58-64-5(e) is repealed.

SECTION 2. G.S. 58-64-5(g) reads as rewritten:

"(g) The Commissioner may require a facility-provider to: (i) provide the report of an actuary that estimates the capacity of the provider to meet its contractual obligation to the resident, or (ii) give consideration to expected rates of mortality and morbidity, expected refunds, and expected capital expenditures in accordance with standards promulgated by the American Academy of Actuaries, within the five-year forecast statements, as required by G.S. 58-64-20(a)(12)."

SECTION 3. G.S. 58-64-20(a)(7)d. reads as rewritten:

| 1 | "d. The conditions under which a living unit occupied by a resid | ent |
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| 2 | may be made available by the facility provider to a different | |
| 3 | new resident other than on the death of the prior resident; and | ". |
| 4 | SECTION 4. G.S. 58-64-20(a)(11) reads as rewritten: | |
| 5 | "(11) In the event the facility provider has had an actuarial report prepare | red |
| 6 | within the prior two years, the summary of a report of an actuary t | hat |
| 7 | estimates the capacity of the provider to meet its contract | ual |
| 8 | obligations to the residents." | |
| 9 | SECTION 5. G.S. 58-64-20(a)(12) reads as rewritten: | |
| 10 | "(12) Forecast Forecasted financial statements for the facility provider of | the |
| 11 | next five years, including a balance sheet, a statement of operations | |
| 12 | statement of cash flows, and a statement detailing all signific | ant |
| 13 | assumptions, compiled by an independent certified public accounts | |
| 14 | Reporting routine, categories, and structure may be further defined | |
| 15 | regulations or forms adopted by the Commissioner." | |
| 16 | SECTION 6. G.S. 58-64-20(a)(14)b. reads as rewritten: | |
| 17 | "b. Narrative disclosure detailing all significant assumptions us | sed |
| 18 | in the preparation of the forecast forecasted finance | |
| 19 | statements, including: | |
| 20 | 1. Details of any long-term financing for the purchase | or |
| 21 | construction of the facility including interest ra | |
| 22 | repayment terms, loan covenants, and assets pledged; | , |
| 23 | 2. Details of any other funding sources that the providence of the | der |
| 24 | anticipates using to fund any start-up losses or to prov | |
| 25 | reserve funds to assure full performance of | |
| 26 | obligations of the provider under contracts for | |
| 27 | provision of continuing care; | |
| 28 | 3. The total life occupancy fees to be received from or | on |
| 29 | behalf of, residents at, or prior to, commencement | |
| 30 | operations along with anticipated accounting metho | |
| 31 | used in the recognition of revenues from and expec | |
| 32 | refunds of life occupancy fees; | |
| 33 | 4. A description of any equity capital to be received by | the |
| 34 | facility; | |
| 35 | 5. The cost of the acquisition of the facility or, if | the |
| 36 | facility is to be constructed, the estimated cost of | |
| 37 | acquisition of the land and construction cost of | |
| 38 | facility; | |
| 39 | 6. Related costs, such as financing any development co | sts |
| 40 | that the provider expects to incur or become obliga | |
| 41 . | for prior to the commencement of operations; | |
| 42 | 7. The marketing and resident acquisition costs to | be |
| 43 | incurred prior to commencement of operations; and | |
| | · · · · · · · · · · · · · · · · · · · | |

8. A description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of government subsidies for health care services."

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SECTION 7. G.S. 58-64-30(a) reads as rewritten:

Within 150 days following the end of each fiscal year, the provider shall file with the Commissioner a revised disclosure statement setting forth current information required pursuant to G.S. 58-64-20. The provider shall also make this revised disclosure statement available to all the residents of the facility. This revised disclosure statement shall include a narrative describing any material differences between (i) the forecast forecasted statements of revenues and expenses and cash flows or other forecast forecasted financial data filed pursuant to G.S. 58-64-20 as a part of the disclosure statement recorded most immediately subsequent to the start of the provider's most recently completed fiscal year and (ii) the actual results of operations during that fiscal year, together with the revised forecast forecasted statements of revenues and expenses and cash flows or other forecast-forecasted financial data being filed as a part of the revised disclosure statement. A provider may also revise its disclosure statement and have the revised disclosure statement recorded at any other time if, in the opinion of the provider, revision is necessary to prevent an otherwise current disclosure statement from containing a material misstatement of fact or omitting a material fact required to be stated therein. Only the most recently recorded disclosure statement, with respect to a facility, and in any event, only a disclosure statement dated within one year plus 150 days prior to the date of delivery, shall be considered current for purposes of this Article or delivered pursuant to G.S. 58-64-20."

SECTION 8. G.S. 58-64-33 reads as rewritten: "§ 58-64-33. Operating reserves.

All continuing care facilities A provider shall maintain after opening: the opening of a facility: an operating reserves reserve equal to fifty percent (50%) of the total operating costs of the facility projected forecasted for the 12-month period following the period covered by the most recent annual-disclosure statement filed with the Department. The forecast statements as required by G.S. 58-64-20(a)(12) shall serve as the basis for computing the operating reserve. In addition to total operating expenses, total operating costs will include debt service, consisting of principal and interest payments along with taxes and insurance on any mortgage loan or other long-term financing, but will exclude depreciation, amortized expenses, and extraordinary items as approved by the Commissioner. If the debt service portion is accounted for by way of another reserve account, the debt service portion may be excluded. Facilities that maintain If a facility maintains an occupancy level in excess of ninety percent (90%) (90%), a provider shall only be required to maintain a twenty-five percent (25%) operating reserve upon approval of the Commissioner, unless otherwise instructed by the Commissioner. The operating reserves may reserve must be funded by cash, by invested cash, cash equivalents, or by investment grade securities, including bonds, stocks, U.S. Treasury obligations, or obligations of U.S. government agencies.

- (b) A provider that has begun construction or has permanent financing in place or is in operation on the effective date of this section has up to five years to meet the operating reserve requirements.
- (c) Operating reserves—An operating reserve shall only be released upon the submittal of a detailed request from the provider or facility and must be approved by the Commissioner. Such requests must be submitted in writing for the Commissioner to review at least 10 business days prior to the date of withdrawal."

SECTION 9. G.S. 58-64-40 reads as rewritten:

"§ 58-64-40. Right to organization.

- (a) A resident living in a facility registered under this Article operated by a provider licensed under this Article has the right of self-organization, the right to be represented by an individual of his the resident's own choosing, and the right to engage in concerted activities to keep informed on the operation of the facility in which he is a resident the resident resides or for other mutual aid or protection.
- (b) The board of directors or other governing body of a facility-provider or its designated representative shall hold semiannual meetings with the residents of the facility each facility operated by the provider for free discussions of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility and discussions of proposed changes in policies, programs, and services. Upon request of the most representative residents' organization, a member of the governing body of the provider, such as a board member, a general partner, or a principal owner shall attend such meetings. Residents shall be entitled to at least seven days advance notice of each meeting. An agenda and any materials that will be distributed by the governing body at the meetings shall remain available upon request to residents."

SECTION 10. G.S. 58-64-45 reads as rewritten:

"§ 58-64-45. Supervision, rehabilitation, and liquidation.

- (a) If, at any time, the Commissioner determines, after notice and an opportunity for the provider to be heard, that:
 - (1) A portion of an entrance fee escrow account required to be maintained under this Article has been or is proposed to be released in violation of this Article;
 - (2) A provider has been or will be unable, in such a manner as may endanger the ability of the provider, to fully perform its obligations pursuant to contracts for continuing care, to meet the projected forecasted financial data previously filed by the provider;
 - (3) A provider has failed to maintain the escrow account required under this Article; or
 - (4) A facility-provider is bankrupt or insolvent, or in imminent danger of becoming bankrupt or insolvent;
- the Commissioner may commence a supervision proceeding pursuant to Article 30 of this Chapter or may apply to the Superior Court of Wake County or to the federal bankruptcy court that may have previously taken jurisdiction over the provider or

facility for an order directing the Commissioner or authorizing the Commissioner to rehabilitate or to liquidate a facility in accordance with Article 30 of this Chapter.

- (b) The definition of "insolvency" or "insolvent" in G.S. 58-30-10(13) shall not apply to facilities providers under this Article. Rules adopted by the Commissioner shall define and describe "insolvency" or "hazardous financial condition" for facilities providers under this Article. G.S. 58-30-12 shall not apply to facilities under this Article.
- (c) If, at any time, the Court finds, upon petition of the Commissioner or provider, or on its own motion, that the objectives of an order to rehabilitate a facility provider have been accomplished and that the facility or facilities owned by, or operated by, the provider can be returned to the provider's management without further jeopardy to the residents of the facility, facility or facilities, the Court may, upon a full report and accounting of the conduct of the facility's provider's affairs during the rehabilitation and of the facility's provider's current financial condition, terminate the rehabilitation and, by order, return the facility or facilities owned by, or operated by, the provider, along with the and its assets and affairs of the provider, to the provider's management.
 - (d), (e) Repealed by Session Laws 1995 (Regular Session, 1996), c. 582, s. 3.
- (f) In applying for an order to rehabilitate or liquidate a facility, provider, the Commissioner shall give due consideration in the application to the manner in which the welfare of persons who have previously contracted with the provider for continuing care may be best served.
- (g) An order for rehabilitation shall be refused or vacated if the provider posts a bond, by a recognized surety authorized to do business in this State and executed in favor of the Commissioner on behalf of persons who may be found entitled to a refund of entrance fees from the provider or other damages in the event the provider is unable to fulfill its contracts to provide continuing care at the facility, facility or facilities, in an amount determined by the Court to be equal to the reserve funding that would otherwise need to be available to fulfill such obligations."

SECTION 11. G.S. 58-64-46 reads as rewritten:

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

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

SECTION 12. G.S. 58-64-55 reads as rewritten:

"§ 58-64-55. Examinations; financial statements.

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a facility-provider offering continuing care in this State to examine its books and records. Expenses incurred by the Commissioner in conducting examinations

under this section shall be paid by the <u>facility-provider</u> examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference."

SECTION 13. G.S. 58-64-60 reads as rewritten:

"§ 58-64-60. Agreements Contracts as preferred claims on liquidation.

In the event of liquidation of a provider, all <u>contracts for</u> continuing care agreements executed by the provider shall be deemed preferred claims against all assets owned by the provider; provided, however, such claims shall be subordinate to the liquidator's cost of administration or any secured claim."

SECTION 14. G.S. 58-64-65 reads as rewritten:

"§ 58-64-65. Rule-making authority; reasonable time to comply with rules.

- (a) The Commissioner is authorized to promulgate rules to carry out and enforce the provisions of this Article.
- (b) Any provider who is offering continuing care may be given a reasonable time, not to exceed one year from the date of publication of any applicable rules promulgated pursuant to this Article, within which to comply with the rules and to obtain a license.rules."

SECTION 15. G.S. 58-64-70 reads as rewritten: "§ 58-64-70. Civil liability.

- (a) A provider who enters into a contract for continuing care at a facility without having first delivered a disclosure statement meeting the requirements of G.S. 58-64-20 to the person contracting for this continuing care, or enters into a contract for continuing care at a facility with a person who has relied on a disclosure statement that omits to state a material fact required to be stated therein or necessary in order to make the statements made therein, in light of the circumstances under which they are made, not misleading, shall be liable to the person contracting for this continuing care for actual damages and repayment of all fees paid to the provider, facility, or person provider violating this Article, less the reasonable value of care and lodging provided to the resident by or on whose behalf the contract for continuing care was entered into prior to discovery of the violation, misstatement, or omission or the time the violation, misstatement, or omission should reasonably have been discovered, together with interest thereon at the legal rate for judgments, and court costs and reasonable attorney fees.
- (b) Liability under this section exists regardless of whether the provider or person liable had actual knowledge of the misstatement or omission.
- (c) A person may not file or maintain an action under this section if the person, before filing the action, received a written offer of a refund of all amounts paid the provider, facility, or person violating this Article together with interest at the rate established monthly by the Commissioner of Banks pursuant to G.S. 24-1.1(c), less the current contractual value of care and lodging provided prior to receipt of the offer, and if the offer recited the provisions of this section and the recipient of the offer failed to accept it within 30 days of actual receipt.

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(d) An action may not be maintained to enforce a liability created under this Article unless brought before the expiration of three years after the execution of the contract for continuing care that gave rise to the violation."

SECTION 16. 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 17. This act is effective when it becomes law.

Attachment #2

SECTION-BY SECTION SUMMARY - PCS for HOUSE BILL 276-INSURANCE FINANCIAL AMENDMENTS OMNIBUS

Sections 1. through 3. Amendments to Initial Deposits Laws.

- **Section 1.** Increases initial deposit required from foreign or alien fire, marine, and fire and marine insurers from \$25,000 to \$100,000.
- Section 2. Increases initial deposit required from foreign or alien fidelity, surety or casualty insurers from \$50,000 to \$200,000.
- **Section 3.** Increases initial deposit required from foreign life insurers from \$100,000 to \$400,000 and an additional \$200,000 rather than \$100,000 when the insurer cannot show three years of operational gains before admission.
- Sections 4. through 13. Conform N.C. Law in Article 7- General Domestic Insurance Companies to the Statements of Statutory Accounting Principles adopted by the NAIC. Note: pursuant to G.S. 58-2-165(c), all financial statements filed under that section must be in accordance with the appropriate procedures and standards adopted by the NAIC unless a different standard or procedure is set forth. These changes remove conflicts between N.C. law and the NAIC SSAPs.
- **Section 4.** Repeals G.S. 58-7-162(2)(a),(b),(c),(d),(e),(f), and (g) to remove all specially designated provisions regarding certain investments, securities, properties and loans acquired or held governing assets allowable or admitted for determining the financial condition of an insurer.
- Section 5. repeals G.S. 58-7-162 (5) and G.S. 58-7-162 (7) to conform NC law to the SSAPs regarding non-admission of uncollected direct bill premiums and installment premiums more than 90 days old.
- **Section 6.** Removes a provision in G.S. 58-7-162(12) placing certain criteria on the counting of electronic and mechanical machines in order to conform to the respective SSAP.
- Section 7. repeals G.S. 58-7-163(1),(4), and (7), to eliminate NC's deviations from the SSAPs regarding the admissibility of assets such as "goodwill", "furniture, fixtures, other equipment" and the like, and "prepaid and deferred expenses" and amends subsection (8) to provide that certain debt-related instruments must be non-admitted assets to the extent that admissibility would allow them to be "double-counted."
- Section 8. repeals G.S. 58-7-192(a),(b),(c),(e) and portions of (d), governing the valuation of securities and investments, to remove certain inconsistencies with the SSAPs, to clarify that the valuations limitations are not restricted to that particular statute but apply throughout the Chapter, and to update cross-reference to the appropriate NAIC publication.
- **Section 9.** Repeals G.S. 58-7-193(a) and (b) governing valuation of real property to remove conflicts with SSAPs.

Section 10. Repeals G.S. 58-7-195, governing valuation of purchase money mortgages to default to the applicable SSAP rules.

Section 11. amends G.S. 58-7-179 (d) to remove reference to G.S. 58-7-195, which is repealed by Section 10 of the bill.

Section 12. amends G.S. 58-23-26(c) to remove reference to G.S. 58-7-195, which is repealed by Section 10 of the bill.

Section 13. amends G.S. 58-47-80 to remove reference to G.S. 58-7-195, which is repealed by Section 10 of the bill.

Sections 14. through 16. Amendments to Article 8 - Mutual Insurance Companies.

Section 14. Amends G.S. 58-8-15, governing directors of mutual insurers, to prohibit more than one half of directors of guaranty capital companies from being elected by guaranty capital holders (investors) unless those guaranty capital holders are also policyholders. The amendment further provides that, for guaranty capital companies, policyholders who are also guaranty capital holders are entitle to one vote for each policy the person holds and one vote for each unit of guaranty capital the person holds.

Section 15. Amends G.S. 58-8-20, which sets forth special rules for mutual insurers with guaranty capital, to:

- Make minor technical wording changes.
- Codify an existing rule to only allow a domestic mutual insurer to issue guaranty capital if: (i) it will aid a financially troubles insurer otherwise facing rehabilitation or liquidation by the Department; or (ii) for any reason presented in a petition to the Commissioner and which the Commissioner finds to be reasonable, justifiable and in the best interest of policyholders. This codification included notice –to-policyholder provisions required if the insurer has to petition the Commissioner to be eligible to issue guaranty capital.
- Clarify that holders of guaranty capital receive "interest" not "dividends' and that the distribution of interest must be in accordance with the insurer filing with the Commissioner.
- Reorganize the statute by moving two provisions, one in subsection (c) governing repayment of guaranty capital in the event the insurer is merged, demutualized or otherwise ceases to exist, and another in subsection (e) restricting asset distribution until all policy obligations have been met, to two new subsections, (g) and (f) respectively.
- Amend subsection (d) of the statute consistent with previous changes regarding voting rights of guaranty capital holders and prohibit guaranty capital holders, unless they are also policyholders, from participating in a vote to petition the Commissioner to allow issuance of more guaranty capital stock

and from participating in any vote to reduce or retire guaranty capital, when the criteria for such a vote have been satisfied pursuant to subsection (e).

Section 16. Increases the penalty from a maximum fine of \$100 to \$1000 for a director, officer or agent of a guaranty capital insurer who gives a policyholder a guaranty against an assessment in violation of G.S. 58-8-50.

Section 17. Amends G.S. 58-65-1, setting forth regulations and definitions applicable to the insurance laws governing hospital, medical and dental service corporations (BCBS) to clarify that the definitions of "hospital service plan", "medical service plan", "dental service plan", "hospital service corporation", and "preferred provider" in Article 65 also apply in Article 66 – Readable Insurance Certificates. This section also makes technical changes and eliminates two "printing" errors inadvertently in the statute due to previous bill drafting anomalies. This section also clarifies that a preferred provider's special reimbursement terms and conditions must be consistent both with Article 65 and Article 66 provisions.

Section 18. Rewords G.S. 58-65-95(a), limiting the kinds of assets and investments that a hospital, medical and dental service corporation can hold to the same as permitted for life and health insurance companies as set forth in Article 7 of Chapter 58.

Section 19. Removes the provision governing the allowance of office furniture as part of net worth to the extent it is less than 10% of an HMOs net worth. The relevant SSAP does not allow furniture and equipment to be included in net worth. This is an additional change to conform NC's law to rules of the SSAP.

Sections 20. through 23. - Amends Article 67- Health Maintenance Organizations.

Section 20. Repeals the reserve requirements for HMOs under G.S.58-67-40 because they are unnecessary due to the risk-based capital (RBC) laws in Article 12.

Section 21. Amends G.S. 58-67-110, governing protection against HMO insolvency to replace old net worth requirements and impose new ones that a full service HMO must maintain a net worth equal to the greater of \$1 million or the amount required under RBC and single service HMO must maintain a net worth equal to the greater of \$50,000 or the amount required under RBC. The PCS corrects an inadvertent drafting error in the First Edition (which accidentally removed an existing and necessary requirement that every full service HMO maintain a plan of insolvency acceptable to the Commissioner.)

- **Section 22.** Eliminates reference to G.S. 58-67-40, which is repealed by Section 19, of the bill.
- Section 23. Technically corrects a cross-reference to G.S. 58-3-210, a non-existent section, to reflect the correct cross-reference, G.S. 58-3-191, Managed care reporting and disclosure requirements.
- Sections 24. and 25. Codify Departmental policy that the initial licensing requirements for groups and employers that self-insure for workers' compensation do not apply to entities that existed prior to the adoption of the new laws but do apply if the entity has subsequently terminated and later seeks to reactivate.
- Sections 26.(a). through 26.(m.) amend numerous statutes throughout Chapter 58 to change the process from annual licensing of companies to perpetual licensing of companies. There is no change in the criteria for issuance of a license. It will save the Department and likely the companies administrative costs and will change the process from "renewal" of licensure to "continuation" of licensure. These changes apply to companies (and fraternal benefit societies) not agents.
 - **Section 27.** Is a severability clause.
- Section 28. Makes Sections 26.(a.) through (m.) of the act effective January 1, 2004. The remainder of the act is to become effective October 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 276 PROPOSED COMMITTEE SUBSTITUTE H276-CSRG-5 [v.1]

3/31/2003 4:30:00 PM

| Short Title: Insurance Financial Amendments OmnibusAB | (Public) |
|---|---|
| Sponsors: | |
| Referred to: | |
| March 6, 2003 | |
| A BILL TO BE ENTITLED AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMENT LAWS CONCERNING INSURANCE COMPANY SOLVENCY. The General Assembly of North Carolina enacts: SECTION 1. G.S. 58-5-5 reads as rewritten: "§ 58-5-5. Amount of deposits required of foreign or alien fire and/insurance companies. Unless otherwise provided in this Article, every fire, marine, or fire a insurance company chartered by any other state or foreign government shall maintain deposits of securities with the Commissioner in the amount of a thousand dollars (\$25,000) one hundred thousand dollars (\$100,000) market with the Company chartery of the same and dollars (\$100,000) market with the Company chartery of thousand dollars (\$100,000) market with the Company chartery of thousand dollars (\$100,000) market with the Company chartery of the same and the | or marine and marine l make and twenty five |
| "§ 58-5-10. Amount of deposits required of foreign or alien fidelity, s | surety and |
| Casualty insurance companies. Unless otherwise provided in this Article, every fidelity, surety or casualty company chartered by any other state or foreign government shall make an deposits of securities with the Commissioner in the amount of fifty thouse (\$50,000) two hundred thousand dollars (\$200,000) market value." SECTION 3. G.S. 58-5-50 reads as rewritten: | d maintain |
| "§ 58-5-50. Deposits of foreign life insurance companies. In addition to other requirements of Articles 1 through 64 of this Chapter, life insurance companies shall deposit securities, as specified in G.S. 58-5-2 market value of one hundred thousand dollars (\$100,000) four hundred thous (\$400,000) as a prerequisite of doing business in this State. All foreign life | 0, having a and dollars |

companies shall deposit an additional one hundred thousand dollars (\$100,000) two

hundred thousand dollars (\$200,000) where such companies cannot show three years of

net operational gains prior to admission. Foreign life insurance companies that are

| | 1 | licensed on or before the effective date of this section shall have one year from that date |
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| | 2 | to comply with this section." |
| | 3 | SECTION 4. G.S. 58-7-162(2) reads as rewritten: |
| | 4 | "(2) Investments, securities, properties, and loans acquired or held in |
| | 5 | accordance with this Chapter, and in connection therewith the |
| | 6 | following items: |
| | 7 | a. Interest due or accrued on any bond or evidence of indebtedness |
| | 8 | that is not in default. |
| | 9 | b. Declared and unpaid dividends on stock and shares, unless that |
| | 10 | amount has otherwise been allowed as an asset. |
| | 11 | e. Interest due or accrued upon a collateral loan in an amount not |
| | 12 | to exceed one year's interest thereon. |
| | 13 | d. Interest due or accrued on deposits in solvent banks, savings |
| | 14 | and loan associations, and trust companies, and interest due or |
| ı | 15 | accrued on other assets, if the interest is, in the Commissioner's |
| | 16 | judgment, a collectible asset. |
| | 17 | e. Interest due or accrued on a current mortgage loan, in an |
| | 18 | amount not exceeding in any event the amount, if any, of the |
| | 19 | excess of the value of the property less delinquent taxes thereon |
| | 20 | over the unpaid principal; but in no event shall interest accrued |
| | 21 | for a period in excess of 90 days be allowed as an asset. |
| | 22 | f. Rent due or accrued on real property if the rent is not in arrears |
| | 23 24 | for more than three months, and rent more than three months in |
| | 2 4 25 | arrears if the payment of the rent is adequately secured by |
| ı | 26 | property held in the tenant's name and conveyed to the insurer |
| | 27 | as collateral and the underlying collateral is admissible under |
| | 28 | this Chapter. The preserved mertion of Chapter in the Chapter. |
| , | 29 | The unaccrued portion of taxes paid before the due date on real |
| 1 | 30 | property. Chapter." |
| : | 31 | SECTION 5. G.S. 58-7-162(5) and G.S. 58-7-162(7) are repealed. |
| | 32 | SECTION 6. G.S. 58-7-162(12) reads as rewritten: |
| | 33 | "(12) Electronic and mechanical machines, including operating and system |
| 1 | 34 | software constituting a management information system, if the cost of |
| 1 | 35 | the system is at least twenty five thousand dollars (\$25,000) but not |
| : | 36 | more than two percent (2%) of total admitted assets; the cost shall be |
| ! | 37 | amortized in full over a period not to exceed seven calendar |
| : | 38 | years.system." |
| 1 | 39 | SECTION 7. G.S. 58-7-163 reads as rewritten: |
| | | "§ 58-7-163. Assets not allowed. |
| : | 41 | In addition to assets impliedly excluded by the provisions of G.S. 58-7-162, the |
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Page 2

condition of an insurer:

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Goodwill, trade names, and other like intangible assets.

following expressly shall not be allowed as assets in any determination of the financial

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- (2) Advances (other than policy loans) to officers, directors, and controlling stockholders, whether secured or not, and advances to employees, agents, and other persons on personal security only.
- (3) Stock of the insurer or any material equity therein or loans secured thereby, or any material proportionate interest in the stock acquired or held through the ownership by the insurer of an interest in another firm, corporation, or business unit.
- Furniture, fixtures, other equipment, safes, vehicles, libraries, stationery, literature, and supplies, other than data processing and accounting systems authorized under G.S. 58-7-162(12), except in the case of title insurers the materials and plants which G.S. 58-7-182 expressly authorizes the insurer to invest in, and except, in the case of any insurer, any personal property that the insurer is permitted to hold under this Chapter, or that is acquired through foreclosure of chattel mortgages acquired under G.S. 58-7-180, or that is reasonably necessary for the maintenance and operation of real estate that the insurer uses for a home office, branch office, and similar purposes.
- (5) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value of the investments as determined under this Chapter.
- (6) Bonds, notes, or other evidences of indebtedness that are secured by mortgages or deeds of trust that are in default, to the extent of the cost or carrying value that is in excess of the value as determined pursuant to other provisions of this Chapter.
- (7) Prepaid and deferred expenses.
- (8) Certificates of contribution contribution, surplus notes or other similar evidences of indebtedness. indebtedness, to the extent that admission of these investments results in the double counting of these investments in the reporting entity's balance sheet.
- (9) Any asset that is encumbered in any manner unless the asset is authorized under G.S. 58-7-187 or G.S. 58-7-162(13)."

SECTION 8. G.S. 58-7-192 reads as rewritten:

"§ 58-7-192. Valuation of securities and investments.

- (a) All securities, investments, and evidences of debt, other than those for which valuation methodologies are specifically set forth in this Chapter, that are held by an insurer shall be valued at their market values, at their appraised values, or at prices determined by the insurer as representing their fair market values, subject to the Commissioner's approval.
- (b) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, in the Commissioner's discretion and in accordance with a method of valuation that the Commissioner approves.
- (c) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of its net value as based upon those assets only of the subsidiary that

would be eligible under this Chapter and G.S. 58-19-10 for investment of the funds of the insurer direct.

- (d) No valuations under this section-shall be greater than any applicable valuation or method contained in the latest edition of the NAIC publications entitled "Valuations of Securities" Purposes and Procedures Manual of the NAIC Securities Valuation Office" or the "Accounting Practices and Procedures Manual", unless the Commissioner determines that another valuation method is appropriate when it results in a more conservative valuation.
- (e) All bonds or fully secured indebtedness having a stated term and a rate of interest that are held by an insurer shall be valued in accordance with the procedures and instructions contained in the NAIC publication entitled "Valuations of Securities", unless the Commissioner determines that a more conservative valuation is appropriate."

SECTION 9. G.S. 58-7-193 reads as rewritten: "§ 58-7-193. Valuation of property.

- (a) Real property acquired pursuant to a mortgage loan or contract for sale shall be valued at the net realizable value, but in no event shall the property be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of the acquisition and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.
- (b) Other real property held by an insurer shall not be valued at an amount in excess of fair market value as determined by recent appraisal and as approved by the Commissioner. If valuation is based on an appraisal more than three years old, the Commissioner may call for and require a new appraisal in order to determine fair value.
- (c) Personal property acquired pursuant to chattel mortgages made in accordance with G.S. 58-7-180 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at the date of acquisition, or the fair market value of the property, whichever amount is less.
- (d) If the Commissioner and an insurer do not agree on the value of real or personal property of an insurer, in carrying out the Commissioner's responsibilities under this section, the Commissioner may retain the services of a qualified real or personal property appraiser. The insurer shall reimburse the Commissioner for the costs of the services of any appraiser incurred with respect to the Commissioner's responsibilities under this section."

SECTION 10. G.S. 58-7-195 is repealed.

SECTION 11. G.S. 58-7-179(d) reads as rewritten:

"(d) In the case of a purchase money mortgage given to secure the purchase price of real estate sold by the insurer, the amount lent or invested shall not exceed the unpaid part of the purchase price and shall be valued in accordance with G.S. 58-7-195.price."

SECTION 12. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168,

58-7-170, 58-7-172, 58-7-173, 58-7-175, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and Articles 13, 19, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

SECTION 13. G.S. 58-47-80 reads as rewritten:

"§ 58-47-80. Assets and invested assets.

Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and 58-19-10."

SECTION 14. G.S. 58-8-15 reads as rewritten:

"§ 58-8-15. Directors in mutual companies.

Every mutual insurance company shall elect by ballot a board of not less than seven directors, who shall manage and conduct its business and hold office for one year or for such term as the bylaws provide and until their successors are qualified. The directors need not be residents of this State or members of the company. In companies with a guaranty capital, no more than one half one-half of the directors shall be ehosen elected by and from the stockholders holders of guaranty capital, except where guaranty capital holders are policyholders. Policyholders which are holders of guaranty capital shall be entitled to one vote for each policy that person holds and one vote for each unit of guaranty capital that person holds."

SECTION 15. G.S. 58-8-20 reads as rewritten:

"§ 58-8-20. Mutual companies with a guaranty capital.

- (a) A mutual insurance company formed as provided in Articles 1 through 64 of this Chapter, in lieu of the contributed surplus required for the organization of mutual companies under the provisions of G.S. 58-7-75, or a mutual insurance company now existing, may, with the prior approval of the Commissioner, establish tender a guaranty capital offering of not less than fifty thousand dollars (\$50,000), divided into shares units of one hundred dollars (\$100.00) each, which shall be invested in the same manner as is provided in this Chapter for the investment of the capital stock of insurance companies.
- (a1) Guaranty capital may be issued by an existing domestic mutual insurance company only under the following terms and conditions:
 - (1) To aid and assist a financially troubled domestic mutual insurance company which otherwise faces rehabilitation or liquidation by this Department; or
 - (2) For any other reason as presented in a petition to the Commissioner and which is found by the Commissioner to be reasonable, justifiable, and in the best interest of all the policyholders of the company.

Guaranty capital issued under subdivision (2) of this subsection shall require written notification of the action proposed by the board of directors of the company to be mailed to the policyholders of the company not less than 30 days before the meeting when the action may be taken. The written notification shall be advertised in two

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newspapers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before the meeting. The written notification to policyholders shall include a proxy statement to allow policyholders to vote on the proposed action without personal attendance at the meeting, and the Commissioner shall approve both the written notification and the proxy statement. The proposed action shall be effected by a vote of two-thirds of the policyholders voting thereon in person or by proxy.

- (b) The board of directors of a company may declare and pay dividends to the stockholders of the guaranty capital of a company, subject to the notification requirements of G.S. 58-19-25(d) and the prior approval requirements of G.S. 58-19-30(c). distribute interest to the holders of guaranty capital in accordance with the guaranty capital filing approved by the Department.
- (c) The guaranty Guaranty capital shall be applied to the payment of losses only when the company has exhausted its cash in hand and the invested assets, exclusive of uncollected premiums, and when thus impaired, the directors may make good the whole or any part of it by assessments upon the contingent funds of the company at the date of such impairment. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.
- (d) Shareholders and members of such companies are subject to the same provisions of law in respect to their right to vote as apply respectively to shareholders in stock companies and policyholders in mutual companies. Guaranty capital holders are entitled to one vote per unit of guaranty capital. Guaranty capital holders who are not policyholders are not entitled to participate in the policyholder votes prescribed under subdivision (a1)(2) and subsection (e) of this section.
- This guaranty Guaranty capital may be reduced or retired by vote of the policyholders of the company and the assent of the Commissioner, if the net assets of the company above its reserve and all other claims and obligations, exclusive of guaranty capital, for two years immediately preceding and including the date of its last annual statement, is not less than twenty-five percent (25%) of the guaranty capital. Due notice of such proposed action on the part of the company must be mailed to each policyholder of the company not less than 30 days before the meeting when the action may be taken, and must also be advertised in two papers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before such meeting. No insurance company with a guaranty capital which has ceased to do new business, shall divide to its stockholders any part of its assets or guaranty capital, except income from investments, until it has performed or canceled its policy obligations. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.

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- No insurance company with guaranty capital shall distribute to its holders of (f) guaranty capital its assets, except as provided in the guaranty capital filing as approved by the Commissioner.
- In the event of a merger, demutualization, or other event where the entity (g) ceases to exist, guaranty capital shall only be returned or repaid to the holders of guaranty capital to the extent that the guaranty capital has been contributed together with accrued interest as specified in the filing approved by the Commissioner."

SECTION 16. G.S. 58-8-50 reads as rewritten:

"§ 58-8-50. Guaranty against assessments prohibited.

If any director, officer, or agent of a mutual insurance company, either officially or privately, shall give gives a guarantee to a policyholder thereof of the company against an assessment to which such that policyholder would otherwise be liable, he the director, officer, or agent shall be punished by a fine not exceeding one hundred dollars (\$100.00) one thousand dollars (\$1,000) for each offense."

SECTION 17. G.S. 58-65-1 reads as rewritten:

Regulation and definitions; application of other laws; profit and "**§** 58-65-1. foreign corporations prohibited.

Any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, unless otherwise provided.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations or any other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical or any other professional services authorized or permitted to be furnished by a duly licensed physician or other provider listed in G.S. 58-50-30. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment 20f of fees toward, or furnishing of dental or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital or medical or dental service plan, as defined in this section. Any corporation organized and subject to the provisions of this Article and Article 66 of this Chapter, Article, the certificate of incorporation of which authorizes the operation of either a hospital or medical or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, Commissioner, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter-or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Article. Except to the extent prohibited either by G.S. 58-65-140 or by rules promulgated adopted by the Department of Insurance—Commissioner not inconsistent with this Article and Article 66 of this Chapter, Article, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

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- (b) through (c) Repealed by Session Laws 2001-297. licensed licensed Social Work and Licensure
- (d) No foreign or alien hospital or medical or dental service corporation as herein defined shall be authorized to do business in this State."

SECTION 18. G.S. 58-65-95(a) reads as rewritten:

"(a) No corporation Corporations subject to this Article shall invest in any securities other than securities or hold only those assets permitted by Article 7 of this Chapter for the investment of assets of life and health insurance companies.

SECTION 19. G.S. 58-67-5(i) reads as rewritten:

"(i) "Net worth" means the excess of total assets over the total liabilities and may include borrowed funds that are repayable only from the net earned income of the health maintenance organization and repayable only with the advance permission of the Commissioner. For the purposes of this subsection, "assets" means (i) tangible assets and (ii) other investments permitted under G.S. 58-67-60; provided, however, that the depreciated cost of office furniture and equipment in the principal office shall not exceed ten percent (10%) of a health maintenance organization's net worth. G.S. 58-67-60."

SECTION 20. G.S. 58-67-40 is repealed.

SECTION 21. G.S. 58-67-110 reads as rewritten:

"§ 58-67-110. Protection against insolvency.

(a) The Commissioner shall require deposits in accordance with the provisions of G.S. 58-67-25.

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- Each full service medical health maintenance organization shall maintain a 1 (b) 2 minimum net worth of not less than one million dollars (\$1,000,000), which shall be increased by the amount of the contingency reserves calculated annually in accordance 3 with the provisions of G.S. 58-67-40. The net worth calculation shall be computed in 4 5 accordance with statutory accounting principles generally recognized in the regulation of health maintenance organizations and the Commissioner may promulgate such 6 7 regulations as he deems appropriate to carry out the provisions of this section. If a health maintenance organization fails to comply with the net worth requirement of this 8 9 subsection or subsections (c) or (d) of this section, the Commissioner is authorized to 10 take appropriate action to assure that the continued operation of the health maintenance 11 organization will not be hazardous to its enrollees, equal to the greater of one million 12 dollars (\$1,000,000) or the amount required pursuant to the risk-based capital provisions of Article 12 of this Chapter. Each single service health maintenance organization shall 13 maintain a minimum net worth equal to the greater of fifty thousand dollars (\$50,000) 14 or that amount required pursuant to the risk-based capital provisions of Article 12 of this 15 16 Chapter. 17
 - (c) The minimum net worth for a health maintenance organization authorized to operate on July 17, 1987, and having a net worth of less than one million dollars (\$1,000,000) shall be as follows:
 - (1) \$150,000 by December 31, 1987
 - (2) \$300,000 by December 31, 1988
 - (3) \$450,000 by December 31, 1989
 - (4) \$750,000 by December 31, 1990
 - (5) \$1,000,000 by December 31, 1991

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- (d) Notwithstanding any other provision of this Article, a health maintenance organization authorized to offer only a single health care service plan providing a single health care service must have a minimum net worth of fifty thousand dollars (\$50,000). The minimum net worth for such plan authorized to operate on July 17, 1987, and having a net worth of less than fifty thousand dollars (\$50,000) shall be as follows:
 - (1) Twenty-five thousand dollars (\$25,000) by December 31, 1987; and
 - (2) Fifty thousand dollars (\$50,000) by December 31, 1988;

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- (e) Every full service medical health maintenance organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Commissioner. In determining the adequacy of such a plan, the Commissioner may consider:
 - (1) A reinsurance agreement preapproved by the Commissioner covering excess loss, stop loss, or catastrophes. The agreement must provide that the Commissioner will be notified no less than 60 days prior to cancellation or reduction of coverage.

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1 (2) A conversion policy or policies that will be offered by an insurer to the enrollees in the event of the health maintenance organization's 2 3 insolvency. Any other arrangements offering protection against insolvency that the 4 (3) 5 Commissioner may require." **SECTION 22.** G.S. 58-67-140(a)(3) reads as rewritten: 6 No longer maintains the financial reserve specified in G.S. 58-67-40 or 7 "(3) is-Is no longer financially responsible and may reasonably be expected 8 to be unable to meet its obligations to enrollees or prospective 9 10 enrollees." 11 **SECTION 23.** G.S. 58-67-140(a)(7) reads as rewritten: 12 Has knowingly published or made to the Department or to the public "(7) 13 any false statement or report, including any report or any data that 14 serves as the basis for any report, required to be submitted under G.S. 15 58-3-210.G.S. 58-3-191." SECTION 24. G.S. 58-47-65(a) reads as rewritten: 16 No group shall self-insure its workers' compensation liabilities under the Act 17 unless it is licensed by the Commissioner under this Part. This subsection does not 18 19 apply to a group that was organized and approved under the North Carolina law before July 1, 1995, and whose authority to self-insure its workers' compensation liabilities 20 21 under the Act has not terminated after that date." 22 **SECTION 25.** G.S. 97-170(a) reads as rewritten: No employer shall self-insure its workers' compensation liabilities under the 23 Act unless it is licensed by the Commissioner under this Article. This subsection does 24 not apply to an employer authorized to self-insure its workers' compensation liabilities 25 under the Act prior to December 1, 1997, whose authority to self-insure its workers' 26 compensation liabilities under the Act has not terminated after that date." 27 28 SECTION 26(a). G.S. 58-3-100 reads as rewritten: "§ 58-3-100. Insurance company licensing provisions. 29 (a) The Commissioner may, after notice and opportunity for 30 a hearing, revoke, suspend, restrict, or refuse to renew or restrict the 31 32 license of any insurer if: 33 (1) The insurer fails or refuses to comply with any law, order or rule applicable to the insurer. 34 35 (2) The insurer's financial condition is unsound, or 36 its assets above its liabilities, exclusive of 37 capital, are less than the amount of its capital or required minimum surplus. 38 39 (3) The insurer has published or made to the Department 40 or to the public any false statement or report. 41 (4) The insurer or any of the insurer's officers, 42 directors, employees, or other representatives 43 refuse to submit to any examination authorized by 44 law or refuse to perform any legal obligation in

relation to an examination.

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- (5) The insurer is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.
- (b) Any suspension, revocation or refusal to renew suspension or revocation of an insurer's license under this section may also be made applicable to the license or registration of any individual regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section."

SECTION 26(b). G.S. 58-4-15 reads as rewritten:

"§ 58-4-15. Revocation or suspension of license.

The Commissioner may suspend, revoke, or refuse to renew suspend or revoke the license of any insurer failing to file its financial statement when due or within any extension of time that the Commissioner, for good cause, may have granted."

SECTION 26(c). G.S. 58-6-7 reads as rewritten:

"§ 58-6-7. <u>Licenses: perpetual licensing; annual license continuation</u> Annual license fees for insurance companies.

(a)In order to do business in this State, an insurance company shall apply for and obtain a license from the Commissioner by March 1 of each year. Commissioner. The license shall be perpetual and become effective the following July 1 and shall remain in effect for one year. shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with this Chapter and subject to any other applicable provision of the insurance laws of this State. Except as provided in subsection (b) of this section, the insurance company shall pay an annual a fee for each year the license is in effect, as follows:

For each domestic farmer's mutual assessment fire insurance company......\$ 25.00

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

- (b) When the paid-in capital stock or surplus, or both, of an insurance company, other than a farmer's mutual assessment company or a fraternal order, does not exceed one hundred thousand dollars (\$100,000), the fee levied in this section shall be one-half the amount specified.
- (c) Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars (\$100.00) for each such additional classification of

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business done. All fees and charges collected by the Commissioner under this Chapter are nonrefundable.

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

SECTION 26(d). G.S. 58-6-15 reads as rewritten:

"§ 58-6-15. Licenses run from July 1. Annual license continuation fee definition; requirements.

The license required of insurance companies shall continue, continue for the next ensuing 12 months after July 1 of each year, unless revoked as provided in Articles 1 through 64 of this Chapter. Application for renewal of the company license For purposes of this Chapter only, "annual license continuation fee" means the fee specified in G.S. 58-6-7 submitted to the Commissioner for each year the license is in effect after the company's year of initial licensing. The annual license continuation fee must be submitted on or before the first day of March on a form to be supplied by the Commissioner. Commissioner each year the license is to remain in effect. If the Commissioner is satisfied Upon satisfying himself-that the company has met all requirements of law and appears to be financially solvent he shall forward the renewal license to the company. Any company which does not qualify for a renewal license before July 1 shall cease to do business in the State of North Carolina as of July 1, unless its license is sooner revoked by the Commissioner. solvent, the Commissioner shall not revoke or suspend the license of the company and the company shall be authorized to do business in this State, subject to all other applicable provisions of the insurance laws of this State. Nothing contained in this section shall be interpreted as applying to licenses issued to individual representatives of insurance companies."

SECTION 26(e). G.S. 58-6-30 reads as rewritten:

"§ 58-15-30. License, surplus, and deposit requirements.

- (a)No reciprocal shall engage in any insurance transaction in this State until it has obtained a license to do so in accordance with the applicable provisions of Articles 1 through 64 of this Chapter. Such The license shall continue in full force and effect, subject to timely payment of an annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State expire on the last day of June of each year.
- (b) No domestic or foreign reciprocal shall be licensed in this State unless it has a surplus to policyholders of at least eight hundred thousand dollars (\$800,000); and no alien reciprocal shall be licensed unless it has a trusteed surplus of at least eight hundred thousand dollars (\$800,000).
- (c) Each domestic, foreign, or alien reciprocal licensed in this State must maintain a minimum deposit with the Commissioner of at least one hundred thousand dollars (\$100,000) in cash or in value of securities of the kind specified in G.S. 58-5-15, which shall be subject to the same conditions as contained in Article 5 of this Chapter."

SECTION 26(f). G.S. 58-19-65 reads as rewritten:

"§ 58-19-65. Revocation, suspension, or nonrenewal Revocation or suspension of insurer's license.

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Whenever it appears to the Commissioner that any person has committed a violation of this Article that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an opportunity to be heard, suspend, revoke, or refuse to renew suspend or revoke such insurer's license to do business in this State for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law."

SECTION 26(g). G.S. 58-24-130 reads as rewritten:

"§ 58-24-130. Annual Perpetual license.

Societies which are now authorized to transact business in this State may continue such business until the 30th day of June next succeeding January 1, 1988. The authority of such societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the 30th day of the succeeding June. However, a license so issued Subject to timely payment of the annual license continuation fee and subject to any other applicable provisions of the insurance laws of this State, a license, other than a preliminary license, to a fraternal benefit society under this Article shall continue in full force and effect until the new license be issued or specifically refused. effect. For each such license or renewal the society shall pay the Commissioner the fee specified in G.S. 58-6-5. The society shall pay the Commissioner, as an annual license continuation fee and a condition of the continuation of the license, the fee specified in G.S. 58-6-7 on or before the first day of March on a form to be supplied by the Commissioner. A duly certified copy or duplicate of suchthe license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of Articles 1 through 64 of this Chapter."

SECTION 26(h). G.S. 58-26-10 reads as rewritten:

"§ 58-26-10. Financial statements and licenses required.

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The license to do business in this State issued to a title insurance company shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State. The Commissioner shall annually license such companies and their agents the agents of title insurance companies."

SECTION 26(i). G.S. 58-30-62 reads as rewritten:

"§ 58-30-62. Administrative supervision of insurers.

(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 revoked or suspended 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."

SECTION 26(j). G.S. 58-65-55 reads as rewritten:

"§ 58-65-55. Issuance of certificate.

- (a) Before issuing or continuing any such license or certificate the Commissioner may make such an examination or investigation as the Commissioner deems expedient. The Commissioner shall issue a certificate of authority or license upon the payment of \underline{a} an annual fee of one thousand dollars (\$1,000) and upon being satisfied on the following points:
 - (1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.
 - (2) The rates charged and benefits to be provided are fair and reasonable.
 - (3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and hospital and medical and/or dental expenses and such reserve as the Department deems adequate, as provided hereinafter.
 - (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.
- (b) The certificate of authority or license shall continue in full force and effect, subject to payment of an annual license continuation fee of one thousand dollars (\$1000), subject all other provisions of subsection (a) of this section, and subject to any other applicable provisions of the insurance laws of this State."

SECTION 26(k). G.S. 58-65-125 reads as rewritten:

"§ 58-65-125. Revocation, suspension, and refusal to renew Revocation and suspension of license; unfair trade practices.

- (a)The Commissioner may revoke, suspend, or refuse to renewrevoke or suspend the license of any service corporation if:
 - (1) The service corporation fails or refuses to comply with any law, order, or rule applicable to the service corporation.
 - (2) The service corporation's financial condition is unsound.
 - (3) The service corporation has published or made to the Department or to the public any false statement or report.

- (4) The service corporation refuses to submit to any examination authorized by law.
- (5) The service corporation is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.
- (b) Any suspension, revocation, or refusal to renew suspension or revocation of a service corporation's license under this section may also be made applicable to the license or registration of any natural person regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.
- (c) Article 63 of this Chapter applies to service corporations and their agents and representatives."

SECTION 26(1). G.S. 58-67-140 reads as rewritten:

"§ 58-67-140. Suspension or revocation of license.

- (a)The Commissioner may suspend, revoke, or refuse to renewsuspend or revoke an HMO license if the Commissioner finds that the HMO:
 - (1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-67-10, unless amendments to such submissions have been filed with and approved by the Commissioner.
 - (2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with G.S. 58-67-50.
 - (3) No longer maintains the financial reserve specified in G.S. 58-67-40 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
 - (4) Has itself or through any person on its behalf advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.
 - (5) Is operating in a manner that would be hazardous to its enrollees.
 - (6) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the HMO or with any order issued by the Commissioner after notice and opportunity for a hearing.
 - (7) Has knowingly published or made to the Department or to the public any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210."

 SECTION 26(m). G.S. 58-67-160 reads as rewritten: "§ 58-67-160. Fees.

Every health maintenance organization subject to this Article shall pay to the Commissioner a fee of two hundred fifty dollars (\$250.00) for filing an application for a license and a an annual license continuation fee of one thousand dollars (\$1,000) for each license renewal. license. The license shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State."

SECTION 27. If any section or provision of this act is declared unconstitutional, preempted, or otherwise invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part declared to be unconstitutional, preempted, or otherwise invalid.

SECTION 28. Sections 26(a) through (m) become effective January 1, 2004, and apply to all company licenses issued or otherwise eligible for renewal or continuation after that date. The remainder of this act becomes effective October 1, 2003

Page 16 House Bill 276 H276-CSRG-5 [v.1]

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| Name: | arah Robertson | |
| Town: | Danbury, Stokes Co. | |
| • | Rex Baker | |
| | | |
| Name: | | |
| Town: | | |
| Sponsor | r: | |

VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

April 1

Name of Committee

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|----------------------------|
| Frank Folger | DOI |
| Mai Junt | NCAMP |
| Im righ | Morning Van Alla |
| Bin Hale | Jordan Pince |
| DAVID BARMS | Payme + Spull LLP |
| chis Nich. ls | Hunton + williams |
| Skve Woodson | NCFIS |
| Susan Valauri | Nation wide |
| DAvid Stollen | 8PATE FARM |
| Robert Paschap | Young, Aporci |
| Camille Stall | Kenned Consister |

VISITOR REGISTRATION SHEET

| HOUSE INSURANCE COMMITTEE | April 1 |
|---------------------------|---------|
| Name of Committee | Date |

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|-------------|----------------------------|
| Julie Allen | NC Stateuntch |
| Sulving | NCMP |
| ANN LORE | OUNS |
| Itam Tarlan | DIOCC |
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Joanna Mills (Rep. Setzer)

From: Carol Bowers (Rep. Holliman)

Sent: Thursday, March 27, 2003 2:13 PM

Subject: House Insurance Committee Meeting 04-01-03

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2003-2004 SESSION

You are hereby notified that the Committee on INSURANCE will meet as follows:

DAY & DATE:

Tuesday, April 1, 2003

TIME:

10:00 AM

LOCATION:

425 LOB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 253 - Continuing Care Ret./Tech. Changes.-AB - Rep. Setzer

HB 276 - Insurance Financial Amendments Omnibus.-AB - Rep. Setzer

Respectfully, Representatives Holliman and Setzer Chairs

| I hereby certify this notice was filed by the committee assistant at the fo | ollowing offices at 2:15 PM on |
|---|--------------------------------|
| March 27, 2003. | |

| Prin | cipal Clerk | |
|------|---------------------------|----|
| Rea | ding Clerk - House Chambe | er |

Carol Bowers (Committee Assistant)

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. Committee Substitute for A BILL TO BE ENTITLED AN ACT MAKE TECHNICAL AND RELATED H.B. 253 SUBSTANTIVE CHANGES TO THE CONTINUING CARE RETIREMENT (CCR) LAWS TO ELIMINATE THE UNNECESSARY PROVISION ALLOWING FOR ACCREDITED BUT UNLICENSED PROVIDERS OF CCR SERVICES; CHANGE REFERENCES FROM "FACILITY" TO "PROVIDER" WHERE APPROPRIATE TO ACCOMMODATE THE SITUATION WHERE AN ENTITY OPERATES MORE THAN ONE FACILITY; CHANGE "FORECAST" TO "FORECASTED" WHERE FOUND; CHANGE THE OPERATING RESERVES STATUTE BY REWORDING SOME PROVISIONS TECHNICALLY; CHANGE REFERENCES TO "REGISTRATION" OF A FACILITY TO "LICENSURE"; MAKE GENDER NEUTRAL CHANGES TO THE CCR LAWS; CLARIFY THAT A PROVIDER MUST HOLD SEMI-ANNUAL MEETINGS WITH THE RESIDENTS OF EACH FACILITY OPERATED BY THE PROVIDER; AND MAKE OTHER TECHNICAL AND CONFORMING CHANGES TO ARTICLE 64. 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,), (and recommendation that the unfavorable as to (the original bill) (Committee Substitute Bill # 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)

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 8, 2003

The House Committee on Insurance met at 10:00 AM on April 8, 2003. The following Representatives attended: Mitchell Setzer, Hugh Holliman, John Hall, Lucy Allen, Bobby Barbee, Charles Johnson, David Lewis, Drew Saunders and William Wainwright.

Chair Hugh Holliman called the meeting to order. He introduced the pages, Brandy Hauser, Sponsored by Rep. McGee, Amy McClellan, Sponsored by Rep. Marvin Lucas. He then introduced the Sergeant-At-Arms, Bob Fowler, Charles Williams and Bill Sullivan. He then called on Rep. Hackney to introduce the bill. HB-744- A BILL TO BE ENTITLED AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMENTS IN THE LAWS CONCERNING INSURANCE COMPANY SOLVENCY. House Bill 744 amends various provisions law governing insurers and managed care organizations to require insurers and the commissioner of Insurance to inform covered persons about the assistance that is available from the Managed Care patient Assistance Program, which was established pursuant to S.L. 2001-446, the Managed Care Patient Bill of Rights. The act becomes effective October I, 2003. See the attachments.

Representative Bobby Barbee made the motion for a favorable report. It passed unanimously.

Representative Setzer called on Frank Folger, Legislative Counsel for the Department of Insurance to explain HB-276 A BILL TO BE ENTITLED AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMENTS IN THE LAWS CONCERNING INSURANCE COMPANY SOLVENCY. Frank Folger explained the bill. Rep. Saunders questioned the fact that the bill had 10 pages last time it was before the committee and now it is 17 pages long. Mr. Folger explained that it did have a number of changes; however these changes simply save the administration a tremendous amount of paper work. See attachment #2.

Representative John Hall moved for a favorable report, unfavorable to original bill. The bill passed unanimously.

The Meeting was adjourned at 10: 40 AM

Ren I. Hugh Holliman Chair

p. Mitehell S. Setzer, Chair

Joanna Mills, Committee Clerk

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003 attacknest HB. 144

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HOUSE BILL 744*

Short Title: Managed Care Patient Assistance. (Public)

Sponsors: Representatives Hackney; Alexander, Glazier, Harrell, Insko, Lucas, Luebke, McLawhorn, Rapp, Ross, Wainwright, Weiss, and Womble.

Referred to: Insurance.

March 27, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURERS TO INFORM COVERED PERSONS ABOUT ASSISTANCE AVAILABLE FROM THE MANAGED CARE PATIENT ASSISTANCE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-61(h), (k), and (m) read as rewritten: "§ 58-50-61. Utilization review.

(h) Notice of Noncertification. – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. An insurer shall also inform the covered person in writing about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

- (k) Nonexpedited Appeals. Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall contain:
 - (1) The professional qualifications and licensure of the person or persons reviewing the appeal.

the Program.

- (2) A statement of the reviewers' understanding of the reason for the covered person's appeal. The reviewers' decision in clear terms and the medical rationale in (3) sufficient detail for the covered person to respond further to the insurer's position. (4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria. A statement advising the covered person of the covered person's right (5)
 - procedure for submitting a second-level grievance under G.S. 58-50-62.

 (6) Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of

to request a second-level grievance review and a description of the

(m) Disclosure Requirements. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes."

SECTION 2.(a) G.S. 58-50-62(c) reads as rewritten:

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

SECTION 2.(b) G.S. 58-50-62(e)(2) reads as rewritten:

"(e) First-Level Grievance Review. – A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance.

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- (2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall contain:
 - a. The professional qualifications and licensure of the person or persons reviewing the grievance.
 - b. A statement of the reviewers' understanding of the grievance.
 - c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
 - d. A reference to the evidence or documentation used as the basis for the decision.
 - e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.
 - f. Notice of the availability of assistance from the Managed Care
 Patient Assistance Program, including the telephone number
 and address of the Program."

SECTION 2.(c) G.S. 58-50-62(f)(1) reads as rewritten:

- "(f) Second-Level Grievance Review. An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance.
 - (1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:
 - a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.
 - b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer

| 1 | | representative, or attorney. If the covered person chooses to be |
|----|---------------|--|
| 2 | | represented by an attorney, the insurer may also be represented |
| 3 | | by an attorney. |
| 4 | | c. The availability of assistance from the Managed Care Patient |
| 5 | | Assistance Program, including the telephone number and |
| 6 | , | address of the Program. |
| 7 | | 11 |
| 8 | SEC | TION 2.(d) G.S. 58-50-62(h) reads as rewritten: |
| 9 | | nd-Level Grievance Review Decisions An insurer shall issue a written |
| 10 | • , | e covered person and, if applicable, to the covered person's provider, |
| 11 | | ousiness days after completing the review meeting. The decision shall |
| 12 | include: | in and the second companies and to the second secon |
| 13 | (1) | The professional qualifications and licensure of the members of the |
| 14 | (-) | review panel. |
| 15 | (2) | A statement of the review panel's understanding of the nature of the |
| 16 | () | grievance and all pertinent facts. |
| 17 | (3) | The review panel's recommendation to the insurer and the rationale |
| 18 | (-) | behind that recommendation. |
| 19 | (4) | A description of or reference to the evidence or documentation |
| 20 | | considered by the review panel in making the recommendation. |
| 21 | (5) | In the review of a noncertification or other clinical matter, a written |
| 22 | (*) | statement of the clinical rationale, including the clinical review |
| 23 | | criteria, that was used by the review panel to make the |
| 24 | | recommendation. |
| 25 | (6) | The rationale for the insurer's decision if it differs from the review |
| 26 | ` ' | panel's recommendation. |
| 27 | (7) | A statement that the decision is the insurer's final determination in the |
| 28 | , , | matter. In cases where the review concerned a noncertification and the |
| 29 | | insurer's decision on the second-level grievance review is to uphold its |
| 30 | | initial noncertification, a statement advising the covered person of his |
| 31 | | or her right to request an external review and a description of the |
| 32 | | procedure for submitting a request for external review to the |
| 33 | | Commissioner of Insurance. |
| 34 | (8) | Notice of the availability of the Commissioner's office for assistance, |
| 35 | | including the telephone number and address of the Commissioner's |
| 36 | | office. |
| 37 | <u>(9)</u> | Notice of the availability of assistance from the Managed Care Patient |
| 38 | | Assistance Program, including the telephone number and address of |
| 39 | | the Program." |
| 40 | SEC' | TION 3. G.S. 58-50-80(b)(3) reads as rewritten: |
| 41 | "8 59_50_90 S | tandard external review |

"(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:

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(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 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. The Commissioner shall also notify the covered person in writing of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program."

SECTION 4. This act becomes effective October 1, 2003, and applies to actions taken by the insurer under the subsections of G.S. 58-50-61, 58-50-62, and 58-50-80 amended by this act, on and after that date. G.S. 58-50-61, as amended by this act, applies to member handbooks printed after October 1, 2003.



HOUSE BILL 744: Managed Care Patient Assistance



BILL ANALYSIS

Committee: He Date: A

Version:

House Insurance

April 8, 2003 Introduced Introduced by:

Rep. Hackney

Summary by: Linda Attarian

Committee Counsel

SUMMARY: House Bill 744 amends various provisions law governing insurers and managed care organizations to require insurers and the Commissioner of Insurance to inform covered persons about the assistance that is available from the Managed Care Patient Assistance Program, which was established pursuant to S.L. 2001-446, the Managed Care Patient Bill of Rights. The act becomes effective October 1, 2003.

CURRENT LAW: The General Assembly enacted Senate Bill 199, Managed Care Patient Bill of Rights in the 2001 General Session. The legislation required insurers to implement numerous patient protection measures and established a managed care patient assistance program (Program) to be administered by an existing State agency that was to be designated by the Governor. In 2002, the Governor established the program within the Office of the Attorney General. The Program has been up and operating since. The purpose of the Program is to provide information and assistance to individuals enrolled in managed care plans. The Program Director is required to publicize the Office.

BILL ANALYSIS: The bill requires insurers to inform covered persons about the availability of the assistance that is available from the Program, including its telephone number and address, at the following points of communication between the insurer and the covered person:

- At the time the insurer provides notice of "noncertification" i.e., a notice that the insure will not reimburse a particular covered service or admission due to a determination that the requested covered health care service or admission does not meet the insurer's reimbursement requirements (e.g., the services or admission does not meet the insurer's requirements of medical necessity, appropriateness, etc.,).
- At the time the insurer provides written notification of its decision to deny the covered person's appeal of a noncertification decision.
- In the certificate of coverage and the member's handbook.
- In the insurer's written procedures concerning for receiving and resolving grievances from covered persons that are required to be included in the certificate of coverage and the member's handbook.
- At the time the insurer provides written notification of its decision to deny a first-level grievance.
- At the time the insurer provides written notification of its decision concerning the second level grievance review.

The bill also requires the Commissioner of Insurance to notify the covered person about the Program at the time the Commissioner informs the covered person whether the person's request for external review has been accepted or not.

The bill is effective October 1, 2003 and the provisions apply to communications on or after that date.

HB-744

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Managed Care Patient Assistance Program

Helping North Carolina - One Patient at a Time

What is the Managed Care Patient Assistance Program?

An important part of the Patient's Rights Legislation, the Managed Care Patient Assistance Program was established in the office of Attorney General Roy Cooper by Governor Michael Easley in July 2002. The Managed Care Patient Assistance Program serves to:

- · explain your rights as a health care consumer;
- · answer your questions about managed care;
- · advise you about the coverage provisions of your specific health care plan; and
- help you understand the utilization review process and grievance, appeal, and external review procedures.

What is managed care?

Many people today have their health insurance provided through *managed care organizations* (MCO). These organizations or plans are commonly called *health maintenance organizations* (HMO), *preferred provider organizations* (PPO) or *point of service providers* (POS). Regardless of the type of MCO, the overall purpose is to enhance the cost-effectiveness and quality of health care. Essentially, managed care plans act as the financial go-between or mediator between health care providers, members and employer groups.

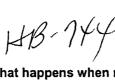
Managed care plans do not provide health care services, although they often require that your health care be arranged and approved through a primary care physician. MCOs contract with select groups of providers (physicians, hospitals, labs, home care, physical therapy and others) to accept negotiated prices or fees for services. Providers who agree to accept these fees are referred to as *in-network providers* and they agree not to bill patients the difference between the contracted managed care plan fees and their normal charges. Providers who do not agree to accept the lower fees are considered *out- of-network providers*. If you receive care from an out-of-network provider, there is a chance that you may have to pay more money out of your pocket than you would if you were to receive care from an in-network provider. Additionally, there is the chance that your claims may not be paid at all. So it is critical to understand the type of managed care plan that you have.

What can I do to understand my managed care plan?

Your plan has the right to limit certain types of care and will only reimburse your physician for care that is considered medically necessary. Often disagreements between the insured, also called a *member*, and the MCO occur because there is not a clear understanding of the scope of insurance coverage. You need to understand this information BEFORE a problem arises so you, the member, will be able to make effective decisions about your care and who will provide it. Read over your member handbook and make notes regarding:

- · When do I need a referral?
- · What services and procedures are not covered?
- · Are any services cut off after a certain amount of use?
- · What happens if I am traveling outside of the network?
- · What are my out of pocket expenses or my co-pays, deductibles or co-insurances?

Knowing the guidelines of your managed care plan will help make your plan work for you. If you have any questions regarding your benefits or are experiencing trouble, first call your managed care plan's member service department. Try to work out any misunderstandings you may have with them. The telephone number should be listed on the back of your insurance card. Be sure to note the person with whom you speak and any pertinent information that may have been provided to you during your conversation.



What happens when my managed care plan denies a service?

Most of the time, managed care plans have the right to limit the care received and to only pay for care that is considered *medically necessary*. The plan makes an initial determination as to whether a course of treatment is medically necessary through a process called *utilization review*. If you and your doctor disagree with the plan's determination, you have the right to appeal that decision to the plan.

What are grievances, appeals and expedited appeals?

As a member of a managed care plan, you do have the right to *appeal* or challenge the medical decisions of the plan. If you require services immediately because waiting could cause you to have potential health risks, you may be entitled to have an *expedited appeal*. Your medical doctor will assist you in establishing the criteria for an expedited appeal. A *grievance* or complaint is the process in which you can voice a concern and seek a remedy about plan determinations that are not based on medical decisions by their nature, grievances can not be expedited.

What are my rights if my appeal is unsuccessful?

North Carolina law gives you the additional right to receive an **external review** by outside experts if your MCO denies your appeal. The Department of Insurance is responsible for overseeing the external review process. You may reach their offices at (toll-free) 1-877-885-0231.

How can the Managed Care Patient Assistance Program help me?

Our office is here to assist you to understand your rights under your plan and under the law. Contact us as early as possible during the appeals process so we can best help you.

When you are disputing a decision, we recommend that you provide your managed care plan and our office with copies (you keep the originals) of the following information:

- G Copy of the front and back of your insurance card
- G A written description of the service or procedure that you wish covered (for a benefit coverage complaint)
- G Information supporting why the service should be covered (for a benefit coverage complaint)
- G Recommendations and referrals from your doctor regarding why the treatment or procedure should be covered
- G References to the sections of the member contract or evidence of coverage that apply to your situation
- G Copies of all letters and notes from telephone calls that you have had with your health plan.
- G Include the names and titles of everyone with whom you have spoken.

■Please make sure that your name, address, telephone number and your health care provider's name appears on your correspondence so that the staff at the MCO can contact you or your doctor.

MANAGED CARE PATIENT ASSISTANCE PROGRAM CONSUMER PROTECTION DIVISION OFFICE OF ATTORNEY GENERAL ROY COOPER TELEPHONE:

TOLL FREE IN NC: 866-867-MCPA (6272) 919-733-MCPA (6272)

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GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2003**

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HOUSE BILL 276 PROPOSED COMMITTEE SUBSTITUTE H276-CSRG-5 [v.2]

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|--|----------------------------|
| Short Title: Insurance Financial Amendments OmnibusAB (Pu | ublic) |
| Sponsors: | |
| Referred to: | |
| March 6, 2003 | |
| A BILL TO BE ENTITLED AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMENTS IN LAWS CONCERNING INSURANCE COMPANY SOLVENCY. The General Assembly of North Carolina enacts: SECTION 1. G.S. 58-5-5 reads as rewritten: "§ 58-5-5. Amount of deposits required of foreign or alien fire and/or mainsurance companies. Links of homology and its thir Article assembly foreign on fire and and the second and | arine |
| Unless otherwise provided in this Article, every fire, marine, or fire and m insurance company chartered by any other state or foreign government shall make maintain deposits of securities with the Commissioner in the amount of twenty thousand dollars (\$25,000) one hundred thousand dollars (\$100,000) market value." SECTION 2. G.S. 58-5-10 reads as rewritten: | e and /-five |
| "§ 58-5-10. Amount of deposits required of foreign or alien fidelity, surety | and |
| Casualty insurance companies. Unless otherwise provided in this Article, every fidelity, surety or casualty insurance company chartered by any other state or foreign government shall make and mai deposits of securities with the Commissioner in the amount of fifty thousand de (\$50,000) two hundred thousand dollars (\$200,000) market value." SECTION 3. G.S. 58-5-50 reads as rewritten: | ntain |
| "8 58.5.50 Denosite of foreign life incurance companies | |

§ 58-5-50. Deposits of foreign life insurance companies.

In addition to other requirements of Articles 1 through 64 of this Chapter, all foreign life insurance companies shall deposit securities, as specified in G.S. 58-5-20, having a market value of one hundred thousand dollars (\$100,000) four hundred thousand dollars

(\$400,000) as a prerequisite of doing business in this State. All foreign life insurance companies shall deposit an additional one-hundred thousand dollars (\$100,000) two hundred thousand dollars (\$200,000) where such companies cannot show three years of

net operational gains prior to admission. Foreign life insurance companies that are

licensed on or before the effective date of this section shall have one year from that date 1 2 to comply with this section." 3 **SECTION 4.** G.S. 58-7-162(2) reads as rewritten: Investments, securities, properties, and loans acquired or held in 4 5 accordance with this Chapter, and in connection therewith the 6 following items: 7 Interest due or accrued on any bond or evidence of indebtedness 8 that is not in default. 9 Declared and unpaid dividends on stock and shares: unless that b. amount has otherwise been allowed as an asset. 10 Interest due or accrued upon a collateral loan in an amount not 11 e. to exceed one year's interest thereon. 12 Interest due or accrued on deposits in solvent-banks, savings 13 d. and loan associations, and trust companies, and interest due or 14 accrued on other assets, if the interest is, in the Commissioner's 15 16 judgment, a collectible asset. Interest due or accrued on a current mortgage loan, in an 17 e. amount not exceeding in any event the amount, if any, of the 18 excess of the value of the property less delinquent taxes thereon 19 over the unpaid principal; but in no event shall interest accrued 20 for a period in excess of 90 days be allowed as an asset. 21 £ Rent due or accrued on real property if the rent is not in arrears 22 23 for more than three months, and rent more than three months in arrears if the payment of the rent is adequately secured by 24 25 property held in the tenant's name and conveyed to the insurer as collateral and the underlying collateral is admissible under 26 this Chapter. 27 The unaccrued portion of taxes paid before the due date on real 28 g. 29 property. 30 Chapter." **SECTION 5.** G.S. 58-7-162(5) and G.S. 58-7-162(7) are repealed. 31 **SECTION 6.** G.S. 58-7-162(12) reads as rewritten: 32 33 "(12) Electronic and mechanical machines, including operating and system 34 software constituting a management information system, if the cost of 35 the system is at least twenty-five thousand dollars (\$25,000) but not 36 more than two percent (2%) of total admitted assets; the cost shall be amortized in full over a period not to exceed seven calendar 37 years.system." 38 39 **SECTION 7.** G.S. 58-7-163 reads as rewritten:

"§ 58-7-163. Assets not allowed.

In addition to assets impliedly excluded by the provisions of G.S. 58-7-162, the following expressly shall not be allowed as assets in any determination of the financial condition of an insurer:

(1) Goodwill, trade names, and other like intangible assets.

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- (2) Advances (other than policy loans) to officers, directors, and controlling stockholders, whether secured or not, and advances to employees, agents, and other persons on personal security only.
- (3) Stock of the insurer or any material equity therein or loans secured thereby, or any material proportionate interest in the stock acquired or held through the ownership by the insurer of an interest in another firm, corporation, or business unit.
- (4) Furniture, fixtures, other equipment, safes, vehicles, libraries, stationery, literature, and supplies, other than data processing and accounting systems authorized under G.S. 58-7-162(12), except in the case of title insurers the materials and plants which G.S. 58-7-182 expressly authorizes the insurer to invest in, and except, in the case of any insurer, any personal property that the insurer is permitted to hold under this Chapter, or that is acquired through foreclosure of chattel mortgages acquired under G.S. 58-7-180, or that is reasonably necessary for the maintenance and operation of real estate that the insurer uses for a home office, branch office, and similar purposes.
- (5) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value of the investments as determined under this Chapter.
- (6) Bonds, notes, or other evidences of indebtedness that are secured by mortgages or deeds of trust that are in default, to the extent of the cost or carrying value that is in excess of the value as determined pursuant to other provisions of this Chapter.
- (7) Prepaid and deferred expenses.
- (8) Certificates of eontribution contribution, surplus notes or other similar evidences of indebtedness. indebtedness, to the extent that admission of these investments results in the double counting of these investments in the reporting entity's balance sheet.
- (9) Any asset that is encumbered in any manner unless the asset is authorized under G.S. 58-7-187 or G.S. 58-7-162(13)."

SECTION 8. G.S. 58-7-192 reads as rewritten:

"§ 58-7-192. Valuation of securities and investments.

- (a) All securities, investments, and evidences of debt, other than those for which valuation methodologies are specifically set forth in this Chapter, that are held by an insurer shall be valued at their market values, at their appraised values, or at prices determined by the insurer as representing their fair market values, subject to the Commissioner's approval.
- (b) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, in the Commissioner's discretion and in accordance with a method of valuation that the Commissioner approves.
- (c) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of its net value as based upon those assets only of the subsidiary that

would be eligible under this Chapter and G.S. 58-19-10 for investment of the funds of the insurer direct.

- (d) No valuations under this section shall be greater than any applicable valuation or method contained in the latest edition of the NAIC publications entitled "Valuations of Securities" Purposes and Procedures Manual of the NAIC Securities Valuation Office" or the "Accounting Practices and Procedures Manual", unless the Commissioner determines that another valuation method is appropriate when it results in a more conservative valuation.
- (e) All-bonds or fully secured indebtedness having a stated term and a rate of interest that are held by an insurer shall be valued in accordance with the procedures and instructions contained in the NAIC publication entitled "Valuations of Securities", unless the Commissioner determines that a more conservative valuation is appropriate."

SECTION 9. G.S. 58-7-193 reads as rewritten:

"§ 58-7-193. Valuation of property.

- (a) Real property acquired pursuant to a mortgage loan or contract for sale shall be valued at the net realizable value, but in no event shall the property be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of the acquisition and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.
- (b) Other real property held by an insurer shall not be valued at an amount in excess of fair market value as determined by recent appraisal and as approved by the Commissioner. If valuation is based on an appraisal more than three years old, the Commissioner may call for and require a new appraisal in order to determine fair value.
- (c) Personal property acquired pursuant to chattel mortgages made in accordance with G.S. 58-7-180 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at the date of acquisition, or the fair market value of the property, whichever amount is less.
- (d) If the Commissioner and an insurer do not agree on the value of real or personal property of an insurer, in carrying out the Commissioner's responsibilities under this section, the Commissioner may retain the services of a qualified real or personal property appraiser. The insurer shall reimburse the Commissioner for the costs of the services of any appraiser incurred with respect to the Commissioner's responsibilities under this section."

SECTION 10. G.S. 58-7-195 is repealed.

SECTION 11. G.S. 58-7-179(d) reads as rewritten:

"(d) In the case of a purchase money mortgage given to secure the purchase price of real estate sold by the insurer, the amount lent or invested shall not exceed the unpaid part of the purchase price and shall be valued in accordance with G.S. 58-7-195.price."

SECTION 12. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168,

58-7-170, 58-7-172, 58-7-173, 58-7-175, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-195, 58-7-200, and Articles 13, 19, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

SECTION 13. G.S. 58-47-80 reads as rewritten:

"§ 58-47-80. Assets and invested assets.

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Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and 58-19-10."

SECTION 14. G.S. 58-8-15 reads as rewritten:

"§ 58-8-15. Directors in mutual companies.

Every mutual insurance company shall elect by ballot a board of not less than seven directors, who shall manage and conduct its business and hold office for one year or for such term as the bylaws provide and until their successors are qualified. The directors need not be residents of this State or members of the company. In companies with a guaranty capital, no more than one half one-half of the directors shall be ehosen elected by and from the stockholders holders of guaranty capital, except where guaranty capital holders are policyholders. Policyholders which are holders of guaranty capital shall be entitled to one vote for each policy that person holds and one vote for each unit of guaranty capital that person holds."

SECTION 15. G.S. 58-8-20 reads as rewritten:

"§ 58-8-20. Mutual companies with a guaranty capital.

- (a) A mutual insurance company formed as provided in Articles 1 through 64 of this Chapter, in lieu of the contributed surplus required for the organization of mutual companies under the provisions of G.S. 58-7-75, or a mutual insurance company now existing, may, with the prior approval of the Commissioner, establish tender a guaranty capital offering of not less than fifty thousand dollars (\$50,000), divided into shares units of one hundred dollars (\$100.00) each, which shall be invested in the same manner as is provided in this Chapter for the investment of the capital stock of insurance companies.
- (a1) Guaranty capital may be issued by an existing domestic mutual insurance company only under the following terms and conditions:
 - (1) To aid and assist a financially troubled domestic mutual insurance company which otherwise faces rehabilitation or liquidation by this Department; or
 - (2) For any other reason as presented in a petition to the Commissioner and which is found by the Commissioner to be reasonable, justifiable, and in the best interest of all the policyholders of the company.

Guaranty capital issued under subdivision (2) of this subsection shall require written notification of the action proposed by the board of directors of the company to be mailed to the policyholders of the company not less than 30 days before the meeting when the action may be taken. The written notification shall be advertised in two

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newspapers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before the meeting. The written notification to policyholders shall include a proxy statement to allow policyholders to vote on the proposed action without personal attendance at the meeting, and the Commissioner shall approve both the written notification and the proxy statement. The proposed action shall be effected by a vote of two-thirds of the policyholders voting thereon in person or by proxy.

- (b) The board of directors of a company may declare and pay dividends to the stockholders of the guaranty capital of a company, subject to the notification requirements of G.S. 58-19-25(d) and the prior approval requirements of G.S. 58-19-30(c). distribute interest to the holders of guaranty capital in accordance with the guaranty capital filing approved by the Department.
- when the company has exhausted its cash in hand and the invested assets, exclusive of uncollected premiums, and when thus impaired, the directors may make good the whole or any part of it by assessments upon the contingent funds of the company at the date of such impairment. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.
- (d) Shareholders and members of such companies are subject to the same provisions of law in respect to their right to vote as apply respectively to shareholders in stock companies and policyholders in mutual companies. Guaranty capital holders are entitled to one vote per unit of guaranty capital. Guaranty capital holders who are not policyholders are not entitled to participate in the policyholder votes prescribed under subdivision (a1)(2) and subsection (e) of this section.
- This guaranty Guaranty capital may be reduced or retired by vote of the policyholders of the company and the assent of the Commissioner, if the net assets of the company above its reserve and all other claims and obligations, exclusive of guaranty capital, for two years immediately preceding and including the date of its last annual statement, is not less than twenty-five percent (25%) of the guaranty capital. Due notice of such proposed action on the part of the company must be mailed to each policyholder of the company not less than 30 days before the meeting when the action may be taken, and must also be advertised in two papers of general circulation. approved by the Commissioner, not less than three times a week for a period of not less than four weeks before such meeting. No insurance company with a guaranty capital which has ceased to do new business, shall divide to its stockholders any part of its assets or guaranty capital, except income from investments, until it has performed or canceled its policy obligations. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.

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guaranty capital its assets, except as provided in the guaranty capital filing as approved by the Commissioner. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the holders of guaranty capital to the extent that the guaranty capital has been contributed together with accrued interest as specified in the filing approved by the Commissioner."

SECTION 16. G.S. 58-8-50 reads as rewritten:

"\\$ 58-8-50. Guaranty against assessments prohibited.

If any director, officer, or agent of a mutual insurance company, either officially or privately, shall give-gives a guarantee to a policyholder thereof of the company against an assessment to which such that policyholder would otherwise be liable, he the director, officer, or agent shall be punished by a fine not exceeding one hundred dollars (\$100.00) one thousand dollars (\$1,000) for each offense."

No insurance company with guaranty capital shall distribute to its holders of

SECTION 17. G.S. 58-65-1 reads as rewritten:

"§ 58-65-1. Regulation and definitions; application of other laws; profit and foreign corporations prohibited.

Any corporation organized under the general corporation laws of the State of (a) North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, unless otherwise provided.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations or any other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical or any other professional services authorized or permitted to be furnished by a duly licensed physician or other provider listed in G.S. 58-50-30. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment 20f of fees toward, or furnishing of dental or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital or medical or dental service plan, as defined in this section. Any corporation organized and subject to the provisions of this Article and Article 66 of this Chapter, Article, the certificate of incorporation of which authorizes the operation of either a hospital or medical or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, Commissioner, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Article. Except to the extent prohibited either by G.S. 58-65-140 or by rules promulgated adopted by the Department of Insurance Commissioner not inconsistent with this Article and Article 66 of this Chapter, Article, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

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- (b) through (c) Repealed by Session Laws 2001-297. licensed licensed Social Work and Licensure
- (d) No foreign or alien hospital or medical or dental service corporation as herein defined shall be authorized to do business in this State."

SECTION 18. G.S. 58-65-95(a) reads as rewritten:

"(a) No corporation Corporations subject to this Article shall invest in any securities other than securities or hold only those assets permitted by Article 7 of this Chapter for the investment of assets of life and health insurance companies.

SECTION 19. G.S. 58-67-5(i) reads as rewritten:

"(i) "Net worth" means the excess of total assets over the total liabilities and may include borrowed funds that are repayable only from the net earned income of the health maintenance organization and repayable only with the advance permission of the Commissioner. For the purposes of this subsection, "assets" means (i) tangible assets and (ii) other investments permitted under G.S. 58-67-60; provided, however, that the depreciated cost of office furniture and equipment in the principal office shall not exceed ten percent (10%) of a health maintenance organization's net worth. G.S. 58-67-60."

SECTION 20. G.S. 58-67-40 is repealed.

SECTION 21. G.S. 58-67-110 reads as rewritten:

"§ 58-67-110. Protection against insolvency.

(a) The Commissioner shall require deposits in accordance with the provisions of G.S. 58-67-25.

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- (b) Each full service medical-health maintenance organization shall maintain a minimum net worth of not less than one million dollars (\$1,000,000), which shall be increased by the amount of the contingency reserves calculated annually in accordance with the provisions of G.S. 58-67-40. The net worth calculation shall be computed in accordance with statutory accounting principles generally recognized in the regulation of health maintenance organizations and the Commissioner may promulgate such regulations as he deems appropriate to carry out the provisions of this section. If a health maintenance organization fails to comply with the net worth requirement of this subsection or subsections (c) or (d) of this section, the Commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees, equal to the greater of one million dollars (\$1,000,000) or the amount required pursuant to the risk-based capital provisions of Article 12 of this Chapter. Each single service health maintenance organization shall maintain a minimum net worth equal to the greater of fifty thousand dollars (\$50,000) or that amount required pursuant to the risk-based capital provisions of Article 12 of this Chapter.
- (c) The minimum net worth for a health maintenance organization authorized to operate on July 17, 1987, and having a net worth of less than one million dollars (\$1,000,000) shall be as follows:
 - (1) \$150,000 by December 31, 1987
 - (2) \$300,000 by December 31, 1988
 - (3) \$450,000 by December 31, 1989
 - (4) \$750,000 by December 31, 1990
 - (5) \$1,000,000 by December 31, 1991

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- (d) Notwithstanding any other provision of this Article, a health maintenance organization authorized to offer only a single health care service plan providing a single health care service must have a minimum net worth of fifty thousand dollars (\$50,000). The minimum net worth for such plan authorized to operate on July 17, 1987, and having a net worth of less than fifty thousand dollars (\$50,000) shall be as follows:
 - (1) Twenty-five thousand dollars (\$25,000) by December 31, 1987; and
 - (2) Fifty thousand dollars (\$50,000) by December 31, 1988;

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- (e) Every full service medical health maintenance organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Commissioner. In determining the adequacy of such a plan, the Commissioner may consider:
 - (1) A reinsurance agreement preapproved by the Commissioner covering excess loss, stop loss, or catastrophes. The agreement must provide that the Commissioner will be notified no less than 60 days prior to cancellation or reduction of coverage.

| 1 | (2) A conversion policy or policies that will be offered by an insurer to the |
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| 2 | enrollees in the event of the health maintenance organization's insolvency. |
| 4 | (3) Any other arrangements offering protection against insolvency that the |
| 5 | Commissioner may require." |
| 6 | SECTION 22. G.S. 58-67-140(a)(3) reads as rewritten: |
| 7 | "(3) No longer maintains the financial reserve specified in G.S. 58-67-40 or |
| 8 | is <u>ls</u> no longer financially responsible and may reasonably be expected |
| 9 | to be unable to meet its obligations to enrollees or prospective |
| 10 | enrollees." |
| 11 | SECTION 23. G.S. 58-67-140(a)(7) reads as rewritten: |
| 12 | "(7) Has knowingly published or made to the Department or to the public |
| 13 | any false statement or report, including any report or any data that |
| 14 | serves as the basis for any report, required to be submitted under G.S. |
| 15 | 58-3-210. G.S. 58-3-191." |
| 16 | SECTION 24. G.S. 58-47-65(a) reads as rewritten: |
| 17 | "(a) No group shall self-insure its workers' compensation liabilities under the Act |
| 18 | unless it is licensed by the Commissioner under this Part. This subsection does not |
| 19 | apply to a group that was organized and approved under the North Carolina law before |
| 20 | July 1, 1995, and whose authority to self-insure its workers' compensation liabilities |
| 21 | under the Act has not terminated after that date." |
| 22 | SECTION 25. G.S. 97-170(a) reads as rewritten: |
| 23 | "(a) No employer shall self-insure its workers' compensation liabilities under the |
| 24 | Act unless it is licensed by the Commissioner under this Article. This subsection does |
| 25. | not apply to an employer authorized to self-insure its workers' compensation liabilities |
| 26 | under the Act prior to December 1, 1997, whose authority to self-insure its workers' |
| 27 | compensation liabilities under the Act has not terminated after that date." |
| 28 | SECTION 26(a). G.S. 58-3-100 reads as rewritten: |
| 29 | "§ 58-3-100. Insurance company licensing provisions. |
| 30 31 | (a) The Commissioner may, after notice and opportunity for |
| | a hearing, revoke, suspend, restrict, or refuse to renew or restrict the |
| ; 3 | license of any insurer if: |
| 4 | (1) The insurer fails or refuses to comply with any |
| 5 | law, order or rule applicable to the insurer. (2) The insurer's financial condition is unsound, or |
| 6 | its assets above its liabilities, exclusive of |
| 7 | capital, are less than the amount of its capital or |
| 8 | required minimum surplus. |
| 9 | (3) The insurer has published or made to the Department |
| 0 | or to the public any false statement or report. |
| 1 | (4) The insurer or any of the insurer's officers, |
| 2 | directors, employees, or other representatives |
| 3 | refuse to submit to any examination authorized by |
| 4 | law or refuse to perform any legal obligation in |
| | |

relation to an examination.

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(5) The insurer is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.

(b) Any suspension, revocation or refusal to renew suspension or revocation of an insurer's license under this section may also be made applicable to the license or registration of any individual regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section."

SECTION 26(b). G.S. 58-4-15 reads as rewritten:

"§ 58-4-15. Revocation or suspension of license.

The Commissioner may suspend, revoke, or refuse to renew suspend or revoke the license of any insurer failing to file its financial statement when due or within any extension of time that the Commissioner, for good cause, may have granted."

SECTION 26(c). G.S. 58-6-7 reads as rewritten:

"§ 58-6-7. <u>Licenses: perpetual licensing; annual license continuation</u> Annual license fees for insurance companies.

(a) In order to do business in this State, an insurance company shall apply for and obtain a license from the Commissioner by March 1 of each year. Commissioner. The license shall be perpetual and become effective the following July 1 and shall remain in effect for one year. shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with this Chapter and subject to any other applicable provision of the insurance laws of this State. Except as provided in subsection (b) of this section, the insurance company shall pay an annual a fee for each year the license is in effect, as follows:

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

- (b) When the paid-in capital stock or surplus, or both, of an insurance company, other than a farmer's mutual assessment company or a fraternal order, does not exceed one hundred thousand dollars (\$100,000), the fee levied in this section shall be one-half the amount specified.
- (c) Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars (\$100.00) for each such additional classification of

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business done. All fees and charges collected by the Commissioner under this Chapter are nonrefundable.

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

SECTION 26(d). G.S. 58-6-15 reads as rewritten:

"§ 58-6-15. Licenses run from July 1. Annual license continuation fee definition; requirements.

The license required of insurance companies shall continue, continue for the next ensuing 12 months after July 1 of each year, unless revoked as provided in Articles 1 through 64 of this Chapter. Application for renewal of the company license For purposes of this Chapter only, "annual license continuation fee" means the fee specified in G.S. 58-6-7 submitted to the Commissioner for each year the license is in effect after the company's year of initial licensing. The annual license continuation fee must be submitted on or before the first day of March on a form to be supplied by the Commissioner. Commissioner each year the license is to remain in effect. If the Commissioner is satisfied Upon satisfying himself that the company has met all requirements of law and appears to be financially solvent he shall forward the renewal license to the company. Any company which does not qualify for a renewal license before July 1 shall cease to do business in the State of North Carolina as of July 1, unless its license is sooner revoked by the Commissioner, solvent, the Commissioner shall not revoke or suspend the license of the company and the company shall be authorized to do business in this State, subject to all other applicable provisions of the insurance laws of this State. Nothing contained in this section shall be interpreted as applying to licenses issued to individual representatives of insurance companies."

SECTION 26(e). G.S. 58-6-30 reads as rewritten:

"§ 58-15-30. License, surplus, and deposit requirements.

- (a)No reciprocal shall engage in any insurance transaction in this State until it has obtained a license to do so in accordance with the applicable provisions of Articles 1 through 64 of this Chapter. Such The license shall continue in full force and effect, subject to timely payment of an annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State.expire on the last day of June of each year.
- (b) No domestic or foreign reciprocal shall be licensed in this State unless it has a surplus to policyholders of at least eight hundred thousand dollars (\$800,000); and no alien reciprocal shall be licensed unless it has a trusteed surplus of at least eight hundred thousand dollars (\$800,000).
- (c) Each domestic, foreign, or alien reciprocal licensed in this State must maintain a minimum deposit with the Commissioner of at least one hundred thousand dollars (\$100,000) in cash or in value of securities of the kind specified in G.S. 58-5-15, which shall be subject to the same conditions as contained in Article 5 of this Chapter."

SECTION 26(f). G.S. 58-19-65 reads as rewritten:

"§ 58-19-65. Revocation, suspension, or nonrenewal Revocation or suspension of insurer's license.

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Whenever it appears to the Commissioner that any person has committed a violation of this Article that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an opportunity to be heard, suspend, revoke, or refuse to renew suspend or revoke such insurer's license to do business in this State for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law."

SECTION 26(g). G.S. 58-24-130 reads as rewritten:

"§ 58-24-130. Annual Perpetual license.

Societies which are now authorized to transact business in this State may continue such business until the 30th day of June next succeeding January 1, 1988. The authority of such societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the 30th day of the succeeding June. However, a license so issued Subject to timely payment of the annual license continuation fee and subject to any other applicable provisions of the insurance laws of this State, a license, other than a preliminary license, to a fraternal benefit society under this Article shall continue in full force and effect until the new license be issued or specifically refused. effect. For each such license or renewal the society shall pay the Commissioner the fee specified in G.S. 58-6-5. The society shall pay the Commissioner, as an annual license continuation fee and a condition of the continuation of the license, the fee specified in G.S. 58-6-7 on or before the first day of March on a form to be supplied by the Commissioner. A duly certified copy or duplicate of such the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of Articles 1 through 64 of this Chapter."

SECTION 26(h). G.S. 58-26-10 reads as rewritten:

"§ 58-26-10. Financial statements and licenses required.

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The license to do business in this State issued to a title insurance company shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State. The Commissioner shall annually license such companies and their agents the agents of title insurance companies."

SECTION 26(i). G.S. 58-30-62 reads as rewritten:

"§ 58-30-62. Administrative supervision of insurers.

(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 revoked or suspended 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."

SECTION 26(j). G.S. 58-65-55 reads as rewritten:

"§ 58-65-55. Issuance of certificate. and continuation of license."

- (a) Before issuing or continuing any such license or certificate the Commissioner may make such an examination or investigation as the Commissioner deems expedient. The Commissioner shall issue a certificate of authority or license upon the payment of a an annual fee of one thousand dollars (\$1,000) and upon being satisfied on the following points:
 - (1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.
 - (2) The rates charged and benefits to be provided are fair and reasonable.
 - (3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and hospital and medical and/or dental expenses and such reserve as the Department deems adequate, as provided hereinafter.
 - (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.
- (b) The certificate of authority or license shall continue in full force and effect, subject to payment of an annual license continuation fee of one thousand dollars (\$1000), subject all other provisions of subsection (a) of this section, and subject to any other applicable provisions of the insurance laws of this State."

SECTION 26(k). G.S. 58-65-125 reads as rewritten:

- "§ 58-65-125. Revocation, suspension, and refusal to renew Revocation and suspension of license; unfair trade practices.
- (a)The Commissioner may revoke, suspend, or refuse to renewrevoke or suspend the license of any service corporation if:
 - (1) The service corporation fails or refuses to comply with any law, order, or rule applicable to the service corporation.
 - (2) The service corporation's financial condition is unsound.
 - (3) The service corporation has published or made to the Department or to the public any false statement or report.

- (4) The service corporation refuses to submit to any examination authorized by law.
- (5) The service corporation is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.
- (b) Any suspension, revocation, or refusal to renew suspension or revocation of a service corporation's license under this section may also be made applicable to the license or registration of any natural person regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.
- (c) Article 63 of this Chapter applies to service corporations and their agents and representatives."

SECTION 26(1). G.S. 58-67-140 reads as rewritten:

"§ 58-67-140. Suspension or revocation of license.

(a) The Commissioner may suspend, revoke, or refuse to renewsuspend or revoke an HMO license if the Commissioner finds that the HMO:

- (1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-67-10, unless amendments to such submissions have been filed with and approved by the Commissioner.
- (2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with G.S. 58-67-50.
- (3) No longer maintains the financial reserve specified in G.S. 58-67-40 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
- (4) Has itself or through any person on its behalf advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.
- (5) Is operating in a manner that would be hazardous to its enrollees.
- (6) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the HMO or with any order issued by the Commissioner after notice and opportunity for a hearing.
- (7) Has knowingly published or made to the Department or to the public any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210."

SECTION 26(m). G.S. 58-67-160 reads as rewritten: "§ 58-67-160. Fees.

Every health maintenance organization subject to this Article shall pay to the Commissioner a fee of two hundred fifty dollars (\$250.00) for filing an application for a license and a an annual license continuation fee of one thousand dollars (\$1,000) for each license renewal. license. The license shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State.

SECTION 26(n). G.S. 58-67-20 reads as rewritten:

§ 58-67-20. Issuance of certificate, and continuation of license.

- (a) Before issuing <u>or continuing</u> any such <u>certificate, license</u>, the Commissioner of Insurance may make such an examination or investigation as he deems expedient. The Commissioner of Insurance shall issue a <u>certificate of authority license</u> upon the payment of the application fee prescribed in G.S. 58-67-160 and upon being satisfied on the following points:
 - (1) The applicant is established as a bona fide health maintenance organization as defined by this Article;
 - (2) The rates charged and benefits to be provided are fair and reasonable;
 - (3) The amounts provided as working capital are repayable only out of earned income in excess of amounts paid and payable for operating expenses and expenses of providing services and such reserve as the Department of Insurance deems adequate, as provided hereinafter;
 - (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the eertificate license and that the health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. Such working capital shall initially be a minimum of one million five hundred thousand dollars (\$1,500,000) for any full service medical health maintenance organization. Initial working capital for a single service health maintenance organization shall be a minimum of one hundred thousand dollars (\$100,000) or such higher amount as the Commissioner shall determine to be adequate.
- (b) In making the determinations required under this section, the Commissioner shall consider:
 - (1) The financial soundness of the health care plan's arrangements for health care services and the schedule of premiums used in connection therewith;
 - (2) The adequacy of working capital;

- (3) Any agreement with an insurer, a hospital or medical service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of alternative coverage in the event of discontinuance of the plan;
- (4) Any agreement with providers for the provision of health care services; and
- (5) Any firm commitment of federal funds to the health maintenance organization in the form of a grant, even though such funds have not been paid to the health maintenance organization, provided that the health maintenance organization certifies to the Commissioner that such funds have been committed, that such funds are to be paid to the health maintenance organization with a current fiscal year and that such funds may be used directly for operating purposes and for the benefit of enrollees of the health maintenance organization.
- (c) A <u>certificate of authoritylicense</u> shall be denied only after compliance with the requirements of G.S. 58-67-155."

SECTION 27. Sections 26(a) through (n) become effective January 1, 2004, and apply to all company licenses issued or otherwise eligible for renewal or continuation after that date. The remainder of this act becomes effective October 1, 2003.

H276-CSRG-5 [v.2]

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 276 PROPOSED COMMITTEE SUBSTITUTE H276-CSRG-5 [v.1]

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| Short Title: Insurance Financial Amendments OmnibusAB (Public) |
| Sponsors: |
| Referred to: |
| March 6, 2003 |
| A BILL TO BE ENTITLED AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMENTS IN THE LAWS CONCERNING INSURANCE COMPANY SOLVENCY. The General Assembly of North Carolina enacts: SECTION 1. G.S. 58-5-5 reads as rewritten: |
| "§ 58-5-5. Amount of deposits required of foreign or alien fire and/or marine |
| insurance companies. Unless otherwise provided in this Article, every fire, marine, or fire and marine insurance company chartered by any other state or foreign government shall make and maintain deposits of securities with the Commissioner in the amount of twenty-five thousand dollars (\$25,000) one hundred thousand dollars (\$100,000) market value." SECTION 2. G.S. 58-5-10 reads as rewritten: |
| "§ 58-5-10. Amount of deposits required of foreign or alien fidelity, surety and |
| Unless otherwise provided in this Article, every fidelity, surety or casualty insurance company chartered by any other state or foreign government shall make and maintain deposits of securities with the Commissioner in the amount of fifty thousand dollars (\$50,000) two hundred thousand dollars (\$200,000) market value." SECTION 3. G.S. 58-5-50 reads as rewritten: |
| "§ 58-5-50. Deposits of foreign life insurance companies. |
| In addition to other requirements of Articles 1 through 64 of this Chapter, all foreign life insurance companies shall deposit securities, as specified in G.S. 58-5-20, having a market value of one hundred thousand dollars (\$100,000) four hundred thousand dollars (\$400,000) as a prerequisite of doing business in this State. All foreign life insurance |

companies shall deposit an additional one hundred thousand dollars (\$100,000) two

hundred thousand dollars (\$200,000) where such companies cannot show three years of

net operational gains prior to admission. Foreign life insurance companies that are

licensed on or before the effective date of this section shall have one year from that date 1 2 to comply with this section." 3 **SECTION 4.** G.S. 58-7-162(2) reads as rewritten: Investments, securities, properties, and loans acquired or held in 4 5 accordance with this Chapter, and in connection therewith the following items: 6 7 Interest due or accrued on any bond or evidence of indebtedness a. 8 that is not in default. 9 b. Declared and unpaid dividends on stock and shares, unless that 10 amount has otherwise been allowed as an asset. Interest due or accrued upon a collateral loan in an amount not 11 e. to exceed one year's interest thereon. 12 Interest due or accrued on deposits in solvent banks, savings 13 d. 14 and loan associations, and trust companies, and interest due or accrued on other assets, if the interest is, in the Commissioner's 15 judgment, a collectible asset. 16 Interest due or accrued on a current mortgage loan, in an 17 e. amount not exceeding in any event the amount, if any, of the 18 excess of the value of the property less delinquent taxes thereon 19 20 over the unpaid principal; but in no event shall interest accrued 21 for a period in excess of 90 days be allowed as an asset. £ Rent due or accrued on real property if the rent is not in arrears 22 for more than three months, and rent more than three months in 23 24 arrears if the payment of the rent is adequately secured by 25 property held in the tenant's name and conveyed to the insurer 26 as collateral and the underlying collateral is admissible under 27 this Chapter. 28 The unaccrued portion of taxes paid before the due date on real g. 29 property. 30 Chapter." **SECTION 5.** G.S. 58-7-162(5) and G.S. 58-7-162(7) are repealed. 31 **SECTION 6.** G.S. 58-7-162(12) reads as rewritten: 32 "(12) Electronic and mechanical machines, including operating and system 33. software constituting a management information system, if the cost of 34 35 the system is at least twenty five thousand dollars (\$25,000) but not more than two percent (2%) of total admitted assets; the cost shall be 36 37 amortized in full over a period not to exceed seven calendar 38 years.system." 39 **SECTION 7.** G.S. 58-7-163 reads as rewritten: 40 "§ 58-7-163. Assets not allowed. In addition to assets impliedly excluded by the provisions of G.S. 58-7-162, the 41

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following expressly shall not be allowed as assets in any determination of the financial

Goodwill, trade names, and other like intangible assets.

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condition of an insurer:

- (2) Advances (other than policy loans) to officers, directors, and controlling stockholders, whether secured or not, and advances to employees, agents, and other persons on personal security only.
- (3) Stock of the insurer or any material equity therein or loans secured thereby, or any material proportionate interest in the stock acquired or held through the ownership by the insurer of an interest in another firm, corporation, or business unit.
- Furniture, fixtures, other equipment, safes, vehicles, libraries, stationery, literature, and supplies, other than data processing and accounting systems authorized under G.S. 58-7-162(12), except in the case of title insurers the materials and plants which G.S. 58-7-182 expressly authorizes the insurer to invest in, and except, in the case of any insurer, any personal property that the insurer is permitted to hold under this Chapter, or that is acquired through foreclosure of chattel mortgages acquired under G.S. 58-7-180, or that is reasonably necessary for the maintenance and operation of real estate that the insurer uses for a home office, branch office, and similar purposes.
- (5) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value of the investments as determined under this Chapter.
- (6) Bonds, notes, or other evidences of indebtedness that are secured by mortgages or deeds of trust that are in default, to the extent of the cost or carrying value that is in excess of the value as determined pursuant to other provisions of this Chapter.
- (7) Prepaid and deferred expenses.
- (8) Certificates of contribution contribution, surplus notes or other similar evidences of indebtedness. indebtedness, to the extent that admission of these investments results in the double counting of these investments in the reporting entity's balance sheet.
- (9) Any asset that is encumbered in any manner unless the asset is authorized under G.S. 58-7-187 or G.S. 58-7-162(13)."

SECTION 8. G.S. 58-7-192 reads as rewritten:

"§ 58-7-192. Valuation of securities and investments.

- (a) All securities, investments, and evidences of debt, other than those for which valuation methodologies are specifically set forth in this Chapter, that are held by an insurer shall be valued at their market values, at their appraised values, or at prices determined by the insurer as representing their fair market values, subject to the Commissioner's approval.
- (b) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, in the Commissioner's discretion and in accordance with a method of valuation that the Commissioner approves.
- (c) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of its net value as based upon those assets only of the subsidiary that

would be eligible under this Chapter and G.S. 58-19-10 for investment of the funds of the insurer direct

- No valuations under this section shall be greater than any applicable valuation or method contained in the latest edition of the NAIC publications entitled "Valuations of Securities" Purposes and Procedures Manual of the NAIC Securities Valuation Office" or the "Accounting Practices and Procedures Manual", unless the Commissioner determines that another valuation method is appropriate when it results in a more conservative valuation.
- All bonds or fully secured indebtedness having a stated term and a rate of interest that are held by an insurer shall be valued in accordance with the procedures and instructions contained in the NAIC publication entitled "Valuations of Securities", unless the Commissioner determines that a more conservative valuation is appropriate."

SECTION 9. G.S. 58-7-193 reads as rewritten:

"§ 58-7-193. Valuation of property.

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- Real property acquired pursuant to a mortgage loan or contract for sale shall be valued at the net realizable value, but in no event shall the property be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of the acquisition and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.
- Other real property held by an insurer shall not be valued at an amount in excess of fair market value as determined by recent appraisal and as approved by the Commissioner. If valuation is based on an appraisal more than three years old, the Commissioner may call for and require a new appraisal in order to determine fair value.
- Personal property acquired pursuant to chattel mortgages made in accordance with G.S. 58-7-180 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at the date of acquisition, or the fair market value of the property, whichever amount is less.
- If the Commissioner and an insurer do not agree on the value of real or personal property of an insurer, in carrying out the Commissioner's responsibilities under this section, the Commissioner may retain the services of a qualified real or personal property appraiser. The insurer shall reimburse the Commissioner for the costs of the services of any appraiser incurred with respect to the Commissioner's responsibilities under this section."

SECTION 10. G.S. 58-7-195 is repealed.

SECTION 11. G.S. 58-7-179(d) reads as rewritten:

In the case of a purchase money mortgage given to secure the purchase price of real estate sold by the insurer, the amount lent or invested shall not exceed the unpaid part of the purchase price and shall be valued in accordance with G.S. 58-7-195.price."

SECTION 12. G.S. 58-23-26(c) reads as rewritten:

Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, "(c)58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-175, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-195, 58-7-200, and Articles 13, 19, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

SECTION 13. G.S. 58-47-80 reads as rewritten:

"§ 58-47-80. Assets and invested assets.

Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and 58-19-10."

SECTION 14. G.S. 58-8-15 reads as rewritten:

"§ 58-8-15. Directors in mutual companies.

Every mutual insurance company shall elect by ballot a board of not less than seven directors, who shall manage and conduct its business and hold office for one year or for such term as the bylaws provide and until their successors are qualified. The directors need not be residents of this State or members of the company. In companies with a guaranty capital, no more than one half one-half of the directors shall be chosen elected by and from the stockholders holders of guaranty capital, except where guaranty capital holders are policyholders. Policyholders which are holders of guaranty capital shall be entitled to one vote for each policy that person holds and one vote for each unit of guaranty capital that person holds."

SECTION 15. G.S. 58-8-20 reads as rewritten:

"§ 58-8-20. Mutual companies with a guaranty capital.

- (a) A mutual insurance company formed as provided in Articles 1 through 64 of this Chapter, in lieu of the contributed surplus required for the organization of mutual companies under the provisions of G.S. 58-7-75, or a mutual insurance company now existing, may, with the prior approval of the Commissioner, establish tender a guaranty capital offering of not less than fifty thousand dollars (\$50,000), divided into shares units of one hundred dollars (\$100.00) each, which shall be invested in the same manner as is provided in this Chapter for the investment of the capital stock of insurance companies.
- (al) Guaranty capital may be issued by an existing domestic mutual insurance company only under the following terms and conditions:
 - (1) To aid and assist a financially troubled domestic mutual insurance company which otherwise faces rehabilitation or liquidation by this Department; or
 - (2) For any other reason as presented in a petition to the Commissioner and which is found by the Commissioner to be reasonable, justifiable, and in the best interest of all the policyholders of the company.

Guaranty capital issued under subdivision (2) of this subsection shall require written notification of the action proposed by the board of directors of the company to be mailed to the policyholders of the company not less than 30 days before the meeting when the action may be taken. The written notification shall be advertised in two

newspapers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before the meeting. The written notification to policyholders shall include a proxy statement to allow policyholders to vote on the proposed action without personal attendance at the meeting, and the Commissioner shall approve both the written notification and the proxy statement. The proposed action shall be effected by a vote of two-thirds of the policyholders voting thereon in person or by proxy.

- (b) The board of directors of a company may declare and pay dividends to the stockholders of the guaranty capital of a company, subject to the notification requirements of G.S. 58-19-25(d) and the prior approval requirements of G.S. 58-19-30(c). distribute interest to the holders of guaranty capital in accordance with the guaranty capital filing approved by the Department.
- (c) The guaranty Guaranty capital shall be applied to the payment of losses only when the company has exhausted its cash in hand and the invested assets, exclusive of uncollected premiums, and when thus impaired, the directors may make good the whole or any part of it by assessments upon the contingent funds of the company at the date of such impairment. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.
- (d) Shareholders and members of such companies are subject to the same provisions of law in respect to their right to vote as apply respectively to shareholders in stock companies and policyholders in mutual companies. Guaranty capital holders are entitled to one vote per unit of guaranty capital. Guaranty capital holders who are not policyholders are not entitled to participate in the policyholder votes prescribed under subdivision (a1)(2) and subsection (e) of this section.
- This guaranty Guaranty capital may be reduced or retired by vote of the policyholders of the company and the assent of the Commissioner, if the net assets of the company above its reserve and all other claims and obligations, exclusive of guaranty capital, for two years immediately preceding and including the date of its last annual statement, is not less than twenty-five percent (25%) of the guaranty capital. Due notice of such proposed action on the part of the company must be mailed to each policyholder of the company not less than 30 days before the meeting when the action may be taken, and must also be advertised in two papers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before such meeting. No insurance company with a guaranty capital which has ceased to do new business, shall divide to its stockholders any part of its assets or guaranty capital, except income from investments, until it has performed or canceled its policy obligations. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall-only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.

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- (g)
- No insurance company with guaranty capital shall distribute to its holders of (f) guaranty capital its assets, except as provided in the guaranty capital filing as approved by the Commissioner.
 - In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the holders of guaranty capital to the extent that the guaranty capital has been contributed together with accrued interest as specified in the filing approved by the Commissioner."

SECTION 16. G.S. 58-8-50 reads as rewritten:

"§ 58-8-50. Guaranty against assessments prohibited.

If any director, officer, or agent of a mutual insurance company, either officially or privately, shall give gives a guarantee to a policyholder thereof of the company against an assessment to which such that policyholder would otherwise be liable, he the director, officer, or agent shall be punished by a fine not exceeding one hundred dollars (\$100.00) one thousand dollars (\$1,000) for each offense."

SECTION 17. G.S. 58-65-1 reads as rewritten:

Regulation and definitions; application of other laws; profit and "§ 58-65-1. foreign corporations prohibited.

Any corporation organized under the general corporation laws of the State of (a) North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, unless otherwise provided.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations or any other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical or any other professional services authorized or permitted to be furnished by a duly licensed physician or other provider listed in G.S. 58-50-30. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment 20f of fees toward, or furnishing of dental or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter-is intended to mean any nonprofit corporation operating a hospital or medical

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or dental service plan, as defined in this section. Any corporation organized and subject to the provisions of this Article and Article 66 of this Chapter, Article, the certificate of incorporation of which authorizes the operation of either a hospital or medical or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, Commissioner, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Article. Except to the extent prohibited either by G.S. 58-65-140 or by rules promulgated adopted by the Department of Insurance Commissioner not inconsistent with this Article and Article 66 of this Chapter, Article, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

licensed licensed

- (b) through (c) Repealed by Session Laws 2001-297. licensed licensed Social Work and Licensure
- (d) No foreign or alien hospital or medical or dental service corporation as herein defined shall be authorized to do business in this State."

SECTION 18. G.S. 58-65-95(a) reads as rewritten:

"(a) No corporation Corporations subject to this Article shall invest in any securities other than securities or hold only those assets permitted by Article 7 of this Chapter for the investment of assets of life and health insurance companies.

SECTION 19. G.S. 58-67-5(i) reads as rewritten:

"(i) "Net worth" means the excess of total assets over the total liabilities and may include borrowed funds that are repayable only from the net earned income of the health maintenance organization and repayable only with the advance permission of the Commissioner. For the purposes of this subsection, "assets" means (i) tangible assets and (ii) other investments permitted under G.S. 58 67-60; provided, however, that the depreciated cost of office furniture and equipment in the principal office shall not exceed ten percent (10%) of a health maintenance organization's net worth. G.S. 58-67-60."

SECTION 20. G.S. 58-67-40 is repealed.

SECTION 21. G.S. 58-67-110 reads as rewritten:

"§ 58-67-110. Protection against insolvency.

(a) The Commissioner shall require deposits in accordance with the provisions of G.S. 58-67-25.

1 minimum net worth of not less than one million dollars (\$1,000,000), which shall be 2 increased by the amount of the contingency reserves calculated annually in accordance 3 with the provisions of G.S. 58-67-40. The net worth calculation shall be computed in 4 accordance with statutory accounting principles generally recognized in the regulation 5 of health maintenance organizations and the Commissioner may promulgate such 6 regulations as he deems appropriate to carry out the provisions of this section. If a 7 health maintenance organization fails to comply with the net worth requirement of this 8 subsection or subsections (c) or (d) of this section, the Commissioner is authorized to 9 10 take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees, equal to the greater of one million 11 12 dollars (\$1,000,000) or the amount required pursuant to the risk-based capital provisions of Article 12 of this Chapter. Each single service health maintenance organization shall 13 14 maintain a minimum net worth equal to the greater of fifty thousand dollars (\$50,000) or that amount required pursuant to the risk-based capital provisions of Article 12 of this 15 16 Chapter.

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(c) The minimum net worth for a health maintenance organization authorized to operate on July 17, 1987, and having a net worth of less than one million dollars (\$1,000,000) shall be as follows:

Each full service medical-health maintenance organization shall maintain a

- \$150,000 by December 31, 1987 (1)
- \$300,000 by December 31, 1988 $\left(2\right)$
- \$450,000 by December 31, 1989 $\left(3\right)$
- \$750,000 by December 31, 1990 (4)
- \$1,000,000 by December 31, 1991

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- Notwithstanding any other provision of this Article, a health maintenance (d) organization authorized to offer only a single health care service plan providing a single health care service must have a minimum net worth of fifty thousand dollars (\$50,000). The minimum net worth for such plan authorized to operate on July 17, 1987, and having a net worth of less than fifty thousand dollars (\$50,000) shall be as follows:
 - Twenty-five thousand dollars (\$25,000) by December 31, 1987; and (1)
 - $\left(2\right)$ Fifty thousand dollars (\$50,000) by December 31, 1988;

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- Every full service medical health maintenance organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Commissioner. In determining the adequacy of such a plan, the Commissioner may consider:
 - (1) A reinsurance agreement preapproved by the Commissioner covering excess loss, stop loss, or catastrophes. The agreement must provide that the Commissioner will be notified no less than 60 days prior to cancellation or reduction of coverage.

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- (2) A conversion policy or policies that will be offered by an insurer to the enrollees in the event of the health maintenance organization's insolvency.
- (3) Any other arrangements offering protection against insolvency that the Commissioner may require."

SECTION 22. G.S. 58-67-140(a)(3) reads as rewritten:

"(3) No longer maintains the financial reserve specified in G.S. 58-67-40 or is-Is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees."

SECTION 23. G.S. 58-67-140(a)(7) reads as rewritten:

"(7) Has knowingly published or made to the Department or to the public any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210.G.S. 58-3-191."

SECTION 24. G.S. 58-47-65(a) reads as rewritten:

"(a) No group shall self-insure its workers' compensation liabilities under the Act unless it is licensed by the Commissioner under this Part. This subsection does not apply to a group that was organized and approved under the North Carolina law before July 1, 1995, and whose authority to self-insure its workers' compensation liabilities under the Act has not terminated after that date."

SECTION 25. G.S. 97-170(a) reads as rewritten:

"(a) No employer shall self-insure its workers' compensation liabilities under the Act unless it is licensed by the Commissioner under this Article. This subsection does not apply to an employer authorized to self-insure its workers' compensation liabilities under the Act prior to December 1, 1997, whose authority to self-insure its workers' compensation liabilities under the Act has not terminated after that date."

SECTION 26(a). G.S. 58-3-100 reads as rewritten:

"§ 58-3-100. Insurance company licensing provisions.

- (a) The Commissioner may, after notice and opportunity for a hearing, revoke, suspend, restrict, or refuse to renew or restrict the license of any insurer if:
 - (1) The insurer fails or refuses to comply with any law, order or rule applicable to the insurer.
 - (2) The insurer's financial condition is unsound, or its assets above its liabilities, exclusive of capital, are less than the amount of its capital or required minimum surplus.
 - (3) The insurer has published or made to the Department or to the public any false statement or report.
 - (4) The insurer or any of the insurer's officers, directors, employees, or other representatives refuse to submit to any examination authorized by law or refuse to perform any legal obligation in

relation to an examination.

- (5) The insurer is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.
- (b) Any suspension, revocation or refusal to renew suspension or revocation of an insurer's license under this section may also be made applicable to the license or registration of any individual regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section."

SECTION 26(b). G.S. 58-4-15 reads as rewritten:

"§ 58-4-15. Revocation or suspension of license.

The Commissioner may suspend, revoke, or refuse to renew suspend or revoke the license of any insurer failing to file its financial statement when due or within any extension of time that the Commissioner, for good cause, may have granted."

SECTION 26(c). G.S. 58-6-7 reads as rewritten:

"§ 58-6-7. <u>Licenses: perpetual licensing; annual license continuation</u> Annual license fees for insurance companies.

(a)In order to do business in this State, an insurance company shall apply for and obtain a license from the Commissioner by March 1 of each year. Commissioner. The license shall be perpetual and become effective the following July 1 and shall remain in effect for one year. shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with this Chapter and subject to any other applicable provision of the insurance laws of this State. Except as provided in subsection (b) of this section, the insurance company shall pay an annual a fee for each year the license is in effect, as follows:

- The fees levied in this subsection are in addition to those specified in G.S. 58-6-5.
- (b) When the paid-in capital stock or surplus, or both, of an insurance company, other than a farmer's mutual assessment company or a fraternal order, does not exceed one hundred thousand dollars (\$100,000), the fee levied in this section shall be one-half the amount specified.
- (c) Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars (\$100.00) for each such additional classification of

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42 43 business done. All fees and charges collected by the Commissioner under this Chapter are nonrefundable.

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

SECTION 26(d). G.S. 58-6-15 reads as rewritten:

"§ 58-6-15. Licenses run from July 1. Annual license continuation fee definition; requirements.

The license required of insurance companies shall continue, continue for the next ensuing 12 months after July 1 of each year, unless revoked as provided in Articles 1 through 64 of this Chapter. Application for renewal of the company license For purposes of this Chapter only, "annual license continuation fee" means the fee specified in G.S. 58-6-7 submitted to the Commissioner for each year the license is in effect after the company's year of initial licensing. The annual license continuation fee must be submitted on or before the first day of March on a form to be supplied by the Commissioner. Commissioner each year the license is to remain in effect. If the Commissioner is satisfied Upon satisfying himself that the company has met all requirements of law and appears to be financially solvent he shall forward the renewal license to the company. Any company which does not qualify for a renewal license before July 1 shall cease to do business in the State of North Carolina as of July 1. unless its license is sooner revoked by the Commissioner. solvent, the Commissioner shall not revoke or suspend the license of the company and the company shall be authorized to do business in this State, subject to all other applicable provisions of the insurance laws of this State. Nothing contained in this section shall be interpreted as applying to licenses issued to individual representatives of insurance companies."

SECTION 26(e). G.S. 58-6-30 reads as rewritten:

"§ 58-15-30. License, surplus, and deposit requirements.

- (a)No reciprocal shall engage in any insurance transaction in this State until it has obtained a license to do so in accordance with the applicable provisions of Articles 1 through 64 of this Chapter. Such The license shall continue in full force and effect, subject to timely payment of an annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State expire on the last day of June of each year.
- (b) No domestic or foreign reciprocal shall be licensed in this State unless it has a surplus to policyholders of at least eight hundred thousand dollars (\$800,000); and no alien reciprocal shall be licensed unless it has a trusteed surplus of at least eight hundred thousand dollars (\$800,000).
- (c) Each domestic, foreign, or alien reciprocal licensed in this State must maintain a minimum deposit with the Commissioner of at least one hundred thousand dollars (\$100,000) in cash or in value of securities of the kind specified in G.S. 58-5-15, which shall be subject to the same conditions as contained in Article 5 of this Chapter."

SECTION 26(f). G.S. 58-19-65 reads as rewritten:

"§ 58-19-65. Revocation, suspension, or nonrenewal Revocation or suspension of insurer's license.

Page 12

Whenever it appears to the Commissioner that any person has committed a violation of this Article that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an opportunity to be heard, suspend, revoke, or refuse to renew suspend or revoke such insurer's license to do business in this State for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law."

SECTION 26(g). G.S. 58-24-130 reads as rewritten:

"§ 58-24-130. Annual Perpetual license.

 Societies which are now authorized to transact business in this State may continue such business until the 30th day of June next succeeding January 1, 1988. The authority of such societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the 30th day of the succeeding June. However, a license so issued Subject to timely payment of the annual license continuation fee and subject to any other applicable provisions of the insurance laws of this State, a license, other than a preliminary license, to a fraternal benefit society under this Article shall continue in full force and effect until the new license be issued or specifically refused. effect. For each such license or renewal the society shall pay the Commissioner the fee specified in G.S. 58-6-5. The society shall pay the Commissioner, as an annual license continuation fee and a condition of the continuation of the license, the fee specified in G.S. 58-6-7 on or before the first day of March on a form to be supplied by the Commissioner. A duly certified copy or duplicate of such the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of Articles 1 through 64 of this Chapter."

SECTION 26(h). G.S. 58-26-10 reads as rewritten:

"§ 58-26-10. Financial statements and licenses required.

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The license to do business in this State issued to a title insurance company shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State. The Commissioner shall annually license such companies and their agents the agents of title insurance companies."

SECTION 26(i). G.S. 58-30-62 reads as rewritten:

"§ 58-30-62. Administrative supervision of insurers."

(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 revoked or suspended 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."

SECTION 26(j). G.S. 58-65-55 reads as rewritten:

"§ 58-65-55. Issuance of certificate.

- (a) Before issuing or continuing any such license or certificate the Commissioner may make such an examination or investigation as the Commissioner deems expedient. The Commissioner shall issue a certificate of authority or license upon the payment of a an annual fee of one thousand dollars (\$1,000) and upon being satisfied on the following points:
 - (1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.
 - (2) The rates charged and benefits to be provided are fair and reasonable.
 - (3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and hospital and medical and/or dental expenses and such reserve as the Department deems adequate, as provided hereinafter.
 - (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.
- (b) The certificate of authority or license shall continue in full force and effect, subject to payment of an annual license continuation fee of one thousand dollars (\$1000), subject all other provisions of subsection (a) of this section, and subject to any other applicable provisions of the insurance laws of this State."

SECTION 26(k). G.S. 58-65-125 reads as rewritten:

"§ 58-65-125. Revocation, suspension, and refusal to renew Revocation and suspension of license; unfair trade practices.

- (a)The Commissioner may revoke, suspend, or refuse to renewrevoke or suspend the license of any service corporation if:
 - (1) The service corporation fails or refuses to comply with any law, order, or rule applicable to the service corporation.
 - (2) The service corporation's financial condition is unsound.
 - (3) The service corporation has published or made to the Department or to the public any false statement or report.

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- (4) The service corporation refuses to submit to any examination authorized by law.
- (5) The service corporation is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.
- (b) Any suspension, revocation, or refusal to renew suspension or revocation of a service corporation's license under this section may also be made applicable to the license or registration of any natural person regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.
- (c) Article 63 of this Chapter applies to service corporations and their agents and representatives."

SECTION 26(1). G.S. 58-67-140 reads as rewritten:

"§ 58-67-140. Suspension or revocation of license.

- (a)The Commissioner may suspend, revoke, or refuse to renewsuspend or revoke an HMO license if the Commissioner finds that the HMO:
 - (1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-67-10, unless amendments to such submissions have been filed with and approved by the Commissioner.
 - (2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with G.S. 58-67-50.
 - (3) No longer maintains the financial reserve specified in G.S. 58-67-40 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
 - (4) Has itself or through any person on its behalf advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.
 - (5) Is operating in a manner that would be hazardous to its enrollees.
 - (6) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the HMO or with any order issued by the Commissioner after notice and opportunity for a hearing.
 - (7) Has knowingly published or made to the Department or to the public any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210."

SECTION 26(m). G.S. 58-67-160 reads as rewritten: "§ 58-67-160. Fees.

Every health maintenance organization subject to this Article shall pay to the Commissioner a fee of two hundred fifty dollars (\$250.00) for filing an application for a license and a an annual license continuation fee of one thousand dollars (\$1,000) for each license renewal. license. The license shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State."

SECTION 27. If any section or provision of this act is declared unconstitutional, preempted, or otherwise invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part declared to be unconstitutional, preempted, or otherwise invalid.

 SECTION 28. Sections 26(a) through (m) become effective January 1, 2004, and apply to all company licenses issued or otherwise eligible for renewal or continuation after that date. The remainder of this act becomes effective October 1, 2003.

attachment II

SECTION-BY SECTION SUMMARY HOUSE BILL 276-INSURANCE FINANCIAL AMENDMENTS OMNIBUS

Sections 1. through 3. Amendments to Initial Deposits Laws.

- **Section 1.** Increases initial deposit required from foreign or alien fire, marine, and fire and marine insurers from \$25,000 to \$100,000.
- **Section 2.** Increases initial deposit required from foreign or alien fidelity, surety or casualty insurers from \$50,000 to \$200,000.
- **Section 3.** Increases initial deposit required from foreign life insurers from \$100,000 to \$400,000 and an additional \$200,000 rather than \$100,000 when the insurer cannot show three years of operational gains before admission.
- Sections 4. through 13. Conform N.C. Law in Article 7- General Domestic Insurance Companies to the Statements of Statutory Accounting Principles adopted by the NAIC. Note: pursuant to G.S. 58-2-165(c), all financial statements filed under that section must be in accordance with the appropriate procedures and standards adopted by the NAIC unless a different standard or procedure is set forth. These changes remove conflicts between N.C. law and the NAIC SSAPs.
- **Section 4.** repeals G.S. 58-7-162(2)(a),(b),(c),(d),(e),(f), and (g) to remove all specially designated provisions regarding certain investments, securities, properties and loans acquired or held governing assets allowable or admitted for determining the financial condition of an insurer.
- **Section 5.** repeals G.S. 58-7-162 (5) and G.S. 58-7-162 (7) to conform NC law with the SSAPs regarding non-admission of uncollected direct bill premiums and installment premiums more than 90 days old.
- **Ssection 6.** Removes a provision in G.S. 58-7-162(12) placing certain criteria on the counting of electronic and mechanical machines in order to conform to the respective SSAP.
- **Section 7.** repeals G.S. 58-7-163(1),(4),(7), and (8) specifying certain items such as "goodwill" and "certificates of contribution" that must be non-admitted assets, to conform with the SSAP rules which conflict with NC law.
- **Section 8.** repeals G.S. 58-7-192(a),(b),(c),(e) and portions of (d), governing the valuation of securities and investments, to remove certain inconsistencies with the SSAPs, to clarify that the valuations limitations are not restricted to that particular statute but apply throughout the Chapter, and to update cross-reference to the appropriate NAIC publication.
- **Section 9.** Repeals G.S. 58-7-193(a) and (b) governing valuation of real property to remove conflicts with SSAPs.
- **Section 10.** Repeals G.S. 58-7-195, governing valuation of purchase money mortgages(PPMs) to default to the SSAP rules on PPMs.

Section 11. amends G.S. 58-7-179 (d) to remove reference to G.S. 58-7-195, which is repealed by Section 10 of the bill.

Section 12. amends G.S. 58-23-26(c) to remove reference to G.S. 58-7-195, which is repealed by Section 10 of the bill.

Section 13. amends G.S. 58-47-80 to remove reference to G.S. 58-7-195, which is repealed by Section 10 of the bill.

Sections 14. through 16. Amendments to Article 8 – Mutual Insurance Companies.

Section 14. Amends G.S. 58-8-15, governing directors of mutual insurers, to prohibit more than one half of directors of guaranty capital companies from being elected by guaranty capital holders (investors) unless those guaranty capital holders are also policyholders. The amendment further provides that, for guaranty capital companies, policyholders who are also guaranty capital holders are entitle to one vote for each policy the person holds and one vote for each unit of guaranty capital the person holds.

Section 15. Amends G.S. 58-8-20, which sets forth special rules for mutual insurers with guaranty capital, to:

- Make minor technical wording changes.
- Codify an existing rule to only allow a domestic mutual insurer to issue guaranty capital if: (i) it will aid a financially troubles insurer otherwise facing rehabilitation or liquidation by the Department; or (ii) for any reason presented in a petition to the Commissioner and which the Commissioner finds to be reasonable, justifiable and in the best interest of policyholders. This codification included notice —to-policyholder provisions required if the insurer has to petition the Commissioner to be eligible to issue guaranty capital.
- Clarify that holders of guaranty capital receive "interest" not "dividends' and that the distribution of interest must be in accordance with the insurer filing with the Commissioner.
- Reorganize the statute by moving two provisions, one in subsection (c) governing repayment of guaranty capital in the event the insurer is merged, demutualized or otherwise ceases to exist, and another in subsection (e) restricting asset distribution until all policy obligations have been met, to two new subsections, (g) and (f) respectively.
- Amend subsection (d) of the statute consistent with previous changes regarding voting rights of guaranty capital holders and prohibit guaranty capital holders, unless they are also policyholders, from participating in a vote to petition the Commissioner to allow issuance of more guaranty capital stock and from participating in any vote to reduce or retire guaranty capital, when the criteria for such a vote have been satisfied pursuant to subsection (e).

Section 16. Increases the penalty from a maximum fine of \$100 to \$1000 for a director, officer or agent of a guaranty capital insurer who gives a policyholder a guaranty against an assessment in violation of G.S. 58-8-50.

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Section 17. Amends G.S. 58-65-1, setting forth regulations and definitions applicable to the insurance laws governing hospital, medical and dental service corporations (BCBS) to clarify that the definitions of "hospital service plan", "medical service plan", "dental service plan", "hospital service corporation", and "preferred provider" in Article 65 also apply in Article 66 – Readable Insurance Certificates. This section also makes technical changes and eliminates two "printing" errors inadvertently in the statute due to previous bill drafting anomalies. This section also clarifies that the a preferred provider's special reimbursement terms and conditions must be consistent both with Article 65 and Article 66 provisions.

Section 18. Removes the provision governing the allowance of office furniture as part of net worth to the extent it is less than 10% of an HMOs net worth. This is an additional change to conform NC's law to rules of the SSAP.

Sections 19. through 22. - Amends Article 67- Health Maintenance Organizations.

Section 19. Repeals the reserves requirements for HMOs under G.S.58-67-40 because they are unnecessary due to the risk-based capital (RBC) laws in Article 12.**

Section 20. Amends G.S. 58-67-110, governing protection against HMO insolvency to replace old net worth requirements and impose new ones that a full service HMO must maintain a net worth equal to the greater of \$1 million or the amount required under RBC and single service HMO must maintain a net worth equal to the greater of \$50,000 or the amount required under RBC. There is a drafting error to be corrected which will maintain the current requirements that every full service HMO maintain a plan of insolvency acceptable to the Commissioner.

- **Section 21.** Eliminates reference to G.S. 58-67-40, which is repealed by Section 19. of the bill.
- **Section 22.** Technically corrects a cross-reference to G.S. 58-3-210, a non-existent section, to reflect the correct cross-reference, G.S. 58-3-191, Managed care reporting and disclosure requirements.
 - **Section 23.** Is a severability clause.
 - **Section 24.** Makes the act become effective October 1, 2003.

HOUSE INSURANCE COMMITTEE APRIL 8, 2003 ROOM 544 LOB

Chairs:

Representative Hugh Holliman Representative Mitchell Setzer

Vice Chair:

Representative John Hall

AGENDA

House Bill 744- MANAGED CARE PATIENT ASSISTANCE Rep. Hackney

House Bill 276-INSURANCE FINANCIAL AMENDMENTS OMNIBUS. -AB Rep. Setzer

VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

04/08/03 Date/

Name of Committee

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

| John Mchillan | MFOS |
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| John Cysus | n.C., State Grange |
| FRANK W. FOLGER | NC DOI |
| barbara Morales Burke | NCDOF |
| Bill Hale | Jordan Pince Jan Frim |
| Head real | NCHIP |
| Je (Cunnel) | MANC |
| Jim Caldwell | Mid-Carolina COG |
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VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

04/08/03 Date

Name of Committee

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME ; . | FIRM OR AGENCY AND ADDRESS |
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| Robert PASchal | Young, hours |
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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 276 PROPOSED COMMITTEE SUBSTITUTE H276-PCS30236-RG-5

| Short Title: Insurance Financial Amendments OmnibusAB | (Public) |
|--|---------------|
| Sponsors: | |
| Referred to: | |
| March 6, 2003 | |
| A BILL TO BE ENTITLED | |
| AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMEN | NTS IN THE |
| LAWS CONCERNING INSURANCE COMPANY SOLVENCY. | |
| The General Assembly of North Carolina enacts: | |
| SECTION 1. G.S. 58-5-5 reads as rewritten: | d/or marina |
| "§ 58-5-5. Amount of deposits required of foreign or alien fire and insurance companies. | u/or marme |
| Unless otherwise provided in this Article, every fire, marine, or fire | and marine |
| insurance company chartered by any other state or foreign government sha | |
| maintain deposits of securities with the Commissioner in the amount of | |
| thousand dollars (\$25,000) one hundred thousand dollars (\$100,000) market | • |
| SECTION 2. G.S. 58-5-10 reads as rewritten: | |
| "§ 58-5-10. Amount of deposits required of foreign or alien fidelity, | surety and |
| casualty insurance companies. | |
| Unless otherwise provided in this Article, every fidelity, surety or casua | |
| company chartered by any other state or foreign government shall make a | |
| deposits of securities with the Commissioner in the amount of fifty thou | isand dollars |
| (\$50,000) two hundred thousand dollars (\$200,000) market value." | |
| SECTION 3. G.S. 58-5-50 reads as rewritten: | |
| "§ 58-5-50. Deposits of foreign life insurance companies. | m all faraign |
| In addition to other requirements of Articles 1 through 64 of this Chapte life insurance companies shall deposit securities, as specified in G.S. 58-5- | |
| market value of one hundred thousand dollars (\$100,000) four hundred thou | |
| (\$400,000) as a prerequisite of doing business in this State. All foreign li | |
| companies shall deposit an additional one hundred thousand dollars (\$1 | |

hundred thousand dollars (\$200,000) where such companies cannot show three years of

net operational gains prior to admission. Foreign life insurance companies that are

licensed on or before the effective date of this section shall have one year from that date 1 2 to comply with this section." 3 **SECTION 4.** G.S. 58-7-162(2) reads as rewritten: 4 Investments, securities, properties, and loans acquired or held in 5 accordance with this Chapter, and in connection therewith the 6 following items: 7 Interest due or accrued on any bond or evidence of indebtedness 8 that is not in default. 9 Declared and unpaid dividends on stock and shares, unless that b. amount has otherwise been allowed as an asset. 10 Interest due or accrued upon a collateral loan in an amount not 11 e. 12 to exceed one year's interest thereon. 13 d. Interest due or accrued on deposits in solvent banks, savings 14 and loan associations, and trust companies, and interest due or 15 accrued on other assets, if the interest is, in the Commissioner's 16 judgment, a collectible asset. Interest due or accrued on a current mortgage loan, in an 17 e. 18 amount not exceeding in any event the amount, if any, of the 19 excess of the value of the property less delinquent taxes thereon 20 over the unpaid principal; but in no event shall interest accrued 21 for a period in excess of 90 days be allowed as an asset. 22 . £ Rent due or accrued on real-property if the rent is not in arrears 23 for more than three months, and rent more than three months in 24 arrears if the payment of the rent is adequately secured by 25 property held in the tenant's name and conveyed to the insurer 26 as collateral and the underlying collateral is admissible under 27 this Chapter. 28 The unaccrued portion of taxes paid before the due date on real g. 29 property. 30 Chapter." **SECTION 5.** G.S. 58-7-162(5) and G.S. 58-7-162(7) are repealed. 31 **SECTION 6.** G.S. 58-7-162(12) reads as rewritten: 32 "(12) Electronic and mechanical machines, including operating and system 33 software constituting a management information system, if the cost of 34 the system is at least twenty-five thousand dollars (\$25,000) but not 35 36 more than two percent (2%) of total admitted assets; the cost shall be 37 amortized in full over a period not to exceed seven calendar .38 years.system." 39 **SECTION 7.** G.S. 58-7-163 reads as rewritten: 40 "§ 58-7-163. Assets not allowed. 41 In addition to assets impliedly excluded by the provisions of G.S. 58-7-162, the

(1) Goodwill, trade names, and other like intangible assets.

condition of an insurer:

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following expressly shall not be allowed as assets in any determination of the financial

- (2) Advances (other than policy loans) to officers, directors, and controlling stockholders, whether secured or not, and advances to employees, agents, and other persons on personal security only.
- (3) Stock of the insurer or any material equity therein or loans secured thereby, or any material proportionate interest in the stock acquired or held through the ownership by the insurer of an interest in another firm, corporation, or business unit.
- Furniture, fixtures, other equipment, safes, vehicles, libraries, stationery, literature, and supplies, other than data processing and accounting systems authorized under G.S. 58-7-162(12), except in the case of title insurers the materials and plants which G.S. 58-7-182 expressly authorizes the insurer to invest in, and except, in the case of any insurer, any personal property that the insurer is permitted to hold under this Chapter, or that is acquired through foreclosure of chattel mortgages acquired under G.S. 58-7-180, or that is reasonably necessary for the maintenance and operation of real estate that the insurer uses for a home office, branch office, and similar purposes.
- (5) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value of the investments as determined under this Chapter.
- (6) Bonds, notes, or other evidences of indebtedness that are secured by mortgages or deeds of trust that are in default, to the extent of the cost or carrying value that is in excess of the value as determined pursuant to other provisions of this Chapter.
- (7) Prepaid and deferred expenses.
- (8) Certificates of contribution contribution, surplus notes, or other similar evidences of indebtedness. indebtedness, to the extent that admission of these investments results in the double counting of these investments in the reporting entity's balance sheet.
- (9) Any asset that is encumbered in any manner unless the asset is authorized under G.S. 58-7-187 or G.S. 58-7-162(13)."

SECTION 8. G.S. 58-7-192 reads as rewritten:

"§ 58-7-192. Valuation of securities and investments.

- (a) All securities, investments, and evidences of debt, other than those for which valuation methodologies are specifically set forth in this Chapter, that are held by an insurer shall be valued at their market values, at their appraised values, or at prices determined by the insurer as representing their fair market values, subject to the Commissioner's approval.
- (b) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, in the Commissioner's discretion and in accordance with a method of valuation that the Commissioner approves.
- (c) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of its net value as based upon those assets only of the subsidiary that

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would be eligible under this Chapter and G.S. 58-19-10 for investment of the funds of the insurer direct.

- (d) No valuations under this section shall be greater than any applicable valuation or method contained in the latest edition of the NAIC publications entitled "Valuations of Securities" Purposes and Procedures Manual of the NAIC Securities Valuation Office" or the "Accounting Practices and Procedures Manual", unless the Commissioner determines that another valuation method is appropriate when it results in a more conservative valuation.
- (e) All-bonds or fully secured indebtedness having a stated term and a rate of interest that are held by an insurer shall be valued in accordance with the procedures and instructions contained in the NAIC publication entitled "Valuations of Securities", unless the Commissioner determines that a more conservative valuation is appropriate."

SECTION 9. G.S. 58-7-193 reads as rewritten:

"§ 58-7-193. Valuation of property.

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- (a) Real property acquired pursuant to a mortgage loan or contract for sale shall be valued at the net realizable value, but in no event shall the property be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of the acquisition and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.
- (b) Other real property held by an insurer shall not be valued at an amount in excess of fair market value as determined by recent appraisal and as approved by the Commissioner. If valuation is based on an appraisal more than three years old, the Commissioner may call for and require a new appraisal in order to determine fair value.
- (c) Personal property acquired pursuant to chattel mortgages made in accordance with G.S. 58-7-180 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at the date of acquisition, or the fair market value of the property, whichever amount is less.
- (d) If the Commissioner and an insurer do not agree on the value of real or personal property of an insurer, in carrying out the Commissioner's responsibilities under this section, the Commissioner may retain the services of a qualified real or personal property appraiser. The insurer shall reimburse the Commissioner for the costs of the services of any appraiser incurred with respect to the Commissioner's responsibilities under this section."

SECTION 10. G.S. 58-7-195 is repealed.

SECTION 11. G.S. 58-7-179(d) reads as rewritten:

"(d) In the case of a purchase money mortgage given to secure the purchase price of real estate sold by the insurer, the amount lent or invested shall not exceed the unpaid part of the purchase price and shall be valued in accordance with G.S. 58-7-195.price."

SECTION 12. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168,

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58-7-170, 58-7-172, 58-7-173, 58-7-175, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and Articles 13, 19, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

SECTION 13. G.S. 58-47-80 reads as rewritten:

"§ 58-47-80. Assets and invested assets.

Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and 58-19-10."

SECTION 14. G.S. 58-8-15 reads as rewritten:

"§ 58-8-15. Directors in mutual companies.

Every mutual insurance company shall elect by ballot a board of not less than seven directors, who shall manage and conduct its business and hold office for one year or for such term as the bylaws provide and until their successors are qualified. The directors need not be residents of this State or members of the company. In companies with a guaranty capital, no more than one half one-half of the directors shall be ehosen elected by and from the stockholders holders of guaranty capital, except where guaranty capital holders are policyholders. Policyholders which are holders of guaranty capital shall be entitled to one vote for each policy that person holds and one vote for each unit of guaranty capital that person holds."

SECTION 15. G.S. 58-8-20 reads as rewritten:

"§ 58-8-20. Mutual companies with a guaranty capital.

- (a) A mutual insurance company formed as provided in Articles 1 through 64 of this Chapter, in lieu of the contributed surplus required for the organization of mutual companies under the provisions of G.S. 58-7-75, or a mutual insurance company now existing, may, with the prior approval of the Commissioner, establish tender a guaranty capital offering of not less than fifty thousand dollars (\$50,000), divided into shares units of one hundred dollars (\$100.00) each, which shall be invested in the same manner as is provided in this Chapter for the investment of the capital stock of insurance companies.
- (a1) Guaranty capital may be issued by an existing domestic mutual insurance company only under the following terms and conditions:
 - (1) To aid and assist a financially troubled domestic mutual insurance company which otherwise faces rehabilitation or liquidation by this Department; or
 - (2) For any other reason as presented in a petition to the Commissioner and which is found by the Commissioner to be reasonable, justifiable, and in the best interest of all the policyholders of the company.

Guaranty capital issued under subdivision (2) of this subsection shall require written notification of the action proposed by the board of directors of the company to be mailed to the policyholders of the company not less than 30 days before the meeting when the action may be taken. The written notification shall be advertised in two

newspapers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before the meeting. The written notification to policyholders shall include a proxy statement to allow policyholders to vote on the proposed action without personal attendance at the meeting, and the Commissioner shall approve both the written notification and the proxy statement. The proposed action shall be effected by a vote of two-thirds of the policyholders voting thereon in person or by proxy.

- (b) The board of directors of a company may declare and pay dividends to the stockholders of the guaranty capital of a company, subject to the notification requirements of G.S. 58-19-25(d) and the prior approval requirements of G.S. 58-19-30(c). distribute interest to the holders of guaranty capital in accordance with the guaranty capital filing approved by the Department.
- (c) The guaranty Guaranty capital shall be applied to the payment of losses only when the company has exhausted its cash in hand and the invested assets, exclusive of uncollected premiums, and when thus impaired, the directors may make good the whole or any part of it by assessments upon the contingent funds of the company at the date of such impairment. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.
- (d) Shareholders and members of such companies are subject to the same provisions of law in respect to their right to vote as apply respectively to shareholders in stock companies and policyholders in mutual companies. Guaranty capital holders are entitled to one vote per unit of guaranty capital. Guaranty capital holders who are not policyholders are not entitled to participate in the policyholder votes prescribed under subdivision (a1)(2) and subsection (e) of this section.
- This guaranty Guaranty capital may be reduced or retired by vote of the policyholders of the company and the assent of the Commissioner, if the net assets of the company above its reserve and all other claims and obligations, exclusive of guaranty capital, for two years immediately preceding and including the date of its last annual statement, is not less than twenty-five percent (25%) of the guaranty capital. Due notice of such proposed action on the part of the company must be mailed to each policyholder of the company not less than 30 days before the meeting when the action may be taken, and must also be advertised in two papers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before such meeting. No insurance company with a guaranty capital which has ceased to do new business, shall divide to its stockholders any part of its assets or guaranty capital, except income from investments, until it has performed or canceled its policy obligations. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.

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- No insurance company with guaranty capital shall distribute to its holders of (f) guaranty capital its assets, except as provided in the guaranty capital filing as approved by the Commissioner.
- In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the holders of guaranty capital to the extent that the guaranty capital has been contributed together with accrued interest as specified in the filing approved by the Commissioner."

SECTION 16. G.S. 58-8-50 reads as rewritten:

"§ 58-8-50. Guaranty against assessments prohibited.

If any director, officer, or agent of a mutual insurance company, either officially or privately, shall give gives a guarantee to a policyholder thereof of the company against an assessment to which such that policyholder would otherwise be liable, he the director, officer, or agent shall be punished by a fine not exceeding one hundred dollars (\$100.00) one thousand dollars (\$1,000) for each offense."

SECTION 17. G.S. 58-65-1 reads as rewritten:

Regulation and definitions; application of other laws; profit and "§ 58-65-1. foreign corporations prohibited.

Any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, unless otherwise provided.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations or any other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical or any other professional services authorized or permitted to be furnished by a duly licensed physician or other provider listed in G.S. 58-50-30. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment 20f of fees toward, or furnishing of dental or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital or medical or dental service plan, as defined in this section. Any corporation organized and subject to the provisions of this Article and Article 66 of this Chapter, Article, the certificate of incorporation of which authorizes the operation of either a hospital or medical or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, Commissioner, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Article. Except to the extent prohibited either by G.S. 58-65-140 or by rules promulgated adopted by the Department of Insurance Commissioner not inconsistent with this Article and Article 66 of this Chapter, Article, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

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- (b) through (c) Repealed by Session Laws 2001-297. licensed licensed Social Work and Licensure
- (d) No foreign or alien hospital or medical or dental service corporation as herein defined shall be authorized to do business in this State."

SECTION 18. G.S. 58-65-95(a) reads as rewritten:

"(a) No corporation Corporations subject to this Article shall invest in any securities other than securities or hold only those assets permitted by Article 7 of this Chapter for the investment of assets of life and health insurance companies."

SECTION 19. G.S. 58-67-5(i) reads as rewritten:

"(i) "Net worth" means the excess of total assets over the total liabilities and may include borrowed funds that are repayable only from the net earned income of the health maintenance organization and repayable only with the advance permission of the Commissioner. For the purposes of this subsection, "assets" means (i) tangible assets and (ii) other investments permitted under G.S. 58-67-60; provided, however, that the depreciated cost of office furniture and equipment in the principal office shall not exceed ten percent (10%) of a health maintenance organization's net worth. G.S. 58-67-60."

SECTION 20. G.S. 58-67-40 is repealed.

SECTION 21. G.S. 58-67-110 reads as rewritten:

"§ 58-67-110. Protection against insolvency.

(a) The Commissioner shall require deposits in accordance with the provisions of G.S. 58-67-25.

1 minimum net worth of not less than one million dollars (\$1,000,000), which shall be 2 increased by the amount of the contingency reserves calculated annually in accordance 3 with the provisions of G.S. 58-67-40. The net worth calculation shall be computed in 4 5 accordance with statutory accounting principles generally recognized in the regulation of health maintenance organizations and the Commissioner may promulgate such 6 regulations as he deems appropriate to carry out the provisions of this section. If a 7 health maintenance organization fails to comply with the net worth requirement of this 8 9 subsection or subsections (c) or (d) of this section, the Commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance 10 organization will not be hazardous to its enrollees, equal to the greater of one million 11 dollars (\$1,000,000) or the amount required pursuant to the risk-based capital provisions 12 of Article 12 of this Chapter. Each single service health maintenance organization shall 13 maintain a minimum net worth equal to the greater of fifty thousand dollars (\$50,000) 14 or that amount required pursuant to the risk-based capital provisions of Article 12 of this 15 16 Chapter. 17 18 19 20 21 22

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The minimum net worth for a health maintenance organization authorized to (c) operate on July 17, 1987, and having a net worth of less than one million dollars (\$1,000,000) shall be as follows:

Each full service medical-health maintenance organization shall maintain a

- (1) \$150,000 by December 31, 1987
- \$300,000 by December 31, 1988 $\left(2\right)$
- \$450,000 by December 31, 1989 (3)
- \$750,000 by December 31, 1990 (4)
- \$1,000,000 by December 31, 1991 (5)

The net worth-amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- Notwithstanding any other provision of this Article, a health maintenance organization authorized to offer only a single health care service plan providing a single health care service must have a minimum net worth of fifty thousand dollars (\$50,000). The minimum net worth for such plan authorized to operate on July 17, 1987, and having a net worth of less than fifty thousand dollars (\$50,000) shall be as follows:
 - Twenty-five thousand dollars (\$25,000) by December 31, 1987; and (1)
 - Fifty thousand dollars (\$50,000) by December 31, 1988;

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- Every full service medical health maintenance organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Commissioner. In determining the adequacy of such a plan, the Commissioner may consider:
 - **(1)** A reinsurance agreement preapproved by the Commissioner covering excess loss, stop loss, or catastrophes. The agreement must provide that the Commissioner will be notified no less than 60 days prior to cancellation or reduction of coverage.

| 1 | ` , | conversion policy or policies that will be offered by an insurer to the |
|----|---|---|
| 2 | | prollees in the event of the health maintenance organization's solvency. |
| 4 | | ny other arrangements offering protection against insolvency that the |
| 5 | ` ' | ommissioner may require." |
| 6 | | N 22. G.S. 58-67-140(a)(3) reads as rewritten: |
| 7 | | o longer maintains the financial reserve specified in G.S. 58-67-40 or |
| 8 | | -Is no longer financially responsible and may reasonably be expected |
| 9 | | be unable to meet its obligations to enrollees or prospective |
| 10 | | arollees." |
| 11 | | ON 23. G.S. 58-67-140(a)(7) reads as rewritten: |
| 12 | | as knowingly published or made to the Department or to the public |
| 13 | • | by false statement or report, including any report or any data that |
| 14 | | erves as the basis for any report, required to be submitted under G.S. |
| 15 | | 3-3-210. G.S. 58-3-191." |
| 16 | | N 24. G.S. 58-47-65(a) reads as rewritten: |
| 17 | | shall self-insure its workers' compensation liabilities under the Act |
| 18 | | ed by the Commissioner under this Part. This subsection does not |
| 19 | | at was organized and approved under the North Carolina law before |
| 20 | | whose authority to self-insure its workers' compensation liabilities |
| 21 | * | ot terminated after that date." |
| 22 | | ON 25. G.S. 97-170(a) reads as rewritten: |
| 23 | | oyer shall self-insure its workers' compensation liabilities under the |
| 24 | | ensed by the Commissioner under this Article. This subsection does |
| 25 | | ployer authorized to self-insure its workers' compensation liabilities |
| 26 | | er to December 1, 1997, whose authority to self-insure its workers' |
| 27 | **** | lities under the Act has not terminated after that date." |
| 28 | | ON 26.(a) G.S. 58-3-100 reads as rewritten: |
| 29 | | rance company licensing provisions. |
| 30 | | nmissioner may, after notice and opportunity for a hearing, revoke, |
| 31 | | refuse to renew or restrict the license of any insurer if: |
| 32 | ` , | he insurer fails or refuses to comply with any law, order or rule |
| 33 | | oplicable to the insurer. |
| 34 | ` , | he insurer's financial condition is unsound, or its assets above its |
| 35 | | abilities, exclusive of capital, are less than the amount of its capital or |
| 36 | | equired minimum surplus. |
| 37 | | he insurer has published or made to the Department or to the public |
| 38 | | ny false statement or report. |
| 39 | | he insurer or any of the insurer's officers, directors, employees, or |
| 40 | | ther representatives refuse to submit to any examination authorized |
| 41 | · | y law or refuse to perform any legal obligation in relation to an |
| 42 | ex | kamination. |

- GENERAL ASSEMBLY OF NORTH CAROLINA The insurer is found to make a practice of unduly engaging in (5) 1 2 litigation or of delaying the investigation of claims or the adjustment or payment of valid claims. 3 Any suspension, revocation or refusal to renew suspension or revocation of 4 an insurer's license under this section may also be made applicable to the license or 5 registration of any individual regulated under this Chapter who is a party to any of the 6 causes for licensing sanctions listed in subsection (a) of this section." 7 **SECTION 26.(b)** G.S. 58-4-15 reads as rewritten: 8 "§ 58-4-15. Revocation or suspension of license. 9 The Commissioner may suspend, revoke, or refuse to renew suspend or revoke the 10 license of any insurer failing to file its financial statement when due or within any 11 extension of time that the Commissioner, for good cause, may have granted." 12 **SECTION 26.(c)** G.S. 58-6-7 reads as rewritten: 13 14 **"**§ 58-6-7. 15
 - Licenses; perpetual licensing; annual license continuation Annual license fees for insurance companies.
 - In order to do business in this State, an insurance company shall apply for and obtain a license from the Commissioner by March 1 of each year. Commissioner. The license shall be perpetual and become effective the following July 1 and shall remain in effect for one year. shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with this Chapter and subject to any other applicable provision of the insurance laws of this State. Except as provided in subsection (b) of this section, the insurance company shall pay an annual a fee for each year the license is in effect, as follows:

For each domestic farmer's mutual assessment fire insurance company.......\$ 25.00 For each of all other insurance companies, except mutual burial associations taxed The fees levied in this subsection are in addition to those specified in G.S. 58-6-5.

- When the paid-in capital stock or surplus, or both, of an insurance company, other than a farmer's mutual assessment company or a fraternal order, does not exceed one hundred thousand dollars (\$100,000), the fee levied in this section shall be one-half the amount specified.
- Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars (\$100.00) for each such additional classification of business done. All fees and charges collected by the Commissioner under this Chapter are nonrefundable.

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

SECTION 26.(d) G.S. 58-6-15 reads as rewritten:

"§ 58-6-15. Licenses run from July 1. Annual license continuation fee definition; requirements.

The license-required of insurance companies shall continue, continue for the next ensuing 12 months after July 1 of each year, unless revoked as provided in Articles 1 through 64 of this Chapter. Application for renewal of the company license For purposes of this Chapter only, "annual license continuation fee means" the fee specified in G.S. 58-6-7 submitted to the Commissioner for each year the license is in effect after the company's year of initial licensing. The annual license continuation fee must be submitted on or before the first day of March on a form to be supplied by the Commissioner. Commissioner each year the license is to remain in effect. If the Commissioner is satisfied Upon satisfying himself that the company has met all requirements of law and appears to be financially solvent he shall forward the renewal license to the company. Any company which does not qualify for a renewal license before July 1 shall cease to do business in the State of North Carolina as of July 1, unless its license is sooner revoked by the Commissioner, solvent, the Commissioner shall not revoke or suspend the license of the company, and the company shall be authorized to do business in this State, subject to all other applicable provisions of the insurance laws of this State. Nothing contained in this section shall be interpreted as applying to licenses issued to individual representatives of insurance companies."

SECTION 26.(e) G.S. 58-6-30 reads as rewritten:

"§ 58-15-30. License, surplus, and deposit requirements.

- (a) No reciprocal shall engage in any insurance transaction in this State until it has obtained a license to do so in accordance with the applicable provisions of Articles 1 through 64 of this Chapter. Such The license shall continue in full force and effect, subject to timely payment of an annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State expire on the last day of June of each year.
- (b) No domestic or foreign reciprocal shall be licensed in this State unless it has a surplus to policyholders of at least eight hundred thousand dollars (\$800,000); and no alien reciprocal shall be licensed unless it has a trusteed surplus of at least eight hundred thousand dollars (\$800,000).
- (c) Each domestic, foreign, or alien reciprocal licensed in this State must maintain a minimum deposit with the Commissioner of at least one hundred thousand dollars (\$100,000) in cash or in value of securities of the kind specified in G.S. 58-5-15, which shall be subject to the same conditions as contained in Article 5 of this Chapter."

SECTION 26.(f) G.S. 58-19-65 reads as rewritten:

"§ 58-19-65. Revocation, suspension, or nonrenewal Revocation or suspension of insurer's license.

Whenever it appears to the Commissioner that any person has committed a violation of this Article that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an

opportunity to be heard, suspend, revoke, or refuse to renew suspend or revoke such insurer's license to do business in this State for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law."

SECTION 26.(g) G.S. 58-24-130 reads as rewritten:

"§ 58-24-130. Annual Perpetual license.

Societies which are now authorized to transact business in this State may continue such business until the 30th day of June next succeeding January 1, 1988. The authority of such societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the 30th day of the succeeding June. However, a license so issued Subject to timely payment of the annual license continuation fee and subject to any other applicable provisions of the insurance laws of this State, a license, other than a preliminary license, to a fraternal benefit society under this Article shall continue in full force and effect until the new license be issued or specifically refused. effect. For each such-license or renewal the society shall pay the Commissioner the fee specified in G.S. 58-6-5. The society shall pay the Commissioner, as an annual license continuation fee and a condition of the continuation of the license, the fee specified in G.S. 58-6-7 on or before the first day of March on a form to be supplied by the Commissioner. A duly certified copy or duplicate of such the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of Articles 1 through 64 of this Chapter."

SECTION 26.(h) G.S. 58-26-10 reads as rewritten:

"§ 58-26-10. Financial statements and licenses required.

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The license to do business in this State issued to a title insurance company shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State. The Commissioner shall annually license such companies and their agents the agents of title insurance companies."

SECTION 26.(i) G.S. 58-30-62 reads as rewritten:

"§ 58-30-62. Administrative supervision of insurers.

(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 revoked or suspended 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."

SECTION 26.(j) G.S. 58-65-55 reads as rewritten:

"§ 58-65-55. Issuance of certificate. and continuation of license.

- (a) Before issuing or continuing any such license or certificate the Commissioner may make such an examination or investigation as the Commissioner deems expedient. The Commissioner shall issue a certificate of authority or license upon the payment of an annual a fee of one thousand dollars (\$1,000) and upon being satisfied on the following points:
 - (1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.
 - (2) The rates charged and benefits to be provided are fair and reasonable.
 - (3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and hospital and medical and/or dental expenses and such reserve as the Department deems adequate, as provided hereinafter.
 - (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.
- (b) The license shall continue in full force and effect, subject to payment of an annual license continuation fee of one thousand dollars (\$1,000), subject to all other provisions of subsection (a) of this section and subject to any other applicable provisions of the insurance laws of this State."

SECTION 26.(k) G.S. 58-65-125 reads as rewritten:

"§ 58-65-125. Revocation, suspension, and refusal to renew Revocation and suspension of license; unfair trade practices.

- (a) The Commissioner may revoke, suspend, or refuse to renewrevoke or suspend the license of any service corporation if:
 - (1) The service corporation fails or refuses to comply with any law, order, or rule applicable to the service corporation.
 - (2) The service corporation's financial condition is unsound.
 - (3) The service corporation has published or made to the Department or to the public any false statement or report.
 - (4) The service corporation refuses to submit to any examination authorized by law.
 - (5) The service corporation is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.

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- Any suspension, revocation, or refusal to renew suspension or revocation of a (b) service corporation's license under this section may also be made applicable to the license or registration of any natural person regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.
- Article 63 of this Chapter applies to service corporations and their agents and representatives."

SECTION 26.(1) G.S. 58-67-140 reads as rewritten:

"§ 58-67-140. Suspension or revocation of license.

- The Commissioner may suspend, revoke, or refuse to renew suspend or revoke an HMO license if the Commissioner finds that the HMO:
 - Is operating significantly in contravention of its basic organizational (1) document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-67-10, unless amendments to such submissions have been filed with and approved by the Commissioner.
 - Issues evidences of coverage or uses a schedule of premiums for health (2) care services that do not comply with G.S. 58-67-50.
 - No longer maintains the financial reserve specified in G.S. 58-67-40 or (3) is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
 - (4) Has itself or through any person on its behalf advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.
 - (5) Is operating in a manner that would be hazardous to its enrollees.
 - Knowingly or repeatedly fails or refuses to comply with any law or (6) rule applicable to the HMO or with any order issued by the Commissioner after notice and opportunity for a hearing.
 - Has knowingly published or made to the Department or to the public **(7)** any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210."

SECTION 26.(m) G.S. 58-67-160 reads as rewritten:

"§ 58-67-160. Fees.

Every health maintenance organization subject to this Article shall pay to the Commissioner a fee of two hundred fifty dollars (\$250.00) for filing an application for a license and a-an annual license continuation fee of one thousand dollars (\$1,000) for each license renewal. license. The license shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State."

SECTION 26.(n) G.S. 58-67-20 reads as rewritten:

"§ 58-67-20. Issuance of certificate. and continuation of license.

Before issuing or continuing any such certificate, license, the Commissioner of Insurance may make such an examination or investigation as he deems expedient. The Commissioner of Insurance shall issue a eertificate of authority license upon the

payment of the application fee prescribed in G.S. 58-67-160 and upon being satisfied on the following points:

- (1) The applicant is established as a bona fide health maintenance organization as defined by this Article;
- (2) The rates charged and benefits to be provided are fair and reasonable;
- (3) The amounts provided as working capital are repayable only out of earned income in excess of amounts paid and payable for operating expenses and expenses of providing services and such reserve as the Department of Insurance deems adequate, as provided hereinafter;
- (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the eertificate—license—and that the health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. Such working capital shall initially be a minimum of one million five hundred thousand dollars (\$1,500,000) for any full service medical health maintenance organization. Initial working capital for a single service health maintenance organization shall be a minimum of one hundred thousand dollars (\$100,000) or such higher amount as the Commissioner shall determine to be adequate.
- (b) In making the determinations required under this section, the Commissioner shall consider:
 - (1) The financial soundness of the health care plan's arrangements for health care services and the schedule of premiums used in connection therewith:
 - (2) The adequacy of working capital;
 - (3) Any agreement with an insurer, a hospital or medical service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of alternative coverage in the event of discontinuance of the plan;
 - (4) Any agreement with providers for the provision of health care services; and
 - (5) Any firm commitment of federal funds to the health maintenance organization in the form of a grant, even though such funds have not been paid to the health maintenance organization, provided that the health maintenance organization certifies to the Commissioner that such funds have been committed, that such funds are to be paid to the health maintenance organization with a current fiscal year and that such funds may be used directly for operating purposes and for the benefit of enrollees of the health maintenance organization.
- (c) A certificate of authority license shall be denied only after compliance with the requirements of G.S. 58-67-155."

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 - SECTION 27. Sections 26(a) through (n) become effective January 1, 2004, and apply to all company licenses issued or otherwise eligible for renewal or continuation after that date. The remainder of this act becomes effective October 1,
- 2003. 4

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | e following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chair) for the Committee on INSURANCE. |
|-----|--|
| | Committee Substitute for B. 744 A BILL TO BE ENTITLED AN ACT TO REQUIRE INSURERS TO INFORM COVERED PERSONS ABOUT ASSISTANCE AVAILABLE FROM THE MANAGED CARE PATIENT ASSISTANCE PROGRAM. |
| X | 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) |

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
|------------|---|
| □ (H.B | Committee Substitute for . 276 A BILL TO BE ENTITLED AN ACT MAKE SUBSTANTIVE AND TECHNICAL AMENDMENTS IN THE LAWS ONCERNING INSURANCE COMPANY SOLVENCY. |
| | 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 (#), \(\subseteq \) 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) |

MINUTES

HOUSE COMMITTEE ON INSURANCE

APRIL 15,2003

The House Committee on Insurance met at 10:00 AM on April 15, 2003 with Representative Mitchell Setzer as Chair. The following members were present: Representatives Holliman, Setzer, Allen, Barbee, C. Johnson, Lewis, Ray, and Saunders.

Representative Setzer called the meeting to order and introduced the pages, Natalie Green from Charlotte, sponsored by Representative Connie Wilson, Greg Thompson from Pinehurst who was sponsored by Richard Morgan and Wells Vance from Statesville, sponsored by Representative Frank Mitchell. He then recognized the Sergeant-At-Arms: Jackson Stancil, Charles Williams and Francis Poole. See attachment I. He also introduced the new Staff Attorney, Sandra Alley, who is replacing Linda Attarian.

Chair Holliman introduced HB-560-DISAPPROVE CERTAIN LIFE INSURANCE RULES. Rep. Holliman explained the bill. See attachments two and three. Representative Saunders made a motion with a favorable report as to the committee substitute bill, unfavorable as to the original bill. It passed unanimously.

Representative Nye introduced HB-283-PROPERTY AND CASUALTY INSURANCES OMNIBUS.-AB. He explained the bill; see attachment number 4. Representative Holliman moved to amend the bill on page 2, line 19 which deletes the word "grazers" and substituting the word "graders". See attachment 5. Representative Holliman moved for a favorable report as to the committee substitute bill, unfavorable as to the original bill. It passed unanimously.

The meeting was adjourned at 10:25 AM.

| Rep. L. Hugh Holliman, Chair | - |
|---------------------------------------|---|
| Mitchell lets | - |
| Representative Mitchell Setzer, Chair | |
| - <u></u> | |
| Carol Bowers, Clerk | |
| Janua Mill | |
| Jøanna Mills, Clerk | |

SANDA Alley. Now Course C Attachment T

| HOUSE PAGES: |
|--|
| Name: NATALIE GLEO |
| Town:Charlotte |
| Sponsor: Connie Wilson |
| |
| Name: Grey Thompson |
| Town: Pinchurst |
| Sponsor: Richard Morgan |
| Wells VANCE - StateSV:'lle Frank Mitchell |

Sigt. & Arms

Johnson Stancia

Charles Williams

Francis Pools

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 560 PROPOSED COMMITTEE SUBSTITUTE H560-CSRC-21 [v.1]

4/9/2003 9:41:31 PM

| Short Title: Disapprove Certain Life Insurance Rules. (Public) |
|--|
| Sponsors: |
| Referred to: |
| March 19, 2003 |
| A BILL TO BE ENTITLED |
| AN ACT TO DISAPPROVE THE ADMINISTRATIVE RULES GOVERNING LIFE |
| INSURANCE REPLACEMENT. |
| The General Assembly of North Carolina enacts: |
| SECTION 1. Pursuant to G.S. 150B-21.3(b), the following Life Insurance |
| Replacement Rules that were adopted by the Department of Insurance and approved by |
| the Rules Review Commission on December 19, 2002, are disapproved: |
| (1) 11 NCAC 12.0601- Purpose and Scope. |
| (2) 11 NCAC 12.0602—Definition of Replacement. (3) 11 NCAC 12.0603—Other Definitions. |
| |
| (4) 11 NCAC 12.0604—Exemptions.(5) 11 NCAC 12.0605—Duties of Producers. |
| (6) 11 NCAC 12.0606—Duties of Existing Insurer. |
| (7) 11 NCAC 12.0607—Duties of Insurers That Use Producers. |
| (8) 11 NCAC 12.0608—Duties of Insurers With Respect to Direct |
| Response Sales. |
| (9) 11 NCAC 12.0609—Violations and Penalties. |
| (10) 11 NCAC 12.0611—Notice Regarding Replacement. |
| (11) 11 NCAC 12.0612—Notice Regarding Replacement. (11) 11 NCAC 12.0612—Duties of Replacing Insurers That Use Producers. |
| SECTION 2. This act is effective when it becomes law. |



HOUSE BILL 560: Diapprove Certain Life Insruance Rules

Mackment

Committee: House Insurance

Date:

April 9, 2003

Version:

Proposed Committee Substitute

H560-CSRC-21

Introduced by: Representative Holliman

Summary by:

Kory J. Goldsmith

Committee Counsel

SUMMARY: HB560 would disapprove certain rules adopted by the Department of Insurance. The act is effective when it becomes law.

CURRENT LAW: Under G.S. 150B-21.3, rules adopted by a administrative agency are not effective until

- The thirty-first legislative day of the next regular session of the General Assembly that begins at least 25 days after the date the Commission approved a rule; or
- The day of adjournment of the next regular session of the General Assembly that begins at least 25 days after the date the Commission approved the rule, which ever is the earlier.

If a bill that specifically disapproves the rule is introduced in either house of the General Assembly before the thirty-first legislative day of that session, the rule becomes effective on the earlier of either the day an unfavorable final action is taken on the bill or the day that session of the General Assembly adjourns without ratifying a bill that specifically disapproves the rule

A bill specifically disapproves a rule if it contains a provision that refers to the rule by appropriate North Carolina Administrative Code citation and states that the rule is disapproved.

See summary provided by the Frank Folger, Legislative Counsel to Department of **BILL ANALYSIS:** Insurance for explanation of why the rule needs to be disallowed.

HB560 was introduced on March 19th, well before the 31st day of the 2003 Regular Session. Therefore, if the act becomes law, the administrative rules referenced in the bill will not become effective.

The PCS adds a rule that was omitted in the introduced version.

H560-SMRC-001

attachment TAIN 3

SUMMARY OF PCS for HOUSE BILL 560 - DISAPPROVE CERTAIN LIFE INSURANCE RULES

Background

This bill is intended to disapprove certain life insurance replacement rules that the Department initially requested and which were approved by the Rules Review Commission on December 19, 2002. Life insurance replacement refers to the practice of replacing an existing life insurance policy with a new policy or cashing in an existing policy to purchase a new policy. These rules were being requested so that the Department's rules would reflect the most recent changes to the life insurance replacement rules adopted by the National Association of Insurance Commissioners. The new rules for which the Department sought approval included notice forms that were required to be used by the agent as part of the process for replacing a policyholder's existing policy. The forms are designed to notify the policyholder of the potential consequences of the replacement. Under the rules, if the agent used the form in the rules, no prior approval of the form was required. Otherwise, the form would have to be submitted to the Department for its review and approval.

During the process of seeking approval of the rules, including the forms, from the Rules Review Commission, two words were removed from one of the forms. The consequence of altering the "uniform" form was that if the rules were to go into effect, the industry would have to submit its forms for pre-approval by the Department and the Department would have to review each form submitted for approval. This result would cost the industry and the Department time and money unnecessarily.

Under the rules as they exist without the change, a sample form can be obtained from the Department. The Department and industry agree that it is better to stick with the existing rules and rerun the rules with the restored form back through the administrative rules process than impose an added administrative burden by letting the rules go into effect as scheduled.

Section 1. Would disapprove all of the life replacement rules sought by the Department and approved by the Rules Review Commission on December 19, 2002.

Section 2. Would make the act effective when it becomes law.

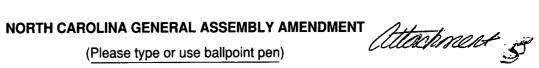
Note: The PCS added in an accidentally omitted rule from the list to be disapproved. It did nothing else.

Attachment 4

HOUSE BILL 283 – PROPERTY AND CASUALTY INSURANCE OMNIBUS/AB

Section-by-Section Bill Summary

- Section 1. Creates a new subsection (c) in G.S. 58-1-20 governing real property warranties to require that companies selling these warranties carry contractual liability insurance, as is already required of other service agreement companies.
- Section 2. Adds a new subsection (e) to G.S. 58-1-36 to require warranty companies to comply with the statutory requirements in Article 1 of Chapter 58 and subject them to the enforcement authority of the Commissioner and the Department under Article 2. This amendment will provide the Commissioner/Department with the authority to issue cease and desist orders, mandate compliance under specified times, impose civil penalties, and seize and examine records.
- Section 3. Requires motor vehicle and home appliance service agreement companies, when submitting required documentation in paper form, to do so on 81/2" x 11" format with pamphlets and brochures unbound or unstapled. This requirement will facilitate scanning and mitigate administrative time wasted.
- Section 4. Requires insurance companies, when submitting required documentation in paper form, to do so on 81/2" x 11" format with pamphlets and brochures unbound or unstapled. This requirement will again facilitate scanning and mitigate administrative time wasted.
- Section 5. Creates a new statute G.S. 58-1-40 to define "mechanical breakdown service agreement companies" and "mechanical breakdown service agreements" and to clarify that mechanical breakdown service agreement companies are subject to the requirements for motor vehicle and home appliance service agreement companies in G.S. 58-1-35 and insurance policy requirements in 58-1-36. This change is "technical" in that it clarifies by statute, definitions and rules are being applied to these companies.
- Section 6. Allows termination of a non-fleet private passenger motor vehicle insurance policy for payment with a bad check when payment is due.
- Section 7. Makes Sections 1 through 5 of the act effective October 1, 2003 and the remainder of the act effective when it becomes law.



| EDITION No. | | | |
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| н. в. No. <u>283</u> | DATE | 4/15/03 | - |
| S. B. No | | Amendment No. | As he filled in his |
| COMMITTEE SUBSTITUTE | | • | to be filled in by Principal Clerk) |
| Rep.) Sen.) | Climo_ | | |
| 1 moves to amend the bill on page | 2 | , line | 7 |
| 2 () WHICH CHANGES THE TITLE | | | 1 |
| 3 by deleting the | word gra | azers" an | <u>d</u> |
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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 283

Short Title: Property and Casualty Insurance Omnibus.-AB (Public)

Sponsors: Representative Nye.

Referred to: Insurance.

March 6, 2003

A BILL TO BE ENTITLED AN ACT TO REQUIRE REAL PROPERTY WARRANTY COMPANIES TO CARRY CONTRACTUAL LIABILITY POLICIES; REQUIRE MOTOR VEHICLE AND HOME APPLIANCE SERVICE AGREEMENT COMPANIES TO USE A SPECIFIC FORMAT ON ALL WRITTEN MATERIALS SUBMITTED; MANDATE ALL REQUIRED SUBMISSIONS TO THE DEPARTMENT OF INSURANCE TO BE IN A SPECIFIC FORMAT IF IN WRITING; REQUIRE WARRANTY COMPANIES TO COMPLY WITH ARTICLE 1 OF CHAPTER 58 OF THE GENERAL STATUTES; DEFINE MECHANICAL BREAKDOWN SERVICE AGREEMENTS AND REOUIRE ALL MECHANICAL BREAKDOWN SERVICE AGREEMENT COMPANIES TO COMPLY WITH ARTICLE 1 OF CHAPTER 58 OF THE GENERAL STATUTES AND WITH THE RULES REGARDING MOTOR VEHICLE AND HOME APPLIANCE SERVICE AGREEMENT COMPANIES; AND PROVIDE THAT A BAD CHECK CONSTITUTES NONPAYMENT OF PREMIUM OF A MOTOR VEHICLE LIABILITY INSURANCE POLICY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-1-20 is amended by adding a new subsection to read:

"(c) Real property warranty companies shall comply with the requirements of G.S. 58-1-36."

SECTION 2. G.S. 58-1-36 is amended by adding a new subsection to read:

"(e) Warranty companies, as defined in G.S. 58-1-15, 58-1-20, 58-1-25, and 58-1-30, shall comply with this section. The Commissioner may enforce compliance with this section using the provisions of Article 2 of this Chapter."

SECTION 3. G.S. 58-1-35 is amended by adding a new subsection to read:

"(m) If not submitted electronically, all contracts, literature, advertising materials, letters, and other documents submitted to the Department to comply with the filing requirements of this Chapter or an administrative rule adopted pursuant to this Chapter

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shall be submitted on paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled or bound."

SECTION 4. G.S. 58-3-150 is amended by adding a new subsection to read:

"(c) If not submitted electronically, all contracts, literature, advertising materials, letters, and other documents submitted to the Department to comply with the filing requirements of this Chapter or an administrative rule adopted pursuant to this Chapter shall be submitted on paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled or bound."

SECTION 5. Article 1 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-1-40. Mechanical breakdown service agreements.

- (a) Except as provided in subsection (c) of this section, all mechanical breakdown service agreement companies soliciting business in this State shall comply with G.S. 58-1-35 and G.S. 58-1-36.
- (b) As used in this section, "mechanical breakdown service agreement companies" include any person that issues mechanical breakdown service agreements and is not a licensed insurer, and "mechanical breakdown service agreements" are applicable to mechanized equipment, including automobiles, riding mowers, scooters, generators, farm implements, logging equipment, road grazers, bulldozers, and power equipment not licensed for road use, whether mobile or not.
- (c) This section does not apply to performance guarantees, warranties, mechanical breakdown service agreements, or motor vehicle service agreements made by:
 - (1) A manufacturer.
 - (2) A distributor.
 - (3) A subsidiary of a manufacturer or distributor."

SECTION 6. G.S. 58-37-50 reads as rewritten:

"§ 58-37-50. Termination of insurance.

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

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

 A check tendered in payment of premium that is dishonored by the bank because the account on which the check is drawn contains insufficient funds or is a closed or nonexistent account constitutes nonpayment of premium.
- (2) The named insured has become a nonresident of this State and would not otherwise be entitled to insurance on submission of new application under this Article.
- (3) A member company has terminated an agency contract for reasons other than the quality of the agent's insureds or the agent has terminated the contract and such agent represented the company in taking the original application for insurance.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

| 1. | (4) | When the insurance contract has been cancelled pursuant to a power of |
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| 2 | | attorney given a company licensed pursuant to the provisions of G.S. |
| 3 | | 58-35-5. |
| 4 | (5) | The named insured, at the time of renewal, fails to meet the |
| 5 | | requirements contained in the corporate charter, articles of |
| 6 | | incorporation, and/or bylaws of the insurer, when the insurer is a |
| 7 | | company organized for the sole purpose of providing members of an |
| 8 | | organization with insurance policies in North Carolina." |
| 9 | | TON 7. Sections 1 through 5 of this act become effective October 1, |
| 10 | 2003. The remains | inder of this act is effective when it becomes law. |
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| HOUSE | COMMITTE | ON INSURANCE |
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4/15/03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|----------------------------|
| BILL HALE | JORDAN PRICE LAW FIRM |
| Louis Belo | NC Dept. of Ins. |
| David Stoller | STATE FARM INS. COS. |
| Ken Kimon | A. I. G. |
| Robert Pasiful | Jama, Asaco |
| Steve Holfman | NCSBA |
| Chris Nichols | Heaten & williams |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
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| Committee Substitute for H.B. 560 A BILL TO BE ENTITLED AN ACT TO DISAPPROVE THE ADMINISTRATIVE RULES GOVERNING LIFE INSURANCE REPLACEMENT. |
| ☐ 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 (# |
| ☐ 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) 03/19/03 |

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. Committee Substitute for A BILL TO BE ENTITLED AN ACT TO REQUIRE REAL PROPERTY H.B. 283 WARRANTY COMPANIES TO CARRY CONTRACTUAL LIABILITY POLICIES; REQUIRE MOTOR VEHICLE AND HOME APPLIANCE SERVICE AGREEMENT COMPANIES TO USE A SPECIFIC FORMAT ON ALL WRITTEN MATERIALS SUBMITTED; MANDATE ALL REQUIRED SUBMISSIONS TO THE DEPARTMENT OF INSURANCE TO BE IN A SPECIFIC FORMAT IF IN WRITING; REQUIRE WARRANTY COMPANIES TO COMPLY WITH ARTICLE 1 OF CHAPTER 58 OF THE GENERAL STATUTES; DEFINE MECHANICAL BREAKDOWN SERVICE AGREEMENTS AND REQUIRE ALL MECHANICAL BREAKDOWN SERVICE AGREEMENT COMPANIES TO COMPLY WITH ARTICLE 1 OF CHAPTER 58 OF THE GENERAL STATUTES AND WITH THE RULES REGARDING MOTOR VEHICLE AND HOME APPLIANCE SERVICE AGREEMENT COMPANIES: AND PROVIDE THAT A BAD CHECK CONSTITUTES NONPAYMENT OF PREMIUM OF A MOTOR VEHICLE LIABILITY INSURANCE POLICY. 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 (#____ title, unfavorable as to the original bill (Committee Substitute Bill # recommendation that the committee substitute bill-#), which changes With a favorable report as to House committee substitute bill (# 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.

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 21, 2003

The House Committee on Insurance met at 5:00PM on April 21, 2003. The following Representatives were present: Hugh Holliman, Mitchell Setzer, Lucy Allen, Robert Grady, Charles Johnson, Linda Johnson, Karen Ray, Drew Saunders and Connie Wilson.

Chair Hugh Holliman called the meeting to order and called on Rep. Setzer to introduce Joe Stewart, Chief Deputy State Treasurer to speak on House Bill 1001-

SUPPLEMENTAL INSURANCE FOR RETIREES. Mr. Stewart explained the specific procedures for supplemental insurance. See attachment 1.

Tim Hovis, Staff Attorney provided the members with a summary of the bill. See attachment II. Attachment III is House Bill 1001.

Representative Saunders made the motion for a favorable report and recommended that House Bill 1001 be re-referred to the Committee on Finance. His motion passed unanimously. See Attachment IV.

The meeting was adjourned at 5:15 PM

Rep/L. Hugh Holliman, Chair

Rep. Mitchell Setzer, Chair

Carol Bowers & Joanna/Mills, Clerk's

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 1001*

Deputy State Measurer

Short Title: Supplemental Insurance for Retirees.

(Public)

Sponsors: Representatives G. Wilson and Bell (Primary

Sponsors).

Referred to: Insurance.

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR COMPETITIVE SELECTION OF CERTAIN SUPPLEMENTAL INSURANCE PRODUCTS FOR RETIRED STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 31 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-31-61. Competitive selection of retirement benefit

payment deduction supplemental insurance products paid for by retired State employees.

Duties of the Board of Trustees. - The Board of Trustees of the Teachers' and State Employees' Retirement System shall:

- (1) Review insurance products currently offered through retirement benefit payment deduction to retired State employees to determine if those products meet the needs and desires of the retired employees.
 - (2) Select the types of insurance products that reflect the needs and desires of retired State employees.
- Competitively select the best (3) insurance products of the types determined by the Department of State Treasurer and the Board of Trustees to reflect the needs and desires of the retired employees.

As used in this section, "insurance product" includes a prepaid legal services plan registered under G.S. 84-23.1.

- (b) Conflicts of Interest. The Board of Trustees shall be autonomous in its selection of insurance products and insurance companies and no member of the Board of Trustees having a conflict of interest in the selection of insurance products or insurance companies shall participate in the discussion or selection of the insurance products or insurance companies. Any decision rendered pursuant to this section by the Board of Trustees where the autonomy of the Board of Trustees or a conflict of interest is questioned shall be subject to appeal to the State Treasurer's Office pursuant to the Administrative Procedure Act.
- (c) Retirement Benefit Payment Deduction Slots. -The company or companies selected by the Board of Trustees shall be permitted to sell through retirement benefit payment

deduction only the products specifically approved by the Board of Trustees. The assignment by the Board of Trustees of a retirement benefit payment deduction slot shall be for a period of not less than two years unless the insurance company shall be in violation of the terms of the written agreement specified in this subsection. The insurance company awarded a retirement benefit payment deduction slot shall, pursuant to a written agreement setting out the rights and duties of the insurance company, be afforded an adequate opportunity to solicit retired State employees by making such retired employees aware that a representative of the company will be available at a specified time and at a location convenient to the retired employees.

Notwithstanding any other provision of the General Statutes, once a retired employee has selected an insurance product for retirement benefit payment deduction, that product may not be removed from retirement benefit payment deduction for that employee without his or her specific written consent.

When retirement benefit payment deduction is no longer available, the insurance company may not terminate life insurance products purchased under the retirement benefit payment deduction plan without the retiree's specific written consent solely because the premium is no longer deducted from retirement benefit payments.

(d) Procedure for Selection of Insurance Product
Proposals. - All insurance product proposals shall be sealed.
The Board of Trustees shall open all proposals in public and record them in the minutes of the Board of Trustees, at which time the proposals become public records open to public inspection.

After the public opening, the Board of Trustees shall review the proposals, examining the cost and quality of the products, the reputation and capabilities of the insurance companies submitting the proposals, and other appropriate criteria. The Board of Trustees shall determine which proposal, if any, would meet the needs and desires of the retired employees and shall award a retirement benefit payment deduction slot to the company submitting the proposal that meets those needs and desires. The Board of Trustees may reject any or all proposals.

A company may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. A company seeking to modify or withdraw a proposal shall submit to the Board of Trustees a written request, with facts and evidence in support of its position, prior to the award of the retirement benefit payment deduction slot, but not later than two days after the public opening of the proposals. The Board of Trustees shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(e) Committee of the Board. - The Board may designate a committee consisting of not less than five members of the Board to carry out the duties of the full Board set forth in this section. If a committee is designated to carry out the full Board's duties, it shall comply with all the provisions of this section and its determination on the award of retirement benefit payment deduction slots to companies submitting proposals shall constitute a recommendation to the full Board rather than a final decision on the award. The full Board shall either adopt or reject each of the recommendations offered by

- the committee. Board adoption of a recommendation of the committee constitutes an award of a retirement benefit payment deduction slot for purposes of this section.
- misdemeanor for any member of the Board of Trustees having a conflict of interest in the selection of insurance products or insurance companies to attempt to influence the Board of Trustees in the selection of insurance products or insurance companies knowing or having reason to know that the member has a conflict of interest in the selection of insurance products or insurance companies, or for anyone to open a sealed insurance product proposal or disclose or exhibit the contents of a sealed insurance product proposal, prior to the public opening of the proposal. The Commissioner of Insurance shall have the authority to investigate complaints alleging acts subject to the criminal penalty and shall report the Commissioner's findings to the Attorney General of North Carolina.
- (g) The Department of State Treasurer may employ clerical and professional staff and such other assistance as may be necessary to assist the Department of State Treasurer in carrying out its duties and responsibilities under this section. The administrative costs to the Department of State Treasurer of carrying out its duties and responsibilities under this section may be charged to participants or deducted from participants' accounts in accordance with nondiscriminatory procedures established by the Department of State Treasurer."
- SECTION 2. This act becomes effective January 1, 2004.



HOUSE BILL 1001: Supplemental Insurance For Retirees

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BILL ANALYSIS

Date:

Committee: House Insurance Committee

April 21, 2003

Version: House Bill 1001 Introduced by: Representatives G. Wilson and

Bell

Tim Hovis Summary by:

Committee Counsel

SUMMARY: House Bill 1001 would authorize the Board of Trustees of the Teachers and State Employees Retirement System, to do the following:

Review insurance products offered through the retirement benefit payment deduction to retired state employees.

- Select insurance products reflecting the needs of state employees.
- Competitively select insurance products to reflect the needs of retired employees.

The bill requires the Board to be autonomous in its selection of products and, if a conflict of interest arises, provides for an appeal under the Administrative Procedure Act.

Only those products authorized for sale by the Board will be submitted for benefit payment deduction by retired employees. Products may be authorized for deduction for a period of not less than two years. Once selected, an insurance product may not be removed without the consent of the employee. Insurance companies are prohibited under the act from terminating products without the retiree's consent solely because the premium in no longer deducted from the retiree's benefits.

The bill provides for a selection process, including sealed proposals opened in public and subject to public inspection. Companies may withdraw or modify a proposal only on the basis of an unintentional clerical error and must submit a written request to the Board to modify the proposal.

The Board may authorize a committee of not less than 5 Board members to carry out the duties under the bill and may submit its recommendation for approval by the Board.

The bill creates a Class 3 misdemeanor for any Board member to have a conflict of interest in the selection of insurance products and authorizes the Commissioner of Insurance to investigate complaints under the act. The Department of State Treasurer may deduct from participants' accounts the costs of carrying duties under the act.

EFFECTIVE DATE: House Bill 1001 becomes effective January 1, 2004.

Attachmen

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 1001*

Short Title: Supplemental Insurance for Retirees. (Public) Representatives G. Wilson and Bell (Primary Sponsors). Sponsors: Referred to: Insurance. April 10, 2003 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR COMPETITIVE SELECTION OF CERTAIN SUPPLEMENTAL INSURANCE PRODUCTS FOR RETIRED STATE EMPLOYEES. The General Assembly of North Carolina enacts: SECTION 1. Article 31 of Chapter 58 of the General Statutes is amended by adding a new section to read: "§ 58-31-61. Competitive selection of retirement benefit payment deduction supplemental insurance products paid for by retired State employees. 9 . Duties of the Board of Trustees. - The Board of Trustees of the Teachers' and (a) State Employees' Retirement System shall: Review insurance products currently offered through retirement (1) benefit payment deduction to retired State employees to determine if those products meet the needs and desires of the retired employees. Select the types of insurance products that reflect the needs and desires <u>(2)</u> of retired State employees. Competitively select the best insurance products of the types <u>(3)</u> determined by the Department of State Treasurer and the Board of Trustees to reflect the needs and desires of the retired employees. As used in this section, "insurance product" includes a prepaid legal services plan registered under G.S. 84-23.1. Conflicts of Interest. - The Board of Trustees shall be autonomous in its selection of insurance products and insurance companies and no member of the Board of Trustees having a conflict of interest in the selection of insurance products or insurance companies shall participate in the discussion or selection of the insurance products or insurance companies. Any decision rendered pursuant to this section by the Board of Trustees where the autonomy of the Board of Trustees or a conflict of interest is questioned shall be subject to appeal to the State Treasurer's Office pursuant to the Administrative Procedure Act.

selected by the Board of Trustees shall be permitted to sell through retirement benefit payment deduction only the products specifically approved by the Board of Trustees. The assignment by the Board of Trustees of a retirement benefit payment deduction slot shall be for a period of not less than two years unless the insurance company shall be in violation of the terms of the written agreement specified in this subsection. The insurance company awarded a retirement benefit payment deduction slot shall, pursuant to a written agreement setting out the rights and duties of the insurance company, be afforded an adequate opportunity to solicit retired State employees by making such retired employees aware that a representative of the company will be available at a specified time and at a location convenient to the retired employees.

Notwithstanding any other provision of the General Statutes, once a retired employee has selected an insurance product for retirement benefit payment deduction, that product may not be removed from retirement benefit payment deduction for that employee without his or her specific written consent.

When retirement benefit payment deduction is no longer available, the insurance company may not terminate life insurance products purchased under the retirement benefit payment deduction plan without the retiree's specific written consent solely because the premium is no longer deducted from retirement benefit payments.

(d) Procedure for Selection of Insurance Product Proposals. – All insurance product proposals shall be sealed. The Board of Trustees shall open all proposals in public and record them in the minutes of the Board of Trustees, at which time the proposals become public records open to public inspection.

After the public opening, the Board of Trustees shall review the proposals, examining the cost and quality of the products, the reputation and capabilities of the insurance companies submitting the proposals, and other appropriate criteria. The Board of Trustees shall determine which proposal, if any, would meet the needs and desires of the retired employees and shall award a retirement benefit payment deduction slot to the company submitting the proposal that meets those needs and desires. The Board of Trustees may reject any or all proposals.

A company may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. A company seeking to modify or withdraw a proposal shall submit to the Board of Trustees a written request, with facts and evidence in support of its position, prior to the award of the retirement benefit payment deduction slot, but not later than two days after the public opening of the proposals. The Board of Trustees shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(e) Committee of the Board. – The Board may designate a committee consisting of not less than five members of the Board to carry out the duties of the full Board set forth in this section. If a committee is designated to carry out the full Board's duties, it shall comply with all the provisions of this section and its determination on the award of retirement benefit payment deduction slots to companies submitting proposals shall constitute a recommendation to the full Board rather than a final decision on the award.

The full Board shall either adopt or reject each of the recommendations offered by the committee. Board adoption of a recommendation of the committee constitutes an award of a retirement benefit payment deduction slot for purposes of this section.

- Griminal Penalty. It shall be a Class 3 misdemeanor for any member of the Board of Trustees having a conflict of interest in the selection of insurance products or insurance companies to attempt to influence the Board of Trustees in the selection of insurance products or insurance companies knowing or having reason to know that the member has a conflict of interest in the selection of insurance products or insurance companies, or for anyone to open a sealed insurance product proposal or disclose or exhibit the contents of a sealed insurance product proposal, prior to the public opening of the proposal. The Commissioner of Insurance shall have the authority to investigate complaints alleging acts subject to the criminal penalty and shall report the Commissioner's findings to the Attorney General of North Carolina.
- (g) The Department of State Treasurer may employ clerical and professional staff and such other assistance as may be necessary to assist the Department of State Treasurer in carrying out its duties and responsibilities under this section. The administrative costs to the Department of State Treasurer of carrying out its duties and responsibilities under this section may be charged to participants or deducted from participants' accounts in accordance with nondiscriminatory procedures established by the Department of State Treasurer."

SECTION 2. This act becomes effective January 1, 2004.

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4-17-03 Date

Name of Committee

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|----------------------------|
| Frank Lawy | 020 M |
| FRANK FOLGER | NC DOT |
| BILL HALE | JORDAN PRICE LAW FIRM |
| DAVID Stoller | State PARM |
| John McLawhorn | Dept of State Treasurer |
| Joe Stewart | il |
| Palogis Cl.1 | abelica vanda |
| Faul Pupley | NCATZ |
| Munder | NCAHP |
| PAUL MAHONEY | |
| JENNIE JONSET | |
| DANA Can | - GARAL |

HOUSE COMMITTE ON INSURANCE

4-17-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|----------------------------|
| Survord Jones | NCHA |
| | SABon |
| PILL SCOGOIN | KCCH |
| Susan Valauri | National rese |
| Robert PASULA | Youry, Aport |
| Katherine Jaga | NCASA |
| Ken Kinion | A.I.G |
| Sayarestera | JP Assad MANNE |
| and During | NCAHP |
| Ham Dollan | NCAHP |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | e following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
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| H.I | Committee Substitute for 3. 1001 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR COMPETITIVE SELECTION OF CERTAIN SUPPLEMENTAL INSURANCE PRODUCTS FOR RETIRED STATE EMPLOYEES. |
| | |
| | With a favorable report. |
| X | 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 (#), \(\subseteq \) 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) 03/19/03 |

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 22, 2003

The House Committee on Insurance met at 10:00 AM on April 22, 2003. The following Representatives attended: Hugh Holliman, Mitchell Setzer; John Hall, Lucy Allen, Bobby Barbee, Robert Grady, Howard Hunter; Charles Johnson, Linda Johnson, David Lewis, Karen Ray, Drew Saunders, Connie Wilson, Tom Wright, Harold Brubaker and Pete Cunningham.

Chair Mitchell Setzer called the meeting to order and introduced the pages, David Welsher from Cumberland County, Sponsored by Rep. Glazier, Casey Best from Wayne County, Sponsored by Rep. Pate and Bobby Brady from Cumberland, sponsored by Rep. Glazier. He introduced the Sergeant-At-Arms, Dusty Rhodes, Charles Grady and Charles Williams. See Attachment I. He welcomed the visitors. Attachment II.

Representative Setzer recognized Representative Holliman to speak on HB-829-ANNUITY NONFORFEITURE RATE CHANGE. Representative Holliman called on Bill Hale, Attorney to explain and answer any questions. See Attachment III. Representative Barbee called for a favorable report and it passed.

Chair Setzer called on Representative Alexander to speak on HB-654-MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY. Representative Alexander encouraged this legislation that has been introduced several times in recent years. See Attachment IV. Visitors speaking in favor of the bill were: Beth Melcher, Attachment V. Sheila Singleton, Director of the Alliance for Bi-Polar Depression spoke in favor of the bill as someone suffering from mental illness. Dr. Mike ZarZar, Psychiatrist, with the North Carolina Psychologist Association spoke on the values and studies. See Attachment VI. Lisa Beam, Attorney from Mecklenburg County with MS spoke on the importance of passing this bill. Tony Muluihill talked on the cost of addiction in North Carolina. See Attachment VII. Mr. Jessie Sell, Counselor shared his personal experiences and how healthcare cost has affected him personally. See Attachment VIII.

Mr. Robert Paschal, Attorney in Wake County, who represents the insurance underwriters, spoke against the bill, as did Paul Mahoney, North Carolina Association of Health Plan. See Attachment IX.

Representative Hunter expressed his concerns of how the premiums would effect small businesses. If the cost goes up much higher he will have to go out of business.

Due to time limitations the meeting was adjourned to continue the following day, April 23, 2003 at 11:00 in Room 544, LOB.

Rep. Mitchell Setzer

Rep. Hugh Holliman

Carol Bowers & Joanna Mills, Clerks

Daniel Weisher Cumberland Rep. Glazier

Cosey Best Wound Cumberland Colazier

Bobby Brady Cumberland Colazier

Sgt at arm
Dusty Rhodes
Charles Gracly
Charles William

HOUSE INSURANCE COMMITTEE

4-22-03 Date

Name of Committee

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|-----------------|---|
| Mark Scheener | Notional MS Society 4265 Brownshow RL, Suite 150 W-S, NC 27106 |
| Kein TIII | North Carolina State Vinerity |
| Gulenne Bankut | NCAHP 5West Hurgett St Swis 310, Ralys |
| ADAM SEARING | NCHAC |
| Richard Nixon | White Horse in the Sty |
| Mai Sun | SCAMP |
| a Dune | NCAHP |
| Loyabetero | SPASSO MAMSI |
| Jahn Cyrus | n.C. Stole Grange |
| 6117aseth Green | national MS Society 2211 W. Meadowner RL SK30 Grensson nc 27407 |
| JANET MILLS | NATIONAL MULTIPLE SCERESIS SOCIETY |
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HOUSE COMMITTE ON INSURANCE

4-22-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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FIRM OR AGENCY AND ADDRESS

| DAVID STOLLER | STATE FARM INS. COS. |
|---|--|
| Steve Woodson | Nc Farm Burew |
| · • • • • • • • • • • • • • • • • • • • | |
| Elizabeth Page | National MS Society Eastern NC. 3101 Endustrial Orive mid Atlantic Raleigh, NC 27609 Central NC. |
| Barbara Grainger | Same as above |
| Barbare Censler | MFSS |
| Lu- ann Coe | NCPA |
| Robin Huffman | De Psychiatric Assoc |
| Dolores Mason | Patient 4 ms aduocate for n.m.s.s. |
| Jessie Cooper | Patent 4 M5 |
| Degane Forske | Patient W/M5 + Mental Illness 1 advocate for NM55 |
| | |

HOUSE INSURANCE COMMITTEE

4-22-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
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| 160 W . Q 1100 | Mational ms Society |
| Heather Potter | Greensburg, NC |
| Joe Donovan | NAM / Wet Multide Selecists - Earling Ne char |
| Bob Bryan | Nath Multiple Schools Society - Earling Ne chy. 3101 In Justing Dr. Rd. 27609 |
| Abby Emanuelson | NMSS |
| Anne Marie McDermott | National MS Society 9844-C Southern Rues Blud Charlotte, NC 28211 |
| Jene J Sule | Addiction Professioner of NC |
| Robert Bode | Alcohol Day Council of Me North Carolina Courseling Des Der Ha |
| mary Ann Oben, ms | NC assoc. of Practicing Psychologists |
| Kathy Goff | NMUS - Eartern NCCharter 3101 Industrial Dr. He 210 Raleyh. NC 27609 |
| Kaye Gooch | Nat'l MS Society, Ste 210 Raley AX 27609 N mss |
| Rondy Penny | NMSS 945 AN Ferry Roy F Jenton NC 28537 |
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HOUSE INSURANCE COMMITTEE 4-22-03

| Name of Committee | / Date |
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| VISITORS: PLEASE SIGN | IN BELOW AND RETURN TO COMMITTEE CLERK |
| NAME | FIRM OR AGENCY AND ADDRESS |
| Sanda Mitchell | WMSS- Lincoln Courty |
| Jeffany Harwell | NMSS- Gaston County |
| STEVE ROBERS | AARP |
| JARA LARSON | DMH/DD/SAS |
| Sully Camera | 12 Psychological Assue |
| Sheila Singlaton | NCDMDA- |
| JIM 20EDS | NWSS MID ATTACHE CHIPTER |
| Waired Boulan | MM38 Mil attente Chapter |
| Kinten Jewell | NMSS - Forsyth Canty |
| TammyHunt | NMSS- Cleveland Co. (Mid-Atlantic Chapter) |
| Kaeen Heath | National US Society-xlid-Atlantic Chapter |
| Lisa D. Beam | |
| | Notional MS Society - Mid-Atlantic Chapter Charlotte (Mek Co) |
| | Charlotte (11th 20) |

HOUSE INSURANCE COMMITTEE

4-22-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Bethn Melo her | NAMI NC |
| Janet Schonzanlor | Mc Courcil The Ar |
| Barbara Morales Burke | NC Dept, of Insurance |
| Thur Kaplan | NCAMP |
| Phil Kirk | NCCBI |
| Den Peters | Neins |
| Murood Pones | NCHA |
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B. Hale attachment III

ANNUITY NONFORFEITURE RATE CHANGE

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. The nonforfeiture value is the value of an insurance policy or annuity contract if it is cancelled or required premium payments are not paid. The nonforfeiture value also comes into play if an annuity is prematurely surrendered or if the annuity holder dies before the payments begin. In all of these circumstances, the law guarantees a minimum interest rate to the contract holder.

North Carolina's law (N.C. General Statute §58-58-60) is based on a model act of the National Association of Insurance Commissioners (NAIC). When it was enacted in 1979, 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 expected by anyone 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 prior law was high in light of very low interest rates in the economy. Insurers believed it might become possible that they simply could not obtain high enough yields on their own investments, pay for selling and administrative expenses, and still guarantee to pay consumers at least 3%.

In 2002 the General Assembly reduced the statutory minimum guaranteed rate from 3% to 1 ½%. This was based on a recommendation by the industry and the NAIC. It was hoped that this change would 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. This was intended to be a stopgap measure while the industry and the NAIC developed an interest rate index to be put into the model act. On March 7, 2003, the NAIC adopted the index to determine the minimum nonforfeiture rate. The result of the index calculation is then compared with a 3% nonforfeiture rate, and the lesser of them is used, with an absolute minimum interest rate of 1%. A large number of states changed the fixed rate from 3% to 1.5% last year. States are now beginning to put this interest rate index into their laws to replace the fixed interest rate.

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2003**

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HOUSE BILL 829*

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(Public) Short Title: Annuity Nonforfeiture Rate Change. Representatives Holliman and Setzer (Primary Sponsors). Sponsors: Referred to: Insurance. April 2, 2003 A BILL TO BE ENTITLED AN ACT TO ADOPT THE NAIC MODEL STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES. The General Assembly of North Carolina enacts: SECTION 1. Article 58 of Chapter 58 of the General Statutes is amended by adding a new section to read: "§ 58-58-61. Standard nonforfeiture law for individual deferred annuities. Title. - This section is and may be cited as the Standard Nonforfeiture Law for Individual Deferred Annuities. Applicability. - This section does not apply to any: (b) (1) Reinsurance. Group annuity purchased under a retirement plan or plan of deferred (2) compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or 14 by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as amended. Premium deposit fund. (3) Variable annuity. <u>(4)</u> Investment annuity. 20 (5) Immediate annuity. **(6)** Deferred annuity contract after annuity payments have commenced. (7) Reversionary annuity. (8) Contract delivered outside this State through an agent or other 24 (9) representative of the company issuing the contract. Nonforfeiture Requirements. - In the case of contracts issued on or after the 26 operative date of this section as defined in subsection (o) of this section, no contract of annuity, except as stated in subsection (b) of this section, shall be delivered or issued for

delivery in this State unless it contains in substance the following provisions, or

corresponding provisions that in the opinion of the Commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

- (1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of the value specified in subsections (g), (h), (i), (j), and (l) of this section.
- Other time, that upon surrender of the contract at or before the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of the amount specified in subsections (g), (h), (j), and (l) of this section. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six months after demand for the payment with surrender of the contract after making written request and receiving written approval of the Commissioner. The request shall address the necessity and equitability to all policyholders of the deferral.
- (3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits.
- (4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this subsection, a deferred annuity contract may provide that if no considerations have been received under the contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than twenty dollars (\$20.00) monthly, the company may at its option terminate the contract by payment in cash of the then-present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

(d) Minimum Values. – The minimum values specified in subsections (g), (h), (i), (j), and (l) of this section 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. The minimum nonforfeiture amount at any time at or

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before the commencement of any annuity payments shall be equal to an accumulation up to that time at rates of interest as indicated in subsection (e) of this section of the net considerations, as hereinafter defined, paid before that time, decreased by the sum of the following:

(1) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in subsection (e) of this section.

Strate State

- (2) An annual contract charge of fifty dollars (\$50.00), accumulated at rates of interest as indicated in subsection (e) of this section.
- (3) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in subsection (e) of this section.
- (4) The amount of any indebtedness to the company on the contract, including interest due and accrued.

The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87 1/2%) of the gross considerations credited to the contract during that contract year.

- (e) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:
 - (1) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one percent (0.05%), specified in the contract no longer than 15 months before the contract issue date or redetermination date under subdivision (4) of this subsection.
 - (2) Reduced by 125 basis points.
 - Where the resulting interest guarantee is not less than one percent (1%).
 - (4) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.
- (f) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subdivision (e)(2) of this section by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each subsequent redetermination date, of the additional reduction shall not exceed the market value of the benefit. The Commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Absent a demonstration that is acceptable to the Commissioner, the Commissioner may disallow or limit the additional reduction. The Commissioner may adopt rules to implement the provisions of this subsection and to provide for further adjustments to the calculation of

minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts for which the Commissioner determines adjustments are justified.

- (g) Computation of Present Value. Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.
- (h) Calculation of Cash Surrender Value. For contracts that provide cash surrender benefits, the cash surrender benefits available before maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by 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. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.
- (i) Calculation of Paid-Up Annuity Benefits. For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time before maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, the present value being calculated for the period before the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide any death benefits before the commencement of any annuity payments, present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.
- subsections (h) and (i) of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be the latest date for which election is permitted by the contract but not later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

- (k) <u>Disclosure of Limited Death Benefits. A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the commencement of any annuity payments shall include a statement in a prominent place in the contract that those benefits are not provided.</u>
- (1) Inclusion of Lapse of Time Considerations. Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.
- Proration of Values; Additional Benefits. For a contract that provides within the same contract, by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subsections (g), (h), (i), (j), and (l) of this section, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this section. The inclusion of those benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits.
- (n) Rules. The Commissioner may adopt rules to implement the provisions of this section.
- (o) Effective Date. On and after October 1, 2003, a company may elect to apply the provisions of this section to annuity contracts on a contract form-by-contract form basis before October 1, 2004. In all other instances, this section shall become operative with respect to annuity contracts issued by the company on and after October 1, 2004."

SECTION 2. G.S. 58-58-60 is repealed.

SECTION 3. G.S. 58-7-95(s) reads as rewritten:

"(s) Except for G.S. 58-58-60 G.S. 58-58-61 and G.S. 58-58-120 in the case of a variable annuity contract and contract, G.S. 58-58-55, 58-58-120, and 58-58-140(1) in the case of a variable life insurance policy policy, and except as otherwise provided in this section, all pertinent provisions of the insurance laws of this State shall this Chapter apply to separate accounts and contracts issued in connection therewith. with separate accounts. Any individual variable life insurance contract, delivered or issued for delivery within this State, shall contain reinstatement and nonforfeiture provisions appropriate to such a that contract. Any group variable life insurance contract, delivered or issued for delivery within this State, shall contain grace provisions appropriate to such a that contract. Any individual variable annuity contract, delivered or issued for

- delivery within this State, shall contain reinstatement provisions appropriate to such a that contract."
- 3 SECTION 4. Sections 2 and 3 of this act become effective October 1, 2004.
- 4 The remainder of this act becomes effective October 1, 2003.



MENTAL HEALTH/CHEMICAL **DEPENDENCY PARITY:** House Bill 654



BILL ANALYSIS

Committee: House Insurance

Date: Version: April 22, 2003 H654-CLSN-12 [v.1]

Introduced by: Reps. Alexander, Insko,

Hackney, Wainwright

Summary by:

Sandra Alley Committee Counsel

SUMMARY OF ORIGINAL BILL: House Bill 808 would mandate coverage of mental illness and chemical dependency and require that the coverage would be at full parity with covered benefits for physical illness. Health benefit plans must provide the same day and visit limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits and nay other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. The bill allows insurers to impose utilization management measures on covered benefits for mental illness and chemical dependency, even if those measures are not placed on covered benefits for physical illness. The act is effective on January 1, 2004.

THE PROPOSED COMMITTEE SUBSTITUTE adds clinical social workers, certified substance abuse counselors and licensed professional counselors to the list of providers to whom benefit payments must be made for necessary care and treatment for chemical dependency treatment as required under the Act.

CURRENT LAW: Chemical Dependency: Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. If the group policyholder accepts the coverage, the benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than \$8,000 in total annual benefits for all illnesses under the policy, it must also provide chemical dependency coverage of at least \$8,000 per year and at least \$16,000 over the lifetime of the policy.

Mental illness: Insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans. However, if the plan does provide mental health benefits, it must ensure that any lifetime and annual limits on that coverage is no less favorable than the benefits provided for physical benefits generally under the plan. Any plan that can show a 1% increase in costs as a result of this requirement can opt out of the requirement, and any plan that has 50 or fewer employees is exempt. This law expires October 1, 2001.

Self-funded plans: Plans governed by ERISA are subject to the federal Mental Health Parity Act of 1996. The Act prohibits these plans from imposing annual or lifetime dollar limits on reimbursement ceilings for mental health benefits that are more restrictive than those applied to care for physical illness. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement

MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY

Page 2

BILL ANALYSIS:

Coverage and Parity Requirements:

The proposed bill requires all insurers to cover chemical dependency benefits and mental illness benefits. Group plans are required to be in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual and lifetime dollar limits, different deductibles, copayments, or coinsurance factors, lower maximum out-of-pocket limits, or for more restrictive day and visit limits for mental illness and chemical dependency benefits than it provides for physical benefits generally under the policy

Cost Control Provisions:

Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case. Plans will meet the parity requirements in the bill if at least one of the patient's choices of treatment options within the patient's policy meets the parity requirement.

Definitions of Mental Illness and Chemical Dependency:

Chemical Dependency:

Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as the "pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal." Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines "chemically dependent" in the same manner, but the bill adds a requirement that the dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions).

Mental Illness:

Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MH/DD/SA Act defines "mental illness" as follows: "(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment. "(GS 122C-3(21)).

MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY

Page 3

Exclusions:

- Mental disorders coded in the DSM-IV as substance abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders, phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.
- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

Effective Date: January 1, 2002.

BACKGROUND: According to a study conducted by Medstat Group for the Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD, 56% of the funding for mental health and substance abuse treatment in 1997 was paid by the public sector, up from 53% in 1987. According to the same study, spending for mental health and substance abuse treatment nationwide reached \$85.3 billion in 1997. There has been a decline in private insurers' real spending for substance abuse services between 1987 and 1997 of 0.6%.

Linda Attarian, former Research Division Staff Attorney, contributed substantially to this summary.

H654-SMSP-001

Sherta Beth Melchen

allachment #

Introduce Self

Statistics tell us that 1 in 5 persons are affected by mental illness. Even higher is add substance abuse Look around this room, significant number of people

When say that usually get snickers, finger pointing To people who have mental illness, it is no laughing matter. It is devastating.

Untreated, people lose jobs, lose relationships, and cost millions in lost productivity.

The fortunate are able to get treatment, either because they have the means to pay or because they have good insurance coverage. Treatments works—people who get treatment get better. It is as effective as treatments for heart disease.

That is really what this bill is all about. Allowing people who have mental illness and chemical dependency disorders the ability to benefit from insurance coverage comparable to the coverage they receive for physical health. Quite simply, it requires that mental health and chemical dependency coverage be offered with the same dollar limits, deductibles, and co-payments as are offered for physical health policies.

We've been kicking this issue around for 10 years. And in that time, 33 states have passed parity laws. Despite dire predictions, these states do not report employers dropping insurance coverage nor significant premium increases. We now have a 10 year history offering mental health parity through the state employee health plan. Over that time, mental health payments as a portion of total health payments has decreased from 6.4% to 1.9% and cost per covered life per month has decreased from \$6.49 to \$3.59. An actuarial study done in North Carolina determined that parity would raise premiums no more than about 1.2%.

The people of North Carolina have waited a long time for this General Assembly to end insurance discrimination against mental illnesses and chemical dependency. I urge you to support this bill.

Dr. Mike ZarZar attachment TV Outline IT Thanks Sor condition heggings
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attachment VII

Parity 2003

Cost of addiction in NC \$9.4 billion

\$1.2 billion health care

\$6.7 billion lost productivity

\$1.5 billion criminal justice and other

Admissions to state psychiatric hospitals with SA diagnosis averaged 6600 per year between 1998-2000. SA admissions averaged 45% of total admissions.

Between 1993 and 2003, the Dept. of Correction added 11,356 new prison beds. 80% of people in DOC custody are there because of some alcohol or drug related crime.

Addiction is a treatable disease. It is a bi-partisan disease. Look at the White House! The way to reduce these human and economic costs is through access to health care.

Not only does lack of parity cost shift to taxpayer, it cost shifts to the little guy. He or she pays the price of lack of access with loss of employment, loss of health, loss of family, loss of freedom. The taxpayer picks up the pieces.

The only reason we don't have parity for Mental Health and Substance Abuse is the shame connected with mental illness and addiction. Ask Betty Ford, Billy Carter, Bush's niece is they can "just say 'no"

Pharmaceuticals are the main driving force behind the increase in insurance. Parity will tend to get people to treatment and with case management, reduce overall health care costs.

We also hear that the insurance industry is hurting. I read in the papers that insurance companies like Blue Cross are doing very well.

Give the taxpayers and policyholders a break. Please pass parity today!

attachment VIII

Alcohol/Drug Council of North Carolina 1-800-688-4232

Economic costs of alcohol and drug abuse - 2002

Health Care Expenditures

| | | Total | Alcohol | Drug |
|---------------------------------|---------|---------|---------|---------|
| Specialty Alcohol/Drug Servi | ices | \$407 | \$227 | \$179 |
| Medical Consequences | | \$766 | \$540 | \$226 |
| · | Sub Tot | \$1,173 | | |
| Productivity Impacts | | | | |
| Lost earnings - premature de | eath | \$1,746 | \$1,192 | \$554 |
| Lost earnings - illness | | \$3,230 | \$2,633 | \$597 |
| Lost earnings - crime/victims | ; | \$1,743 | \$247 | \$1,496 |
| | Sub Tot | \$6,718 | • | |
| Other Impacts | | | | |
| Crashes, fires, criminal justic | ce | \$1,541 | \$845 | \$696 |
| Total | | \$9,433 | | |

Cost expressed in \$millions

Alcohol/Drug Costs developed by ADCNC from "Economic Cost of Alcohol and Drug Abuse in the United States", 1995 updated estimate, National Institute of Alcoholism and Alcohol Abuse, National Institute of Health. ADCNC adjusted the national costs by the 2002 population estimate of North Carolina as a percent of the whole, and by inflating the 1995 figure by the July1, 2002 all item CPI.

These data were developed by Tony Mulvihill, Executive Director, ADCNC. Contact at tony@alcoholdrughelp.org

Paul Mahoney com Sub Collactment 1X NCANP number plans sypert heatment of newbal illness. -BCBS 23,000 Groves -ONLY 37 NO MA CARMER - CURRENT SYSTEM STRIKES A BALANTE BUTHER BREADTH OF COVERNES AND AFTERDAGUN 26 USITS - HAVE TO DO BOTH TO GET BENEFITS TO PEOPLE RYPINGS - ALL OR NOTING" CHOICE COLD BACKFIRE - BUSINESS AND HEOLTD PLANS ALREDY DUNG EVERY THING THEY CAN IN THIS ANGE. INPATIENT Thomas WRONG TIME NOW LOSTS 120 COST ESTIMATES DIFFIGURE UMRY (3%) COUPERS LYBEORD MANATES -> Apra Rucin ESS Journa 01 Common STUST: LOTS of NEW RETURNS THE WILL WIT SOMETRING 1.4 US BCBS\$34.2 MILLION BUMP IN ...Z...Z - promounts - BLISINGS ALPHADY IN COST CRISIS Employers Sitore of premium & HEALTH BENEFITS EMPLOYUES DRIPPING FAMILY CHEMIE 1 BIGGEST. PARTICIPATION PROST & APTER SALAM 3) NB 654 15 much too Broad - Bre sour TIME BULL CASSED IN AM THER STATE - CATER ALANST ALL IF THE DIMA -Complete - UNLIMITED MA CATURET - WINTED DONG 1000 2000 / ALCOHOLO BETTENENT - WEXEMPTUS SMAN BIZ J350 - NO CAP ON PREMIUM IN MESSES BM BUSINES AND HPS DUNG WHIT THEY GOB TOO THE

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

H

HOUSE BILL 654

Short Title: Mental Health/Chemical Dependency Parity. (Public)

Sponsors: Representatives Alexander, Insko, Hackney, Wainwright (Primary Sponsors); Church, Luebke, and Weiss.

Referred to: Insurance.

March 25, 2003

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.

1 2

Definitions – As used in this section, the term "chemical term:
 (1) 'Chemical dependency' means the pathological use or a

- (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 (e) of this section, benefits Benefits for treatment of chemical dependency shall be subject to the same durational limits, dellar 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

| 1 | impose limits on the chamical dependence to the state of the state of |
|----|---|
| 2 | impose limits on the chemical dependency treatment benefits based on a weighted |
| 3 | average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits |
| 4 | on the selected physical illness and injury benefits. The weighted average shall be |
| 5 | calculated in accordance with rules adopted by the Commissioner. |
| | (b2) Case Management An insurer may use a case management program for |
| 6 | chemical dependency treatment benefits to evaluate and determine medically necessary |
| 7 | and medically appropriate care and treatment for each patient, provided that the |
| 8 | program complies with rules adopted by the Commissioner. These rules shall ensure |
| 9 | that case management programs are not designed to avoid the requirements of this |
| 10 | section concerning parity between the benefits for chemical dependency treatment and |
| 11 | those for physical illness generally. |
| 12 | (b3) Medical Necessity. – Nothing in this section prohibits a group health benefit |
| 13 | plan from managing the provision of benefits through common methods, including, but |
| 14 | not limited to, preadmission screening, prior authorization of services, or other |
| 15 | mechanisms designed to limit coverage to services for chemical dependency treatment |
| 16 | only to those that are deemed medically necessary. |
| 17 | (c) Every group policy or group contract of insurance that provides benefits for |
| 18 | chemical dependency treatment and that provides total annual benefits for all illnesses |
| 19 | in excess of eight thousand dollars (\$8,000) is subject to the following conditions: |
| 20 | (1) The policy or contract shall provide, for each 12-month period, a |
| 21 | minimum benefit of eight thousand dollars (\$8,000) for the necessary |
| 22 | care and treatment of chemical dependency. |
| 23 | (2) The policy or contract shall provide a minimum benefit of sixteen |
| 24 | thousand dollars (\$16,000) for the necessary care and treatment of |
| 25 | chemical dependency for the life of the policy or contract. |
| 26 | (d) Provisions for benefits for necessary care and treatment of chemical |
| 27 | dependency in group policies or group contracts of insurance shall provide benefit |
| 28 | payments for the following providers of necessary care and treatment of chemical |
| 29 | dependency: |
| 30 | (1) The following units of a general hospital licensed under Article 5 of |
| 31 | General Statutes Chapter 131E: 131E of the General Statutes: |
| 32 | a. Chemical dependency units in <u>licensed facilities</u> ; facilities |
| 33 | licensed after October 1, 1984; |
| 34 | b. Medical units; |
| 35 | c. Psychiatric units; and |
| 36 | (2) The following facilities or programs licensed after July 1, 1984, under |
| 37 | Article 2 of General Statutes Chapter 122C: under Article 2 of Chapter |
| 38 | 122C of the General Statutes: |
| 39 | a. Chemical dependency units in psychiatric hospitals; |

Chemical dependency hospitals;

Residential chemical dependency treatment facilities;

Social setting detoxification facilities or programs;

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(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C under Article 2 of Chapter 122C of the General Statutes.

Provided, however, that nothing in this subsection shall prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

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

SECTION 2. G.S. 58-51-55 reads as rewritten:

"§ 58-51-55. No discrimination against the mentally ill and chemically dependent.dependent individuals.

- (a) Definitions. As used in this section, the term:
 - (1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.
 - (2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-5058-51-50, 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) <u>Case Management.</u> 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.
 - '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.

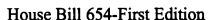
- (a) <u>Definition.</u>—As used in this section, the term 'chemical dependency' means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.
- (b) <u>Chemical Dependency Parity Requirement.</u> Every group insurance certificate or group subscriber contract under any hospital or medical plan governed by this Article and Article 66 of this Chapter that is issued, renewed, or amended on or after January 1, 1985, shall offer shall provide to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. Except as provided in subsection (c) of this section, benefits for chemical dependency shall be subject to the same durational limits,



dollar limits, deductibles, and coinsrance 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 licensed psychologist' Duly licensed psychologist' 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. 58-65-7558-65-75, 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.





Coverage of Physical Illness. - No service corporation governed by this 1 (b) Chapter shall, solely because an individual to be insured has or had a mental illness or 2 3 chemical dependency: 4 Refuse to issue or deliver to that individual any individual or group (1) 5 subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury; 6 Have a higher premium rate or charge for physical illness or injury 7 **(2)** coverages or benefits for that individual; or 8 9 Reduce physical illness or injury coverages or benefits for that (3) 10 individual. Coverage of Mental Illness. A subscriber contract that covers both physical 11 illness or injury and mental illness may not impose a lesser-lifetime or annual dollar 12 limitation on the mental health benefits than on the physical illness or injury benefits, 13 subject to the following: 14 15 (1) A lifetime limit or annual limit may be made applicable to all benefits under the subscriber contract, without distinguishing the mental health 16 17 benefits. 18 (2) If the subscriber contract contains lifetime limits only on selected 19 physical illness or injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the 20 subscriber contract, the service corporation may impose a lifetime limit on the mental health benefits that is based on a weighted average 22 23 of the respective lifetime limits on the selected physical illness and 24 injury benefits. The weighted average shall be calculated in 25 accordance with rules adopted by the Commissioner. 26 (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 28 29 subscriber contract, the service corporation may impose an annual limit on the mental health benefits that is based on a weighted average 30 of the respective annual limits on the selected physical-illness and 32 injury benefits. The weighted average shall be calculated in 33 accordance with rules adopted by the Commissioner. 34 (4) Except as otherwise provided in this section, the subscriber contract 35 may distinguish between mental illness benefits and physical injury or 36 illness benefits with respect to other terms of the subscriber contract, 37 including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity. 38 39 If the service corporation offers two or more benefit package options (5) under a subscriber contract, each package must comply with this 40 subsection.





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This subsection does not apply to a subscriber contract if the service corporation can demonstrate to the Commissioner that compliance will 1 2 3

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) <u>Definition.</u> 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) <u>Chemical Dependency Requirement.</u> 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,



| 1 | including, but | not limited to, preadmission screening, prior authorization of services, or |
|----|-------------------------------|---|
| 2 | other mechan | isms designed to limit coverage to services for chemical dependency |
| 3 | treatment only | y to those that are deemed medically necessary. |
| 4 | (c) Eve | ery group health care plan that provides benefits for chemical dependency |
| 5 | treatment-and | that provides total annual benefits for all illnesses in excess of eight |
| 6 | thousand dolla | ars (\$8,000) is subject to the following conditions: |
| 7 | (1) | The plan shall provide, for each 12 month period, a minimum benefit |
| 8 | | of eight thousand dollars (\$8,000) for the necessary care and treatment |
| 9 | | of chemical dependency. |
| 10 | (2) | The plan shall provide a lifetime minimum benefit of sixteen thousand |
| 11 | | dollars (\$16,000) for the necessary care and treatment of chemical |
| 12 | | dependency for each enrollee. |
| 13 | (d) Pro | visions for benefits for necessary care and treatment of chemical |
| 14 | dependency i | n group health care plans shall provide for benefit payments for the |
| 15 | following pro | viders of necessary care and treatment of chemical dependency: |
| 16 | (1) | The following units of a general hospital licensed under Article 5 of |
| 17 | | General Statutes Chapter 131E: Chapter 131E of the General Statutes: |
| 18 | | a. Chemical dependency units in facilities licensed after October |
| 19 | | 1, 1984; licensed facilities; |
| 20 | | b. Medical units; |
| 21 | | c. Psychiatric units; and |
| 22 | (2) | The following facilities or programs licensed after July 1, 1984, under |
| 23 | | Article 2 of General Statutes Chapter 122C: under Article 2 of Chapter |
| 24 | | 122C of the General Statutes: |
| 25 | | a. Chemical dependency units in psychiatric hospitals; |
| 26 | | b. Chemical dependency hospitals; |
| 27 | | c. Residential chemical dependency treatment facilities; |
| 28 | | d. Social setting detoxification facilities or programs; |
| 29 | | e. Medical detoxification facilities or programs; and |
| 30 | (3) | Duly licensed physicians and duly licensed practicing psychologists |
| 31 | | and certified professionals working under the direct supervision of |
| 32 | | such physicians or psychologists in facilities described in (1) and (2) |
| 33 | | above and in day/night programs or outpatient treatment facilities |
| 34 | | licensed after July 1, 1984, under Article 2 of General Statutes Chapter |

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.

122C.under Article 2 of Chapter 122C of the General Statutes.

- Coverage for chemical dependency treatment as described in this section shall not be applicable to any group that rejects the coverage in writing.
- 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



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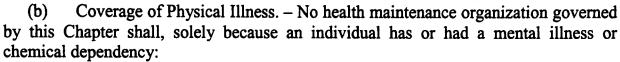


constitute compliance with the provisions of this section; and any health maintenance organization may provide that the benefits provided under this section must be obtained through providers affiliated with the health maintenance organization."

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. 58-67-70G.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.



- (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.



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| 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. |
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- (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.
- (e) 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



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- prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.
- (6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.
- (7) 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.
- (a1), (a2) Repealed by Session Laws 1999-197, s. 2.
- (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, 2004, 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. To the extent this act is in conflict with G.S. 58-50-63, this act prevails.



HOUSE INSURANCE COMMITTEE

April 22, 2003 10:00 AM Room 544 LOB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

referred to

HB 654 – Mental Health/Chemical Dependency Parity. Rep. Alexander

HB 829 – Annuity NonForfeiture Rate Change Rep. Holliman

HB-986 - MV Insurer To Disclose Financial Interest. Rep.-Lucas

MINUTES HOUSE COMMITTEE ON INSURANCE April 23, 2003

The House Committee on Insurance met at 10:00 AM on April 23, 2003. The following Representatives were present: Holliman, Setzer, Hall, Allen, Barbee, Grady, Hunter, C. Johnson, L. Johnson, Lewis, Minor, Ray, Saunders, Wainwright, Wilson, Wright, and Ex-officios Brubaker and Eddins.

Chair Holliman called the meeting to order and introduced the pages and the Sgt.-At-Arms. House Bill 654-MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY is the bill that was before the committee today. Chair Holliman recognized Representative Martha Alexander to speak on the bill. Representative Alexander called on Phil Kirk to discuss the bill. See remarks by Phil Kirk. Attachment I.

Chairman Holliman called on Paul Mahoney, Executive Director of the North Carolina Association of Health Plans to give his views on the bill. Mr. Mahoney's notes are attached. Attachment II.

The next speaker was Perri Morgan, Executive Director of NFIB. She spoke against the bill. See Attachment III.

Chairman Holliman called on Carol Lawson who strongly supports the bill. See Attachment IV.

Representative Martha Alexander went to the podium to answer any questions that the members might have. Rep. Wainwright wanted to know why there is no coverage for mental health and chemical dependency. Rep. Alexander called on Paul Mahoney. Mr. McMahoney spoke on the control of cost and limitations and stated people deserve coverage.

Page 2

Representative Alexander suggested a meeting with the opposition to negotiate and discuss a compromise. Rep. Wainwright agreed this meeting would be beneficial.

Due to time restraints, Chair Holliman adjourned the meeting at 11:05.

Rep. L. Hugh Holliman, Chair

Rep. Mitchell Setzer, Chair

Carol Bowers, Joanna Mills, Committee Clerks

Perrey Margan

NFIB Talking Points

Mental Health/Substance Abuse Mandate April 23, 2003

I represent 15,700 member small businesses in North Carolina. We don't argue the question of whether or not mental health parity – or any other mandated benefit - is a good idea. Every mandate is important to the person who needs it. What we're talking about here today is simply this: Who is going to pay for it?

For those of you who missed the ABC Nightly News last night, a new Mercer study concluded that small with Be businesses are paying premiums that average 15% more than their big business counterparts. The cost of Paying For health care is the fastest growing cost that a business has of all its fixed expenses – more than rent, utilities, inventory. In fact, recognizing that the state's small businesses are at a crisis point, last session this legislature enacted a Moratorium on Health Insurance Mandates, which goes into effect on July 1. The idea is to have an impartial third party actuarial to advise lawmakers on the actual financial costs and effects, rather than having each mandated benefit decided on an emotional basis. Until we do this, this meeting room will fill with recipients who need whatever the mandate is covering. As employers, we want to cover ourselves and our employees, but you must allow us to provide good dependable Fords Escorts to as many people as possible, rather than forcing us to provide Cadillacs to a select few who can afford it.

H0654 places an unfair burden on small business. Small businesses, who are least able to afford it, would be the <u>only</u> ones forced to comply with this mandate, since large self-insured businesses are exempt by virtue of federal ERISA guidelines.

high cost of premiums as a result of this mandated henefit. New national trends tell us that the percentage of employers who are providing insurance for their employees is dropping due to staggering cost increases – and experience with the State Employees Health Plan indicates clearly that employees will not pay for coverage themselves. Dependent coverage may also be sacrificed. Bottom line: less people will end up with the basic health coverage they need.

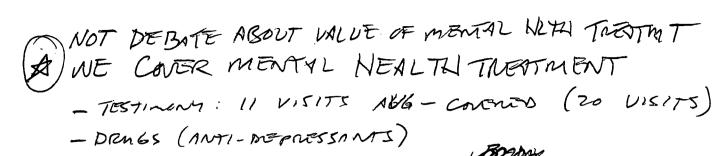
H0654 will force employers to make "all or nothing" choices. Since the language provides that only employers who are already providing health insurance must expand their policies to include this coverage, businesses will be left with no alternative but to <u>drop all health insurance altogether</u> if they are unable to afford this expensive additional mandated benefit.

make it very difficult for businesses to provide basic health benefits — but small employers want to supply the best insurance they can afford; and they need to provide benefits to remain competitive in the marketplace. Under H0654, small businesses will be forced to provide broader and more expensive health insurance than large businesses, and at a much greater cost. For many North Carolina businesses, H0654 could be the last straw.

that other states which have adopted similar measures have not experienced any detrimental cost increases – but in fact, no other state has adopted legislation as far-reaching as the bill currently before the North Carolina legislature. Its cost to small employers cannot be determined – but its effect is clear: the rolls of the uninsured will grow as a result of H064! I've keard it said that this measure will cost not him a dopinional legislature. I met with Rep. Alexander early this session about this legislation, and I told her that there are two new things service that we have to bring to the table this year: First, we have for the first time a clearly quantifiable trend that the employers are dropping coverage. Second, members who did not formerly want to identify themselves are coming forward to speak.

has opposed nextel health parity for for DAR coverige - not because They are **USA TODAY April 21, 2003** Page 1A Health costs, more than taxes, drain small businesses. Workers also feeling the pain NICEBI represents were than 2000 By Jim Hopkins USA TODAY SAN FRANCISCO -- For the first time in nearly 20 years, small businesses say soaring worker health costs, not taxes, are their biggest headache. Taxes had been No. 1 since 1986. The increase in health costs could cause more workers to lose company-sponsored insurance or shift,more of the expense to employees. impact could be wide: The nation's 5.8 million small companies employ about half of all workers. If they spend more on health care, they'll spend less on other goods. Health care costs are rising about 15% this year for employers with fewer than 200 workers vs. 13.5% for those with 500 or more, says Mercer Human Resource Consulting, Many small employers cite increases of 20% or more. That's made insurance the No. 1 small business problem, according to four months of surveys by the National Federation of Independent Business (NFIB). The higher costs come as small companies struggle to grow in a soft economy. The NFIB says 1% of firms surveyed last month plan to add workers, the lowest such figure since December 1991. Historically, small companies create most jobs, making them crucial to economic recovery. But as their health premiums climb, more are: * Eliminating benefits. About 61% of companies with fewer than 200 workers offered health coverage last year, down from 67% in 2000, says the Kaiser Family Foundation. About 99% of larger companies offer it. * Shifting costs to employees. In Atlanta, eCommSecurity's premiums soared 39% this year on top of similar increases in each of the past two years. The computer network security firm might ask its 63 employees to pay all their dental, vision and life insurance premiums, CEÓ Jeff Moore says. In the future, the company might offer coverage only for catastrophic illnesses such as cancer, and ask workers to pay for routine doctor visits. Annual deductibles paid by the 48 workers at Packaging Logic in La Porte, Ind., jumped in January to \$1,000 from \$500. That helped reduce the corrugated box maker's premium increase to 9% from an initial 18%. Also, doctor visit co-pays rose to \$20 from \$15. Near Birmingham, Ala., Concept's 11 employees are paying more for hospital visits to keep the design firm's insurance increase to 7% this year rather than a proposed 10%. Starting June 1, employees will pay part of their premiums. * Cutting overhead. Employment agency Abator in Pittsburgh has delayed upgrading computers, even though CEO Joanne Peterson knows that will slow productivity growth. Abator was socked with a 36% premium increase this year on top of 17% in 2002.

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Carol Lawson

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 654 PROPOSED COMMITTEE SUBSTITUTE H654-PCS60292-LNf-12

| | Short Title: Mental Health/Chemical Dependency Parity. | (Public) |
|----|--|---------------------------|
| | Sponsors: | |
| | Referred to: | · |
| | March 25, 2003 | |
| 1 | A BILL TO BE ENTITLED | |
| 2 | AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE COV | ERAGE FOR |
| 3 | MENTAL ILLNESS AND CHEMICAL DEPENDENCY. | |
| 4 | The General Assembly of North Carolina enacts: | |
| 5 | SECTION 1. G.S. 58-51-50 reads as rewritten: | |
| 6 | "§ 58-51-50. Coverage for chemical dependency treatment. | · |
| 7 | (a) <u>Definitions</u> As used in this section, the term "chemical term: | |
| 8 | (1) 'Chemical dependency' means the pathological use or al | buse of alcohol |
| 9 | or other drugs in a manner or to a degree that produces | |
| 0 | in personal, social or occupational functioning and w | hich may, but |
| 1 | need not, include a pattern of tolerance and withdrawal. | • |
| 2 | (2) 'Health benefit plan' has the same meaning as in G.S. 58 | -3-167. |
| 3 | (3) 'Insurer' has the same meaning as in G.S. 58-3-167. | |
| 4 | (b) Every insurer that writes a policy or contract of group or | blanket health |
| 5 | insurance or group or blanket accident and health insurance that is issue | ed, renewed, or |
| 6 | amended on or after January 1, 1985, shall offer to its insureds shall r | provide in each |
| 7 | group health benefit plan benefits for the necessary care and treatme | nt of chemical |
| 8 | dependency that are not less favorable than benefits for physical illi | ness generally. |
| 9 | Except as provided in subsection (c) of this section, benefits Benefits f | or treatment of |
| 20 | chemical dependency shall be subject to the same durational limits. | , dollar limits, |
| 21 | deductibles, and coinsurance factors limits as are benefits for physical ill | ness generally. |
| 22 | For purposes of this subsection, 'limits' includes durational limit | s, deductibles, |
| 23 | coinsurance factors, co-payments, maximum out-of-pocket limits, annu | al and lifetime |
| 24 | dollar limits, and any other dollar limits or fees for covered services. | |
| 25 | (b1) Weighted Average. – If a group health benefit plan contains | annual limits, |
| 26 | lifetime limits, co-payments, deductibles, or coinsurance only on sel | ected physical |
| 27 | illness and injury benefits, and these benefits do not represent substant | |
| 28 | physical illness and injury benefits under the health benefit plan, then t | he 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 <u>licensed facilities</u>; facilities <u>licensed after October 1, 1984;</u>
 - 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

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(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.

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(4) Duly licensed clinical social workers, duly certified substance abuse professionals, and licensed professional counselors working within the scope of practice in facilities described in subdivisions (1) and (2) of this subsection and in day/night programs or outpatient treatment facilities licensed under Article 2 of Chapter 122C of the General Statutes.

Provided, however, that nothing in this subsection shall prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

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

SECTION 2. G.S. 58-51-55 reads as rewritten:

"§ 58-51-55. No discrimination against the mentally ill and chemically dependent.dependent individuals.

- (a) Definitions. As used in this section, the term:
 - (1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.
 - (2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-5058-51-50, 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.
 - '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) <u>Definition.</u> 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 coinstance 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.

| 1 | (d) Provi | sions for benefits for necessary care and treatment of chemical |
|----|------------------|---|
| 2 | | group certificates or group contracts shall provide for benefit payments |
| 3 | for the followin | g providers of necessary care and treatment of chemical dependency: |
| 4 | . (1) | The following units of a general hospital licensed under Article 5 of |
| 5 | | General Statutes Chapter 131E: Chapter 131E of the General Statutes: |
| 6 | | a. Chemical dependency units in facilities licensed after October |
| 7 | | 1, 1984; licensed facilities; |
| 8 | | b. Medical units; |
| 9 | | c. Psychiatric units; and |
| 10 | (2) | The following facilities or programs licensed after July 1, 1984, under |
| 11 | | Article 2 of General Statutes Chapter 122C:under Article 2 of Chapter |
| 12 | | 122C of the General Statutes: |
| 13 | | a. Chemical dependency units in psychiatric hospitals; |
| 14 | | b. Chemical dependency hospitals; |
| 15 | | c. Residential chemical dependency treatment facilities; |
| 16 | | d. Social setting detoxification facilities or programs; |
| 17 | | e. Medical detoxification facilities or programs; and |
| 18 | (3) | Duly licensed physicians and duly licensed psychologists and certified |
| 19 | | professionals working under the direct supervision of such physicians |
| 20 | | or psychologists in facilities described in (1) and (2) above and in |
| 21 | | day/night programs or outpatient treatment facilities licensed after July |
| 22 | | 1, 1984, under Article 2 of General Statutes Chapter 122C.under |
| 23 | | Article 2 of Chapter 122C of the General Statutes. After January 1, |
| 24 | | 1995, "duly licensed psychologist Duly licensed psychologist shall be |
| 25 | | defined as means licensed psychologists who hold permanent licensure |
| 26 | | and certification as health services provider psychologist issued by the |
| 27 | | North Carolina Psychology Board. |
| 28 | <u>(4)</u> | Duly licensed clinical social workers, duly certified substance abuse |
| 29 | | professionals, and licensed professional counselors working within the |
| 30 | | scope of practice in facilities described in subdivisions (1) and (2) of |
| 31 | | this subsection and in day/night programs or outpatient treatment |
| 32 | | facilities licensed under Article 2 of Chapter 122C of the General |
| 33 | | Statutes. |
| 34 | Provided, how | ever, that nothing in this subsection shall prohibit any certificate or |
| 35 | contract from r | equiring the most cost effective treatment setting to be utilized by the |
| 36 | _ | ing necessary care and treatment for chemical dependency. |
| 37 | | rage for chemical dependency treatment as described in this section shall |
| 38 | not be applicab | ole 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:

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| 1 | (1) | 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); |
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| 2 | | and G.S. 122C-3(21), with a mental disorder defined in the Diagnostic |
| 3 | | and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent |
| 4 | | edition published by the American Psychiatric Association, except |
| 5 | | those mental disorders coded in the DSM-IV or subsequent edition as |
| 6 | | substance-related disorders (291.0 through 292.9 and 303.0 through |
| 7 | | 305.9) and those coded as 'V' codes. |
| 8 | (2) | 'Chemical dependency' has the same meaning as defined in G.S. |
| 9 | | 58-65-7558-65-75, with a mental disorder defined in the Diagnostic |
| 10 | | and Statistical Manual of Mental Disorders, DSM-IV, or subsequent |
| 11 | | editions of this manual. |
| 12 | with a diagnos | is found in the Diagnostic and Statistical Manual of Mental Disorders |
| 13 | | e International Classification of Diseases ICD/9/CM, or a later edition of |
| 14 | those manuals. | |
| 15 | (b) Cove | erage of Physical Illness No service corporation governed by this |
| 16 | | solely because an individual to be insured has or had a mental illness or |
| 17 | chemical depen | · |
| 18 | (1) | Refuse to issue or deliver to that individual any individual or group |
| 19 | () | subscriber contract in this State that affords benefits or coverage for |
| 20 | | medical treatment or service for physical illness or injury; |
| 21 | (2) | Have a higher premium rate or charge for physical illness or injury |
| 22 | (-7 | coverages or benefits for that individual; or |
| 23 | (3) | Reduce physical illness or injury coverages or benefits for that |
| 24 | (0) | individual. |
| 25 | (bl) Cove | erage of Mental Illness. A subscriber contract that covers both physical |
| 26 | | y and mental illness may not impose a lesser lifetime or annual dollar |
| 27 | | ne mental health benefits than on the physical illness or injury benefits, |
| 28 | subject to the fo | |
| 29 | J | A lifetime limit or annual limit may be made applicable to all benefits |
| 30 | (-) | under the subscriber contract, without distinguishing the mental health |
| 31 | | benefits: |
| 32 | (2) | If the subscriber contract contains lifetime limits only on selected |
| 33 | (-) | physical illness or injury benefits, and these benefits do not represent |
| 34 | | substantially all of the physical illness and injury benefits under the |
| 35 | | subscriber contract, the service corporation may impose a lifetime |
| 36 | | limit on the mental health benefits that is based on a weighted average |
| 37 | | of the respective lifetime limits on the selected physical illness and |
| 38 | | injury benefits. The weighted average shall be calculated in |
| 39 | | accordance with rules adopted by the Commissioner. |
| 40 | (3) | If the subscriber contract contains annual limits only on selected |
| 41 | (5) | physical illness and injury benefits, and these benefits do not represent |
| 42 | | substantially all of the physical illness and injury benefits under the |
| 43 | | subscriber contract, the service corporation may impose an annual |
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limit on the mental health benefits that is based on a weighted average

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| of the | respective | annu | al limits o | n the sele | ected p | hysic | al illness | ane |
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| injury | benefits. | The | weighted | average | shall | -be- | calculated | in |
| accord | ance with r | ules a | dopted by t | he Comm | issione | r. | | |

(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.

" called the transfer to be a south or the delication at the

- (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) <u>Definition.</u> 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) <u>Chemical Dependency Requirement.</u> 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 |
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| 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.

(4) Duly licensed clinical social workers, duly certified substance abuse professionals, and licensed professional counselors working within the scope of practice in facilities described in subdivisions (1) and (2) of this subsection and in day/night programs or outpatient treatment facilities licensed 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 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.
 - 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70G.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."

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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) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.
 - (7) 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.
 - (a1), (a2) Repealed by Session Laws 1999-197, s. 2.
- (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, 2004, 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. To the extent this act is in conflict with G.S. 58-50-63, this act prevails.



MENTAL HEALTH/CHEMICAL **DEPENDENCY PARITY:**

House Bill 654

Committee: House Insurance

Introduced by: Reps. Alexander, Insko,

Date:

April 22, 2003

Hackney, Wainwright

Version:

H654-CLSN-12 [v.1]

Summary by:

Sandra Alley Committee Counsel

SUMMARY OF ORIGINAL BILL: House Bill 808 would mandate coverage of mental illness and chemical dependency and require that the coverage would be at full parity with covered benefits for physical illness. Health benefit plans must provide the same day and visit limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits and nay other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. The bill allows insurers to impose utilization management measures on covered benefits for mental illness and chemical dependency, even if those measures are not placed on covered benefits for physical illness. The act is effective on January 1, 2004.

THE PROPOSED COMMITTEE SUBSTITUTE adds clinical social workers, certified substance abuse counselors and licensed professional counselors to the list of providers to whom benefit payments must be made for necessary care and treatment for chemical dependency treatment as required under the Act.

CURRENT LAW: Chemical Dependency: Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. If the group policyholder accepts the coverage, the benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than \$8,000 in total annual benefits for all illnesses under the policy, it must also provide chemical dependency coverage of at least \$8,000 per year and at least \$16,000 over the lifetime of the

Mental illness: Insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans.

Self-funded plans: Plans governed by ERISA are subject to the federal Mental Health Parity Act of 1996. The Act prohibits these plans from imposing annual or lifetime dollar limits on reimbursement ceilings for mental health benefits that are more restrictive than those applied to care for physical illness. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement

MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY

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BILL ANALYSIS:

Coverage and Parity Requirements:

The proposed bill requires all insurers to cover chemical dependency benefits and mental illness benefits. Group plans are required to be in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual and lifetime dollar limits, different deductibles, copayments, or coinsurance factors, lower maximum out-of-pocket limits, or for more restrictive day and visit limits for mental illness and chemical dependency benefits than it provides for physical benefits generally under the policy

Cost Control Provisions:

Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case. Plans will meet the parity requirements in the bill if at least one of the patient's choices of treatment options within the patient's policy meets the parity requirement.

Definitions of Mental Illness and Chemical Dependency:

• Chemical Dependency:

Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as the "pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal." Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines "chemically dependent" in the same manner, but the bill adds a requirement that the dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions).

Mental Illness:

Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MH/DD/SA Act defines "mental illness" as follows: "(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment. "(GS 122C-3(21)).

MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY

Page 3

Exclusions:

- Mental disorders coded in the DSM-IV as substance abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders, phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.
- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

Effective Date: January 1, 2004.

BACKGROUND: According to a study conducted by Medstat Group for the Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD, 56% of the funding for mental health and substance abuse treatment in 1997 was paid by the public sector, up from 53% in 1987. According to the same study, spending for mental health and substance abuse treatment nationwide reached \$85.3 billion in 1997. There has been a decline in private insurers' real spending for substance abuse services between 1987 and 1997 of 0.6%.

Linda Attarian, former Research Division Staff Attorney, contributed substantially to this summary.

H654-SMSP-002

VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

4-23-03 Date

Name of Committee

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|----------------------------|
| BILL HALE | DROAN PRICE LAW FIRM |
| Robert PASchal | Young, Appre |
| Pru mitanzy | NCAMP |
| Jaia LARSE | Dntt/OD/SAS |
| Dong Palse | DMH/DD/SAS |
| Tong Mulville | & DCN C |
| J. Crucken | UHS |
| ANN LORE | DVYS |
| Carolelawen | EGNS |
| Sally Cameron | NC Psychological Acses |
| BaluMelcher | NAWI NC |
| Robin Hofman | NC Paychiatric |

VISITOR REGISTRATION SHEET

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MINUTES

HOUSE INSURANCE COMMITTEE

April 24, 2003

The House Committee on Insurance met at 10:00 AM on April 24, 2003 with Representative Setzer as the Chair. The following representatives were present: Holliman, Setzer, Allen, Barbee, Hunter, C. Johnson, Lewis, Ray, Saunders, Wainwright, Wilson, and Wright.

Chair Setzer called the meeting to order and introduced the pages, Jay Hawley, Austin Branch and Meagan Hawley and the Sergeant-At-Arms, Martha Gadison, Jackson Stancil and Charles Williams.

Chair Setzer called on Representative Martha Alexander to explain HB-822-HEALTH INSURANCE COVERAGE/EARLY INTERVENTION. Rep. Alexander spoke on why the legislation is needed. See Attachment I. Karen Chester, Executive Director of the NC Interagency Coordinating Council. She addressed the issue of cost and who pays. House Bill 822 was displaced due to an amendment to come from Rep. C. Wilson.

The Chair called on Rep. Wright to speak on HB-339-LIFE AND HEALTH INSURANCE OMNIBUS.-AB. Rep. Wright asked staff to which they deferred to Frank Folger, DOI to explain all fourteen sections. See Attachment II. After much discussion Rep. Saunders made a motion for a favorable report, committee substitute passes the committee.

The Chair calls on Rep. Wright to explain the changes in the committee substitute in HB-208-MANAGED CARE/HLTH BENEFITS CLARIFYING-AB. After much discussion, Rep. Wainwright made a motion for a favorable report; committee substitute passes the committee.

The meeting was adjourned at 1055 AM.

Rep. Mitchell Setzer, Chair

Rep. Hugh Holliman, Chair

Carol Bowers, Joanna Mills, Clerks



HOUSE BILL 822:



Health Insurance Coverage/Early Intervention

Committee: House Insurance Committee

Date:

April 24, 2003

Version:

House Bill 822

Introduced by: Representatives Alexander and

Warren

Summary by:

Tim Hovis

Committee Counsel

SUMMARY: House Bill 822 would require all health benefit plans and preferred provider benefit plans that provide benefits for sickness, illness, or disability of a minor child or that provide medical treatment or service to a minor child to provide coverage for medically necessary early intervention services for children ages birth to 36 months.

To be eligible for early intervention services, the child must meet the eligibility requirements established by the Department of Health and Human Services.

Coverage under the bill must:

- Provide services that are part of the Individualized Family Services Plan (limited to not more than \$5,000 annually and not more than \$15,000 over the three year eligibility period.).
- Be provided by a certified early intervention specialist.
- Be provided only for those services not covered by Medicaid or other public assistance.

EFFECTIVE DATE: House Bill 822 becomes effective January 1, 2004 and applies to plans issued or renewed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2003**

H

HOUSE BILL 822

Short Title: Health Insurance Coverage/Early Intervention.

| | Sponsors: | Representatives Alexander, Warren (Primary Sponsors); Insko, Weiss, and Goodwin. |
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| | Referred to: | Insurance. |
| | | April 1, 2003 |
| 1 | | A BILL TO BE ENTITLED |
| 2 | AN ACT T | O REQUIRE HEALTH BENEFIT PLANS TO COVER MEDICALLY |
| 3 | NECESS | ARY EARLY INTERVENTION SERVICES FOR CHILDREN FROM |
| 4 | BIRTH ' | TO THREE YEARS OF AGE WHO ARE COVERED UNDER THE |
| 5 | PLAN. | |
| 6 | The General | Assembly of North Carolina enacts: |
| 7 | SI | ECTION 1. Article 51 of Chapter 58 of the General Statutes is amended by |
| 8 | adding the fo | ollowing new section to read: |
| 9 | " <u>§ 58-51-36</u> | . Coverage for early intervention services to children from birth to |
| 10 | | ree years of age. |
| 11 | | efinitions As used in this section, unless the context clearly requires |
| 12 | otherwise, th | |
| 13 | <u>(1</u> | |
| 14 | | and toddlers required by the Individuals with Disabilities Education |
| 15 | | Act (IDEA), P.L. 105-17, as codified in 20 U.S.C.§ 1400, et seq., and |
| 16 | | applied and implemented in accordance with rules adopted by the |
| 17 | | Secretary of the North Carolina Department of Health and Human |
| 18 | | Services. |
| 19 | <u>(2</u> | |
| 20 | <u>(3</u> | |
| 21 | | Individuals with Disabilities Education Act (IDEA), P.L. 105-17, as |
| 22 | | codified in 20 U.S.C.§ 1400, et seq., and applied and implemented in |
| 23 | | accordance with rules adopted by the Secretary of the North Carolina |
| 24 | | Department of Health and Human Services. |
| 25 | <u>(4</u> | |
| 26 | | otwithstanding G.S. 58-50-63, every health benefit plan issued by an |
| 27 | | every preferred provider benefit plan under G.S. 58-50-56 that provides |
| 28 | benefits for | any sickness, illness, or disability of any minor child or that provides |

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| benefits for any medical treatment or service furnished by a health care provider or |
|--|
| institution to any minor child shall provide coverage for medically necessary early |
| intervention services for children ages birth to 36 months who are eligible for these |
| services and who are otherwise covered under the health benefit plan. A child is eligible |
| for early intervention services if the child is between the ages of birth to 36 months and |
| meets the eligibility requirements established in rules adopted by the Secretary of the |
| North Carolina Department of Health and Human Services. Coverage for early |
| intervention services shall be as follows: |
| |

- (1) Services that are not otherwise covered by the health benefit plan and are part of the child's Individualized Family Services Plan. Benefits payable for the services provided under this subdivision may be limited to not more than five thousand dollars (\$5,000) annually and not more than fifteen thousand dollars (\$15,000) over the three-year eligibility period, per child covered. These limits shall be in addition to any annual or lifetime limits applicable under the health benefit plan.
- (2) Covered services shall be provided by a certified early intervention specialist in accordance with rules adopted by the Secretary of the North Carolina Department of Health and Human Services.
- (4) Coverage is required under this section only for those early intervention services not covered by Medicaid or other public assistance program for which the child is eligible."

SECTION 2. G.S. 58-50-155(a) reads as rewritten:

"§ 58-50-155. Standard and basic health care plan coverages.

- (a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:
 - (1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.
 - (2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.
 - (3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.
 - (4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.
 - (5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.
 - (6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

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<u>(7)</u> Coverage of medically necessary early intervention services for children eligible for these services at least equal to the coverage required by G.S. 58-51-36.

SECTION 3. This act becomes effective January 1, 2004, and applies to health benefit plans and preferred provider plans issued or renewed on and after that date.



HOUSE BILL 339: Life and Health Omnibus-AB



BILL ANALYSIS

Committee: House Insurance Date:

April 15, 2003

Version: PCS H339-PCS 8026/ Introduced by: Rep. Wright

Summary by: Linda Attarian

Committee Counsel

SUMMARY: House Bill 339 makes numerous substantive and technical changes to laws governing the regulation of insurance including:

Conforms Article 56 of Chapter 58 governing third party administrators, to the National Association of Insurance Commissioners (NAIC) model act on third party administrators. SECTIONS 1.1-1.12.

Amends G.S. 58-58-145 which defines group annuity contracts, to require the insurer of such contracts to issue individual certificates of coverage to each annuitant. SECTION 2.

Amends current disclosure requirements regarding the solicitation of life insurance products and annuities. SECTION 3-3.7.

Amends G.S. 58-58-75 which gives a principle or an employer an insurable interest in the life or physical ability of an employee or agent, to require insurers to notify employees of the existence of such policies. SECTION 4.

Amends G.S. 58-51-80 which defines group accident and health insurance, to require that association premium rates for accident and health insurance be actuarially sound and that associations be rated as a single group when the coverage provided is not employer-based. SECTION 5.

Amends G.S. 58-51-95 to limit an insurer's ability to use an individual's own claims' experience to increase the individual's renewal rates on individual health insurance policies. SECTION 6.

Amends G.S. 58-65-60 governing subscribes' contracts, to exempt a sole proprietor or owner or operator of a business from the full-time basis or the 30-hour workweek requirements to be eligible for large group health coverage like the proprietor's full-time employees. SECTIONS 7 - 7.2.

Amends G.S. 58-50-150 to shorten the membership on the Small Employer Health Reinsurance Pool Board Amendments from nine to six. SECTION 10.

Amends G.S. 58-54-45 governing the issuance of Medicare Supplement Plans by reason of disability, to require insurer to allow persons retroactively enrolled in Medicare Part B the same six-month open enrollment period for Medicare Supplemental Plans as person enrolled in Medicare Part B without a retroactive effective date of coverage. SECTION 11

Adds a new section to Article 3 to require health benefit plans to provide coverage for designated travel expenses when the required distance traveled threshold is met. SECTION 13

Makes other clarifying and technical changes.

The act (except for sections 10-12) becomes effective January 1, 2004. Sections 10, 11, and 12 (which include technical corrections) become effective when the act becomes law.

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BILL ANALYSIS: Frank Folger, from the Department of Insurance provided the following section-by-section explanation.

PART I. THIRD PARTY ADMINISTRATOR REWRITE (Sections 1 –1.12). This part adopts the NAIC model statute, which provides reciprocity, among other benefits.

Section 1. Repeals the existing definitions section for Article 56 – Third Party Administrators-G.S. 58-56-2.

Section 1.1 enacts new G.S. 58-56-2 with revised and expanded definitions. Added terms include "insurance producer", "nonresident administrator" and "Uniform Application".

Section 1.2 makes technical clarifying changes to the wording of G.S. 58-56-6., governing the written agreement requirements.

Section 1.3 rewrites and reorganizes portions of G.S. 58-56-16 regarding Commissioner access to third party administrator (TPA) books and records and adds new subsections (e) through (i) to:

- Provide that TPA records and books in the possession or control of the Commissioner are confidential and privileged, not public record, not subject to discovery, not subject to subpoena, and inadmissible in evidence in any private civil action; and provide that immunity from testifying on the documents applies to the Commissioner and anyone receiving that material while acting under the authority of the Commissioner.
- Provide that the Commissioner can share such material with and receive such material
 from other state, federal and international regulatory and law enforcement agencies and the
 NAIC, provided it is agreed the confidentiality and privilege will be maintained; and can
 enter into agreements governing the sharing of such material consistent with the rules in
 that subsection.
- Provide that disclosure by the Commissioner does not constitute waiver of the privilege or claim of confidentiality;
- Clarify that the confidentiality and privilege requirements do not restrict the Commissioner from releasing final adjudicated action including for cause terminations.

Section 1.4. Repeals the existing TPA licensing statute.

Section 1.5. Enacts new G.S. 58-56-52. Home state certificate of authority or license. This new statute:

- Provides for licensure or issuance of a certificate of authority by a TPA's home state (as defined in G.S. 58-56-3) upon application using the Uniform Application and submission of a \$100 filing fee. The Uniform Application must include or be accompanied by designated organizational documents, bylaws and internal regulatory documents, NAIC Biographical Affidavits for the officers, directors and all individuals responsible for the conduct of the affairs of the applicant, audited financial statements, a description of the business plan of the TPA, and any other pertinent information.
- Requires the TPA to provide for inspection and examination by the Commissioner all TPA
 contracts with insurers or others using the TPA's services and all accounts, records and
 files.
- Authorizes the Commissioner to refuse to issue a certificate of authority or license to a TPA upon determining that the TPA or any individual responsible for conducting the affairs of the TPA:

Page 3

- □ Is not competent
- Is not trustworthy
- □ Is not financially responsible
- ☐ Is not of good personal and business reputation
- Has had an insurance or an administrator certificate of authority or license denied or revoked for cause by any jurisdiction
- Or upon determining that any of the grounds for denial, suspension or revocation of a certificate of authority under G.S. 58-56-72 exists.
- Provides for the perpetuity of a license or certificate of authority.
- Requires the TPA to notify the Commissioner of any material change in change of ownership, control, or other fact or circumstance affecting its qualification for a certificate of authority or license and requires the Commissioner to notify the producer database maintained by the NAIC or its affiliates or subsidiaries.

Section 1.6. Repeals the existing provision on waiver of application for license, G.S. 58-56-56.

Section 1.7. Enacts new G.S.58-56-57. Registration requirement, to require any person underwriting, collecting charges or premiums from, or adjusting or settling claims on NC residents in connection with a self-funded plan for life, health or annuity coverage to register annually with the Commissioner.

Section 1.8. Enacts new G.S. 58-56-62 to require each TPA licensed under G.S. 58-56-52 to file an annual report, including an independent CPA-audited financial report verified by at least two officers of the TPA with contents and format as prescribed by the Commissioner. The annual report must include the names and addresses of all the insurers with which the TPA has contracted in the past fiscal year and must be submitted along with an annual \$100 filing fee. The Commissioner must review the annual report before September 1 of each year and either certify that, according to the annual report, the TPA has a positive net worth and is in good standing, or note any deficiencies found in the annual report; or update the aforementioned NAIC electronic database consistent with the Commissioner's review and assessment.

Section 1.9. Repeals existing G.S. 58-56-66 Grounds for suspension or revocation of license. Section 1.10. Enacts new G.S. 58-56-67. Nonresident administrator certificate of authority, which:

- Requires any TPA performing TPA services in N.C. that does not carry a N.C. license or certificate of authority to file a Uniform Application with the Commissioner accompanied by certificate or license from the TPA's home state and that state has adopted the NAIC Third Party Administrator Statute or substantially similar laws governing TPAs in order to obtain a nonresident administrator certificate of authority for N.C.
- Requires a \$100 filing fee as part of the application process.
- Subject the nonresident TPA to examination of its accounts, records, and files by the Commissioner.
- Exempts from the requirements of a nonresident certificate of authority nonresident TPAs that only perform administrator services on a group policy or plan with no more 100 insureds residing in N.C.

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• Authorizes the Commissioner to refuse to issue a nonresident certificate of authority if the Commissioner determines that events or information obtained following the licensure of the TPA in its home state, the TPA cannot satisfy the requirements of Article 56 or grounds exist for the home state's suspension or revocation of the TPA's license or certificate.

Section 1.11. Enacts new G.S. 58-56-72 to require denial, suspension or revocation of certificate of authority if the Commissioner finds the TPA:

- Is financially unsound
- Is using methods or practices rendering its future transactions hazardous or injurious to insured persons or the public.
- Has failed to pay any judgment rendered against it in N.C. within 60 days after the judgment has become final.

The Commissioner, after notice and hearing, may deny, suspend, or revoke the certificate of authority or license if the Commissioner finds the TPA:

- Has violated any lawful rule or order of the Commissioner or any provision of the N.C. insurance laws.
- Or any person or entity exercising control of the TPA has refused to cooperate with examination by the Commissioner.
- Has, without cause, refused to pay proper claims or fulfill its contractual obligations.
- Fails to satisfy, at any time, the conditions upon which the license or certificate of authority was initially granted.
- Or any of the individuals responsible for the conduct of the TPA enters a plea or guilt or nolo contendere or is found guilty of a felony.
- Is under suspension or revocation in another state.
- Has failed to timely file its annual report pursuant to G.S. 58-56-62 if a resident TPA or its statement and filing fee, as applicable, if a nonresident administrator.

The Commissioner may without advance notice or hearing, immediately suspend the certificate of authority or license if the Commissioner finds that one or more of the following circumstances exist:

- The TPA is insolvent or impaired.
- A proceeding for receivership, rehabilitation or other delinquency proceeding has been instituted in any state.
- The TPA's financial condition or business practices pose an imminent threat to the public health, safety or welfare of N.C. citizens.

The Commissioner may impose a fine in lieu of suspension or revocation.

Section 1.12. Prohibits acting as a TPA in N.C. without a resident certificate of authority or a non-resident certificate of authority.

PART II. GROUP ANNUITY CONTRACTS

Section 2. Amends G.S. 58-58-145 requires group annuity insurers to issue certificates of coverage to each annuitant via the policyholder on a form approved by the Commissioner.

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PART III. DISCLOSURES FOR ANNUITIES AND LIFE INSURANCE

Sections 3. through 3.7. Adopts the new NAIC models on Annuity, Home Service Life Insurance and Small Face Amount Life Insurance Disclosure and updates our current life insurance disclosure provisions in Article 60 of Chapter 58 to reflect the current NAIC Life Insurance Disclosure model act.

This Part reorganizes Article 60 to create a life insurance and annuity product disclosure article, with separate parts for each different product disclosure requirement. Each model specifically addresses disclosure requirements to assist the consumer when making a purchasing decision by requiring notice of the feature, including potentially negative aspects of each product. For example:

- (1) Sellers of small face life insurance (insurance with a face amount less than \$15,000) would have to disclose up front that premiums paid-in could exceed the face value of the policy, if that is a possibility at any time;
- (2) Sellers of life insurance through the home service distribution system must disclose whether the policyholder is allowed to change the method of premium payment, whether the policyholder can combine multiple policies from the same company or its affiliates or subsidiaries into one policy and what the impact, if any, such a consolidation would have regarding underwriting, waiting periods, contestable periods and the like, and they would have to provide and maintain evidence of payment of premiums; and
- (3) Sellers of annuities would have to provide to the applicant for an annuity a copy of the NAIC Model Guide to Fixed Deferred Annuities and a disclosure document, containing information on the insurer, specifics of the contract including its long-term nature, the specific amount of charges applicable to the contract, and information on the variability of guaranteed rates and the current guaranteed rate.

PART IV. EMPLOYER OWNED LIFE INSURANCE DISCLOSURE

Section 4. Amends G.S. 58-58-75 to require employers that purchase life insurance policies on the lives of their employees for the benefit of the employer to disclose that practice to its employees within 30 days of the effective date a provider who has appropriate expertise, and each panel reviewing a second-level grievance involving a noncertification or a clinical issue shall include of the coverage and, if applicable, that these employer-owned life insurance (sometimes referred to a COLI for "corporate-owned life insurance") polices can be maintained after the employment has terminated..

Part V. Requires association group accident and health premium rates to be actuarially sound and to rate associations as a single group when the coverage is not employer based.

This Part reorganizes Article 60 to create a life insurance and annuity product disclosure article, with separate parts for each different product disclosure requirement. Each model specifically addresses disclosure requirements to assist the consumer when making a purchasing decision by requiring notice of the potentially negative aspects of each product. For example: sellers of small

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face life insurance (insurance with a face amount less than \$15,000) would have to disclose that premiums paid in could exceed the face value of the policy.

Part IV. EMPLOYER-OWNED LIFE INSURANCE DISCLOSURE

Section 4. Amends G.S. 58-58-75 to require employers that purchase life insurance policies on the lives of their employees for the benefit of the employer to disclose that practice to its employees within 30 days of the effective date of the coverage and, if applicable, that these employer-owned life insurance (sometimes referred to as COLI for "corporate-owned life insurance") policies can be maintained after the employment has terminated.

Part V. ACTUARIALLY SOUND ASSOCIATION GROUP ACCIDENT AND HEALTH PREMIUM RATES

Section 5. Amends G.S. 58-51-80 to requires association group accident and health premium rates to be actuarially sound and to rate associations as a single group when the coverage is not employer based in order to prevent reunderwriting practices in which insurers are re-rating individual members in (non-employer based) associations as single one man groups each, rather than using the entire association's experience to determine renewal rates.

Part VI. INDIVIDUAL ACCIDENT AND HEALTH INSURANCE RENEWAL RATE LIMITATIONS

Section 6. Amends G.S. 58-51-95 to limits an individual accident and health insurer's ability to increase an individual's renewal rate based on the individual's health status-related factors including: health status; medical condition (including both physical and mental illnesses); claims' experience; duration from issue; receipt of health care; medical history; or genetic information.

Part VII. LARGE GROUP HEALTH INSURANCE SOLE PROPRIETOR EXEMPTION

Sections 7. -7.2. Amend G.S. 58-65-60, 58-67-85, and 58-51-80(c) to exempt, for large group health insurance (more than 50 employees), a sole proprietor or owner or operator of a business from the full-time basis or 30 hour workweek requirements in order to be eligible for the same coverage provided to the sole proprietor's employees.

Part VIII. NEWBORN COVERAGE REINSTATEMENT

Section 8. Amends 58-51-30(b) to correct an oversight in a 2001 enactment and again apply newborn coverage provisions to a more comprehensive list of insurance lines rather than just major medical insurance. Before the 2001 Session, newborn coverage requirements applied to generally all types of health insurance coverage that provided coverage to children. When changes were made in the 2001 session to expand coverage to provide for foster and adopted children, an erroneous reference was made to G.S. 58-3-167 and thus coverage requirements were inadvertently limited to apply only to major medical health coverages. This amendment would return coverage to its status before the 2001 error.

Part IX. LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES TECHNICAL CORRECTIONS

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Section 9. Amends G.S. 58-51-15(a) (2)b. and 58-51-15(h) to technically correct a definitional problem regarding pre-existing conditions as applied to limited health, supplemental health, and specified disease policies. HB 760 in the 2001 Session corrected an "unintended consequence" which threatened the availability of limited health, supplement health and specified disease policies. This availability problem was caused by earlier legislation imposing portability requirements on these policies and subjecting them to the same pre-existing conditions rules as other health insurance policies. In correcting the availability problem, HB 760 created a different problem in the form of a definitional gap for "pre-existing condition" respecting these policies. This amendment technically fixes this new problem.

Part X. SMALL EMPLOYER HEALTH REINSURANCE POOL BOARD AMENDMENTS

Section 10. Shortens the membership on the Board from nine to six members as it has become difficult to find persons willing to serve on the Board.

Part XI. EQUITABLE ENROLLMENT PERIOD FOR SUPPLEMENTAL MEDICARE PLANS

Section 11. Amends G.S. 58-54-45(a) to allows persons retroactively enrolled in Part B Medicare 6 months to enroll in Medicare Supplement Plans A, C, and J after notice of the retroactive enrollment decision so they are not penalized or precluded from enrolling in those plans. This proposal would assist persons who are eligible for Medicare retroactively. These persons are always disabled under age 65 and by virtue of the retroactive enrollment miss the deadline for open enrollment for Medicare Supplement Plans. This amendment provides that in the case of retroactive enrollment, the Medicare beneficiary should be entitled to a six-month open enrollment for Medicare Supplement Plans, beginning with the month the beneficiary receives notice of the retroactive enrollment, so that the beneficiary is entitled to the same period for enrollment in supplement plans like everyone else who becomes eligible due to a disability.

Part XII. REVOCATION AND SUSPENSION TECHNICAL CORRECTION

Section 12. Amends G.S. 58-3-100(c) to technically correct the revocation and suspension law to include "beneficiary of a life or annuity contract" as a claimant to clarify said beneficiary's entitlement to the acknowledgement of a claim within 30 days of receipt.

Part XIII. HEALTH BENEFIT PLAN TRAVEL EXPENSES COVERAGE

Section 13. Creates a new G.S. 58-3-270 to mandate health benefit plan coverage for certain travel expenses associated with obtaining care when the person must travel more than 250 miles, one way, to obtain treatment. This amendment codifies a long standing Department policy that health benefit plans provide coverage for certain travel expenses for an insured, and a parent/guardian if the insured is a child, when the insurer requires the person to travel a significant distance from their home to obtain in-network care.

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Part XIV. CREDIT INSURANCE AMENDMENT

Sections 14. Through 14.4. Amends G.S. 58-57-5, 58-57-50(b), 58-57-55, 58-57-60, and 58-57-110 in Article 57 (Credit Insurance) to codify Departmental policy or to clarify statutory requirements. The amendments:

- (1) Define "critical period coverage" This is a definition presently permitted by the Department.
- (2) Allow credit card credit insurance to be provided through out-of-state insurance contracts (consistent with existing market conditions) Credit card coverages are almost exclusively provided through out-of-state contracts because the large credit card companies are not located in North Carolina. This amendment will allow the continued availability of this type of insurance in North Carolina;
- (3) Set an appropriate refund method for decreasing term credit life insurance;
- (4) Require acknowledgement of credit insurance claims not paid within 60 days Currently there are no provisions in the credit insurance provisions to require acknowledgement of a claim. This would bring credit insurance in uniformity with other lines regarding acknowledgement of a claim; and
- (5) Allow a requirement of registration with the state unemployment office for involuntary unemployment benefits under a credit unemployment policy but prohibit the placing of a deadline for that registration or qualification for state unemployment benefits to qualify for the insurance benefits Some Involuntary Unemployment Insurance (IUI) insurers have submitted forms that require an insured to register with the state unemployment office within 15 or 30 days of the loss of employment in order to qualify for credit involuntary unemployment benefits under the coverage. This deadline for registering would restrict payment of an otherwise valid claim. This amendment prohibits IUI insurers from imposing a deadline for registration with the state unemployment office, prohibits conditioning benefits upon qualification for state unemployment benefits but allows a requirement of registration (without deadline) with the state unemployment office in order to qualify for benefits.

PART XV. EFFECT OF HEADINGS, SEVERABILITY AND EFFECTIVE DATES

Sections 15 through 15.2. These sections contain a proviso on the naming of headings for parts, contain a severability clause, make sections 1 through 8, 9, 9.1, 13, and 14 through 14.4 effective January 1, 2004 and the remainder of the act effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

H

HOUSE BILL 339 PROPOSED COMMITTEE SUBSTITUTE H339-PCS80261-RM-17

| Short Title: | Life and Health Insurance OmnibusAB | (Public) |
|--------------|-------------------------------------|----------|
| Sponsors: | | |
| Referred to: | | |

March 6, 2003

A BILL TO BE ENTITLED 1 NORTH CAROLINA'S THIRD CONFORM 2 AN ACT TO ADMINISTRATOR ARTICLE TO REVISIONS TO THE NAIC MODEL THIRD 3 PARTY ADMINISTRATOR STATUTE; REQUIRE GROUP 4 INSURERS TO ISSUE INDIVIDUAL CERTIFICATES OF COVERAGE TO 5 EACH ANNUITANT; REORGANIZE ARTICLE 60 OF CHAPTER 58 OF THE 6 AMEND **CURRENT** DISCLOSURE **GENERAL STATUTES** AND 7 REQUIREMENTS FOR SOLICITATION OF LIFE INSURANCE PRODUCTS 8 AND ANNUITIES; REQUIRE INSURERS TO NOTIFY EMPLOYEES OF THE 9 EXISTENCE OF EMPLOYER-OWNED LIFE INSURANCE POLICIES WITHIN 10 THIRTY DAYS AFTER THE EFFECTIVE DATE OF COVERAGE; REQUIRE 11 THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH 12 INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE 13 RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT 14 EMPLOYER-BASED; LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH 15 INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS' EXPERIENCE TO 16 DEVELOP THE INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE 17 PROPRIETOR FROM THE FULL-TIME BASIS OR THIRTY-HOUR 18 WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP 19 HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES; 20 CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER TO 21 REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP 22 OF INSURERS; TECHNICALLY CORRECT AN OMISSION REGARDING 23 PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED 24 HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; 25 DECREASE THE TOTAL NUMBER OF MEMBERS THAT SERVE ON THE 26 SMALL EMPLOYER REINSURANCE POOL BOARD FROM NINE TO SIX; 27 ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B 28

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THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE; TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT; MANDATE HEALTH BENEFIT COVERAGE FOR DESIGNATED TRAVEL EXPENSES WHEN THE REQUIRED DISTANCE TRAVELED THRESHOLD IS MET; AND MAKE TECHNICAL CORRECTIONS TO THE CREDIT INSURANCE LAWS.

The General Assembly of North Carolina enacts:

PART I. THIRD PARTY ADMINISTRATOR ACT REWRITE

SECTION 1. G.S. 58-56-2 is repealed.

SECTION 1.1. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-3. Definitions.

As used in this Article:

- "Administrator", "third party administrator", and "TPA" mean a person who directly or indirectly underwrites, collects, or charges premiums from, or adjusts or settles claims on, residents of this State in connection with life, annuity, or health coverage offered or provided by an insurer, except any of the following:
 - a. An employer, or a wholly owned direct or indirect subsidiary of an employer, on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer.
 - b. A union on behalf of its members.
 - c. An insurer that is authorized to transact insurance in this State pursuant to Articles 1 through 67 of this Chapter.
 - d. An insurance producer licensed to sell life, annuity, or health coverage in this State, whose activities are limited exclusively to the sale of insurance.
 - e. A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.
 - f. A trust and its trustees, agents, and employees acting pursuant to a trust established in conformity with 29 U.S.C. § 186.
 - g. A trust exempt from taxation under section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to the trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which meets the requirements of section 401(f) of the Internal Revenue Code.
 - h. A credit union or a financial institution that is subject to supervision or examination by federal or State banking

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| 1. | | | authorities, or a mortgage lender, to the extent it collects and |
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| 2 . | | | remits premiums to licensed insurance producers or to limited |
| 3 | | | lines producers or authorized insurers in connection with loan |
| 3 | | | payments. |
| 5 | | <u>i.</u> | A credit card issuing company that advances for and collects |
| 6 | | | insurance premiums or charges from its credit card holders who |
| 7 | | | have authorized collection. |
| 8 | | <u>i.</u> | A person who adjusts or settles claims in the normal course of |
| 9 | | _ | that person's practice or employment as a licensed attorney and |
| 10 | | | who does not collect charges or premiums in connection with |
| 11 | | | life, annuity, or health coverage. |
| 12 | | <u>k.</u> | An adjuster licensed by this State whose activities are limited to |
| 13 | | | adjustment of claims. |
| 14 | | <u>l.</u> | A person licensed as a managing general agent in this State, |
| 15 | | | whose activities are limited exclusively to the scope of activities |
| 16 | | | conveyed under the license. |
| 17 | | <u>m.</u> | An administrator who is affiliated with an insurer and who only |
| 18 | | | performs the contractual duties (between the administrator and |
| 19 | | | the insurer) of an administrator for the direct and assumed |
| 20 | | | insurance business of the affiliated insurer. The insurer is |
| 21 | | | responsible for the acts of the administrator and is responsible |
| 22 | | | for providing all of the administrator's books and records to the |
| 23 | | | Commissioner, upon a request from the Commissioner. |
| 24 | <u>(2)</u> | <u>"Affi</u> | liate or affiliated" means an entity or person who directly or |
| 25 | | indire | ectly, through one or more intermediaries, controls or is controlled |
| 26 | | | r is under common control with, a specified entity or person. |
| 27 | <u>(3)</u> | "Con | missioner" means the Commissioner of Insurance of this State. |
| 28 | <u>(4)</u> | "Con | trol" means the term as defined in G.S. 58-19-5(2). |
| 29 | <u>(5)</u> | <u>"GA</u> | AP" means United States generally accepted accounting principles |
| 30 | | consi | stently applied. |
| 31 | <u>(6)</u> | <u>"Hon</u> | ne state" means the District of Columbia and any state or territory |
| 32 | | of th | e United States in which an administrator is incorporated or |
| 33 | | main | tains its principal place of business. If neither the state in which |
| 34 | | the a | dministrator is incorporated nor the state in which it maintains its |
| 35 | | princ | ipal place of business has adopted the NAIC Third Party |
| 36 | | Adm | inistrator Statute, or a substantially similar law governing |
| 37 | | <u>admi</u> | nistrators, the administrator may declare another state in which it |
| 38 | | condi | ucts business to be its "home state". |
| 39 | <u>(7)</u> | | rance producer" means a person who sells, solicits, or negotiates |
| 40 | • | a con | tract of insurance as those terms are defined in this Article. |
| 41 | <u>(8)</u> | <u>"Insu</u> | rer" means an insurance company subject to this Chapter, a |
| 42 | . •- | servi | ce corporation organized under Article 65 of this Chapter, a health |
| 43 | | | tenance organization organized under Article 67 of this Chapter, |

| | | · · · · · · · · · · · · · · · · · · · |
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| 1 | | and a multiple employer welfare arrangement subject to Article 49 of |
| 2 | | this Chapter. |
| 3 | <u>(9)</u> | "Negotiate" means the act of conferring directly with, or offering |
| 4 | | advice directly to, a purchaser or prospective purchaser of a particular |
| 5 | | contract of insurance concerning any of the substantive benefits, terms, |
| 6 | | or conditions of the contract, provided that the person engaged in that |
| 7 | | act either sells insurance or obtains insurance from insurers for |
| 8 | | purchasers. |
| 9 | (10) | "Nonresident administrator" means a person who is applying for |
| 10 | | licensure or is licensed in any state other than the administrator's home |
| 11 | | state. |
| 12 | <u>(11)</u> | "Person" means an individual or a business entity. |
| 13 | <u>(12)</u> | "Sell" means to exchange a contract of insurance by any means, for |
| 14 | | money or its equivalent, on behalf of an insurance company. |
| 15 | <u>(13)</u> | "Solicit" means attempting to sell insurance or asking or urging a |
| 16 | | person to apply for a particular kind of insurance from a particular |
| 17 | | company. |
| 18 | <u>(14)</u> | "Underwrites" or "underwriting" includes the acceptance of employer |
| 19 | | or individual applications for coverage of individuals in accordance |
| 20 | | with the written rules of the insurer or self-funded plan and also |
| 21 | | includes the overall planning and coordinating of a benefits program. |
| 22 | <u>(15)</u> | "Uniform Application" means the current version of the NAIC |
| 23 | | Uniform Application for Third Party Administrators." |
| 24 | | FION 1.2. G.S. 58-56-6 reads as rewritten: |
| 25 | | itten agreement necessary. |
| 26 | | PA may act as a TPA without a written agreement between the TPA and |
| 27 | | e written agreement shall be retained as part of the official records of |
| 28 | both the insure | r and the TPA for the duration of the agreement and for five years |
| 29 | | agreement shall contain all provisions required by this Article, to the |
| 30 | | uirements apply to the functions performed by the TPA. except insofar |
| 31 | | ments do not apply to the functions performed by the TPA. |
| 32 | (b) The a | greement shall include a statement of duties that the TPA is expected to |
| 33 | | alf of the insurer and the kinds of insurance the TPA is to be authorized |
| 34 | to administer. lir | nes, classes, or types of insurance for which the TPA is to be authorized |

- to administer. The agreement shall provide for underwriting or other standards pertaining to the business underwritten by the insurer.
- The insurer or TPA may, with written notice, terminate the written agreement for cause as provided in the agreement. The insurer may suspend the underwriting authority of the TPA during the pendency of any dispute regarding the cause for termination of the agreement. The insurer must shall fulfill any lawful obligations with respect to policies affected by the agreement, regardless of any dispute between the insurer and the TPA."

SECTION 1.3. G.S. 58-56-16 reads as rewritten:

"§ 58-56-16. Records to be kept.

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(a) Every TPA shall maintain and make available to the insurer complete books and records of all transactions performed on behalf of the insurer. The books and records shall be maintained in accordance with prudent standards of insurance record keeping and must be maintained for a period of at least five years after the date of their creation.

- (b) The Commissioner shall have access to books and records maintained by a TPA for the purposes of examination, audit, and inspection. The Commissioner shall keep confidential any trade secrets contained in those books and records, including the identity and addresses of policyholders and certificate holders, except that the Commissioner may use the information in any judicial or administrative proceeding instituted against the TPA.
- (c) The insurer shall own the records generated by the TPA pertaining to the insurer, but the TPA shall retain the right to continuing access to books and records to permit the TPA to fulfill all of its contractual obligations to insured parties, claimants, and the insurer.
- (d) In the event the insurer and the TPA cancel their agreement, notwithstanding the provisions of subsection (a) of this section, the TPA may, by written agreement with the insurer, transfer all records to a new TPA rather than retain them for five years. In this case, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA as required in subsection (a) of this section.
- TPA for the purposes of examination, audit, and inspection. Any documents, materials, or other information in the possession or control of the Commissioner that are furnished by a TPA, insurer, insurance producer, or an employee or agent thereof acting on behalf of the TPA, insurer, or insurance producer, or obtained by the Commissioner in an investigation shall be confidential by law and privileged, shall not constitute a public record as defined by G.S. 132-1, shall not be subject to subpoena, shall not be subject to discovery, and shall not be admissible in evidence in any private civil action. However, the Commissioner is authorized to use such documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.
- (f) Neither the Commissioner nor any person who receives documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (e) of this section.
- (g) In order to assist in the performance of the Commissioner's duties, the Commissioner:
 - (1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (e) of this section, with other State, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates, or its subsidiaries, and with State, federal, and international law enforcement authorities, provided

that the recipient agrees to maintain the confidentiality and privileged 1 status of the document, material, or other information; 2 May receive documents, materials, or information, including otherwise 3 (2) confidential and privileged documents, materials, or information, from 4 the National Association of Insurance Commissioners, its affiliates, or 5 its subsidiaries, and from regulatory and law enforcement officials of 6 other foreign or domestic jurisdictions and shall maintain as 7 confidential or privileged any document, material, or information 8 received with notice or the understanding that it is confidential or 9 privileged under the laws of the jurisdiction that is the source of the 10 document, material, or information; and 11 May enter into agreements governing sharing and use of information 12 (3) consistent with this subsection. 13 No waiver of any applicable privilege or claim of confidentiality in the 14 (h) documents, materials, or information shall occur as a result of disclosure to the 15 Commissioner under this section or as a result of sharing as authorized in subsection (g) 16 of this section. 17 Nothing in this Article shall prohibit the Commissioner from releasing final, 18 adjudicated actions including for-cause terminations that are open to public inspection 19 pursuant to Chapter 132 of the General Statutes or to a database or other clearinghouse 20 service maintained by the National Association of Insurance Commissioners, its 21 affiliates, or its subsidiaries." 22 **SECTION 1.4.** G.S. 58-56-51 is repealed. 23 SECTION 1.5. Article 56 of Chapter 58 of the General Statutes is amended 24 by adding a new section to read: 25 "§ 58-56-52. Home state certificate of authority or license. 26 A person shall apply to be a TPA in its home state upon the Uniform 27 Application and shall receive a certificate of authority or license from the Commissioner 28 of its home state prior to performing any function of a TPA in this State. Each 29 application shall be accompanied by a nonrefundable filing fee of one hundred dollars 30 (\$100.00). 31 The Uniform Application shall include or be accompanied by the following 32 (b) information and documents: 33 All basic organizational documents of the applicant, including any 34 (1) articles of incorporation, articles of association, partnership agreement, 35 trade name certificate, trust agreement, shareholder agreement, and 36 other applicable documents and all amendments to those documents. 37 The bylaws, rules, regulations, or similar documents regulating the 38 <u>(2)</u> internal affairs of the applicant. 39 NAIC Biographical Affidavit for the individuals who are responsible 40 (3) for the conduct of affairs of the applicant, including all members of the 41 board of directors, board of trustees, executive committee, or other 42 governing board or committee; the principal officers in the case of a 43 corporation or the partners or members in the case of a partnership,

- association, or limited liability company; any shareholders or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities, or voting interest of the applicant; and any other person who exercises control or influence over the affairs of the applicant.
- Audited annual financial statements or reports for the two most recent fiscal years that prove that the applicant has a positive net worth. If the applicant has been in existence for less than two fiscal years, the Uniform Application shall include financial statements or reports, certified by an officer of the applicant and prepared in accordance with GAAP, for any completed fiscal years and for any month during the current fiscal year for which the financial statements or reports have been completed. The applicant shall also include any other information the Commissioner requires in order to review the current financial condition of the applicant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include all of the following:
 - <u>a.</u> Amounts shown on the consolidated audited financial report shall be shown on the worksheet.
 - b. Amounts for each entity shall be stated separately.
 - c. Explanations of consolidating and eliminating entries.
- (5) A statement describing the business plan including information on staffing levels and activities proposed in this State and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping, and underwriting.
- (6) Any other pertinent information required by the Commissioner.
- (c) A TPA licensed or applying for licensure under this section shall make available for inspection by the Commissioner copies of all contracts with insurers or other persons utilizing the services of the TPA.
- (d) A TPA licensed or applying for licensure under this section shall produce its accounts, records, and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the Commissioner.
- (e) The Commissioner may refuse to issue a certificate of authority or license if the Commissioner determines that the TPA, or any individual responsible for the conduct of affairs of the TPA, is not competent, trustworthy, financially responsible, or of good personal and business reputation, has had an insurance or an administrator certificate of authority or license denied or revoked for cause by any jurisdiction, or if the Commissioner determines that any of the grounds set forth in G.S. 58-56-72 exists with respect to the TPA.

- (f) A certificate of authority or license issued under this section shall remain valid, unless surrendered, suspended, or revoked by the Commissioner, for so long as the TPA continues in business in this State and remains in compliance with this Article.
- (g) A TPA licensed or applying for licensure under this section shall immediately notify the Commissioner of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a certificate of authority or license in this State. The Commissioner shall report any such changes to the producer database maintained by the NAIC or affiliates or subsidiaries of the NAIC."

SECTION 1.6. G.S. 58-56-56 is repealed.

SECTION 1.7. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-57. Registration requirement.

A person who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this State in connection with life, annuity, or health coverage provided by a self-funded plan shall register with the Commissioner annually, verifying its status as herein described in a format prescribed by the Commissioner."

SECTION 1.8. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-62. Annual report and filing.

- (a) Each TPA licensed under G.S. 58-56-52 shall file an annual report for the preceding calendar year with the Commissioner on or before July 1 of each year or within such extension of time as the Commissioner for good cause may grant. The annual report shall include an audited financial statement performed by an independent certified public accountant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the information required under G.S. 58-56-52(b)(4)a. through c. The report shall be in the form and contain such matters as the Commissioner prescribes and shall be verified by at least two officers of the TPA.
- (b) The annual report shall include the complete names and addresses of all insurers with which the administrator had agreements during the preceding fiscal year.
- (c) At the time of filing its annual report, the administrator shall pay a nonrefundable filing fee of one hundred dollars (\$100.00).
- (d) The Commissioner shall review the most recently filed annual report of each administrator on or before September 1 of each year. Upon completion of its review, the Commissioner shall either:
 - (1) Issue a certification to the administrator that the annual report shows that the administrator has a positive net worth as evidenced by audited financial statements and is currently licensed and in good standing, or noting any deficiencies found in the annual report and financial statements; or
 - (2) Update any electronic database maintained by the National Association of Insurance Commissioners, or its affiliates or subsidiaries, indicating that the annual report shows that the

administrator has a positive net worth as evidenced by audited financial statements and is in compliance with existing law, or noting any deficiencies found in the annual report."

SECTION 1.9. G.S. 58-56-66 is repealed.

SECTION 1.10. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-67. Nonresident administrator certificate of authority.

- (a) Unless a TPA has obtained a home state certificate of authority or license in this State under G.S. 58-56-52, any TPA who performs administrator duties in this State shall obtain a nonresident administrator certificate of authority or license in accordance with this section by filing with the Commissioner the Uniform Application accompanied by a letter of certification from the home state of the TPA. In lieu of requiring a TPA to file a letter of certification with the Uniform Application, the Commissioner may verify the nonresident administrator's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.
- (b) A TPA shall not be eligible for a nonresident administrator certificate of authority or license under this section if it does not hold a certificate of authority as a resident in a home state that has adopted the NAIC Third Party Administrator Statute or a substantially similar law governing TPAs.
- (c) Except as provided in subsections (b) and (h) of this section, the Commissioner shall issue to the TPA a nonresident administrator certificate of authority or license promptly upon receipt of a complete application.
- (d) Unless notified by the Commissioner that the Commissioner is able to verify the nonresident TPA's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, or its affiliates or subsidiaries, each nonresident TPA annually shall file a statement that its home state administrator certificate of authority or license remains in force and has not been revoked or suspended by its home state during the preceding year. The statement required by this subsection shall be filed by November 1 each year.
- (e) At the time of filing the statement required under subsection (d) of this section or if the Commissioner has notified the nonresident administrator that the Commissioner is able to verify the nonresident administrator's home state certificate of authority or license status through an electronic database, the nonresident TPA shall pay, no later than November 1, a nonrefundable filing fee of one hundred dollars (\$100.00).
- (f) A TPA licensed or applying for licensure under this section shall produce its accounts, records, and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the Commissioner.
- (g) A nonresident TPA is not required to hold a nonresident administrator certificate of authority or license in this State if the TPA's duties in this State are limited to the administration of a group policy or plan of insurance and no more than a total of 100 persons insured for all plans reside in this State.

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SECTION 1.11. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-72. Grounds for denial, suspension, or revocation of certificate of authority.

- (a) The certificate of authority or license of a TPA shall be denied, suspended, or revoked if the Commissioner finds that the TPA:
 - (1) Is in an unsound financial condition;
 - (2) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this State hazardous or injurious to insured persons or the public; or
 - (3) Has failed to pay any judgment rendered against it in this State within 60 days after the judgment has become final.
- (b) The Commissioner may, after notice and opportunity for hearing, deny, suspend, or revoke the certificate of authority or license of a TPA if the Commissioner finds that the TPA:
 - (1) Has violated any lawful rule or order of the Commissioner or any provision of the insurance laws of this State;
 - Has refused to be examined or to produce its accounts, records, and files for examination, or if any individual responsible for the conduct of affairs of the TPA has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination when required by the Commissioner, including:
 - <u>a.</u> <u>Members of the board of directors, board of trustees, executive committee, or other governing board or committee;</u>
 - b. The principal officers in the case of a corporation or the partners or members in the case of a partnership, association, or limited liability company;
 - c. Any shareholder or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities, or voting interest of the TPA; and

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| 1 | | d. Any other person who exercises control or influence over the |
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| 2 | | affairs of the TPA; |
| 3 | (3) | Has, without just cause, refused to pay proper claims or perform |
| 4 | 1 | services arising under its contracts or has, without just cause, caused |
| 5 | | covered individuals to accept less than the amount due them or caused |
| 6 | | covered individuals to employ attorneys or bring suit against the TPA |
| 7 | | to secure full payment or settlement of such claims; |
| 8 | <u>(4)</u> | Fails, at any time, to meet any qualification for which issuance of the |
| 9 | 1/ | certificate could have been refused had the failure then existed and |
| 10 | | been known to the Commissioner; |
| 11 | <u>(5)</u> | Or any of the individuals responsible for the conduct of its affairs has |
| 12 | | been convicted of, or has entered a plea of guilty or nolo contendere to, |
| 13 | | a felony without regard to whether adjudication was withheld, |
| 14 | | including: |
| 15 | | a. Members of the board of directors, board of trustees, executive |
| 16 | | committee or other governing board or committee; |
| 17 | | b. The principal officers in the case of a corporation or the |
| 18 | | partners or members in the case of a partnership, association, or |
| 19 | | limited liability company; |
| 20 | | c. Any shareholder or member holding directly or indirectly ten |
| 21 | | percent or more of its voting stock, voting securities, or voting |
| 22 | | interest; and |
| 23 | | d. Any other person who exercises control or influence over its |
| 24 | | <u>affairs;</u> |
| 25 | <u>(6)</u> | Is under suspension or revocation in another state; or |
| 26 | <u>(7)</u> | Has failed to timely file its annual report pursuant to G.S. 58-56-62 if a |
| 27 | | resident administrator or its statement and filing fee, as applicable, |
| 28 | | pursuant to G.S. 58-56-67(d) and (e) if a nonresident administrator. |
| 29 | | Commissioner may, without advance notice or hearing, immediately |
| 30 | suspend the cer | tificate of authority or license of a TPA if the Commissioner finds that |
| 31 | one or more of | the following circumstances exist: |
| 32 | <u>(1)</u> | The TPA is insolvent or impaired. |
| 33 | <u>(2)</u> | A proceeding for receivership, conservatorship, rehabilitation, or other |
| 34 | | delinquency proceeding regarding the TPA has been commenced in |
| 35 | | any state. |
| 36 | <u>(3)</u> | The financial condition or business practices of the TPA otherwise |
| 37 | | pose an imminent threat to the public health, safety, or welfare of the |
| 38 | | residents of this State. |
| 39 | | Commissioner finds that one or more grounds exist for the suspension |
| 40 | | f a certificate of authority issued under this part, the Commissioner may, |
| 41 | in lieu of suspe | nsion or revocation, impose a fine upon the TPA." |
| 42 | | TION 1.12. Article 56 of Chapter 58 of the General Statutes is amended |
| 43 | • | v section to read: |
| 44 | " <u>§ 58-56-73. P</u> | rohibited practices. |

No person shall act as, offer to act as, or hold himself or herself out as a TPA in this State without a valid domestic or nonresident administrator certificate of authority issued by the Commissioner."

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PART II. GROUP ANNUITY CONTRACTS

SECTION 2. G.S. 58-58-145 reads as rewritten:

"§ 58-58-145. Group annuity contracts defined; requirements.requirements; issuance of individual certificates.

- Any policy or contract, except a joint, reversionary or survivorship annuity (a) contract, whereby annuities are payable to more than one person, is a group annuity contract. The person, firm or corporation to whom or to which such contract is issued, as herein provided, is the holder of the contract. The term "annuitant" means any person to whom or which payments are made under the group annuity contract. No authorized insurer shall deliver or issue for delivery in this State any group annuity contract except upon a group of annuitants that conforms to the following: under a contract issued to an employer, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, the stipulated payments on which shall be paid by the holder of such contract either wholly from the employer's funds or funds contributed by him, or partly from such funds and partly from funds contributed by the employees covered by such contract, and providing a plan of retirement annuities under a plan which permits all of the employees of such employer or of any specified class or classes thereof to become annuitants. Any such group of employees may include retired employees, and may include officers and managers as employees, and may include the employees of subsidiary or affiliated corporations of a corporation employer, and may include the individual proprietors, partners and employees of affiliated individuals and firms controlled by the holders through stock ownership, contract or otherwise.
- (b) The insurer of a group annuity contract shall issue to the policyholder, within 30 days of the effective date of the group annuity contract, an individual certificate for delivery to each annuitant which:
 - (1) Identifies the annuity to which the annuitant is entitled.
 - (2) States the name of the person to whom the annuity is payable.
 - Discloses all of the rights and obligations of the insurer, the policyholder, the annuitant, and the persons to whom the annuity is payable with respect to the group annuity contract.
- G.S. 58-3-150 applies to the form of the individual certificate required by this subsection.
- (c) Each group annuity contract shall include a provision that the insurer will issue to the policyholder within 30 days of the effective date of the contract, for delivery to each annuitant, an individual certificate setting forth the information described in subsection (b) of this section."

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PART III. DISCLOSURES FOR ANNUITIES AND LIFE INSURANCE

SECTION 3. The title of Article 60 of Chapter 58 of the General Statutes 1 2 reads as rewritten: 3 "Article 60. Regulation of Life Insurance Solicitation. 4 Standards of Disclosure for Annuities and Life Insurance." 5 SECTION 3.1. Article 60 of Chapter 58 of the General Statues is amended 6 by designating G.S. 58-60-1 through G.S. 58-60-35 as: 7 "Part 1. Regulation of Life Insurance Solicitation." 8 SECTION 3.2. G.S. 58-60-1 reads as rewritten: 9 "§ 58-60-1. Purpose of Article. Short title; purpose. 10 This Part may be cited as the "Life Insurance Disclosure Act". 11 (a) The purpose of this Article Part is to require insurers to deliver to purchasers (b) 12 of life insurance, information which will improve the buyer's ability to select the most 13 appropriate plan of life insurance for their the buyer's needs, improve the buyer's 14 understanding of the basic features of the policy which has been purchased or which is 15 under consideration and to improve the ability of the buyer to evaluate the relative costs 16 of similar plans of life insurance. 17 This Article Part does not prohibit an insurer to use from using additional material 18 which that is not in violation of Articles 1 through 64 of this Chapter nor any other 19 statute or regulation." 20 **SECTION 3.3.** G.S. 58-60-5 reads as rewritten: 21 "§ 58-60-5. Scope of Article; Scope; exemptions. 22 Except as otherwise provided in this Article, Part, this Article Part applies to 23 any solicitation, negotiation or procurement of life insurance occurring within this State. 24 This Article-Part applies to any issuer of a life insurance contract, including fraternal 25 benefit societies. 26 Unless otherwise specifically included, this Article Part does not apply to: 27 (b) Annuities, Individual group annuity contracts. (1) 28 Credit life insurance, insurance. (2) 29 Group life insurance, insurance (except for disclosures relating to 30 (3) preneed funeral contracts or prearrangements; these disclosure 31 requirements shall extend to the issuance or delivery of certificates as 32 well as to the master policy). 33 Life insurance policies issued in connection with pension and welfare 34 (4) plans as defined by and that are subject to the federal Employee 35 Retirement Income Security Act of 1974 (ERISA), (ERISA). 36 Variable life insurance under which the death benefits and cash values 37 (5) vary in accordance with unit values of investments held in a separate 38 account. 39 The policy summary in this Article-Part is not required for policies that are 40 (c) sold subject to rules adopted by the Commissioner for life insurance illustrations." 41 **SECTION 3.4.** G.S. 58-60-10(7)k. reads as rewritten: 42

"k.

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The date on which the Policy Summary is prepared.

The Policy Summary must consist of a separate document. 1 All information required to be disclosed must be set out in such 2 a manner as to not minimize or render any portion thereof 3 obscure. Any amounts which remain level for two or more 4 years of the policy may be represented by a single number if it 5 is clearly indicated what amounts are applicable for each policy 6 year. Amounts in subparagraph e of this paragraph shall be 7 listed in total, not on a per thousand nor per unit basis. If more 8 than one insured is covered under one policy or rider, 9 guaranteed death benefits shall be displayed separately for each 10 insured or for each class of insureds if death benefits do not 11 differ within the class. Zero amounts shall be displayed as zero 12 and shall not be displayed as a blank space. If the insurer makes 13 a material revision in the terms and conditions under which it 14 will limit its right to change any nonguaranteed factor, it shall, 15 no later than the first policy anniversary following the revision, 16 advise each affected policy owner residing in this State." 17 18

SECTION 3.5. Article 60 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 3. Regulation of Home Service Life Insurance Solicitation.

"§ 58-60-40. Title and reference.

This Part may be cited as the "Home Service Disclosure Act".

"§ 58-60-45. Purpose.

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The purpose of this Part is to establish standards that ensure that meaningful information is provided to the purchasers of insurance policies distributed through the home service distribution system.

"§ 58-60-50. Definitions.

As used in this Part:

- "Home service distribution system" means a system in which insurance products are marketed, sold, or serviced by agents in person in the home or business of the insured, owner, or premium payor in assigned territories and may be identified as "debits". The policies are issued on a monthly or more frequent premium payment basis and agents are charged with the responsibilities of servicing the debit, which may include the collection of premium payments in the home or designated location on a monthly or more frequent basis, along with other services normally rendered.
- (2) "Small face amount life insurance policy" means an insurance policy or certificate with a face amount of fifteen thousand dollars (\$15,000) or less.

"§ 58-60-55. General disclosure requirements.

(a) In accordance with the disclosure simplification standards set forth in G.S. 58-60-80 and at the time an insurance policy is issued through the home service distribution system, the insurer shall disclose:

Whether the policyholder is allowed to change the method of premium (1) 1 2 payment and any conditions for that change: Whether or not at a subsequent date a policyholder may combine 3 <u>(2)</u> multiple policies from the same insurance company, its affiliates, and 4 its subsidiaries into one policy in order to provide like or enhanced 5 coverage at a comparable or reduced premium to eliminate duplicate 6 administrative costs associated with each policy and, if the option is 7 available: 8 9 Whether a policyholder will be subject to underwriting when <u>a.</u> combining multiple policies into one policy; and 10 Whether a policyholder will be subject to a new contestable 11 b. period, waiting periods, etc., when combining multiple policies 12 into one policy. 13 In accordance with the disclosure simplification standards set forth in G.S. 14 (b) 15 58-60-80, an insurer issuing a small face amount life insurance policy through the home service distribution system shall provide the current disclosure included in Appendix A 16 of the NAIC's Home Service Disclosure Model if at any point in time over the term of 17 the policy the cumulative premiums paid may exceed the face amount of the policy at 18 that point in time. The required disclosure shall be provided to the policy owner or 19 certificate holder no later than at the time the policy or certificate is delivered. The 20 disclosure shall not be attached to the policy but may be delivered with the policy. 21 If, for a particular policy form, the cumulative premiums may exceed the face for 22 some demographic or benefit combination but not for all combinations, the insurer may 23 choose to either: 24 Provide the disclosure only in those circumstances where the 25 (1) premiums may exceed the face amount; or 26 27 (2) Provide the disclosure for all demographic and benefit combinations. Cumulative premiums shall include premiums paid for riders. However, the face 28 amount shall not include the benefit attributable to the riders. 29 If an illustration has been provided that satisfies the requirements of Title 11, 30 Chapter 4. Section .0500 of the North Carolina Administrative Code, the disclosure 31 requirements of subsection (b) of this section are deemed to have been met. 32 "\\$ 58-60-60. Disclosure of payment methods. 33 In accordance with the disclosure simplification standards set forth in G.S. 58-60-80, 34 at the time an insurance policy is issued through the home service distribution system, 35 the insurer shall disclose: 36 What premium savings may be realized by a different method or less 37 (1) frequent mode of premium payment. 38 That premiums are still due and payable by the person responsible for 39 <u>(2)</u> premium payments even when an agent does not collect the premiums. 40 The mailing address for payment of premiums to the company. 41 (3) (4) That the consumer is entitled to receive a receipt for premium 42

"§ 58-60-65. Evidence of payment.

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payments when premium payments are made in cash or in person.

For every premium collected on a policy of life or disability insurance marketed, sold, or serviced through the home service distribution system in this State, the agent, solicitor, or broker, or any employee acting on the agent, solicitor, or broker's behalf, collecting or receiving the premium in person shall:

- Maintain and furnish to the policyholder a receipt indicating payment of premiums, which shall provide the payor with clearly understandable, written evidence of payment at the time the premium is collected. At a minimum it shall clearly show:
 - a. The name of the payor.
 - b. The name of insured under each policy covered by the premium.
 - c. The amount paid.
 - d. The date paid.
 - e. The date paid-to-status of the policy.
 - f. The policy number.
 - g. The face amount and type of policy for which the payment will be credited.
 - h. The signature of the agent.
 - i. The agent's printed name and unique identification number.
 - The name, complete address, and phone number of the insurer.
- (2) Remit to the insurer's home office or applicable district office, or deposit in a fiduciary account, the premium collected on behalf of the policyholder within 10 days of receipt from the premium payor or policy owner. In the event that the insurer utilizes an accounting system based on a monthly list bill, all premiums collected shall be credited from the date of collection. The premium shall be fully applied to that particular account.

"§ 58-60-70. Proof of policy delivery.

If an insurance policy marketed, sold, or serviced through the home service distribution system is delivered by an agent, solicitor, or broker, or an employee acting on the agent, solicitor, or broker's behalf, a receipt shall be signed by the purchaser and the agent acknowledging delivery to the purchaser of the policy or contract and the disclosures required by this Part. The receipt shall contain the name of the purchaser, the policy or contract number, the amount of the initial premium payment, and the date the delivery was completed. A policy shall be deemed to have been received six months after the date of issuance if the insured has paid premiums pursuant to the contract. All delivery receipts required by this section shall be retained by the company for not less than three years following delivery and shall be available for inspection upon request of the Commissioner.

"§ 58-60-75. Company duties.

Each insurer engaged in the home service distribution system in this State shall make available to the Commissioner for review:

(1) Established written procedures to audit agencies engaged in the home service system of distribution of policies in this State; and

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| 1 | (2) Proof of audits conducted periodically that reasonably ensure that the |
|----|---|
| 2 | premium payor's records accurately reflect the premium due date and |
| 3 | premium paid-to-status of the policy or policies purchased. |
| 4 | "§ 58-60-80. Minimum disclosure language standards. |
| 5 | All disclosure forms shall comply with the readability standards in Article 38 of this |
| 6 | Chapter. It is presumed the disclosure form in Appendix A of the NAIC's Home Service |
| 7 | Disclosure Model Act complies with this Part." |
| 8 | SECTION 3.6. Article 60 of Chapter 58 of the General Statutes is amended |
| 9 | by adding a new Part to read: |
| 10 | "Part 3. Regulation of Small Face Amount Life Insurance Solicitation. |
| 11 | "§ 58-60-85. Title and reference. |
| 12 | This Part may be cited as the "Small Face Amount Life Insurance Disclosure Act". |
| 13 | "§ 58-60-90. Purpose; intent; and scope. |
| 14 | (a) The purpose of this Part is to establish standards that ensure meaningful |
| 15 | information is provided to the purchasers of small face amount policies. |
| 16 | (b) This Part applies to any life insurance policy or certificate with an initial face |
| 17 | amount of fifteen thousand dollars (\$15,000) or less. |
| 18 | (c) This Part does not apply to: |
| 19 | (1) Variable life insurance. |
| 20 | (2) <u>Individual and group annuity contracts.</u> |
| 21 | (3) <u>Credit life insurance.</u> |
| 22 | (4) Group or individual policies of life insurance issued to members of an |
| 23 | employer group or other permitted group where: |
| 24 | <u>a.</u> Every plan of coverage was selected by the employer or other |
| 25 | group representative; |
| 26 | b. Some portion of the premium is paid by the group or through |
| 27 | payroll deduction; and |
| 28 | c. Group underwriting or simplified underwriting is used. |
| 29 | (5) Policies and certificates where an illustration has been provided |
| 30 | pursuant to the requirements of Title 11, Chapter 4, Section .0500 of |
| 31 | the North Carolina Administrative Code. |
| 32 | "§ 58-60-95. Disclosure requirements. |
| 33 | (a) An insurer issuing a small face amount policy shall provide the current |
| 34 | disclosure included in Appendix A of the NAIC Disclosure for Small Face Amount Life |
| 35 | Insurance Policies Model Act if at any point in time over the term of the policy the |
| 36 | cumulative premiums paid may exceed the face amount of the policy at that point in |
| 37 | time. The required disclosure shall be provided to the policy owner or certificate holder |
| 38 | no later than at the time the policy or certificate is delivered. The disclosure shall not be |
| 39 | attached to the policy but may be delivered with the policy. |
| 40 | (b) If, for a particular policy form, the cumulative premiums may exceed the face |
| 41 | amount for some demographic or benefit combination but not for all combinations, the |
| 42 | insurer may choose to either: |
| 43 | (1) Provide the disclosure only in those circumstances where the |
| 44 | premiums may exceed the face amount; or |

| 1 | | | <u>(2)</u> | Provide the disclosure for all demographic and benefit | <u>it</u> |
|----|-------------------|----------------|------------------------|--|------------|
| 2 | | | | combinations. | |
| 3 | (c) | Cumu | ılative | premiums shall include premiums paid for riders. However, th | <u>e</u> |
| 4 | face amo | unt sha | ll not i | nclude the benefits attributable to the riders. | |
| 5 | "§ 58-60- | | | | |
| 6 | | | | its producers shall have a duty to provide information t | <u>:0</u> |
| 7 | policyhol | ders or | certifi | icate holders that ask questions about the disclosure statement." | |
| 8 | <u>p</u> | SECT | TION 3 | 3.7. Article 60 of Chapter 58 of the General Statutes is amende | d |
| 9 | by adding | | | | |
| 10 | | 9 44 4 11 | | "Part 4. Regulation of Annuity Solicitation. | |
| 11 | " <u>§ 58-60-</u> | -105. T | Title an | nd reference. | |
| 12 | This I | Part ma | y be ci | ited as the "Annuity Disclosure Act". | |
| 13 | "§ 58-60- | -110. I | urpos | se; intent; scope. | |
| 14 | (a) | The p | urpose | e of this Part is to provide standards for the disclosure of certain | <u>in</u> |
| 15 | minimum | ı inforr | nation | about annuity contracts to protect consumers and foster consumer | <u>er</u> |
| 16 | education | n. This | Part sr | pecifies the minimum information that must be disclosed and the | <u>1e</u> |
| 17 | method f | or disc | losing | it in connection with the sale of annuity contracts. The goal of | <u>of</u> |
| 18 | this Part | is to | ensure | that purchasers of annuity contracts understand certain basis | <u>ic</u> |
| 19 | features of | of annu | ity con | ntracts. | |
| 20 | (b) | This l | Part ap | plies to all group and individual annuity contracts and certificate | <u>es</u> |
| 21 | except: | | | | |
| 22 | | <u>(1)</u> | Regis | stered or nonregistered variable annuities or other registere | <u>ed</u> |
| 23 | | | produ | | |
| 24 | | <u>(2)</u> | Imme | ediate and deferred annuities that contain no nonguarantee | <u>ed</u> |
| 25 | | | <u>eleme</u> | ents. | |
| 26 | | <u>(3)</u> | <u>Annu</u> | nities used to fund: | |
| 27 | | | <u>a.</u> | An employee pension plan, which is covered by the Employee | <u>ee</u> |
| 28 | | | | Retirement Income Security Act (ERISA); | _ |
| 29 | | | <u>b.</u> | A plan described by section 401(a), 401(k), or 403(b) of the | <u>ne</u> |
| 30 | | | | Internal Revenue Code, where the plan, for purposes of ERISA | <u>A,</u> |
| 31 | | | | is established or maintained by an employer; | |
| 32 | | | <u>c.</u> | A governmental or church plan defined in section 414, or | <u>a</u> |
| 33 | | | | deferred compensation plan of a state or local government or | <u>a</u> |
| 34 | | | | tax exempt organization under section 457, of the Intern | <u>ıal</u> |
| 35 | | | | Revenue Code; | |
| 36 | | | <u>d.</u> | A nonqualified deferred compensation arrangement established | <u>ea</u> |
| 37 | | | | or maintained by an employer or plan sponsor; | |
| 38 | | | <u>e.</u> <u>f.</u> | Structured settlement annuities; | |
| 39 | | | <u>f.</u> | Charitable gift annuities; or | |
| 40 | | | <u>g.</u> | Funding agreements. | |
| 41 | <u>(c)</u> | <u>This</u> | Part sh | nall apply to annuities used to fund a plan or arrangement that | <u>1S</u> |
| 42 | funded s | olely t | y cont | tributions an employee elects to make, whether on a pre-tax | or |
| 43 | after-tax | basis. | and | where the insurance company has been notified that pl | <u>an</u> |
| 44 | participa | nts ma | y choo | se from among two or more fixed annuity providers and there is | <u>s a</u> |

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direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement.

"§ 58-60-115. Definitions.

As used in this Part:

- (1) "Annuity buyer's guide" or "buyer's guide" means the current NAIC Model Buyer's Guide to Fixed Deferred Annuities, including any appendix thereto.
- (2) "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.
- (3) "Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.
- (4) "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only or from both determinable and guaranteed elements.
- (5) "Disclosure document" means the document the contents of which are described in G.S. 58-60-125.
- (6) "Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.
- (7) "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity".
- (8) "Guaranteed elements" means the premiums, credited interest rates, including any bonus, benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these, that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

| 1 | (9) | "Nonguaranteed elements" means the premiums, credited interest rates |
|----------|------------------|---|
| 2 | | (including any bonus), benefits, values, noninterest-based credits, |
| 3 | | charges, or elements of formulas used to determine any of these that |
| 4 | | are subject to company discretion and are not guaranteed at issue. An |
| 5 | • | element is considered nonguaranteed if any of the underlying |
| 6 | | nonguaranteed elements are used in its calculation. |
| 7 | <u>(10)</u> | "Structured settlement annuity" means a "qualified funding asset" as |
| 8 | (10) | defined in section 130(d) of the Internal Revenue Code or an annuity |
| 9 | | that would be a qualified funding asset under section 130(d) but for the |
| 10 | | fact that it is not owned by an assignee under a qualified assignment. |
| 11 | "8 58-60-120 | Standards for the disclosure document and buyer's guide. |
| 12 | (a) When | e the application for an annuity contract is taken in a face-to-face |
| 13 | meeting the or | oplicant, at or before the time of application, shall be given both the |
| 14 | | ment described in G.S. 58-60-125 and a copy of the buyer's guide. |
| 15 | (b) When | e the application for an annuity contract is taken by means other than in |
| | o food to food m | neeting, the applicant shall be sent both the disclosure document and the |
| 16 17 | huver's guide no | later than five business days after the completed application is received |
| 18 | | rater than five business days after the completed application is received |
| 19 | by the insurer. | With respect to an application received as a result of a direct |
| | <u>(1)</u> | |
| 20 | | solicitation through the mail: |
| 21 | | a. Providing a buyer's guide in a mailing inviting prospective |
| 22 | | applicants to apply for an annuity contract shall be deemed to |
| 23 | | satisfy the requirement that the buyer's guide be provided no |
| 24 | | later than five business days after receipt of the application. |
| 25 | | b. Providing a disclosure document in a mailing inviting a |
| 26 | | prospective applicant to apply for an annuity contract shall be |
| 27 | | deemed to satisfy the requirement that the disclosure document |
| 28 | | be provided no later than five business days after receipt of the |
| 29 | (2) | application. |
| 30 | <u>(2)</u> | With respect to an application received via the Internet: |
| 31 | | a. Taking reasonable steps to make the buyer's guide available for |
| 32 | | viewing and printing on the insurer's web site shall be deemed |
| 33 | | to satisfy the requirement that the buyer's guide be provided no |
| 34 | | later than five business days after receipt of the application. |
| 35 | | b. Taking reasonable steps to make the disclosure document |
| 36 | | available for viewing and printing on the insurer's web site shall |
| 37 | | be deemed to satisfy the requirement that the disclosure |
| 38 | | document be provided no later than five business days after |
| 39 | (2) | receipt of the application. |
| 40 | <u>(3)</u> | A solicitation for an annuity contract provided in other than a |
| 41 | | face-to-face meeting shall include a statement that the proposed |
| 42 | | applicant may contact the Department for a free annuity buyer's guide. |
| 43 | | In lieu of the foregoing statement, an insurer may include a statement |

| 1 | | that 1 | he prospective applicant may contact the insurer for a free annuity |
|----|-------------------------|------------------------|---|
| 2 | | <u>buye</u> | <u>r's guide.</u> |
| 3 | | | buyer's guide and disclosure document are not provided at or |
| 4 | before the time | of a | oplication, a free look period of no less than 15 days shall be |
| 5 | | | cant to return the annuity contract without penalty. This free look |
| 6 | | | with any other free look provided under State law or regulation. |
| 7 | | | nts of disclosure document. |
| 8 | | | of the following information shall be included in the disclosure |
| 9 | document requi | | |
| 10 | <u>(1)</u> | <u>The</u> | generic name of the contract, the company product name, if |
| 11 | | diffe | rent, and form number, and the fact that it is an annuity. |
| 12 | <u>(2)</u> | The: | insurer's name and address. |
| 13 | <u>(3)</u> | <u>A</u> d | escription of the contract and its benefits, emphasizing its |
| 14 | | long- | term nature, including the following, if appropriate: |
| 15 | | <u>a.</u> | The guaranteed, nonguaranteed, and determinable elements of |
| 16 | | | the contract, and their limitations, if any, and an explanation of |
| 17 | | | how they operate. |
| 18 | | <u>b.</u> | An explanation of the initial crediting rate, specifying any |
| 19 | | | bonus or introductory portion, the duration of the rate, and the |
| 20 | | | fact that rates may change from time to time and are not |
| 21 | | | guaranteed. |
| 22 | | <u>c.</u> | Periodic income options both on a guaranteed and |
| 23 | | | nonguaranteed basis. |
| 24 | • | <u>d.</u> | Any value reductions caused by withdrawals from or surrender |
| 25 | | | of the contract. |
| 26 | | <u>e.</u> | How values in the contract can be accessed. |
| 27 | • | <u>e.</u> <u>f.</u> | The death benefit, if available, and how it will be calculated. |
| 28 | | <u>g.</u> | A summary of the federal tax status of the contract and any |
| 29 | | | penalties applicable on withdrawal of values from the contract. |
| 30 | | <u>h.</u> | The impact of any rider, such as a long-term care rider. |
| 31 | <u>(4)</u> | The | specific dollar amount or percentage charges and fees with an |
| 32 | | expla | nation of how they apply. |
| 33 | <u>(5)</u> | <u>Info</u> | mation about the current guaranteed rate for new contracts that |
| 34 | | conta | nins a clear notice that the rate is subject to change. |
| 35 | Insurers sha | all de | fine terms used in the disclosure statement in language that |
| 36 | facilitates the u | ınderst | anding by a typical person within the segment of the public to |
| 37 | which the disclo | osure s | tatement is directed. |
| 38 | " <u>§ 58-60-130.</u>] | Repor | t to contract owners. |
| 39 | | | e payout period with changes in nonguaranteed elements and for |
| 40 | | _ | od of a deferred annuity, the insurer shall provide each contract |
| 41 | owner with a re | port, a | it least annually, on the status of the contract that contains at least |

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all of the following information:

The beginning and end date of the current report period.

The accumulation and cash surrender value, if any, at the end of the (2) 1 previous report period and at the end of the current report period. 2 The total amounts, if any, that have been credited, charged to the 3 (3) contract value, or paid during the current report period. 4 The amount of outstanding loans, if any, as of the end of the current 5 (4) report period." 6 7 EMPLOYER-OWNED LIFE INSURANCE DISCLOSURE 8 PART IV. 9 **SECTION 4.** G.S. 58-58-75 reads as rewritten: "§ 58-58-75. Insurable interest in life and physical ability of employee or agent. 10 An employer, whether a partnership, joint venture, business trust, mutual 11 association, corporation, any other form of business organization, or one or more 12 individuals, or any religious, educational, or charitable corporation, institution or body, 13 has an insurable interest in and the right to insure the physical ability or the life, or both 14 the physical ability and the life, of an employee for the benefit of such employer. Any 15 principal shall have a life insurable interest in and the right to insure the physical ability 16 or the life, or both the physical ability and the life, of an agent for the benefit of such 17 principal. 18 An employee described in subsection (a) of this section shall be insured for 19 (b) the benefit of an employer described in subsection (a) of this section only if the 20 employee receives written notification from the insurer of the existence of the coverage. 21 The notice shall be provided to the employee within 30 days after the effective date of 22 the coverage and shall include a statement that the employer may maintain the life 23 insurance coverage on the employee even after employment is terminated. 24 For nonkey or nonmanagerial employees, the aggregate amount of coverage 25 (c) shall be reasonably related to the benefits provided to the employees in the aggregate. 26 With respect to employer-provided pension and welfare plans, the life 27 insurance coverage purchased to finance the plans may only cover the lives of those 28 employees and retirees who, at the time their lives were first insured under the plan, 29 either are participants, or would be eligible to participate, upon the satisfaction of age, 30 service, or similar eligibility criteria in the plan." 31 32 ACTUARIALLY SOUND ASSOCIATION GROUP ACCIDENT 33 PART V. AND HEALTH PREMIUM RATES 34 **SECTION 5.** G.S. 58-51-80(1a) reads as rewritten: 35 "(1a) Under a policy issued to an association or to a trust or to the trustee or 36 trustees of a fund established, created, or maintained for the benefit of 37 members of one or more associations. The association or associations 38 shall have at the outset a minimum of 500 persons and shall have been 39 organized and maintained in good faith for purposes other than that of 40 obtaining insurance; shall have been in active existence for at least five 41 years; and shall have a constitution and bylaws that provide that (i) the 42

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association or associations hold regular meetings not less than annually

to further purposes of the members; (ii) except for credit unions, the

| 1 | association or associations collect dues or solicit contributions from |
|----|--|
| 2 | members; and (iii) the members, other than associate members, have |
| 3 | voting privileges and representation on the governing board and |
| 4 | committees. The policy is subject to the following requirements: |
| 5 | a. The policy may insure members of the association or |
| 6 | associations, employees of the association or associations, or |
| 7 | employees of members, or one or more of the preceding or all |
| 8 | of any class or classes for the benefit of persons other than the |
| 9 | employee's employer. |
| 10 | b. The premium for the policy shall be paid from funds |
| 11 | contributed by the association or associations, or by employer |
| 12 | members, or by both, or from funds contributed by the covered |
| 13 | persons or from both the covered persons and the association, |
| 14 | associations, or employer members. The premium rates for each |
| 15 | association policy shall be developed, and applied to the |
| 16 | certificates thereunder, on an actuarially sound basis. |
| 17 | c. Repealed by Session Laws 1997-259, s. 8." |
| 18 | |
| 19 | PART VI. INDIVIDUAL ACCIDENT AND HEALTH INSURANCE |
| 20 | RENEWAL RATE LIMITATIONS |
| 21 | SECTION 6. G.S. 58-51-95 is amended by adding a new subsection to read: |
| 22 | "(g) For policies subject to this section, an individual health insurer shall not |
| 23 | increase an individual's renewal premium for continued health insurance coverage under |
| 24 | the terms of the individual's health insurance policy based on any health status-related |
| 25 | factors in relation to the individual or a dependent of the individual, including: |
| 26 | (1) Health status. |
| 27 | (2) Medical condition (including both physical and mental illnesses). |
| 28 | (3) Claims experience. |
| 29 | (4) <u>Duration from issue.</u> |
| 30 | (5) Receipt of health care. |
| 31 | (6) Medical history. |
| 32 | (7) Genetic information." |
| 33 | THE RESERVE THE PROPERTY OF TH |
| 34 | PART VII. LARGE GROUP HEALTH INSURANCE SOLE PROPRIETOR |
| 35 | EXEMPTION |
| 36 | SECTION 7. G.S. 58-65-60 is amended by adding a new subsection to read: |
| 37 | "(e3) When determining employee eligibility for a large employer, as defined in |
| 38 | G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an |
| 39 | "employee" for the purpose of obtaining coverage under the employee group health plan |
| 40 | and shall not be held to a minimum workweek requirement as imposed on other eligible |
| 41 | employees." |
| 42 | SECTION 7.1. G.S. 58-67-85 is amended by adding a new subsection to |

read:

"(d1) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(1), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

SECTION 7.2. G.S. 58-51-80(c) reads as rewritten:

The term "employees" as used in this section shall be deemed to include, for "(c) the purposes of insurance hereunder, employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. Employees shall be added to the group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. The term "employer" as used herein may be deemed to include the State of North Carolina, any county, municipality or corporation, or the proper officers, as such, of any unincorporated municipality or any department or subdivision of the State, county, such corporation, or municipality determined by conditions pertaining to the employment. When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

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PART VIII. NEWBORN COVERAGE REINSTATEMENT

SECTION 8. G.S. 58-51-30(b) reads as rewritten:

"(b) Every health benefit plan, as defined in G.S. 58-3-167, G.S. 58-51-115(a)(1), that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Every health benefit plan shall extend coverage to a foster child or adopted child without requirements for prior notification unless an additional premium charge to add the foster child or adopted child is due. If an additional premium charge is due to cover the foster

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child or adopted child, the health benefit plan shall cover the foster child or adopted child upon placement in the foster home or placement for adoption if the foster child or adopted child is enrolled within 30 days after the placement in the foster home or placement for adoption."

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PART IX. LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES TECHNICAL CORRECTIONS

SECTION 9. G.S. 58-51-15(a)(2)b. reads as rewritten:

"b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy _____ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." Credit Except for the excepted benefits described in G.S. 58-68-25(b), credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-68-30."

SECTION 9.1. G.S. 58-51-15(h) reads as rewritten:

- "(h) Preexisting Condition Exclusion Clarification. Sub-subdivision (a)(2)b. of this section does not apply to: to
 - (1) Policies policies issued to eligible individuals under G.S. 58-68-60.
 - (2) Excepted benefits as described in G.S. 58-68-25(b)."

PART X. SMALL EMPLOYER HEALTH REINSURANCE POOL BOARD AMENDMENTS

SECTION 10. G.S. 58-50-150(b) reads as rewritten:

"(b) Within 30 days after January 1, 1992, the Commissioner shall give notice to all earriers of the time and place for the initial organizational meeting, which shall take place within 90 days after the notice from the Commissioner. The members shall select the initial Board, subject to the Commissioner's approval. The Board shall consist of nine six members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The voting rights to determine initial Board membership shall be weighted based upon net group health benefit plan premium derived from this State in the previous calendar year. Thereafter, voting Voting rights shall be based on net group health benefit plan premium derived from small employer business. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact accident and health insurance, one HMO, one nonprofit hospital or medical service plan. Six Five of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented."

PART XI. EQUITABLE ENROLLMENT PERIOD FOR SUPPLEMENTAL MEDICARE PLANS

SECTION 11. G.S. 58-54-45(a) reads as rewritten:

"(a) In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plans A, C, and J available to persons eligible for Medicare by reason of disability before age 65. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision."

PART XII. REVOCATION AND SUSPENSION TECHNICAL CORRECTION SECTION 12. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be one of the following:

- (1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.
- (2) Payment of the claim.
- (3) A bona fide written offer of settlement.
- (4) A written denial of the claim.

A claimant includes an insured, a beneficiary of life or annuity contract, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer, HMO, service corporation, or MEWA. With respect to a claim under an accident, health, or disability policy, if the acknowledgement sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgement includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225."

PART XIII. HEALTH BENEFIT PLAN TRAVEL EXPENSES COVERAGE

SECTION 13. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-3-270. Insurance coverage for travel expenses associated with obtaining care.

- (a) As used in this section, the terms "health benefit plan" and "insurer" have the meaning as found in G.S. 58-3-167.
- (b) Each health benefit plan shall provide coverage for reasonable transportation, lodging, and boarding expenses incurred by a covered person to access covered health care services when the insurer, through its referral or network contracting arrangements, requires the covered person to travel more than 250 miles from the covered person's residence to obtain those covered health care services from a network provider.
- (c) The coverage specified by this section is limited to transportation, lodging and boarding expenses incurred by a covered person when required by the health plan to travel to access covered health care services as provided in subsection (b) of this section when those health care services are not also available from a network provider who is located within 250 miles of the covered person's residence.
- (d) The coverage required by this section shall be subject to plan requirements including any overall health care benefit plan aggregate limitations and shall last for the duration of the health care benefit plan's coverage of the treatment subject to this section. An insurer may utilize a per diem limit for the expenses specified in subsection (c) of this section as long as the limit reflects the high-low per diem method as annually published by the Internal Revenue Service or the Domestic Per Diem Rate as published annually by the federal General Services Administration in the area where the health care services are being obtained. All travel, lodging, and boarding expenses in excess of the insurer's per diem or the health benefit plan's aggregate limits shall be the responsibility of the covered person.
 - (e) An insurer may require prior approval of all expenses subject to this section.
- (f) The coverage required by this section shall apply only to those travel, lodging, and boarding expenses incurred by the covered person accessing covered health care services in accordance with this section. If the covered person accessing covered health care services in accordance with this section is a minor, the health benefit plan shall also cover the expenses specified in subsection (c) of this section for a parent or guardian who accompanies the minor."

PART XIV. CREDIT INSURANCE AMENDMENTS

SECTION 14. G.S. 58-57-5 is amended by adding a new subdivision to read:

"(5a) "Critical period coverage" means insurance coverage for which benefits are limited to a stated number of payments or the payments end with the expiration of the policy, whichever is less."

SECTION 14.1. G.S. 58-57-50(b) reads as rewritten:

"(b) The refund of premiums for decreasing term credit life insurance shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy. The refund of premiums for decreasing term credit life insurance in transactions of 60 months duration or less and the refund of premiums for single interest credit property insurance and single interest physical damage insurance shall be

equal to the amount computed by the sum of digits formula known as the "Rule of 78." The refund of premiums for decreasing term credit life insurance in transactions of more than 60 months duration shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy. The refund of premiums for level term credit life insurance and dual interest credit property insurance and dual interest physical damage insurance shall be equal to the pro rata unearned gross premiums."

SECTION 14.2. G.S. 58-57-55 reads as rewritten:

"§ 58-57-55. Issuance of policies.

All policies of credit life insurance and credit accident and health insurance shall be issued only by an insurer authorized to do business in this State and shall be issued only through holders of licenses or authorizations issued by the Commissioner. All-With the exception of credit insurance issued in accordance with G.S. 58-57-105, all policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this State only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner. State. The enrollment of debtors under a group policy issued to a creditor and authorized under this Article shall not constitute the issuance of a policy of insurance."

SECTION 14.3. G.S. 58-57-60 is amended by adding a new subsection to read:

- "(d) A claim acknowledgement shall be sent to the claimant within 30 days after receiving written or electronic notice of the claim. Acknowledgement shall include the following:
 - (1) A statement made to the insured or the claimant advising that the claim is being investigated.
 - (2) Payment of the claim.
 - (3) A bona fide written offer of settlement.
 - (4) A written denial of the claim."

SECTION 14.4. G.S. 58-57-110 reads as rewritten:

"§ 58-57-110. Credit unemployment insurance rate standards; policy provisions.

- (a) Each year the Commissioner shall prescribe a minimum incurred loss ratio standard requirement to develop a premium rate reasonable in relation to the benefits provided by credit unemployment insurance coverage. The following requirements must be met:
 - (1) Coverage is provided or offered, with or without underwriting, to all debtors regardless of age who are working for salary, wages, or other employment income for at least 30 hours per week and have done so for 12 consecutive months;
 - (2) Coverage sets forth a definition of involuntary unemployment as a loss of employment income that may include, but is not limited to, loss caused by layoff, general strike, termination of employment, or lockout;
 - (3) Coverage does not contain any exclusion except: debts with irregular monthly payments; voluntary forfeiture of salary, wages, or other

monthly payments; voluntary tortesture of salary, wages, or other Page 28

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- employment income; resignation; retirement; sickness, disease, or normal pregnancy; or loss of income due to termination as a result of willful misconduct that is a violation of some established, definite rule of conduct, a forbidden act, or willful dereliction of duty, or criminal misconduct.misconduct;

 As long as there is no required time period limitation for registration,
 - As long as there is no required time period limitation for registration, the insured may be required to register with the State unemployment office in order to qualify for benefit payments under the credit unemployment coverage. Qualification for State unemployment benefits shall not be required in order to qualify for benefit payments under the credit unemployment coverage.
 - (b) The Commissioner may approve other policy provisions and coverages consistent with the purposes of unemployment coverage.
 - (c) Joint coverage rates for credit unemployment insurance shall be one and two-thirds (1 2/3) times the approved single rate of coverage.
 - (d) The refund provision for credit unemployment insurance shall be equal to the pro rata unearned gross premium."

PART XV. EFFECT OF HEADINGS, SEVERABILITY, AND EFFECTIVE DATES

SECTION 15. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

SECTION 15.1. 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 15.2. Sections 1 through 8 and Sections 9, 9.1, 13, 14, 14.1, 14.2, 14.3, and 14.4 of this act become effective January 1, 2004, and apply to policies or certificates issued or renewed on or after that date. The remainder of this act is effective when it becomes law and applies to policies or certificates issued or renewed on or after that date.

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. Committee Substitute for H.B. 339 A BILL TO BE ENTITLED AN ACT CONFORM NORTH CAROLINA'S THIRD PARTY ADMINISTRATOR ARTICLE TO REVISIONS TO THE NAIC MODEL THIRD PARTY ADMINISTRATOR STATUTE; REQUIRE GROUP ANNUITY INSURERS TO ISSUE INDIVIDUAL CERTIFICATES OF COVERAGE TO EACH ANNUITANT; REORGANIZE ARTICLE 60 OF CHAPTER 58 OF THE GENERAL STATUTES AND AMEND CURRENT DISCLOSURE REQUIREMENTS FOR SOLICITATION OF LIFE INSURANCE PRODUCTS AND ANNUITIES; REQUIRE INSURERS TO NOTIFY EMPLOYEES OF THE EXISTENCE OF EMPLOYER-OWNED LIFE INSURANCE POLICIES WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF COVERAGE; REQUIRE THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT EMPLOYER-BASED; LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS' EXPERIENCE TO DEVELOP THE INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE PROPRIETOR FROM THE FULL-TIME BASIS OR THIRTY-HOUR WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES; CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER TO REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP OF INSURERS: TECHNICALLY CORRECT AN OMISSION REGARDING PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; REQUIRE A GROUP HEALTH INSURER FOR AN EMPLOYER TO PROVIDE, UPON THE GROUP POLICYHOLDERS' REQUEST, THE GROUP'S EXPERIENCE INFORMATION; ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE: TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT: MANDATE HEALTH BENEFIT COVERAGE FOR DESIGNATED TRAVEL EXPENSES WHEN THE REQUIRED DISTANCE TRAVELED THRESHOLD IS MET; AND MAKE TECHNICAL CORRECTIONS TO THE CREDIT INSURANCE LAWS. With a favorable report. With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations Finance With a favorable report, as amended. With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations Finance With a favorable report as to the committee substitute bill (#), which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill# recommendation that the committee substitute bill # _____) be re-referred to the Committee

attachment III

Proposed Committee Substitute for HOUSE BILL 208 – MANAGED CARE/HEALTH BENEFITS CLARIFYING/AB Section-by-Section Bill Summary

Sections 1. (a) through 1. (c) Make various amendments to statute mandating prompt payment of health insurance claims (G.S. 58-3-225).

Section 1. (a) Amends G.S. 58-3-225(a) to include "the insured" under the definition of "claimant", thereby entitling that person to notice under the prompt pay provisions.

Section 1. (b) Amends G.S. 58-3-225(c) through (f) to:

- Add the word "calendar" after each enumerate day-deadline reference in which the word is missing to clarify that the reference is to "_____ calendar days" as opposed to business days or other delineation.
- Replace an outdated reference to "HCFA" with "CMS" (Centers for Medicare and Medicaid Services), the new name for the federal agency to which the reference applies.
- Clarify that the provision setting a <u>90-calendar</u> day deadline for receipt of additional information from the insured at the request of the insurer only applies to pended claims and not claims that have already been denied.

Section 1. (c). Amends G.S. 58-3-225(g) to require insurers, even when the insurer is awaiting requested information from the insured's provider, to send claimants a status report every 30 days when a claim has not been paid or denied within 60 calendar days of receipt. Prior to the amendment, the insurer did not have to provide a claim status report while awaiting that information.

Section 2. Removes reference in the uniform credentialing statute (G.S. 58-3-230) to "applicants for licensure as health care practitioners" because it is impossible for insurers to credential practitioners until they are licensed.

Section 3. Clarifies that, under the insurance grievance procedures statute (G.S. 58-50-62), a second level grievance review panel may be a "one person panel" or may be a panel made up of more than one person. At present, there is no provision addressing the numbers on the panel.

Section 4. Makes Section 1. (c) of the act effective January 1, 2004 and the remainder of the act effective when it becomes law.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 208 PROPOSED COMMITTEE SUBSTITUTE H208-CSLN-15 [v.5]

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| Short Title: Managed Care/Hlth Benefits Clarifying-AB. | | (Public) | |
|--|--|----------|--|
| Sponsors: | | | |
| Referred to: | | | |
| | | | |

March 5, 2003

A BILL TO BE ENTITLED AN ACT TO AMEND THE PROMPT PAY LAW TO CLARIFY THAT A "CLAIMANT" UNDER THE LAW INCLUDES "AN INSURED"; THAT THIRTY DAYS REFERENCES ARE TO THIRTY "CALENDAR" DAYS; THAT AN INSURER MUST PROVIDE NOTICE OF A PROBLEM WITH A CLAIM WITHIN FIFTEEN DAYS OF RECEIPT OF THE CLAIM; THAT THE **DEADLINE** FOR RESPONDING TO **ADDITIONAL** NINETY-DAY INFORMATION REQUESTS FROM AN INSURER ONLY APPLIES TO CLAIMS NOT ALREADY DENIED; TO REQUIRE, UNDER THE PROMPT PAY LAWS, A STATUS REPORT WHEN CLAIMS ARE NOT PAID OR DENIED WITHIN SIXTY DAYS EVEN WHEN THE INSURER IS AWAITING INFORMATION REQUESTED FROM THE CLAIMANT: TO REMOVE FROM STATUTE AN UNNECESSARY UNIFORM CREDENTIALING PROVISION; AND TO AMEND UTILIZATION REVIEW LAWS TO CLARIFY THAT A SECOND-LEVEL GRIEVANCE REVIEW PANEL CAN CONSIST OF ONE OR MORE PERSONS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-3-225(a)(1) reads as rewritten:

"§ 58-3-225. Prompt claim payments under health benefit plans.

- "(a) As used in this section:
 - (1) "Claimant" includes the insured or a health care provider or facility that is responsible or permitted under contract with the insurer or by valid assignment of benefits for directly making the claim with an insurer.

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SECTION 1.(b) G.S. 58-3-225(b) through (g) read as rewritten:

"§ 58-3-225. Prompt claim payments under health benefit plans.

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- "(b) An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the elaimant: claimant the payment or notice stated in subdivisions (1) and (2) of this subsection, as applicable. An insurer shall, within 15 calendar days after receipt of a claim, send by electronic or paper mail to the claimant the notice stated in subdivisions (3) through (6) of this subsection, as applicable.

(1) Payment of the claim.

7 8 (2) Notice of denial of the claim.

9[.] 10 (3) Notice that the proof of loss is inadequate or incomplete.
(4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.

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(5) Notice that coordination of benefits information is needed in order to pay the claim.

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(6) Notice that the claim is pending based on nonpayment of fees or premiums.

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For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

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If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 calendar days days, or the notice of contested status within 15 calendar days, after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFACMS

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form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 <u>calendar</u> days after receiving the additional information.

- (d) If a claim has not already been denied, an insurer requests additional information under subsection (c) of this sectionsection, and the insurer does not receive the additional information within 90 calendar days after the request was made, the insurer shall deny the claim and send the notice of denial to the claimant in accordance with subsection (c) of this section. The insurer shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. The insurer shall inform the claimant in the notice that the claim will be reopened if the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.
- (e) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by the insurer under subsection (b) of this section, interest on health benefit claim payments shall begin to accrue on the 31st calendar day after the insurer received the additional information. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant. This subsection does not apply to claims for benefits that are not covered by the health benefit plan; nor does this subsection apply to deductibles, co-payments, or other amounts for which the insurer is not liable.
- (f) Insurers may require that claims be submitted within 180 <u>calendar</u> days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 <u>calendar</u> days after the date of the patient's discharge from the facility. However, an insurer may not limit the time in which claims may be submitted to fewer than 180 <u>calendar</u> days. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

SECTION 1.(c) G.S. 58-3-225(g) reads as rewritten:

"(g) If a claim for which the claimant is a health care provider or health care facility has not been paid or denied within 60 <u>calendar</u> days after receipt of the initial claim, the insurer shall send a claim status report to the insured. Provided, however, that the claims status report is not required during the time an insurer is awaiting information requested under subsection (c) of this section. The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall

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send a claim status report to the insured with a copy to the provider 30 <u>calendar</u> days after the previous report was sent."

SECTION 2. G.S. 58-3-230(a) reads as rewritten:

"(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care practitioner, or applicant for licensure as a health care practitioner, practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application."

SECTION 3. G.S. 58-50-62(f) reads as rewritten:

- "(f) Second-Level Grievance Review. An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance.
 - (1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:
 - a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.
 - b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.
 - An insurer shall convene a second-level grievance review panel (2) consisting of one or more persons for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. No person on the panel shall have been previously involved in any matter giving rise to the second-level grievance, shall be an employee of the insurer or URO, or shall have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons Each panel grievance involving member reviewing a second-level

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SESSION 2003

| 1 | noncertification or a clinical issue shall be providers who have |
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| 2 | appropriate expertise, including a provider who has appropriate |
| 3 | expertise, and each panel reviewing a second-level grievance involving |
| 4 | a noncertification or a clinical issue shall include at least one clinical |
| 5 | peer. Provided, however, an insurer that uses a clinical peer on an |
| 6 | appeal of a noncertification under G.S. 58-50-61 or on a first-level |
| 7 | grievance review panel under this section may use one of the insurer's |
| 8 | employees on the second-level grievance review panel in the same |
| 9 | matter if the second-level grievance review panel comprises three or |
| 10 | more persons " |

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SECTION 4. Section 1.(c) of this act becomes effective January 1, 2004. The remainder of this act is effective when it becomes law.

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VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

4-23-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
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| COURTNEY CROWDER | NC DOI |
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| Robert Milas | Yonna, Norre |
| CARUL ROBERISON | Ne Don H |
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HOUSE INSURANCE COMMITTEE

April 24, 2003 10:00 AM Room 544 LOB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

HB 339 – Life and Health Insurance Omnibus-AB. – Rep. Wright

HB 208 – Managed Care/Hlth Benefits Clarifying-AB. – Reps. Wright and Hunter

HB 822 – Health Insurance Coverage/Early Intervention. – / Reps. Alexander and Warren

HB-596 - Motor Vehicle Insurance Rates. --Rep. Starnes

VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

4-23-03

Name of Committee

Date

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| NAME | FIRM OR AGENCY AND ADDRESS |
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| Berbara Cansler | MFS'S |
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| BILLABRE | JURDAN PRICE LAW FIRM |
| Jim Newman | DOI |
| John Boward | ArhaZencea |
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VISITOR REGISTRATION SHEET

| HOUSE INSURANCE COMMITTEE | 4-23-03 |
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| Name of Committee | Date |

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Main Jak | Inter |
| Dawn Bieschbach | NAMI Cabarrus P.O. Box 1495, Concord 280 |
| Marcia Garatt | NAMI Cabarrus, POBOX 1495, Concord = |
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HOUSE COMMITTEE ON INSURANCE

April 29, 2003

The House Committee on Insurance met at 10:00 AM on April 29, 2003. The following Representatives were present: Hugh Holliman, Mitchell Setzer; John Hall, Lucy Allen, Bobby Barbee, Robert Grady, Howard Hunter, Charles Johnson, Linda Johnson, David Lewis, Karen Ray, Drew Saunders, Connie Wilson, Tom Wright, Harold Brubaker.

Chair Hugh Holliman called the meeting to order and introduced the pages and the Sergeant-At-Arms. He then recognized Rep. Connie Wilson to explain HB-Il07-UTILIZ.REVIEW & GRIEVANCE AMENDMENTS. Rep. Wilson spoke on the bill. See Attachment I. Paul Mahoney explained how the federal laws differ from the state laws. A PCS was distributed for consideration. Frank Folger, DOI explained the changes. Rep. Grady questioned the length of the bill and the fact that he had not seen this bill prior to the meeting. After much discussion HB 1107 was displaced.

Chair Holliman called on Rep. Starnes to speak on HB 596. Rep. Starnes explained how this bill is like a bill in the Senate. See Attachment II. Rep. Hall made a motion to adopt the PCS. Goldsmith, Staff Attorney, explained the committee substitute. Rep. Hall commended Rep. Starnes on this legislation and asked for a favorable report. Rep. Allen and Rep. Barbee addressed questions concerning person's credit. Susan Valouri, Nationwide Insurance spoke on how credit is established and how credit rating is used to retain coverage. After much discussion, the bill failed with a vote of 7 to 5.

Rep. Saunders was called on to explain HB-892-and the language chances on page 2. The intent is to clarify independent contractors. After some discussion, Rep. Saunders asked for support of this bill. Rep. Barbee made a motion for a favorable report. An amendment was adopted. See Attachment III.

See Attachment IV for the visitors who were in attendance.

The meeting was adjourned at ll:00 AM to be continued on Wednesday, April 30th at ll:00 in room 643 LOB.

Rep. L. Hugh Holliman, Chair

Rep. Mitchell S. Setzer, Char

Carol Bowers, Joanna Mills, Clerks



HOUSE BILL 1107: Utiliz/ Review & Grievance Amendments

Attachmen

BILL ANALYSIS

Committee: House Insurance

Date:

April 28, 2003

Version:

Proposed Committee Substitute

H1107-CSRC-45[v.3]

Introduced by: Representive C. Wilson

Kory J. Goldsmith Summary by:

Committee Counsel

SUMMARY: HB1107 makes revisions to North Carolina's laws relating to the review and appeal of decisions made by any type of health benefit plan. The proposed changes are consistent with the regulations adopted by the U.S. Department of Labor that became effective January 1, 2003.

There are two primary changes to current law: (1) the type of decisions that are subject to Utilization Review (UR) are expanded; and (2) decisions regarding UR must be made within a specified timeframe.

BACKGROUND: G.S. 58-50-61 provides the process by which a covered person under a health benefit plan may appeal a decision by insurer to not provide health care that the covered person and the covered person's doctor have requested. This process is called "utilization review". Utilization review compares the request for health care with what other doctors commonly do in similar cases. It also involves a determination of whether the requested care is "medically necessary." Care is medically necessary if it is required to prevent, diagnose, correct or cure conditions that cause suffering, endanger life, result in illness or infirmity, interfere with the capacity for normal activity, or threaten a significant handicap.

G.S. 58-50-62 provides the process by which a covered person may file a grievance with a health care plan. A grievance is a complaint regarding issues that are not covered under utilization review. For example, a covered person might file a grievance regarding a doctor who provided care, or a billing dispute.

BILL ANALYSIS: Sections 1(a) through 1(e) provide new definitions related to utilization review. Some of the new or revised definitions are:

- "Adverse benefit determination" means a denial, reduction, termination, or failure to provide payment for benefits including a denial based upon a beneficiary's eligibility to participate in a health plan or a determination that the benefit is not medically necessary.
- "Claim involving urgent care" means a claim for medical treatment where the normal time frames for utilization review could seriously jeopardize the life or health of the covered person.
- "Notice" is a defined in federal regulations, but generally means measures reasonably calculated to ensure actual receipt of information by the covered person, and includes the U.S. mail.
- "Preservice claim" means a claim for a benefit that must be approved prior to its receipt.
- "Postservice claim" means a claim for a benefit that is not a preservice benefit.

Section 2 amends the procedure of utilization review. The primary change is the creation of specific time lines for determination. Current law requires a decision within 3 days of the insurer receives all necessary information. Under the proposed changes, the insurer would have to give a determination within 15 days of receipt of the claim, regardless of whether all claim information has been received.

HOUSE BILL 1107

Page 2

Section 3 amends the grievance procedure. It basically provides that a health benefit plan must have a procedure similar to utilization review and appeal for grievances. A grievance is any decision, policy or action by an insurer that affects a covered person, but is not an "adverse benefit determination".

Section 4 through 17 make conforming changes.

The act becomes effective March 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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(Public)

HOUSE BILL 1107 PROPOSED COMMITTEE SUBSTITUTE H1107-CSRC-46 [v.3]

4/28/2003 11:44:07 PM

Short Title: Utiliz. Review & Grievance Amendments.

| | Sponsors: | |
|----|-----------------|---|
| | Referred to: | |
| | | April 10, 2003 |
| 1 | | A BILL TO BE ENTITLED |
| 2 | AN ACT TO A | MEND THE LAW GOVERNING MANAGED CARE UTILIZATION |
| 3 | REVIEW A | ND GRIEVANCE PROCEDURES TO MAKE THEM CONFORM |
| 4 | WITH THE | UNITED STATES DEPARTMENT OF LABOR CLAIM RULES. |
| 5 | The General As | sembly of North Carolina enacts: |
| 6 | SECT | FION 1.(a) The catch line of G.S. 58-50-61 reads as rewritten: |
| 7 | | ilization review. review, claim determinations, and appeals. |
| 8 | SECT | FION 1.(b) G.S. 58-50-61(a) is amended by adding the following new |
| 9 | subdivisions to | read: |
| 10 | "(1) | 'Adverse benefit determination' means any of the following: a denial, |
| 11 | | reduction, or termination of, or a failure to provide or make payment |
| 12 | | (in whole or in part) for, a benefit, including any such denial, |
| 13 | | reduction, termination, or failure to provide or make payment that is |
| 14 | | based on a determination of a participant's or beneficiary's eligibility to |
| 15 | | participate in a health benefit plan, and including the issuance of a |
| 16 | | noncertification indicating denial, reduction, or termination of, or a |
| 17 | | failure to provide or make payment (in whole or in part) for, a benefit |
| 18 | | resulting from the application of any utilization review, as well as a |
| 19 | | failure to cover an item or service for which benefits are otherwise |
| 20 | | provided because it is determined to be experimental or investigational |
| 21 | | or not medically necessary or appropriate. |
| 22 | (2) | 'Claim for benefits' means a a request for a plan benefit or benefits |
| 23 | | made by a covered person in accordance with an insurer's reasonable |
| 24 | | procedure for filing benefit claims, and a claim for benefits includes |
| 25 | | any preservice claims within the meaning of subdivision (14a) of this |
| 26 | | subsection and any postservice claims within the meaning of |
| 27 | | subdivision (14b) of this subsection. |
| 28 | <u>(3)</u> | 'Claim involving urgent care': |
| | | |

| 1 | <u>a.</u> | Is any claim for medical care or treatment with respect to which the |
|------|-------------|--|
| 2 | | application of the time periods for making nonurgent care |
| 3 | | determinations: |
| 4 | | 1. Could seriously jeopardize the life or health of the |
| 5 | | covered person or the ability of the covered person to |
| 6 | | regain maximum function; or |
| 7 | | 2. In the opinion of a physician with knowledge of the |
| 8 | | covered person's medical condition, would subject the |
| 9 | | covered person to severe pain that cannot be adequately |
| 10 | | managed without the care or treatment that is the subject |
| 11 | | of the claim. |
| 12 | | b. Except as provided in sub-subdivision c. of this subsection, |
| 13 | | whether a claim is a "claim involving urgent care" within the |
| 14 | | meaning of sub-subdivision a. of this subsection is to be |
| 15 | | determined by an individual acting on behalf of the insurer |
| 16 | | applying the judgment of a prudent layperson who possesses an |
| 17 | | average knowledge of health and medicine. |
| 18 | | c. Any claim that a physician with knowledge of the covered |
| 19 | | person's medical condition determines is a "claim involving |
| 20 | | urgent care" within the meaning of sub-subdivision a. of this |
| 21 , | | subsection shall be treated as a "claim involving urgent care" |
| 22 | | for purposes of this section. |
| 23 | ••• | |
| 24 | (13a) | 'Notice' or 'notification' means the delivery or furnishing of |
| 25 | | information to an individual in a manner that satisfies the standards of |
| 26 | | 29 CFR § 2520.104b-1(b) as appropriate with respect to material |
| 27 | | required to be furnished or made available to an individual. |
| 28 | ••• | |
| 29 | (14a) | 'Preservice claim' means any claim for a benefit under a health benefit |
| 30 | <u> </u> | plan with respect to which the terms of the plan condition receipt of |
| 31 | | the benefit, in whole or in part, on approval of the benefit in advance |
| 32 | | of obtaining medical care. |
| 33 | (14b) | 'Postservice claim' means any claim for a benefit under a health benefit |
| 34 | (110) | plan that is not a preservice claim as defined in this section |
| 35 | | production and a productive ordinary as defined in this section |
| 36 | (15a) | 'Relevant', when used to describe a document, record, or other |
| 37 | (104) | information concerning a covered person's claim, means a document, |
| 38 | | record, or other information that: |
| 39 | | YYY 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |
| 40 | | <u>a.</u> Was relied upon in making the benefit determination. <u>b.</u> Was submitted, considered, or generated in the course of |
| 41 | | making the benefit determination, without regard to whether |
| 42 | | such document, record, or other information was relied upon in |
| 43 | | making the benefit determination. |
| T.) | | making the benefit determination. |

| 1. | <u>c.</u> | Demonstrates compliance with the administrative processes and |
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| 2 | | safeguards required pursuant to subdivision (f)(5) of this section |
| 3 | | in making the benefit determination. |
| 4 | <u>d.</u> | Constitutes a statement of policy or guidance with respect to the |
| 5 | | health benefit plan concerning the denied treatment option or |
| 6 | | benefit for the covered person's diagnosis, without regard to |
| 7 | | whether such advice or statement was relied upon in making the |
| 8 | | benefit determination." |
| 9 | SECTION | N 1.(c) G.S. 58-50-61(a)(6) reads as rewritten: |
| 10 | | ievance' means a written complaint submitted by a covered person |
| 11 | abo | out any of the following: a matter that is not a claim determination |
| 12 | exc | ept that any complaint that is solely about the fact that a service |
| 13 | <u>wh</u> | ich is clearly excluded in the certificate of coverage is an excluded |
| 14 | ser | vice, and that is not about a claim determination, is not a grievance. |
| 15 | a. | An insurer's decisions, policies, or actions related to |
| 16 | | availability, delivery, or quality of health care services. A |
| 17 | | written complaint submitted by a covered person about a |
| 18 | | decision rendered solely on the basis that the health benefit plan |
| 19 | | contains a benefits exclusion for the health care service in |
| 20 | | question is not a grievance if the exclusion of the specific |
| 21 | | service requested is clearly stated in the certificate of coverage. |
| 22 | b. | Claims payment or handling; or reimbursement for services. |
| 23 | e. | The contractual relationship between a covered person and ar |
| 24 | | insurer. d. The outcome of an appeal of a noncertification under |
| 25 | | this section." |
| 26 | SECTION | V 1.(d) G.S. 58-50-61(a)(8) reads as rewritten: |
| 27 | | ealth care provider" or 'health care professional' means any persor |
| 28 | | o is licensed, registered, or certified under Chapter 90 of the |
| 29 | | neral Statutes or the laws of another state to provide health care |
| 30 | | vices in the ordinary care of business or practice or a profession or |
| 31 | in | an approved education or training program; program and also |
| 32 | | ludes a health care facility as defined in G.S. 131E-176(9b) or the |
| 33 | | s of another state to operate as a health care facility; or a |
| 34 | | rmacy." |
| 35 | SECTION | V 1.(e) G.S. 58-50-61(a)(16) reads as rewritten: |
| 36 . | | abilize" means to provide medical care that is appropriate to |
| 37 | | vent a material deterioration of the person's condition, withir |
| 38 | | sonable medical probability, in accordance with the HCFA (Health |
| 39 | | e Financing Administration) CMS (Centers for Medicare and |
| 40 | | dicaid Services) interpretative guidelines, policies, and regulations |
| 41 | | taining to responsibilities of hospitals in emergency cases (as |
| 42 | | vided under the Emergency Medical Treatment and Labor Act |
| 43 | | tion 1867 of the Social Security Act. 42 U.S.C.S. 8 1395dd) |

including medically necessary services and supplies to maintain stabilization until the person is transferred."

SECTION 1.(f) The Revisor of Statutes is authorized to renumber the definitions in G.S. 58-50-61(a) to maintain alphabetical order.

SECTION 2. Subsections (b) through (l) of G.S.58-50-61 read as rewritten:

- "(b) Insurer Oversight. Oversight of Utilization Review.- Every insurer shall monitor all utilization review carried out by or on behalf of the insurer and ensure compliance with this section. An insurer shall ensure that appropriate personnel have operational responsibility for the conduct of the insurer's utilization review program. If an insurer contracts to have a URO perform its utilization review, the insurer shall monitor the URO to ensure compliance with this section, which shall include:
 - (1) A written description of the URO's activities and responsibilities, including reporting requirements.
 - (2) Evidence of formal approval of the utilization review organization program by the insurer.
 - (3) A process by which the insurer evaluates the performance of the URO.
- (c) Scope and Content of <u>Utilization Review Program</u>. Every insurer shall prepare and maintain a utilization review program document that describes all delegated and nondelegated review functions for covered services including:
 - (1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.
 - (2) Data sources and clinical review criteria used in decision making.
 - (3) The process for conducting appeals of noncertifications.
 - (4) Mechanisms to ensure consistent application of review criteria and compatible decisions.
 - (5) Data collection processes and analytical methods used in assessing utilization of health care services.
 - (6) Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.
 - (7) The organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to the insurer's governing body.
 - (8) The staff position functionally responsible for day-to-day program management.
 - (9) The methods of collection and assessment of data about underutilization and overutilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.
- (d) <u>Utilization Review</u> Program Operations. In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in

 the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

- (e) Insurer Responsibilities. Responsibilities for Utilization Review. Every insurer shall:
 - (1) Routinely assess the effectiveness and efficiency of its utilization review program.
 - (2) Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.
 - (3) Provide covered persons and their providers with access to its review staff by a toll-free or collect call telephone number whenever any provider is required to be available to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.
 - (4) Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.
 - (5) Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.
 - (6) Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.
- (f) Prospective and Concurrent Reviews. As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall

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- be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification.
- 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.
- Notice of Noncertification. A written notification of a noncertification shall (h) include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request.
- Requests for Informal Reconsideration. An insurer may establish procedures for informal reconsideration of noncertifications and, if established, the procedures shall be in writing. After a written notice of noncertification has been issued in accordance with subsection (h) of this section, the reconsideration shall be conducted between the covered person's provider and a medical doctor-licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration, the insurer upholds the noncertification decision, the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, it shall treat the request for informal reconsideration as a request for an appeal; provided that the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.
- Appeals of Noncertifications. Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a

medical doctor licensed to practice medicine in this State who was not involved in the noncertification.

- (k) Nonexpedited Appeals. Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall contain:
 - (1) The professional qualifications and licensure of the person or persons reviewing the appeal.
 - (2) A statement of the reviewers' understanding of the reason for the covered person's appeal.
 - (3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
 - (4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
 - (5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.
- (l) Expedited Appeals. An expedited appeal of a noncertification may be requested by a covered person or his or her provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical doctor licensed to practice medicine in this State, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications.
- (f) Obligation to Establish and Maintain-Reasonable Claims Procedures. Every insurer that offers a—health benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification-of benefit determinations, and appeal of adverse benefit—determinations (hereinafter collectively referred to as

claims-procedures). The claims procedures for a health benefit plan will-be deemed to 1 2 be reasonable only if: 3 The claims procedures comply with the requirements of this subsection (1) 4 and subsections (h) through (k) of this section, as appropriate. A description of all claims procedures, including any procedures for 5 (2) obtaining prior approval as a prerequisite for obtaining a benefit, such 6 7 as preauthorization procedures or utilization review procedures and the 8 applicable time frames is included as part of a certificate or policy of 9 coverage. 10 The claims procedures do not contain any provision and are not (3) 11 administered in a way that unduly inhibits or hampers the initiation or 12 processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim 13 or to appealing an adverse benefit determination would be considered 14 15 to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under 16 circumstances that would make obtaining such prior approval 17 impossible or where application of the prior approval process could 18 seriously jeopardize the life or health of the covered person (e.g., the 19 20 covered person is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that 21 unduly inhibits the initiation and processing of a claim. 22 The claims procedures do not preclude an authorized representative of 23 (4) 24 a covered person from acting on behalf of such covered person in pursuing a benefit claim or appeal of an adverse benefit determination. 25 26 Nevertheless, an insurer may establish reasonable procedures for determining whether an individual has been authorized to act on behalf 27 28 of a covered person, provided that, in the case of a claim involving 29 urgent care within the meaning of subdivision (3) of subsection (a) of 30 this section, a health care professional, within the meaning of 31 subdivision (8) of subsection (a) of this section, with knowledge of a covered person's medical condition shall be permitted to act as the 32 33 authorized representative of the covered person. The claims procedures contain administrative processes and safeguards 34 (5) 35 designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that where 36 37 appropriate, the plan provisions have been applied consistently with 38 respect to similarly situated covered persons. 39 The claims procedures provide for the handling of claims filed not in **(6)** 40 accordance with procedures. a. The claims procedures provide that, in 41 the case of a failure by a covered person or an authorized

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of subsection

representative of a covered person to follow the insurer's procedures

for filing a preservice claim, within the meaning of subdivision (14a)

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- (a) of this section, the covered person or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the covered person or authorized representative, as appropriate, as soon as possible, but not later than five days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the covered person or authorized representative.
- b. Sub-subdivision a. of this subdivision shall apply only in the case of a failure that is a communication (i) by a covered person or an authorized representative of a covered person that is received by a person or organizational unit of the insurer that is customarily responsible for handling benefit matters, and (ii) that names a specific covered person, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.
- (7) The claims procedures do not contain any provision and are not administered in a way that requires a covered person to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of ERISA.
- (8) To the extent that an insurer offers voluntary levels of appeal other than external review under Part 4 of this Article, including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by subdivision (7) of this subsection, the claims procedures provide that:
 - a. The insurer waives any right to assert that a covered person has failed to exhaust administrative remedies because the covered person did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the insurer.
 - b. The insurer agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending.
 - c. The claims procedures provide that a covered person may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by subdivision (7) of this subsection.
 - d. The insurer provides to any covered person, upon request, sufficient information relating to the voluntary level of appeal to enable the covered person to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a covered person as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the covered

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person's rights to any other benefits under the health benefit plan and information about the applicable rules, the covered person's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process.

- e. No fees or costs are imposed on the covered person as part of the voluntary level of appeal.
- (9) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations except to the extent that the health benefit plan or procedures provide that:
 - a. The arbitration is conducted as one of the two appeals described in subdivision (7) of this subsection and in accordance with the requirements applicable to such appeals.
 - b. The covered person is not precluded from challenging the decision under section 502(a) of ERISA, external review under Part 4 of this Article, or G.S. 90-21.50 through G.S. 90-21.56.
- (g) Timing of Notification of Benefit-Determination.
 - (1) The insurer shall notify a covered person of the plan's benefit determination in accordance with sub-subdivisions a. through c. of this subdivision, as appropriate.
 - Urgent care claims. In the case of a claim involving urgent care, the insurer shall notify the covered person of its benefit determination, whether adverse or not, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the insurer, unless the covered person fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the health benefit plan. In the case of such a failure, the insurer shall notify the covered person as soon as possible, but not later than 24 hours after its receipt of the claim, of the specific information necessary to complete the claim. The covered person shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this subsection shall be made in accordance with subsection (h) of this section. The insurer shall notify the covered person of its benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (i) the insurer's receipt of the specified information, or (ii) the end of the period afforded the covered person to provide the specified additional information.

- b. Concurrent care decisions. If an insurer has approved an ongoing course of treatment to be provided over a period of time or number of treatments:
 - 1. Any reduction or termination by the insurer of such course of treatment, other than by plan amendment or termination before the end of such period of time or number of treatments that is permitted under G.S. 58-3-200(c), shall constitute an adverse benefit determination. The insurer shall notify the covered person, in accordance with subsection (h) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the covered person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
 - <u>2.</u> Any request by a covered person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the insurer shall notify the covered person of the benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the insurer at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment. whether involving urgent care or not, shall be made in accordance with subsection (h) of this section, and appeal shall be governed by subdivision (1) of subsection (j) of this section, as appropriate.
- c. Other claims. In the case of a claim not described in subsubdivision a. or b. of this subdivision, the insurer shall notify the covered person of its benefit determination in accordance with sub-subdivision a. of this subdivision, as appropriate.
 - 1. Preservice claims. In the case of a preservice claim, the insurer shall notify the covered person of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the insurer both determines that such an extension is necessary due to matters beyond the control of the insurer and notifies the

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covered person, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If such an extension is necessary due to a failure of the covered person to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the covered person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this subsection shall be made in accordance with subsection (h) of this section.

Postservice claims. - In the case of a postservice claim. the insurer shall notify the covered person, in accordance with subsection (h) of this section, of its adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the insurer for up to 15 days, provided that the insurer both determines that such an extension is necessary due to matters beyond the control of the insurer and notifies the covered person, prior to the expiration of the initial 30- day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If such an extension is necessary due to a failure of the covered person to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the covered person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Calculating time periods. - For purposes of this subsection, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of an insurer, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to sub-subdivision c. of subdivision (1) of this subsection due to a covered person's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the covered person until the date on which the covered person responds to the request for additional information.

(h) Manner and Content of Notification of Benefit-Determination. –

| 1 | <u>(1)</u> | Exce | ept as pr | ovided in subdivisio n (2) of this subsection, the insurer |
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| 2 | | shall | provide | a covered person with written or electronic notification |
| 3 | | of a | ny adver | se benefit determination. The notification shall set forth, |
| 4 | | in a | manner c | calculated to be understood by the covered person: |
| 5 | | <u>a.</u> | The sr | pecific reason or reasons for the adverse determination. |
| 6 | | <u>b.</u> | | ence to the specific health benefit plan provisions on |
| 7 | | | | the determination is based. |
| 8 | | <u>c.</u> | | scription of any additional material or information |
| 9 | | | · · · | ary for the covered person to perfect the claim and an |
| 10 | | | • | nation of why such material or information is necessary. |
| 11 | | <u>d.</u> | | cription of the insurer's appeal procedures and the time |
| 12 | | _ | | applicable to such procedures, including a statement of |
| 13 | | | | vered person's right to bring a civil action under section |
| 14 | | | | of ERISA following an adverse benefit determination on |
| 15 | | | | , if applicable, and right to request an external review |
| 16 | | | | Part 4 of this Article, if the claim determination is a |
| 17 | | | | rtification. |
| 18 | | <u>e.</u> | In the | case of an adverse benefit determination. – |
| 19 | | | 1. | If an internal rule, guideline, protocol, or other similar |
| 20 | | | _ | criterion was relied upon in making the adverse |
| 21 | | | | determination, either the specific rule, guideline. |
| 22 | | | | protocol, or other similar criterion; or a statement that |
| 23 | | | | such a rule, guideline, protocol, or other similar criterion |
| 24 | | | | was relied upon in making the adverse determination and |
| 25 | | | | that a copy of such rule, guideline, protocol, or other |
| 26 | | | | criterion will be provided free of charge to the covered |
| 27 | | | | person upon request. |
| 28 | | | <u>2.</u> | If the adverse benefit determination is based on a |
| 29 | | | _ | medical necessity or experimental treatment or similar |
| 30 | | | | exclusion or limit, either an explanation of the scientific |
| 31 | | | | or clinical judgment for the determination, applying the |
| 32 | | | | terms of the health benefit plan to the covered person's |
| 33 | | | | medical circumstances, or a statement that such |
| 34 | | | | explanation will be provided free of charge upon request. |
| 35 | | <u>f.</u> | In the | case of an adverse benefit determination concerning a |
| 36 | | | | involving urgent care, a description of the expedited |
| 37 | | | | s applicable to an appeal of such claims. |
| 38 | | g. | | of the availability of assistance from: |
| 39 | | <u>1.</u> | | ommissioner's office, including the telephone number and |
| 40 | | <u> </u> | | s of the Commissioner's office. |
| 41 | | <u>2.</u> | | Managed Care Patient Assistance Program, including the |
| 42 | | _ | | one number and address of the Program. |
| 43 | <u>(2)</u> | In t | | of an adverse benefit determination by an insurer |
| 11 | | conc | | claim involving preant care the information described in |

| 1 | | | subdi | vision (1) of this subsection may be provided to the covered |
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| 2 | | | perso | n orally within the time frame prescribed in sub-subdivision |
| 3 | | | _ | a. of this section, provided that a written or electronic |
| 4 | | | | cation in accordance with subdivision (1) of this subsection is |
| 5 | | | | shed to the covered person not later than three days after the ora |
| 6 | | | | cation. |
| 7 | <u>(i)</u> | Appe | | dverse Benefit Determinations. – |
| 8 | <u>۸۲</u> | (1) | | neral Every insurer shall establish and maintain a procedure by |
| 9 | | <u>1-7</u> | | n a covered person shall have a reasonable opportunity to appear |
| 10 | | | | verse benefit determination to an appropriate named fiduciary of |
| 11 | | | | lan, and under which there will be a full and fair review of the |
| 12 | | | | and the adverse benefit determination. |
| 13 | | <u>(2)</u> | | and fair review The claims procedures of an insurer will not be |
| 14 | | 121 | | ed to provide a covered person with a reasonable opportunity for |
| 15 | | | | and fair review of a claim and adverse benefit determination |
| 16 | | | | s the claims procedures: |
| 17 | | <u>a.</u> | | de covered persons the opportunity to submit written comments. |
| 18 | | <u>u.</u> | | ments, records, and other information relating to the claim for |
| 19 | | | benef | |
| 20 | | | b. | Provide that a covered person shall be provided, upon request |
| 21 | | | <u>v.</u> | and free of charge, reasonable access to, and copies of, al |
| 22 | | | | documents, records, and other information relevant to the |
| 23 | | | | |
| 23 24 | | | | covered person's claim for benefits. Whether a document record, or other information is relevant to a claim for benefits |
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| | | | | shall be determined by reference to the definition provided |
| 26 27 | | | | under subdivision (15a) of subsection (a) of this section. |
| 27 | | | <u>c.</u> | Provide for a review that takes into account all comments |
| 28 | , | | | documents, records, and other information submitted by the |
| 29 | | | | covered person relating to the claim, without regard to whether |
| 30 | | | | such information was submitted or considered in the initial |
| 31 | | | | benefit determination. |
| 32 | | | <u>d.</u> | Provide covered persons at least 180 days following receipt of a |
| 33 | | | | notification of an adverse benefit determination within which to |
| 34 | | | _ | appeal the determination. |
| 35 | | | <u>e.</u> | Provide for a review that does not afford deference to the initial |
| 36 | | | | adverse benefit determination and that is conducted by ar |
| 37 | | | | appropriately named fiduciary of the plan who is neither the |
| 38 | | | | individual who made the adverse benefit determination that is |
| 39 | | | C | the subject of the appeal, nor the subordinate of such individual. |
| 40 | | | <u>f.</u> | Provide that, in deciding an appeal of any adverse benefit |
| 41 | | | | determination that is based in whole or in part on a medical |
| 42 | | | | judgment, including determinations with regard to whether a |
| 43 | | | | particular treatment, drug, or other item is experimental |
| 44 | | | | investigational, or not medically necessary or appropriate, the |
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| 1 | | | | appropriately named fiduciary shall consult with a health care |
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| 2 | | | | professional who has appropriate training and experience in the |
| 3 | | | | field of medicine involved in the medical judgment. |
| 4 | | | <u>g.</u> | Provide for the identification of medical or vocational experts |
| 5 | | | | whose advice was obtained on behalf of the insurer in |
| 6 | | | | connection with a covered person's adverse benefit |
| 7 | | | | determination, without regard to whether the advice was relied |
| 8 | | | | upon in making the benefit determination. |
| 9 | | | <u>h.</u> | Provide that the health care professional engaged for purposes |
| 10 | | | _ | of a consultation under sub-subdivision c. of this subdivision |
| 11 | | | | shall be an individual who is neither an individual who was |
| 12 | | | | consulted in connection with the adverse benefit determination |
| 13 | | | | that is the subject of the appeal, nor the subordinate of any such |
| 14 | | | | individual. |
| 15 | | | <u>i.</u> | Provide, in the case of a claim involving urgent care, for ar |
| 16 | | | <u>=-</u> | expedited review process pursuant to which (i) a request for ar |
| 17 | | | | expedited appeal of an adverse benefit determination may be |
| 18 | | | | submitted orally or in writing by the covered person; and (ii) al |
| 19 | | | | necessary information, including the insurer's benefit |
| 20 | | | | determination on review, shall be transmitted between the |
| 21 | | | | insurer and the covered person by telephone, facsimile, or other |
| 22 | | | | available similarly expeditious method. |
| 23 | (i) | Timir | ng of N | otification of Benefit-Determination on Appeal. – |
| 24 | 3J.Z | $\overline{(1)}$ | | nsurer shall notify a covered person of its benefit determination |
| 25 | | 3,=,/ | | view in accordance with sub-subdivisions a. through c. of this |
| 26 | | | | vision as appropriate. |
| 27 | | | <u>a.</u> | Urgent care claims In the case of a claim involving urgen |
| 28 | | | | care, the insurer shall notify the covered person, in accordance |
| 29 | | | | with subsection (k) of this section, of its benefit determination |
| 30 | | | | on review as soon as possible, taking into account the medica |
| 31 | | | | exigencies, but not later than 72 hours after receipt of the |
| 32 | | | | covered person's request for review of an adverse benefit |
| 33 | | | | determination by the insurer. |
| 34 | | | <u>b.</u> | Preservice claims In the case of a preservice claim, the insured |
| 35 | | | _ | shall notify the covered person, in accordance with subsection |
| 36 | | | | (k) of this section, of its benefit determination on review within |
| 37 | | | | a reasonable period of time appropriate to the medica |
| 38 | | | | circumstances as follows: |
| 39 | | | | 1. In the case of an insurer that provides for one appeal of |
| 40 | | | | an adverse benefit determination, notification shall be |
| 41 | | | | provided not later than 30 days after receipt by the |
| 42 | | | | insurer of the covered person's request for review of ar |
| 43 | | | | adverse benefit determination. |
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- 2. In the case of an insurer that provides for two appeals of an adverse benefit determination and makes the second level mandatory for purposes of a covered person's access to federal remedies under section 502(a) of ERISA, notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination.
- 3. In the case of an insurer that provides for two appeals of an adverse benefit determination and makes the second level voluntary for purposes of a covered person's access to federal remedies under section 502(a) of ERISA, notification shall be provided, for the first level, within 30 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination and, for the second level, within 55 days of receipt by the insurer of the covered person's request for review of the adverse benefit determination.
- c. Postservice claims. In the case of a postservice claim, the insurer shall notify the covered person, in accordance with subsection (k) of this section, of its benefit determination on review within a reasonable period of time as follows:
 - 1. In the case of an insurer that provides for one appeal of an adverse benefit determination, notification shall be provided not later than 60 days after receipt by the insurer of the covered person's request for review of an adverse benefit determination.
 - 2. In the case of an insurer that provides for two appeals of an adverse benefit determination and makes the second level mandatory for purposes of a covered person's access to federal remedies under section 502(a) of ERISA, notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination.
 - 3. In the case of an insurer that provides for two appeals of an adverse benefit determination and makes the second level voluntary for purposes of a covered person's access to federal remedies under section 502(a) of ERISA, notification shall be provided, for the first level, within 60 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination and, for the second level, within 55 days

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| 1 | | | of receipt by the insurer of the covered person's request |
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| 2 | | | for review of the adverse benefit determination. |
| 3 | | <u>(2)</u> | Calculating time periods For purposes of this subsection, the period |
| 4 | | | of time within which a benefit determination on review is required to |
| 5 | | • | be made shall begin at the time an appeal is filed in accordance with |
| 6 | | | the reasonable procedures of an insurer, without regard to whether all |
| 7 | | | the information necessary to make a benefit determination on review |
| 8 | | | accompanies the filing. |
| 9 | | <u>(3)</u> | Furnishing documents In the case of an adverse benefit |
| 10 | | | determination on review, the insurer shall provide such access to, and |
| 11 | | | copies of, documents, records, and other information described in |
| 12 | | | subdivisions (3) and (4) of subsection (k) of this section as is |
| 13 | | | appropriate. |
| 14 | <u>(k)</u> | | er and Content of Notification of Benefit-Determination on Appeal |
| 15 | | | 1 provide a covered-person with written or electronic notification of the |
| 16 | | | it determination on review. In the case of an adverse—benefit |
| 17 | determina | tion, t | he notification shall set forth, in a-manner calculated to be understood |
| 18 | by the co | vered p | person: |
| 19 | | <u>(1)</u> | The specific reason or reasons for the adverse determination. |
| 20 | | <u>(2)</u> | Reference to the specific health benefit plan provisions on which the |
| 21 | | | adverse benefit determination is based. |
| 22 | | <u>(3)</u> | A statement that the covered person is entitled to receive, upon request |
| 23 | | | and free of charge, reasonable access to, and copies of, all documents. |
| 24 | | | records, and other information relevant to the covered person's claim |
| 25 | | | for benefits. Whether a document, record, or other information is |
| 26 | | | relevant to a claim for benefits shall be determined by reference to |
| 27 | | | subdivision (15a) of subsection (a) of this section. |
| 28 | | <u>(4)</u> | A statement describing any appeal procedures, including any voluntary |
| 29 | | | appeal procedures, offered by the insurer and the covered person's |
| 30 | | | right to obtain the information about such procedures described in |
| 31 | | | subsection (f) of this section, a statement of the covered person's right |
| 32 | | | to bring a civil action under section 502(a) of ERISA following an |
| 33 | | | adverse benefit determination on appeal, if applicable, and a statement |
| 34 | | | describing the external review process under Part 4 of this Article and |
| 35 | | | the right to request an external review under Part 4 of this Article, if |
| 36 | | | the claim determination is a noncertification. |
| 37 | | | a. If an internal rule, guideline, protocol, or other similar criterion |
| 38 | | | was relied upon in making the adverse determination, either the |
| 39 | | | specific rule, guideline, protocol, or other similar criterion, or a |
| 40 | | | statement that such rule, guideline, protocol, or other similar |
| 41 | | | criterion was relied upon in making the adverse determination |
| 42 | | | and that a copy of the rule, guideline, protocol, or other similar |
| 43 | | | criterion will be provided free of charge to the covered person |
| 44 | | | upon request. |

b. If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limit or other noncertification: (i) either an explanation of the scientific or clinical judgment for the determination, applying the terms of the health benefit plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (ii) a description of the external review process under Part 4 of this Article, a statement of the covered person's right to request an external review, and notice of the availability of assistance from the Commissioner's office, including the telephone number and address of the Commissioner's office, and the Managed Care Patient Assistance Program, including the telephone number and address of the Program."

SECTION 3. G.S. 58-50-62 reads as rewritten:

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

- (a) Purpose and Intent. The purpose of this section is-to provide standards for the establishment and maintenance of-procedures by insurers to assure that covered persons have the-opportunity for appropriate resolutions of their grievances.
- (b) Availability of Grievance Process. Every insurer shall-have a grievance process whereby a covered person may-voluntarily request a review of a grievance. any decision, policy, or action of the insurer that affects that covered person. A decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question is not subject to the insurer's grievance procedures, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. The grievance process may provide-for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall grievance and shall provide for first—and second-level reviews of grievances. Appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section. a formal review of grievances.
- (b1) Informal Consideration of Grievances. If the insurer-provides procedures for informal consideration of grievances, the procedures shall be in writing, and the following-requirements apply:
 - (1) If the grievance concerns a clinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner;
 - (2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the covered person, the insurer

- shall issue a written decision that includes the information set forth in subsection (c) of this section; or
- (3) If the insurer is unable to render an informal consideration decision within 10 business days after receipt of the grievance, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply beginning on the day the insurer determines an informal consideration decision cannot be made before the tenth business day after receipt of the grievance.
- (c) Grievance Procedures. Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that them grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office and Managed Care Patient Assistance program for assistance, including the telephone number and address of the each office.
- (d) Maintenance of Records. Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.
- (e) First-Level Grievance Review. A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance.
 - (1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Except as provided in subdivision (3) of this subsection, within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. Except as provided in subdivisions (2) through (4) of this subsection, a grievance shall be reviewed in accordance with the standards for review of an appeal of an adverse benefit determination under G.S. 58-50-61, including the requirements for full and fair review, the requirements for timing of notification for a determination on appeal of a postservice claim, and the requirements for content of notification of decision.
 - (2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially

| 1 | | handled the matter that is the subject of the grievance and, if the issue |
|----|-----------------|---|
| 2 | | is a clinical one, at least one of whom shall be a medical doctor with |
| 3 | | appropriate expertise to evaluate the matter. Except as provided in |
| 4 | | subdivision (3) of this subsection, if the decision is not in favor of the |
| 5 | | covered person, the written decision issued in a first-level grievance |
| 6 | | review shall contain: |
| 7 | | a. The professional qualifications and licensure of the person or |
| 8 | | persons reviewing the grievance. |
| 9 | | b. A statement of the reviewers' understanding of the grievance. |
| 10 | | c. The reviewers' decision in clear terms and the contractual basis |
| 11 | | or medical rationale in sufficient detail for the covered person |
| 12 | | to respond further to the insurer's position. |
| 13 | | d. A reference to the evidence or documentation used as the basis |
| 14 | | for the decision. |
| 15 | | e. A statement advising the covered person of his or her right to |
| 16 | | request a second-level grievance review and a description of the |
| 17 | | procedure for submitting a second-level grievance under this |
| 18 | | section. |
| 19 | | Notification of a determination on a grievance review shall include a |
| 20 | | statement that the decision is the insurer's final determination in the |
| 21 | | matter, when the determination is made at the final level of grievance |
| 22 | | review. |
| 23 | (3) | For grievances concerning the quality of clinical care delivered by the |
| 24 | | covered person's provider, the insurer shall acknowledge the grievance |
| 25 | | within 10 business days. The acknowledgement shall advise the |
| 26 | | covered person that (i) the insurer will refer the grievance to its quality |
| 27 | | assurance committee for review and consideration or any appropriate |
| 28 | | action against the provider and (ii) State law does not allow for a |
| 29 | | second-level grievance review for grievances concerning quality of |
| 30 | | care. |
| 31 | <u>(4)</u> | Provisions under G.S. 58-50-61(i) and (k) relating to clinical aspects of |
| 32 | | an appeal of an adverse benefit determination shall apply to grievance |
| 33 | | review only to the extent that the subject matter of a grievance is |
| 34 | | clinical in nature. Provisions under G.S. 58-50-61(j) and (l) that apply |
| 35 | | only to noncertifications shall not apply to grievance review, except |
| 36 | | that the requirement under G.S. 58-50-61(j)(4)b. to notify the covered |
| 37 | | person of the availability of assistance from the Commissioner's office |
| 38 | | and the Managed Care Patient Assistance Program shall apply. |
| 39 | (f) Seco | nd-Level Grievance Review An insurer shall establish a second-level |
| 40 | grievance revie | www process for covered persons who are dissatisfied with the first-level |
| 41 | grievance revie | w decision or a utilization review appeal decision. A covered person or |
| 42 | _ | erson's provider acting on the covered person's behalf may submit a |

second-level grievance.

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- (1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:
 - a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.
 - b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.
- (2)An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.
- (g) Second-Level Grievance Review Procedures. An insurer's procedures for conducting a second level grievance review shall include:
- (1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second level review.
- (2) The covered person shall be notified in writing at least 15 days before the review meeting date.
- (3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.
- (h) Second-Level Grievance Review Decisions. An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:
 - (1) The professional qualifications and licensure of the members of the review panel.

- A statement of the review panel's understanding of the nature of the (2)1 2 grievance and all pertinent facts. The review panel's recommendation to the insurer and the rationale 3 (3)4 behind that recommendation. 5 A description of or reference to the evidence or documentation (4) considered by the review panel in making the recommendation. 6 In the review of a noncertification or other clinical matter, a written 7 (5) statement of the clinical rationale, including the clinical review 8 criteria, that was used by the review panel to make the 9 10 recommendation. The rationale for the insurer's decision if it differs from the review 11 (6) panel's recommendation. 12 13 (7)A statement that the decision is the insurer's final determination in the 14 matter. In cases where the review concerned a noncertification and the 15 insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his 16 or her right to request an external review and a description of the 17 procedure for submitting a request for external review to the 18 19 Commissioner of Insurance. 20 Notice of the availability of the Commissioner's office for assistance, (8) including the telephone number and address of the Commissioner's 21 22 Expedited Second-Level Procedures. - An expedited second-level review 23 (i) shall be made available where medically justified as provided in G.S. 58-50-61(1), 24 whether or not the initial review was expedited. The provisions of subsections (f), (g), 25 and (h) of this section apply to this subsection except for the following timetable: When 26 a covered person is eligible for an expedited second-level review, the insurer shall 27 28 conduct the review proceeding and communicate its decision within four days after 29 receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information. 30 31 No insurer shall discriminate against any provider based-on any action taken
 - Violation. A violation of this section subjects an-insurer to G.S. 58-2-70." **SECTION 4.** G.S. 58-3-225(c) reads as rewritten:

"(c) If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or

by the provider under this section or G.S. 58-50-61 on behalf of a covered person. (k)

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43 44 shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information. Any retraction of a determination or reduction of payments that is made because of the discovery of a misrepresentation shall only be made in accordance with G.S. 58-50-61(g) if the determination being reversed is a concurrent care determination."

SECTION 5. G.S. 58-50-75 reads are rewritten:

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

- (a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.
- (b) This Part applies to all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to G.S. 58-50-61, the Teachers' and State Employees' Comprehensive Major Medical Plan, and the Health Insurance Program for Children. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.
 - (c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:
 - (1) "Covered benefits" or "benefits" means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.
 - "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another person, including the covered person's health care provider, acting on behalf of the covered person. Nothing in this subdivision shall require the covered person's health care provider to act on behalf of the covered person.
 - (3) "Independent review organization" or "organization" means an entity that conducts independent external reviews of appeals of

 noncertifications and second-level grievance review decisions. (2001-446, s. 4.5.) noncertifications."

SECTION 6. G.S. 58-50-77 reads are rewritten:

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

- (a) An insurer shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in this section at the time the insurer sends written notice of:
 - (1) A noncertification decision under G.S. 58-50-61; and
 - (2) An appeal decision A notice of determination on an appeal under G.S. 58-50-61 G.S. 58-50-61(j) upholding a noncertification; and noncertification.
 - (3) A second-level grievance review decision under G.S. 58-50-62 upholding the original noncertification.
- (b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a noncertification decision under G.S. 58-50-61, a statement informing the covered person that if the covered person has a medical condition where the time frame for completion of an expedited review urgent care claim review of an appeal decision involving a noncertification decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, then the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review urgent care claim review of an appeal involving a noncertification decision under G.S. 58-50-61, but that the Commissioner will determine whether the covered person shall be required to complete the expedited review urgent care claim review of the grievance before conducting the expedited external review.
- (c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:
 - (1) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance urgent care claim review involving an appeal decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of a grievance urgent care claim review involving an appeal decision under G.S. 58-50-62, but that the Commissioner will determine whether the covered person shall be required to complete the expedited review urgent care claim review of the grievance—before conducting the expedited external review.
 - (2) If the covered person has not received a written decision from the insurer within 60 days after the date the covered person files the

- second-level grievance with the insurer pursuant to G.S. 58-50-62 five (5) days of the date by which the insurer was to have notified the covered person of its determination pursuant to G.S. 58050-61(j) and the covered person has not requested or agreed to a delay, the covered person may file a request for external review under G.S. 58-50-80 and shall be considered to have exhausted the insurer's internal grievance appeal process for purposes of G.S. 58-50-79.
- (d) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a final second-level grievance review decision under G.S. 58-50-62, any notice of determination on an appeal under G.S. 58-50-61(k), a statement informing the covered person that:
 - (1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or
 - (2) If the second-level grievance review final appeal decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.
- (e) In addition to the information to be provided under this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information."

SECTION 7. G.S. 58-50-79 reads as rewritten:

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

- (a) Except as provided in G.S. 58-50-82, a request for an external review under G.S. 58-50-80 or G.S. 58-50- 82 shall not be made until the covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62. G.S. 58-50-61.
- (b) A covered person shall be considered to have exhausted the insurer's internal grievance appeal process for purposes of this section, if the covered person:
 - (1) Has filed a second-level grievance completed the appeals process for involving a noncertification appeal decision decisions under G.S. 58-50-61 and G.S. 58-50-62, G.S. 58-50-61, and
 - (2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 60 days since the date the covered person filed the grievance with the insurer five (5) days of the date by which the insurer was to have notified the covered person of its determination pursuant to G.S. 58-50-61(j).

- (c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal grievance-appeal process.
- (d) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance and appeal procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the insurer's internal grievance appeal procedures is waived, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82. In addition, the insurer may choose to eliminate the second level grievance review under G.S. 58-50-62. In such case, the covered person may file a request in writing for a standard external review under G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82 within 60 days after receiving notice of an appeal decision upholding a noncertification."

SECTION 8. G.S. 58-50-80(b) reads as rewritten

- "(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:
- (1) Notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The notice shall include a request for any information that the Commissioner requires to conduct the preliminary review under subdivision (2) of this subsection and require that the insurer deliver the requested information to the Commissioner within three business days of receipt of the notice.
 - (2) Conduct a preliminary review of the request to determine whether:
 - a. The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.
 - b. The health care service that is the subject of the <u>insurer's</u> noncertification appeal decision or the second-level grievance review decision upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.
 - c. The covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61-and G.S. 58-50-62, unless the covered person is considered to have exhausted the insurer's internal appeal or grievance process under G.S. 58-50-79, or unless the insurer has waived its right to conduct an expedited urgent care claim review of the appeal decision.
 - d. The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.
 - (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 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. The Commissioner shall also notify the covered person in writing of the availability of assistance from the Managed Care Patient Assistance Program. including the telephone number and address of the Program.
- (4) Notify the insurer in writing whether the request for external review has been accepted. If the request has been accepted, the notice shall direct the insurer or its designee utilization review organization to provide to the assigned organization, within seven days of receipt of the notice, the documents and any information considered in making the noncertification appeal decision or the second-level grievance review-decision.
- (5) Assign the review to an independent review organization approved under G.S. 58-50-85. The assignment shall be made using an alphabetical list of the independent review organizations, systematically assigning reviews on a rotating basis to the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the Commissioner shall return to the top of the list to continue assigning reviews.
- (6) Forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review.'

SECTION 9. G.S. 58-50-80(e) reads as rewritten:

"(e) Failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review. However, if the insurer or its utilization review organization fails to provide the documents and information within the time specified in subdivision (b)(4) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision—or the second—level grievance review—decision. Within one business day of making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner."

SECTION 10. G.S. 58-50-80(g) reads as rewritten:

"(g) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision—that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision—under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level

grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision. or second-level grievance review decision. "

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SECTION 11. G.S. 58-50-80(h) reads as rewritten:

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

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SECTION 12. G.S. 58-50-80(i) reads as rewritten:

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"(i) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision—to the covered person, the insurer, the covered person's provider who performed or requested the service, and the Commissioner. In reaching a decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance appeal process under G.S. 58-50-61. and G.S. 58-50-62. G.S. 58-50-61."

SECTION 13. G.S. 58-50-80(l) reads as rewritten:

"(1) Upon receipt of a notice of a decision under subsection (k) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall within three business days reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification appeal decision or second-level grievance review decision. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (k) of this section reversing the noncertification appeal decision or second level grievance review decision, the insurer that made the noncertification appeal decision or second-level grievance review decision shall be responsible under this section only for the costs of those services or supplies the covered person received or would have received prior to disenrollment if the service had not been denied when first requested."

SECTION 14. G.S. 58-50-82 reads as rewritten:

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

- (a) Except as provided in subsection (g) of this section, a covered person may make a written or oral request for an expedited external review with the Commissioner at the time the covered person receives:
 - (1) A noncertification decision under G.S. 58-50-61(f) G.S. 58-50-61(g) if:
 - a. The covered person has a medical condition where the time frame for completion of an expedited urgent care claim review of an appeal involving a noncertification set forth in G.S. 58-50-61(1) G.S. 58-50-61 (j) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

- b. The covered person has filed a request for an expedited appeal an urgent care claim review of an appeal under G.S. 58-50-61(1) G.S. 58-50-61(j).
- (2) An appeal decision under G.S. 58-50- 61(j)-or (l) that is not the insurers final level of appeal upholding a noncertification if:
 - a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i)-appeal of an urgent care claim would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; and
 - b. The covered person has filed a request for an expedited second-level review an urgent care claim review of an appeal of a noncertification at the final level of appeal offered by the insurer as set forth in G.S. 58-50-61(i); G.S. 58-50-61

 (i); or
- (3) A second-level grievance review A final appeal decision under G.S. 58-60-62(h) or (i) G.S. 58-50-61(j) upholding a noncertification:
 - a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or
 - b. If the second level grievance <u>final appeal</u> concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.
- (b) Within three days of receiving a request for an expedited external review, the Commissioner shall complete all of the following:
 - (1) Notify the insurer that made the noncertification, noncertification or noncertification appeal-decision, or second-level grievance review-decision which is the subject of the request that the request has been received and provide a copy of the request or verbally convey all of the information included in the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one day after the request was made.
 - (2) Determine whether the request is eligible for external review and, if it is eligible, determine whether it is eligible for expedited review.
 - a. For a request made pursuant to subdivision (a)(1) of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of an expedited review urgent care claim review of an appeal under G.S. 58-50-61(1)

- G.S. 58-50-61(j) would reasonably be expected to seriously jeopardize the life or 1 2 health of the covered person or would jeopardize the covered person's ability to 3 regain maximum function. The Commissioner shall then inform the covered 4 person, the covered person's provider who performed or requested the service, 5 and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the 6 7 covered person's request for an expedited external review, then the 8 Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to 9 conduct the review within the appropriate time frame. If the Commissioner has 10 not accepted the covered person's request for an expedited external review, then the covered person shall be informed by the Commissioner that the covered 11 person must exhaust, at a minimum, one level of the insurer's internal appeal 12 process under G.S. 58-50-61(1) G.S. 58-50-61(j) before making another request 13 for an external review with the Commissioner. 14
 - b. For a request made pursuant to subdivision (a)(2) of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of an expedited review urgent care claim review of an appeal under G.S. 58-50-62-G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person, the covered person's provider who performed or requested the service. and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be informed by the Commissioner that the covered person must exhaust the insurer's internal grievance appeal process under G.S. 58-50-62 G.S. 58-50-61 to obtain the insurer's final appeal decision before making another request for an external review with the Commissioner.
 - c. For a request made pursuant to sub-subdivision (a)(3)a. of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The

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- Commissioner shall then inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.
- d. For a request made pursuant to sub- subdivision (a)(3)b. of this section, that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision.
- (c) As soon as possible, but within the same day of receiving notice under subdivision (b)(2) of this section that the request has been assigned to a review organization, the insurer or its designee utilization review organization shall provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision—to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method.
- (d) In addition to the documents and information provided or transmitted under subsection (c) of this section, the assigned organization, to the extent the information or documents are available, shall consider the following in reaching a decision:
 - (1) The covered person's pertinent medical records.
 - (2) The attending health care provider's recommendation.
 - (3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
 - (4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
 - (5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.
 - (6) Medical necessity, as defined in G.S. 58-3-200(b).
 - (7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation. The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan. The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.
- (e) As expeditiously as the covered person's medical condition or circumstances require, but not more than four days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification, noncertification or noncertification appeal decision, or second-level grievance review decision and notify the covered person, the covered person's provider who performed or requested the service, the insurer, and the

1 Commissioner of the decision. In reaching a decision, the assigned organization is not 2 bound by any decisions or conclusions reached during the insurer's utilization review 3 process or internal grievance appeal process under G.S. 58-50-61 and G.S. 58-50-62. 4 (f) If the notice provided under subsection (e) of this section was not in writing.

- (f) If the notice provided under subsection (e) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(m). Upon receipt of the notice of a decision under subsection (e) of this section that reverses the noncertification, noncertification or noncertification appeal decision, or second-level grievance review decision, the insurer shall within one day reverse the noncertification, noncertification or noncertification, decision or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification, noncertification or noncertification appeal decision. or second-level grievance review decision.
- (g) An expedited external review shall not be provided for retrospective noncertifications."

SECTION 15. G.S. 58-50-84(c) reads as rewritten:

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

SECTION 16. G.S. 58-50-90(c) reads as rewritten:

- "(c) The report shall include in the aggregate and for each insurer:
 - (1) The total number of requests for external review.
- (2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.
 - (3) The average length of time for resolution.
- (4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.
- (5) The number of external reviews under G.S. 58-50-80 that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.
 - (6) Any other information the Commissioner may request or require." **SECTION 17.** G.S. 58-50-93(b) reads as rewritten:
- "(b) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of a noncertification, noncertification or noncertification appeal decision or a second-level grievance review decision—upholding a

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noncertification with the Commissioner. The statement shall include the telephone number and address of the Commissioner." 2

SECTION 18. This act becomes effective upon ratification and shall be implemented not later than March 1, 2004.



HOUSE BILL 596: Motor Vehicle Insurance Rates

BILL ANALYSIS

Committee: House Insurance

Date:

April 23, 2003

Version:

Proposed Committee Substitute

H596-CSRC-42[v.3]

Introduced by: Representative Starnes

Summary by:

Kory J. Goldsmith

(ittachment 1

Committee Counsel

SUMMARY: HB 596 would prohibit the use of credit scoring by insurance companies for setting rates, terminating coverage or increasing rates for automobile insurance.

BILL ANALYSIS: Credit score is defined under the bill as "a score that is derived from an individual's credit report in an algorithm, computer program, model, or other process that reduces the data to a number or rating."

The bill specifically prohibits private passenger motor vehicle insurers from using credit scoring as the sole basis to:

- Setting rates for new policies
- Terminate an existing policy or any coverage in an existing policy.
- Subject a policy to consent to rate. "Consent to rate" is the process by which an insurer may charge a rate in excess of the rate promulgated by the Rate Bureau with the written consent of the insured.

EFFECTIVE DATE: Senate Bill 771 would become effective January 1, 2004 and would apply to policies issued or renewed on or after that date and to applications made on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 596 PROPOSED COMMITTEE SUBSTITUTE H596-CSRC-42 [v.3]

4/23/2003 6:48:23 PM

| | Short Tit | le: Mo | otor Vehicle Insurance Rates. | (Public) | |
|--------|-------------------------------|----------------|---|--------------------|--|
| | Sponsors: | | | | |
| | Referred | to: | | | |
| | | | March 24, 2003 | • | |
| 1 2 | | | A BILL TO BE ENTITLED PROHIBIT INSURERS FROM USING A PERSON'S WHEN DETERMINING AUTOMOBILE INSURANCE | | |
| 3 | LEDI HIST | OR I MINIAT | ING INSURANCE COVERAGE OR SUBJECTING A P | OLICY TO | |
| 4 5 | | | EASES. | OLICI IO | |
| 6 | KAI | L INCK | EASES. | | |
| 7 | • | The C | General Assembly of North Carolina enacts: | | |
| 8 | | | FION 1. Article 36 of Chapter 58 of the General Statutes is | amended by | |
| 9 | adding a new section to read: | | | | |
| 10 | | | rohibition on using credit scoring to rate nonfleet private | <u>e passenger</u> | |
| 11 | | | r vehicle. | | |
| 12 | <u>(a)</u> | Defin | itions. – As used in this section: | | |
| 13 | | <u>(1)</u> | "Credit report" means any written, oral, or other communic | | |
| 14 | | | information by a consumer reporting agency that b | | |
| 15 | | | consumer's credit worthiness, credit standing, or credit cap | | |
| 16 | | | report does not include accident or traffic violation | | |
| 17 | | | maintained by the North Carolina Division of Motor Veh | | |
| 18 | | | other law enforcement agency, a property loss report or cl | | |
| 19 | | | that does not include information that bears on a consu | | |
| 20 | | | worthiness, credit standing, or credit capacity, or any report | | |
| 21 | | | information solely as to transactions or experiences b | between the | |
| 22 | | (2) | consumer and the person making the report. | lata from an | |
| 23 | | <u>(2)</u> | "Credit score" means a score that is derived by utilizing of | | |
| 24 | | | individual's credit report in an algorithm, computer program | n, model, or | |
| 25 | | (2) | other process that reduces the data to a number or rating. "Private passenger motor vehicle" has the same meaning a | s set forth in | |
| 26 | | <u>(3)</u> | | s set totul III | |
| 27 | | | <u>G.S. 58-40-10.</u> | | |

GENERAL ASSEMBLY OF NORTH CAROLINA

| 1 | (b) Prohibitions In the rating and underwriting of private passenger motor |
|-----|---|
| 2 | vehicle insurance, insurers shall not use credit scoring in any manner for the following |
| 3 | purposes: |
| 4 | (1) Providing a quote or establishing the rate for a new policy. |
| 5 | (2) Terminating an existing policy or any coverage in an existing policy. |
| 6 | (3) Subjecting a policy to consent to rate, as specified in G.S. 58-36- |
| 7 | <u>30(b)."</u> |
| 8 | SECTION 2. This act becomes effective January 1, 2004, and applies to |
| 9 | policies issued or renewed on or after that date and to applications for coverage made on |
| 0 | or after that date. |
| l 1 | |
| | |



HOUSE BILL 892: Workers Comp. Interstate Carrier Duties

BILL ANALYSIS

Committee: House Insurance Committee

Date:

April 28, 2003

Version:

House Bill 892-First Edition

Introduced by: Representatives Saunders and

Attachment

McComas

Summary by:

Tim Hovis

Committee Counsel

SUMMARY: House Bill 892 would amend Chapter 97 of the General Statutes (Workers Compensation) to provide that the common law shall determine whether a truck or tractor trailer driver is an independent contractor or an "employee" under the state's workers compensation laws.

The statutory definition of an employee is included in the bill.

Under common law, the courts examine a variety of factors to determine whether a person is an employee or an independent contractor including the following:

- An employer's control over the individual's work environment.
- Method of payment (lump sum or hourly).
- Source of materials.
- An individual's right to employ other persons.
- Whether an individual maintains an independent business.
- An employer's right to terminate an individual's employment, with or without good cause.
- Payment of benefits by an employer, including insurance coverage.

EFFECTIVE DATE: House Bill 892 is effective when it becomes law and applies to claims arising on or after October 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 892 PROPOSED COMMITTEE SUBSTITUTE H892-CSRA-5 [v.1]

4/29/2003 9:42:02 AM

| Short Title: | Workers Comp./Interstate Carrier Drivers. | (Public) |
|--------------|---|----------|
| Sponsors: | | |
| Referred to: | | |
| | | |

April 7, 2003

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A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE COMMON LAW DETERMINES WHETHER A DRIVER OF A TRUCK OR TRACTOR TRAILER OF AN INTERSTATE MOTOR CARRIER IS AN EMPLOYEE SUBJECT TO THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

"(2)

SECTION 1. G.S. 97-2(2) reads as rewritten:

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Employee. - The term "employee" means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term "employee" shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term "employee" shall include all officers and employees thereof, including such as are elected by the people. The term "employee" shall include members of the North Carolina national guard while on State active duty under orders of the Governor and members of the North Carolina State Defense Militia while on State active duty under orders of the Governor. The term "employee" shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving on a fee basis or on a salary basis, or whether deputy sheriffs serving

upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment, and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been injured shall, when the employee is dead, include also his legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee as herein defined of a municipality, county, or of the State of North Carolina while engaged in the discharge of his official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of his employer.

Every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation specifically excluding such executive officer in such contract of insurance and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term employee shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-491(a) when

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20 21 performing duties in the course and scope of a State approved mission pursuant to Article 11 of Chapter 143B.

Employee shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

Any sole proprietor or partner of a business or any member of a limited liability company may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article.

An individual in the interstate carrier industry who operates a truck, tractor, or truck tractor licensed by a governmental motor vehicle regulatory agency may be an employer or an independent contractor under this Article dependent upon the application of the common law test for determining employment status."

SECTION 2. This act is effective when it becomes law and applies to any claim arising on or after October 1, 2003.

attachment

VISITOR REGISTRATION SHEET

HOUSE INSURANCE COMMITTEE

4-29-03

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|-----------------|--|
| Camille Stell | Kennely Coveretor |
| SUSan Valan | Northmerie |
| D. Prys | NCDOS |
| RAY WARNER | CERTIFIED HUTOMOTIVE PARTS PASOCIATION |
| Fileen Sottile | veystore Automotive |
| Melvin South | Keyston Patonitive |
| Michael Houser | NCAE |
| Randy Lisk | Automative Fetermarket Assin. |
| John McMillan | MESS |
| Barbaru Cansler | MFSS |
| Bile Wilson | ncath |
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HOUSE INSURANCE COMMITTEE

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Coretney of CROWLIZ | NC DO (|
| Collean Kochanek | Hafer & Caldwell, P. A. |
| TONN PETERSON | NCINS |
| KEITH WATERS | KEYSTONE AGTOROTINE GARNEZ, NC |
| Carl Neville | Kesstone Andropphe Borno N.C. |
| Daw Richard | The Arc |
| James Andrews | NC State AFL-CIO |
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HOUSE INSURANCE COMMITTEE

4-29-03

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|-------------------|---------------------------------|
| Melvin Smith | Keystone Automotive, Charolte |
| Bonnie Oakland | Larns Collision, Zebulon |
| Mark Barnes | Barner Collision, Zebulon |
| Lon O'neal | Barnes Collision, Zebulon |
| Revin Tuln | Worth Carolina State University |
| Barbra Morales- | NCDOI |
| Memmie Harrington | Inturn w mike (quey |
| Robert Paschal | Johns, Masci |
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| PERRI MORGON | NFIB |
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HOUSE INSURANCE COMMITTEE

4-29-03

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------------|----------------------------|
| Jim Lors | R. JAMES LORS Att pt LOW |
| Victor Farah | Jernigan Law Firm |
| Chip Killian | Morey Van Allen |
| Steve Woodson | NC Farm Bureau |
| Charlie Diehl | NC Trucking Aurociation |
| David Stoller | STATE FARM |
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| C. L. Cocha | UCPNC |

| HOUSE INSURANCE COMMITTEE | | |
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| Name of Committee | Date | |

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Ken Minion Carol Scheels | AIG |
| Carol Scheels | NCMS |
| ANN LORE | OUDS |
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MINUTES

HOUSE COMMITTEE ON INSURANCE

April 30, 2003

The House Committee on Insurance met at 11:00 AM on April 29, 2003. The following Representatives were present: Hugh Holliman, Mitchell Setzer, John Hall, Lucy Allen, Bobby Barbee, Robert Grady, Charles Johnson, Linda Johnson, David Lewis, David Miner, Karen Ray, Drew Saunders, William Wainwright, Connie Wilson, Tom Wright, and Ex-officio Harold Brubaker.

Chair Mitchell Setzer called the meeting to order and recognized the clerks and thanked us for the hard work in preparing for the meeting. He recognized the visitors and thanked them for attending. See Attachment I-AA. He then recognized Rep. Saunders to explain HB-892. Rep. Wainwright explained the changes in the PCS and asked for a motion for a favorable report unfavorable to original bill. See Attachments I and I-A.

HB-339 was re-referred back to Insurance. Tim Hovis, Staff Attorney explained the amendment and Linda Attarian spoke to several questions raised by Rep. Wilson and Rep. Grady. It was amended on page 30, line 23. Rep. Saunders moved for a favorable report as amended and the amendment carried. Rep. Saunders made a motion for a favorable report on the bill. See Attachments II and II-A.

Rep. Cole was called on the explain HB-ll52. Rep. Cole showed a video and used props to demonstrate the importance of this legislation. See Attachments, III, III-A, III-B, III-C, III-D. The video is a WRAL-TV tape with Jennifer Julian, Titled "Poor Parts Policy". Mark Barnes of Zebulon, Henry Jones, Lobbyist, and Mike Causey, Lobbyist and Paul White, a car

dealer of Wendell all spoke in favor of this legislation. Eileen Sottile spoke against the bill.

Chair Setzer announced the meeting would move to reconvene in room 424. After a show of hands and not having a quorum it was decided the meeting would adjourn. A motion was on the floor for a favorable report for HB-ll52. Rep. Setzer asked if there was any more discussion, hearing none, the motion passed.

The meeting was adjourned at 12:00. The next meeting will tomorrow, May 1, 2003 at 8:30 AM.

Rep. Hugh Holliman

Rep. Mitchell Setzer

Carol Bowers/Joanna Mills, Clerks

VISITOR REGISTRATION SHEET I- AA

HOUSE INSURANCE COMMITTEE

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|----------------------------|
| Stephon Bowens | LLPP |
| RAY RIFFE | NC AFL-CIO |
| Frank Johnson | Privite citizen. |
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HOUSE INSURANCE COMMITTEE

4-30-03

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
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| FRANK W. FOLGER | NCDOI |
| Mila Caux | ASANC IABA |
| Carol Scheele | NC Medical Society |
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| BOB HAVELY | PREVENT BUNDNESS NC |
| Colleen Kochenek | Hafer : Celdwell, P.A. |
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| DANE RICHARD | the Arc |
| Lopi Ann Armens | LAHA |

HOUSE INSURANCE COMMITTEE

4-30-03

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|---------------------|----------------------------|
| David R. Johes, JR. | LORILLARD TOBACCO COMPANY |
| - Vina Cheek | Lorillard Tobacco Co. |
| Melvin Smith | Kepstere Automotive |
| Randy Lisk | Auton. Aftermarket Ass. |
| Fleir Sothie | neystru Automotive |
| Ann Wallach | Residera Raleigh NC |
| Caul Newville | Keyston Antomotice |
| Michelle Eury | Bury and assor |
| Erni allatt | LBA |
| Sougher A. Ceredus | VC DD 1 |
| Barbara Maraly Burk | 2 NC DOI |

HOUSE INSURANCE COMMITTEE

4-30-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

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| Molula Mills | Brans Cullision |
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| | East Coast Auto Krafters Inc. |
| MIKE ROBERTS | LEITH BUICK-PONFIAC-GMC |
| Albert Ellis | lerch Tuck-Portrac- finc |
| Rick Thompson | RYR Body Shop Inc. |
| Tommy Brown | Brown Brothers Body Works FAR |
| RONNIE DAKLY | Balne collision |
| Jan Mel | Bornes Callier Zebulon |
| Laura Betts | Lorillary Tobacco G Greensboro |
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HOUSE INSURANCE COMMITTEE

4-30-03

Name of Committee

Date

| FIRM OR AGENCY AND ADDRESS |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. X Committee Substitute for A BILL TO BE ENTITLED AN ACT TO CONFORM NORTH CAROLINA'S THIRD H.B. 339 PARTY ADMINISTRATOR ARTICLE TO REVISIONS TO THE NAIC MODEL THIRD PARTY ADMINISTRATOR STATUTE; REQUIRE GROUP ANNUITY INSURERS TO ISSUE INDIVIDUAL CERTIFICATES OF COVERAGE TO EACH ANNUITANT: REORGANIZE ARTICLE 60 OF CHAPTER 58 OF THE GENERAL STATUTES AND AMEND CURRENT DISCLOSURE REQUIREMENTS FOR SOLICITATION OF LIFE INSURANCE PRODUCTS AND ANNUITIES; REQUIRE INSURERS TO NOTIFY EMPLOYEES OF THE EXISTENCE OF EMPLOYER-OWNED LIFE INSURANCE POLICIES WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF COVERAGE; REQUIRE THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT EMPLOYER-BASED; LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS' EXPERIENCE TO DEVELOP THE INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE PROPRIETOR FROM THE FULL-TIME BASIS OR THIRTY-HOUR WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES; CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER TO REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP OF INSURERS; TECHNICALLY CORRECT AN OMISSION REGARDING PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; DECREASE THE TOTAL NUMBER OF MEMBERS THAT SERVE ON THE SMALL EMPLOYER REINSURANCE POOL BOARD FROM NINE TO SIX; ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE: TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT; MANDATE HEALTH BENEFIT COVERAGE FOR DESIGNATED TRAVEL EXPENSES WHEN THE REQUIRED DISTANCE TRAVELED THRESHOLD IS MET; AND MAKE TECHNICAL CORRECTIONS TO THE CREDIT INSURANCE LAWS. With a favorable report. With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations Finance With a favorable report, as amended. With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations Finance With a favorable report as to the committee substitute bill (# 2 -). which changes the

title, unfavorable as to (the original bill) (Committee Substitute Bill #), (and

-) be-re-referred to the Committee

recommendation that the committee substitute bill #--

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| Th | e following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
|-----|--|
| H.J | Committee Substitute for 3. 892 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THE COMMON LAW DETERMINES WHETHER A DRIVER OF A TRUCK OR TRACTOR TRAILER OF AN INTERSTATE MOTOR CARRIER IS AN EMPLOYEE SUBJECT TO THE WORKERS' COMPENSATION ACT. |
| | With a favorable report. |
| | With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations Finance. |
| | With a favorable report, as amended. |
| | With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations Finance . |
| X | With a favorable report as to the committee substitute bill (#), \(\big \) 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 (#), \(\subseteq \) 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) 03/19/03 |

attachment I

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 892 PROPOSED COMMITTEE SUBSTITUTE H892-CSRG-15 [v.1]

4/30/2003 8:31:20 AM

| Short Title: | Workers Comp./Interstate Carrier Drivers. | (Public) |
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| Sponsors: | | |
| Referred to: | | |
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April 7, 2003

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A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE COMMON LAW DETERMINES WHETHER A DRIVER OF A TRUCK, TRACTOR, OR TRUCK TRACTOR TRAILER OF AN INTERSTATE MOTOR CARRIER IS AN EMPLOYEE SUBJECT TO THE WORKERS' COMPENSATION ACT AND TO DEFINE THE OBLIGATIONS UNDER THE ACT FOR SUCH DRIVERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 97 of the General Statutes is amended by adding a new section to read:

"§ 97-19.1. Truck, tractor or truck tractor driver's status as employee or independent contractor.

An individual in the interstate carrier industry who operates a truck, tractor, or truck tractor licensed by a governmental motor vehicle regulatory agency may be an employee or an independent contractor under this Article dependent upon the application of the common law test for determining employment status.

Any principal contractor, intermediate contractor or subcontractor, irrespective of whether such contractor regularly employs three or more employees, who contracts with an individual in the interstate carrier industry who operates a truck, tractor, or truck tractor licensed by a governmental motor vehicle regulatory agency, who has not secured the payment of compensation in the manner provided for employers set forth in G.S. 97-93 for himself personally and for his employees and subcontractors, if any, shall be liable as an employer under this Article for the payment of compensation and other benefits on account of the injury or death of the independent contractor and his employees or subcontractors due to an accident arising out of and in the course of the performance of the work covered by such contract.

The principal contractor, intermediate contractor, or subcontractor may insure any and all of his independent contractors and their employees or subcontractors in a blanket

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9 10 policy and when insured the independent contractors, subcontractors and employees will be entitled to compensation benefits under the blanket policy.

A principal contractor, intermediate contractor, or subcontractor may include in the governing contract with an independent contractor in the interstate carrier industry who operates a truck, tractor, or truck tractor licensed by a governmental motor vehicle regulatory agency an agreement for the independent contractor to reimburse the cost of covering that independent contractor under the principal contractors, intermediate contractor's or subcontractor's coverage of his business."

SECTION 2. This act is effective when it becomes law and applies to any claim arising on or after October 1, 2003.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

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| 1 | moves to amend the bill on page | 1 | , line |
| 2 3 | () WHICH CHANGES THE TITLE by <u>deleting</u> the | words | "TRUCK OR TRACTOR |
| 4 | TRAILER" | and | 4 |
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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 339 Committee Substitute Favorable 4/24/03 PROPOSED COMMITTEE SUBSTITUTE H339-CSLN-20 [v.1]

4/29/2003 6:56:29 PM

Short Title: Life and Health Insurance Omnibus.-AB (Public)

Sponsors:

Referred to:

March 6, 2003

A BILL TO BE ENTITLED 1 **CAROLINA'S THIRD** AN **ACT** CONFORM NORTH **PARTY** 2 TO 3 ADMINISTRATOR ARTICLE TO REVISIONS TO THE NAIC MODEL THIRD 4 ADMINISTRATOR STATUTE; REQUIRE **GROUP** INSURERS TO ISSUE INDIVIDUAL CERTIFICATES OF COVERAGE TO 5 EACH ANNUITANT: REORGANIZE ARTICLE 60 OF CHAPTER 58 OF THE 6 7 **GENERAL STATUTES** AND **AMEND CURRENT DISCLOSURE** 8 REQUIREMENTS FOR SOLICITATION OF LIFE INSURANCE PRODUCTS 9 AND ANNUITIES; REQUIRE INSURERS TO NOTIFY EMPLOYEES OF THE EXISTENCE OF EMPLOYER-OWNED LIFE INSURANCE POLICIES WITHIN 10 THIRTY DAYS AFTER THE EFFECTIVE DATE OF COVERAGE; REQUIRE 11 THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH 12 INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE 13 RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT 14 EMPLOYER-BASED; LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH 15 INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS' EXPERIENCE TO 16 DEVELOP THE INDIVIDUAL'S RENEWAL RATE: EXEMPT A SOLE 17 PROPRIETOR FROM THE FULL-TIME BASIS OR THIRTY-HOUR 18 WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP 19 HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES; 20 CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER 21 REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP 22 OF INSURERS: TECHNICALLY CORRECT AN OMISSION REGARDING 23 PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED 24 HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; 25 DECREASE THE TOTAL NUMBER OF MEMBERS THAT SERVE ON THE 26 SMALL EMPLOYER REINSURANCE POOL BOARD FROM NINE TO SIX; 27

ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE; TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT; MANDATE HEALTH BENEFIT COVERAGE FOR DESIGNATED TRAVEL EXPENSES WHEN THE REQUIRED DISTANCE TRAVELED THRESHOLD IS MET; TO REQUIRE RATE METHODOLOGY UNDER MEDICARE SUPPLEMENTAL INSURANCE POLICIES TO BE BASED ON ISSUE AGE AND TO MAKE OTHER CHANGES TO THE LAW PERTAINING TO MEDICARE SUPPLEMENTAL INSURANCE POLICIES; AND MAKE TECHNICAL CORRECTIONS TO THE CREDIT INSURANCE LAWS.

The General Assembly of North Carolina enacts:

PART I. THIRD PARTY ADMINISTRATOR ACT REWRITE

SECTION 1. G.S. 58-56-2 is repealed.

SECTION 1.1. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-3. Definitions.

As used in this Article:

- (1) "Administrator", "third party administrator", and "TPA" mean a person who directly or indirectly underwrites, collects, or charges premiums from, or adjusts or settles claims on, residents of this State in connection with life, annuity, or health coverage offered or provided by an insurer, except any of the following:
 - a. An employer, or a wholly owned direct or indirect subsidiary of an employer, on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer.
 - b. A union on behalf of its members.
 - c. An insurer that is authorized to transact insurance in this State pursuant to Articles 1 through 67 of this Chapter.
 - d. An insurance producer licensed to sell life, annuity, or health coverage in this State, whose activities are limited exclusively to the sale of insurance.
 - e. A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.
 - f. A trust and its trustees, agents, and employees acting pursuant to a trust established in conformity with 29 U.S.C. § 186.
 - g. A trust exempt from taxation under section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to the trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which

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| 1 | | | meets the requirements of section 401(f) of the Internal |
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| 2 | | | Revenue Code. |
| 3 | | <u>h.</u> | A credit union or a financial institution that is subject to |
| 4 | | _ | supervision or examination by federal or State banking |
| 5 | | | authorities, or a mortgage lender, to the extent it collects and |
| 6 | | | remits premiums to licensed insurance producers or to limited |
| 7 | | | lines producers or authorized insurers in connection with loan |
| 8 | | | payments. |
| 9 | | <u>i.</u> | A credit card issuing company that advances for and collects |
| 10 | | _ | insurance premiums or charges from its credit card holders who |
| 11 | , | | have authorized collection. |
| 12 | | <u>j.</u> | A person who adjusts or settles claims in the normal course of |
| 13 | | - | that person's practice or employment as a licensed attorney and |
| 14 | | | who does not collect charges or premiums in connection with |
| 15 | | | life, annuity, or health coverage. |
| 16 | | <u>k.</u> | An adjuster licensed by this State whose activities are limited to |
| 17 | | | adjustment of claims. |
| 18 | | <u>l.</u> | A person licensed as a managing general agent in this State, |
| 19 | | _ | whose activities are limited exclusively to the scope of activities |
| 20 | | | conveyed under the license. |
| 21 | | <u>m.</u> | An administrator who is affiliated with an insurer and who only |
| 22 | | _ | performs the contractual duties (between the administrator and |
| 23 | | | the insurer) of an administrator for the direct and assumed |
| 24 | | | insurance business of the affiliated insurer. The insurer is |
| 25 | | • | responsible for the acts of the administrator and is responsible |
| 26 | | | for providing all of the administrator's books and records to the |
| 27 | | | Commissioner, upon a request from the Commissioner. |
| 28 | (2) | <u>"Affi</u> | liate or affiliated" means an entity or person who directly or |
| 29 | | indire | ectly, through one or more intermediaries, controls or is controlled |
| 30 | | by, o | r is under common control with, a specified entity or person. |
| 31 | <u>(3)</u> | "Con | nmissioner" means the Commissioner of Insurance of this State. |
| 32 | <u>(4)</u> | "Con | trol" means the term as defined in G.S. 58-19-5(2). |
| 33 | <u>(5)</u> | "GA | AP" means United States generally accepted accounting principles |
| 34 | | consi | stently applied. |
| 35 | <u>(6)</u> | "Hon | ne state" means the District of Columbia and any state or territory |
| 36 | | of th | e United States in which an administrator is incorporated or |
| 37 | | main | tains its principal place of business. If neither the state in which |
| 38 | · | the a | dministrator is incorporated nor the state in which it maintains its |
| 39 | | princ | ipal place of business has adopted the NAIC Third Party |
| 40 | | Adm | inistrator Statute, or a substantially similar law governing |
| 41 | | admi | nistrators, the administrator may declare another state in which it |
| 42 | | cond | ucts business to be its "home state". |
| 43 | <u>(7)</u> | <u>"Ins</u> u | rance producer" means a person who sells, solicits, or negotiates |
| 44 | | | stract of insurance as those terms are defined in this Article. |

- (8) 1 "Insurer" means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health 2 3 maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of 4 5 this Chapter. "Negotiate" means the act of conferring directly with, or offering (9) 6 7 advice directly to, a purchaser or prospective purchaser of a particular 8 contract of insurance concerning any of the substantive benefits, terms, 9 or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for 10 purchasers. 11 12
 - (10) "Nonresident administrator" means a person who is applying for licensure or is licensed in any state other than the administrator's home state.
 - (11) "Person" means an individual or a business entity.
 - (12) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.
 - (13) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.
 - "Underwrites" or "underwriting" includes the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer or self-funded plan and also includes the overall planning and coordinating of a benefits program.
 - (15) "Uniform Application" means the current version of the NAIC Uniform Application for Third Party Administrators."

SECTION 1.2. G.S. 58-56-6 reads as rewritten:

"§ 58-56-6. Written agreement necessary.

- (a) No TPA may act as a TPA without a written agreement between the TPA and the insurer. The written agreement shall be retained as part of the official records of both the insurer and the TPA for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by this Article, to the extent those requirements apply to the functions performed by the TPA. except insofar as those requirements do not apply to the functions performed by the TPA.
- (b) The agreement shall include a statement of duties that the TPA is expected to perform on behalf of the insurer and the kinds of insurance the TPA is to be authorized to administer. Ines, classes, or types of insurance for which the TPA is to be authorized to administer. The agreement shall provide for underwriting or other standards pertaining to the business underwritten by the insurer.
- (c) The insurer or TPA may, with written notice, terminate the <u>written</u> agreement for cause as provided in the agreement. The insurer may suspend the underwriting authority of the TPA during the pendency of any dispute regarding the cause for termination of the agreement. The insurer must-shall fulfill any lawful obligations with

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respect to policies affected by the agreement, regardless of any dispute between the insurer and the TPA."

SECTION 1.3. G.S. 58-56-16 reads as rewritten:

"§ 58-56-16. Records to be kept.

- (a) Every TPA shall maintain and make available to the insurer complete books and records of all transactions performed on behalf of the insurer. The books and records shall be maintained in accordance with prudent standards of insurance record keeping and must be maintained for a period of at least five years after the date of their creation.
- (b) The Commissioner shall have access to books and records maintained by a TPA for the purposes of examination, audit, and inspection. The Commissioner shall keep confidential any trade secrets contained in those books and records, including the identity and addresses of policyholders and certificate holders, except that the Commissioner may use the information in any judicial or administrative proceeding instituted against the TPA.
- (c) The insurer shall own the records generated by the TPA pertaining to the insurer, but the TPA shall retain the right to continuing access to books and records to permit the TPA to fulfill all of its contractual obligations to insured parties, claimants, and the insurer.
- (d) In the event the insurer and the TPA cancel their agreement, notwithstanding the provisions of subsection (a) of this section, the TPA may, by written agreement with the insurer, transfer all records to a new TPA rather than retain them for five years. In this case, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA as required in subsection (a) of this section.
- (e) The Commissioner shall have access to books and records maintained by a TPA for the purposes of examination, audit, and inspection. Any documents, materials, or other information in the possession or control of the Commissioner that are furnished by a TPA, insurer, insurance producer, or an employee or agent thereof acting on behalf of the TPA, insurer, or insurance producer, or obtained by the Commissioner in an investigation shall be confidential by law and privileged, shall not constitute a public record as defined by G.S. 132-1, shall not be subject to subpoena, shall not be subject to discovery, and shall not be admissible in evidence in any private civil action. However, the Commissioner is authorized to use such documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.
- (f) Neither the Commissioner nor any person who receives documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (e) of this section.
- (g) <u>In order to assist in the performance of the Commissioner's duties, the Commissioner:</u>
 - (1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (e) of this section, with other State, federal, and

- GENERAL ASSEMBLY OF NORTH CAROLINA international regulatory agencies, with the National Association of 1 Insurance Commissioners, its affiliates, or its subsidiaries, and with 2 State, federal, and international law enforcement authorities, provided 3 that the recipient agrees to maintain the confidentiality and privileged 4 status of the document, material, or other information; 5 May receive documents, materials, or information, including otherwise 6 (2) confidential and privileged documents, materials, or information, from 7 the National Association of Insurance Commissioners, its affiliates, or 8 its subsidiaries, and from regulatory and law enforcement officials of 9 other foreign or domestic jurisdictions and shall maintain as 10 confidential or privileged any document, material, or information 11 received with notice or the understanding that it is confidential or 12 privileged under the laws of the jurisdiction that is the source of the 13 document, material, or information; and 14 15 <u>(3)</u> 16
 - May enter into agreements governing sharing and use of information consistent with this subsection.
 - No waiver of any applicable privilege or claim of confidentiality in the (h) documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (g) of this section.
 - Nothing in this Article shall prohibit the Commissioner from releasing final, adjudicated actions including for-cause terminations that are open to public inspection pursuant to Chapter 132 of the General Statutes or to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates, or its subsidiaries."

SECTION 1.4. G.S. 58-56-51 is repealed.

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SECTION 1.5. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-52. Home state certificate of authority or license.

- A person shall apply to be a TPA in its home state upon the Uniform Application and shall receive a certificate of authority or license from the Commissioner of its home state prior to performing any function of a TPA in this State. Each application shall be accompanied by a nonrefundable filing fee of one hundred dollars (\$100.00).
- The Uniform Application shall include or be accompanied by the following (b) information and documents:
 - All basic organizational documents of the applicant, including any (1) articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and other applicable documents and all amendments to those documents.
 - The bylaws, rules, regulations, or similar documents regulating the (2) internal affairs of the applicant.
 - NAIC Biographical Affidavit for the individuals who are responsible (3) for the conduct of affairs of the applicant, including all members of the

House Bill 339 H339-CSLN-20 [v.1] Page 6

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- board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association, or limited liability company; any shareholders or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities, or voting interest of the applicant; and any other person who exercises control or influence over the affairs of the applicant.
- Audited annual financial statements or reports for the two most recent fiscal years that prove that the applicant has a positive net worth. If the applicant has been in existence for less than two fiscal years, the Uniform Application shall include financial statements or reports, certified by an officer of the applicant and prepared in accordance with GAAP, for any completed fiscal years and for any month during the current fiscal year for which the financial statements or reports have been completed. The applicant shall also include any other information the Commissioner requires in order to review the current financial condition of the applicant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include all of the following:
 - <u>a.</u> Amounts shown on the consolidated audited financial report shall be shown on the worksheet.
 - b. Amounts for each entity shall be stated separately.
 - c. Explanations of consolidating and eliminating entries.
- (5) A statement describing the business plan including information on staffing levels and activities proposed in this State and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping, and underwriting.
- (6) Any other pertinent information required by the Commissioner.
- (c) A TPA licensed or applying for licensure under this section shall make available for inspection by the Commissioner copies of all contracts with insurers or other persons utilizing the services of the TPA.
- (d) A TPA licensed or applying for licensure under this section shall produce its accounts, records, and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the Commissioner.
- (e) The Commissioner may refuse to issue a certificate of authority or license if the Commissioner determines that the TPA, or any individual responsible for the conduct of affairs of the TPA, is not competent, trustworthy, financially responsible, or of good personal and business reputation, has had an insurance or an administrator certificate of authority or license denied or revoked for cause by any jurisdiction, or if

the Commissioner determines that any of the grounds set forth in G.S. 58-56-72 exists with respect to the TPA.

- (f) A certificate of authority or license issued under this section shall remain valid, unless surrendered, suspended, or revoked by the Commissioner, for so long as the TPA continues in business in this State and remains in compliance with this Article.
- (g) A TPA licensed or applying for licensure under this section shall immediately notify the Commissioner of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a certificate of authority or license in this State. The Commissioner shall report any such changes to the producer database maintained by the NAIC or affiliates or subsidiaries of the NAIC."

SECTION 1.6. G.S. 58-56-56 is repealed.

SECTION 1.7. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-57. Registration requirement.

1 2

 A person who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this State in connection with life, annuity, or health coverage provided by a self-funded plan shall register with the Commissioner annually, verifying its status as herein described in a format prescribed by the Commissioner."

SECTION 1.8. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-62. Annual report and filing.

- (a) Each TPA licensed under G.S. 58-56-52 shall file an annual report for the preceding calendar year with the Commissioner on or before July 1 of each year or within such extension of time as the Commissioner for good cause may grant. The annual report shall include an audited financial statement performed by an independent certified public accountant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the information required under G.S. 58-56-52(b)(4)a. through c. The report shall be in the form and contain such matters as the Commissioner prescribes and shall be verified by at least two officers of the TPA.
- (b) The annual report shall include the complete names and addresses of all insurers with which the administrator had agreements during the preceding fiscal year.
- (c) At the time of filing its annual report, the administrator shall pay a nonrefundable filing fee of one hundred dollars (\$100.00).
- (d) The Commissioner shall review the most recently filed annual report of each administrator on or before September 1 of each year. Upon completion of its review, the Commissioner shall either:
 - (1) <u>Issue a certification to the administrator that the annual report shows</u> that the administrator has a positive net worth as evidenced by audited financial statements and is currently licensed and in good standing, or noting any deficiencies found in the annual report and financial statements; or

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(2) Update any electronic database maintained by the National Association of Insurance Commissioners, or its affiliates or subsidiaries, indicating that the annual report shows that the administrator has a positive net worth as evidenced by audited financial statements and is in compliance with existing law, or noting any deficiencies found in the annual report."

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SECTION 1.9. G.S. 58-56-66 is repealed.

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SECTION 1.10. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-67. Nonresident administrator certificate of authority.

- Unless a TPA has obtained a home state certificate of authority or license in this State under G.S. 58-56-52, any TPA who performs administrator duties in this State shall obtain a nonresident administrator certificate of authority or license in accordance with this section by filing with the Commissioner the Uniform Application accompanied by a letter of certification from the home state of the TPA. In lieu of requiring a TPA to file a letter of certification with the Uniform Application, the Commissioner may verify the nonresident administrator's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.
- A TPA shall not be eligible for a nonresident administrator certificate of (b) authority or license under this section if it does not hold a certificate of authority as a resident in a home state that has adopted the NAIC Third Party Administrator Statute or a substantially similar law governing TPAs.
- Except as provided in subsections (b) and (h) of this section, the Commissioner shall issue to the TPA a nonresident administrator certificate of authority or license promptly upon receipt of a complete application.
- Unless notified by the Commissioner that the Commissioner is able to verify (d) the nonresident TPA's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, or its affiliates or subsidiaries, each nonresident TPA annually shall file a statement that its home state administrator certificate of authority or license remains in force and has not been revoked or suspended by its home state during the preceding year. The statement required by this subsection shall be filed by November 1 each year.
- At the time of filing the statement required under subsection (d) of this (e) section or if the Commissioner has notified the nonresident administrator that the Commissioner is able to verify the nonresident administrator's home state certificate of authority or license status through an electronic database, the nonresident TPA shall pay, no later than November 1, a nonrefundable filing fee of one hundred dollars (\$100.00).
- A TPA licensed or applying for licensure under this section shall produce its (f) accounts, records, and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the Commissioner.

- (g) A nonresident TPA is not required to hold a nonresident administrator certificate of authority or license in this State if the TPA's duties in this State are limited to the administration of a group policy or plan of insurance and no more than a total of 100 persons insured for all plans reside in this State.
- (h) The Commissioner may refuse to issue a nonresident administrator certificate of authority or license, or delay the issuance of a nonresident administrator certificate of authority or license, if the Commissioner determines that, due to events or information obtained subsequent to the home state's licensure of the TPA, the nonresident TPA cannot satisfy the requirements of this Article or that grounds exist for the home state's revocation or suspension of the administrator's home state certificate of authority or license. If the Commissioner refuses to issue a certificate of authority of license pursuant to this section, the Commissioner shall give written notice of its determination to the Commissioner of the home state, and the Commissioner may delay the issuance of a nonresident administrator certificate of authority to the nonresident TPA until the Commissioner determines that the administrator can satisfy the requirements of this Article and that no grounds exist for the home state's revocation or suspension of the administrator's home state certificate of authority or license."

SECTION 1.11. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-72. Grounds for denial, suspension, or revocation of certificate of authority.

- (a) The certificate of authority or license of a TPA shall be denied, suspended, or revoked if the Commissioner finds that the TPA:
 - (1) Is in an unsound financial condition;
 - (2) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this State hazardous or injurious to insured persons or the public; or
 - (3) Has failed to pay any judgment rendered against it in this State within 60 days after the judgment has become final.
- (b) The Commissioner may, after notice and opportunity for hearing, deny, suspend, or revoke the certificate of authority or license of a TPA if the Commissioner finds that the TPA:
 - (1) Has violated any lawful rule or order of the Commissioner or any provision of the insurance laws of this State;
 - (2) Has refused to be examined or to produce its accounts, records, and files for examination, or if any individual responsible for the conduct of affairs of the TPA has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination when required by the Commissioner, including:
 - <u>a.</u> <u>Members of the board of directors, board of trustees, executive committee, or other governing board or committee;</u>
 - b. The principal officers in the case of a corporation or the partners or members in the case of a partnership, association, or limited liability company;

| 1 | | c. Any shareholder or member holding directly or indirectly ten |
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| 2 | | percent (10%) or more of the voting stock, voting securities, or |
| 3 | | voting interest of the TPA; and |
| 4 | | d. Any other person who exercises control or influence over the |
| 5 | | affairs of the TPA; |
| 6 | (3) | Has, without just cause, refused to pay proper claims or perform |
| 7 | * | services arising under its contracts or has, without just cause, caused |
| 8 | | covered individuals to accept less than the amount due them or caused |
| 9 | | covered individuals to employ attorneys or bring suit against the TPA |
| 10 | | to secure full payment or settlement of such claims; |
| 11 | <u>(4)</u> | Fails, at any time, to meet any qualification for which issuance of the |
| 12 | | certificate could have been refused had the failure then existed and |
| 13 | | been known to the Commissioner; |
| 14 | <u>(5)</u> | Or any of the individuals responsible for the conduct of its affairs has |
| 15 | 1,=,r | been convicted of, or has entered a plea of guilty or nolo contendere to, |
| 16 | | a felony without regard to whether adjudication was withheld, |
| 17 | | including: |
| 18 | | a. Members of the board of directors, board of trustees, executive |
| 19 | | committee or other governing board or committee; |
| 20 | | b. The principal officers in the case of a corporation or the |
| 21 | | partners or members in the case of a partnership, association, or |
| 22 | | limited liability company; |
| 23 | | c. Any shareholder or member holding directly or indirectly ten |
| 24 | | percent or more of its voting stock, voting securities, or voting |
| 25 | | interest; and |
| 26 | | d. Any other person who exercises control or influence over its |
| 27 | | affairs; |
| 28 | <u>(6)</u> | Is under suspension or revocation in another state; or |
| 29 | $\overline{(7)}$ | Has failed to timely file its annual report pursuant to G.S. 58-56-62 if a |
| 30 | | resident administrator or its statement and filing fee, as applicable, |
| 31 | | pursuant to G.S. 58-56-67(d) and (e) if a nonresident administrator. |
| 32 | (c) The | Commissioner may, without advance notice or hearing, immediately |
| 33 | | rtificate of authority or license of a TPA if the Commissioner finds that |
| 34 | | the following circumstances exist: |
| 35 | (1) | The TPA is insolvent or impaired. |
| 36 | (2) | A proceeding for receivership, conservatorship, rehabilitation, or other |
| 37 | | delinquency proceeding regarding the TPA has been commenced in |
| 38 | | any state. |
| 39 | <u>(3)</u> | The financial condition or business practices of the TPA otherwise |
| 40 | | pose an imminent threat to the public health, safety, or welfare of the |
| 41 | | residents of this State. |
| 42 | | e Commissioner finds that one or more grounds exist for the suspension |
| 43 | or revocation o | f a certificate of authority issued under this part, the Commissioner may, |
| 44 | in lieu of suspe | nsion or revocation, impose a fine upon the TPA." |

SECTION 1.12. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-73. Prohibited practices.

No person shall act as, offer to act as, or hold himself or herself out as a TPA in this State without a valid domestic or nonresident administrator certificate of authority issued by the Commissioner."

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PART II. GROUP ANNUITY CONTRACTS

SECTION 2. G.S. 58-58-145 reads as rewritten:

"§ 58-58-145. Group annuity contracts defined; requirements, requirements; issuance of individual certificates.

- Any policy or contract, except a joint, reversionary or survivorship annuity (a) contract, whereby annuities are payable to more than one person, is a group annuity contract. The person, firm or corporation to whom or to which such contract is issued, as herein provided, is the holder of the contract. The term "annuitant" means any person to whom or which payments are made under the group annuity contract. No authorized insurer shall deliver or issue for delivery in this State any group annuity contract except upon a group of annuitants that conforms to the following: under a contract issued to an employer, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, the stipulated payments on which shall be paid by the holder of such contract either wholly from the employer's funds or funds contributed by him, or partly from such funds and partly from funds contributed by the employees covered by such contract, and providing a plan of retirement annuities under a plan which permits all of the employees of such employer or of any specified class or classes thereof to become annuitants. Any such group of employees may include retired employees, and may include officers and managers as employees, and may include the employees of subsidiary or affiliated corporations of a corporation employer, and may include the individual proprietors, partners and employees of affiliated individuals and firms controlled by the holders through stock ownership, contract or otherwise.
- (b) The insurer of a group annuity contract shall issue to the policyholder, within 30 days of the effective date of the group annuity contract, an individual certificate for delivery to each annuitant which:
 - (1) Identifies the annuity to which the annuitant is entitled.
 - (2) States the name of the person to whom the annuity is payable.
 - (3) <u>Discloses all of the rights and obligations of the insurer, the policyholder, the annuitant, and the persons to whom the annuity is payable with respect to the group annuity contract.</u>
- G.S. 58-3-150 applies to the form of the individual certificate required by this subsection.
- (c) Each group annuity contract shall include a provision that the insurer will issue to the policyholder within 30 days of the effective date of the contract, for delivery to each annuitant, an individual certificate setting forth the information described in subsection (b) of this section."

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PART III. DISCLOSURES FOR ANNUITIES AND LIFE INSURANCE

SECTION 3. The title of Article 60 of Chapter 58 of the General Statutes reads as rewritten:

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"Article 60.

Regulation of Life Insurance Solicitation.

Standards of Disclosure for Annuities and Life Insurance."

SECTION 3.1. Article 60 of Chapter 58 of the General Statues is amended by designating G.S. 58-60-1 through G.S. 58-60-35 as:

"Part 1. Regulation of Life Insurance Solicitation."

SECTION 3.2. G.S. 58-60-1 reads as rewritten:

"§ 58-60-1. Purpose of Article. Short title; purpose.

- (a) This Part may be cited as the "Life Insurance Disclosure Act".
- (b) The purpose of this Article Part is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for their the buyer's needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and to improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

This Article Part does not prohibit an insurer to use from using additional material which that is not in violation of Articles 1 through 64 of this Chapter nor any other statute or regulation."

SECTION 3.3. G.S. 58-60-5 reads as rewritten:

"§ 58-60-5. Scope of Article; Scope; exemptions.

- (a) Except as otherwise provided in this Article, Part, this Article Part applies to any solicitation, negotiation or procurement of life insurance occurring within this State. This Article Part applies to any issuer of a life insurance contract, including fraternal benefit societies.
 - (b) Unless otherwise specifically included, this Article Part does not apply to:
 - (1) Annuities, Individual group annuity contracts.
 - (2) Credit life insurance, insurance.
 - (3) Group life insurance, insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy).
 - (4) Life insurance policies issued in connection with pension and welfare plans as defined by and that are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).
 - (5) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.
- (c) The policy summary in this Article-Part is not required for policies that are sold subject to rules adopted by the Commissioner for life insurance illustrations."

SECTION 3.4. G.S. 58-60-10(7)k. reads as rewritten:

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"k. The date on which the Policy Summary is prepared.

The Policy Summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in subparagraph e of this paragraph shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space. If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor, it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this State."

SECTION 3.5. Article 60 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 3. Regulation of Home Service Life Insurance Solicitation.

"§ 58-60-40. Title and reference.

This Part may be cited as the "Home Service Disclosure Act".

"<u>§ 58-60-45</u>. Purpose.

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The purpose of this Part is to establish standards that ensure that meaningful information is provided to the purchasers of insurance policies distributed through the home service distribution system.

"§ 58-60-50. Definitions.

As used in this Part:

- "Home service distribution system" means a system in which insurance products are marketed, sold, or serviced by agents in person in the home or business of the insured, owner, or premium payor in assigned territories and may be identified as "debits". The policies are issued on a monthly or more frequent premium payment basis and agents are charged with the responsibilities of servicing the debit, which may include the collection of premium payments in the home or designated location on a monthly or more frequent basis, along with other services normally rendered.
- (2) "Small face amount life insurance policy" means an insurance policy or certificate with a face amount of fifteen thousand dollars (\$15,000) or less.

"§ 58-60-55. General disclosure requirements.

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- (a) In accordance with the disclosure simplification standards set forth in G.S. 58-60-80 and at the time an insurance policy is issued through the home service distribution system, the insurer shall disclose:
 - (1) Whether the policyholder is allowed to change the method of premium payment and any conditions for that change;
 - Whether or not at a subsequent date a policyholder may combine multiple policies from the same insurance company, its affiliates, and its subsidiaries into one policy in order to provide like or enhanced coverage at a comparable or reduced premium to eliminate duplicate administrative costs associated with each policy and, if the option is available:
 - a. Whether a policyholder will be subject to underwriting when combining multiple policies into one policy; and
 - b. Whether a policyholder will be subject to a new contestable period, waiting periods, etc., when combining multiple policies into one policy.
- (b) In accordance with the disclosure simplification standards set forth in G.S. 58-60-80, an insurer issuing a small face amount life insurance policy through the home service distribution system shall provide the current disclosure included in Appendix A of the NAIC's Home Service Disclosure Model if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy but may be delivered with the policy.
- If, for a particular policy form, the cumulative premiums may exceed the face for some demographic or benefit combination but not for all combinations, the insurer may choose to either:
 - (1) Provide the disclosure only in those circumstances where the premiums may exceed the face amount; or
 - (2) Provide the disclosure for all demographic and benefit combinations.

Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.

If an illustration has been provided that satisfies the requirements of Title 11, Chapter 4, Section .0500 of the North Carolina Administrative Code, the disclosure requirements of subsection (b) of this section are deemed to have been met.

"§ 58-60-60. Disclosure of payment methods.

In accordance with the disclosure simplification standards set forth in G.S. 58-60-80, at the time an insurance policy is issued through the home service distribution system, the insurer shall disclose:

- (1) What premium savings may be realized by a different method or less frequent mode of premium payment.
- (2) That premiums are still due and payable by the person responsible for premium payments even when an agent does not collect the premiums.
- (3) The mailing address for payment of premiums to the company.

(4) That the consumer is entitled to receive a receipt for premium payments when premium payments are made in cash or in person.

"§ 58-60-65. Evidence of payment.

1.

For every premium collected on a policy of life or disability insurance marketed, sold, or serviced through the home service distribution system in this State, the agent, solicitor, or broker, or any employee acting on the agent, solicitor, or broker's behalf, collecting or receiving the premium in person shall:

- (1) Maintain and furnish to the policyholder a receipt indicating payment of premiums, which shall provide the payor with clearly understandable, written evidence of payment at the time the premium is collected. At a minimum it shall clearly show:
 - <u>a.</u> The name of the payor.
 - b. The name of insured under each policy covered by the premium.
 - c. The amount paid.
 - <u>d.</u> The date paid.
 - e. The date paid-to-status of the policy.
 - <u>f.</u> The policy number.
 - g. The face amount and type of policy for which the payment will be credited.
 - h. The signature of the agent.
 - i. The agent's printed name and unique identification number.
 - <u>The name, complete address, and phone number of the insurer.</u>
- Remit to the insurer's home office or applicable district office, or deposit in a fiduciary account, the premium collected on behalf of the policyholder within 10 days of receipt from the premium payor or policy owner. In the event that the insurer utilizes an accounting system based on a monthly list bill, all premiums collected shall be credited from the date of collection. The premium shall be fully applied to that particular account.

"§ 58-60-70. Proof of policy delivery.

If an insurance policy marketed, sold, or serviced through the home service distribution system is delivered by an agent, solicitor, or broker, or an employee acting on the agent, solicitor, or broker's behalf, a receipt shall be signed by the purchaser and the agent acknowledging delivery to the purchaser of the policy or contract and the disclosures required by this Part. The receipt shall contain the name of the purchaser, the policy or contract number, the amount of the initial premium payment, and the date the delivery was completed. A policy shall be deemed to have been received six months after the date of issuance if the insured has paid premiums pursuant to the contract. All delivery receipts required by this section shall be retained by the company for not less than three years following delivery and shall be available for inspection upon request of the Commissioner.

"§ 58-60-75. Company duties.

| 1 | Each insure | r engaged in the home service distribution system in this State shall |
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| 2 | make available | to the Commissioner for review: |
| 3 | <u>(1)</u> | Established written procedures to audit agencies engaged in the home |
| 4 | | service system of distribution of policies in this State; and |
| 5 | <u>(2)</u> | Proof of audits conducted periodically that reasonably ensure that the |
| 6 | | premium payor's records accurately reflect the premium due date and |
| 7 | | premium paid-to-status of the policy or policies purchased. |
| 8 | " <u>§ 58-60-80. M</u> | <u> Iinimum disclosure language standards.</u> |
| 9 | All disclosu | re forms shall comply with the readability standards in Article 38 of this |
| 10 | Chapter. It is pr | resumed the disclosure form in Appendix A of the NAIC's Home Service |
| 11 | | lel Act complies with this Part." |
| 12 | SEC' | TION 3.6. Article 60 of Chapter 58 of the General Statutes is amended |
| 13 | by adding a new | v Part to read: |
| 14 | " <u>Part 3</u> | 3. Regulation of Small Face Amount Life Insurance Solicitation. |
| 15 | | itle and reference. |
| 16 | | ay be cited as the "Small Face Amount Life Insurance Disclosure Act". |
| 17 | | urpose; intent; and scope. |
| 18 | | purpose of this Part is to establish standards that ensure meaningful |
| 19 | | provided to the purchasers of small face amount policies. |
| 20 | | Part applies to any life insurance policy or certificate with an initial face |
| 21 | | en thousand dollars (\$15,000) or less. |
| 22 | | Part does not apply to: |
| 23 | <u>(1)</u> | Variable life insurance. |
| 24 | (2) | Individual and group annuity contracts. |
| 25 | (3) | Credit life insurance. |
| 26 | <u>(4)</u> | Group or individual policies of life insurance issued to members of an |
| 27 | | employer group or other permitted group where: |
| 28 | | a. Every plan of coverage was selected by the employer or other |
| 29 | | group representative; |
| 30 | | b. Some portion of the premium is paid by the group or through |
| 31 | | payroll deduction; and |
| 32 | | c. Group underwriting or simplified underwriting is used. |
| 33 | <u>(5)</u> | Policies and certificates where an illustration has been provided |
| 34 | | pursuant to the requirements of Title 11, Chapter 4, Section .0500 of |
| 35 | | the North Carolina Administrative Code. |
| 36 | | visclosure requirements. |
| 37 | | nsurer issuing a small face amount policy shall provide the current |
| 38 | | ided in Appendix A of the NAIC Disclosure for Small Face Amount Life |
| 39 | | eies Model Act if at any point in time over the term of the policy the |
| 40 | | miums paid may exceed the face amount of the policy at that point in |
| 41 | | red disclosure shall be provided to the policy owner or certificate holder |
| 42 | | the time the policy or certificate is delivered. The disclosure shall not be |
| 43 | attached to the | policy but may be delivered with the policy. |

| 1 | (b) | If, fo | r a parti | cular policy form, the cumulative premiums may exceed the face |
|----|--------------------|----------------|--------------|--|
| 2 | amount f | | _ | ographic or benefit combination but not for all combinations, the |
| 3 | insurer n | | | |
| 4 | | · | (1) | Provide the disclosure only in those circumstances where the |
| 5 | | | | premiums may exceed the face amount; or |
| 6 | | | <u>(2)</u> | Provide the disclosure for all demographic and benefit |
| 7 | | | | combinations. |
| 8 | (c) | Cum | ulative | premiums shall include premiums paid for riders. However, the |
| 9 | | | | nclude the benefits attributable to the riders. |
| 10 | "§ 58-60- | | | |
| 11 | • | | | ts producers shall have a duty to provide information to |
| 12 | | | | cate holders that ask questions about the disclosure statement." |
| 13 | • | | | 3.7. Article 60 of Chapter 58 of the General Statutes is amended |
| 14 | by adding | | | - |
| 15 | | | 1 | Part 4. Regulation of Annuity Solicitation. |
| 16 | " <u>§ 58-60</u> - | -105. 7 | | d reference. |
| 17 | This l | Part ma | y be cit | ted as the "Annuity Disclosure Act". |
| 18 | | | - | e; intent; scope. |
| 19 | <u>(a)</u> | | | of this Part is to provide standards for the disclosure of certain |
| 20 | minimun | | | about annuity contracts to protect consumers and foster consumer |
| 21 | | | | ecifies the minimum information that must be disclosed and the |
| 22 | | | | it in connection with the sale of annuity contracts. The goal of |
| 23 | | | | that purchasers of annuity contracts understand certain basic |
| 24 | features of | | | - |
| 25 | <u>(b)</u> | This] | Part app | plies to all group and individual annuity contracts and certificates |
| 26 | except: | | | |
| 27 | | <u>(1)</u> | Regist | tered or nonregistered variable annuities or other registered |
| 28 | | | <u>produ</u> | cts. |
| 29 | | <u>(2)</u> | <u>Imme</u> | diate and deferred annuities that contain no nonguaranteed |
| 30 | | | <u>eleme</u> | |
| 31 | | <u>(3)</u> | Annui | ties used to fund: |
| 32 | | | <u>a.</u> | An employee pension plan, which is covered by the Employee |
| 33 | | | | Retirement Income Security Act (ERISA); |
| 34 | | | <u>b.</u> | A plan described by section 401(a), 401(k), or 403(b) of the |
| 35 | | | | Internal Revenue Code, where the plan, for purposes of ERISA, |
| 36 | | | | is established or maintained by an employer; |
| 37 | | | <u>c.</u> | A governmental or church plan defined in section 414, or a |
| 38 | | | | deferred compensation plan of a state or local government or a |
| 39 | | | | tax exempt organization under section 457, of the Internal |
| 40 | | | _ | Revenue Code; |
| 41 | | | <u>d.</u> | A nonqualified deferred compensation arrangement established |
| 42 | | | | or maintained by an employer or plan sponsor; |
| 43 | | | <u>e.</u> | Structured settlement annuities: |
| 44 | | | f. | Charitable gift annuities; or |

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g. Funding agreements.

(c) This Part shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement.

"§ 58-60-115. Definitions.

As used in this Part:

- (1) "Annuity buyer's guide" or "buyer's guide" means the current NAIC Model Buyer's Guide to Fixed Deferred Annuities, including any appendix thereto.
- "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.
- (3) "Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.
- (4) "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only or from both determinable and guaranteed elements.
- (5) "Disclosure document" means the document the contents of which are described in G.S. 58-60-125.
- (6) "Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.
- (7) "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity".

| 1 | | <u>(8)</u> | "Gua | ranteed elements" means the premiums, credited interest rates, |
|------|------------|-------------|---------------|--|
| 2 | | | | ding any bonus, benefits, values, noninterest-based credits, |
| 3 | | | | es, or elements of formulas used to determine any of these, that |
| 4 | | | | uaranteed and determined at issue. An element is considered |
| 5 | | | _ | nteed if all of the underlying elements that go into its calculation |
| 6 | | | _ | uaranteed. |
| 7 | | <u>(9)</u> | "Non | guaranteed elements" means the premiums, credited interest rates |
| 8 | | | | iding any bonus), benefits, values, noninterest-based credits, |
| 9 | | | - | es, or elements of formulas used to determine any of these that |
| 10 , | | • | | ibject to company discretion and are not guaranteed at issue. An |
| 11 | | | | ent is considered nonguaranteed if any of the underlying |
| 12 | | | | uaranteed elements are used in its calculation. |
| 13 | | (10) | | ctured settlement annuity" means a "qualified funding asset" as |
| 14 | | | | ed in section 130(d) of the Internal Revenue Code or an annuity |
| 15 | | | | would be a qualified funding asset under section 130(d) but for the |
| 16 | | | _ | hat it is not owned by an assignee under a qualified assignment. |
| 17 | "§ 58-60 | -120. 5 | | rds for the disclosure document and buyer's guide. |
| 18 | <u>(a)</u> | | | application for an annuity contract is taken in a face-to-face |
| 19 | meeting, | the ar | plicant | t, at or before the time of application, shall be given both the |
| 20 | disclosur | e docu | ment d | escribed in G.S. 58-60-125 and a copy of the buyer's guide. |
| 21 | <u>(b)</u> | Wher | e the a | pplication for an annuity contract is taken by means other than in |
| 22 | a face-to | -face n | neeting | , the applicant shall be sent both the disclosure document and the |
| 23 | buyer's g | uide no | o later t | than five business days after the completed application is received |
| 24 | by the in | surer. | | |
| 25 | | <u>(1)</u> | With | respect to an application received as a result of a direct |
| 26 | | | <u>solici</u> | tation through the mail: |
| 27 | | | <u>a.</u> | Providing a buyer's guide in a mailing inviting prospective |
| 28 | | | | applicants to apply for an annuity contract shall be deemed to |
| 29 | | | | satisfy the requirement that the buyer's guide be provided no |
| 30 | | | | later than five business days after receipt of the application. |
| 31 | | | <u>b.</u> | Providing a disclosure document in a mailing inviting a |
| 32 | | | | prospective applicant to apply for an annuity contract shall be |
| 33 | | | | deemed to satisfy the requirement that the disclosure document |
| 34 | | | | be provided no later than five business days after receipt of the |
| 35 | | | | application. |
| 36 | | <u>(2)</u> | With | respect to an application received via the Internet: |
| 37 | | | <u>a.</u> | Taking reasonable steps to make the buyer's guide available for |
| 38 | | | | viewing and printing on the insurer's web site shall be deemed |
| 39 | | | | to satisfy the requirement that the buyer's guide be provided no |
| 40 | | | | later than five business days after receipt of the application. |
| 41 | | | <u>b.</u> | Taking reasonable steps to make the disclosure document |
| 42 | | | | available for viewing and printing on the insurer's web site shall |

be deemed to satisfy the requirement that the disclosure

| 1 | | | document be provided no later than five business days after |
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| 2 - | | | receipt of the application. |
| 3 | <u>(3)</u> | A so | licitation for an annuity contract provided in other than a |
| 4 | | face-1 | to-face meeting shall include a statement that the proposed |
| 5 | | appli | cant may contact the Department for a free annuity buyer's guide. |
| 6 | | <u>In lie</u> | u of the foregoing statement, an insurer may include a statement |
| 7 | | that t | he prospective applicant may contact the insurer for a free annuity |
| 8 | | buyer | 's guide. |
| 9 | (c) When | e the | buyer's guide and disclosure document are not provided at or |
| 10 | before the time | e of ap | plication, a free look period of no less than 15 days shall be |
| 11 | provided for the | e applio | cant to return the annuity contract without penalty. This free look |
| 12 | shall run concu | rrently | with any other free look provided under State law or regulation. |
| 13 | " <u>§ 58-60-125.</u> (| Conten | ts of disclosure document. |
| 14 | At a minim | <u>um, all</u> | of the following information shall be included in the disclosure |
| 15 | document requi | red und | ler this Part: |
| 16 | <u>(1)</u> | The | generic name of the contract, the company product name, if |
| 17 | | differ | ent, and form number, and the fact that it is an annuity. |
| 18 | <u>(2)</u> | The i | nsurer's name and address. |
| 19 | <u>(3)</u> | A de | escription of the contract and its benefits, emphasizing its |
| 20 | • | long- | term nature, including the following, if appropriate: |
| 21 | | <u>a.</u> | The guaranteed, nonguaranteed, and determinable elements of |
| 22 | | | the contract, and their limitations, if any, and an explanation of |
| 23 | | | how they operate. |
| 24 | | <u>b.</u> | An explanation of the initial crediting rate, specifying any |
| 25 | | | bonus or introductory portion, the duration of the rate, and the |
| 26 | | | fact that rates may change from time to time and are not |
| 27 | | | guaranteed. |
| 28 | | <u>c.</u> | Periodic income options both on a guaranteed and |
| 29 | | | nonguaranteed basis. |
| 30 | | <u>d.</u> | Any value reductions caused by withdrawals from or surrender |
| 31 | | | of the contract. |
| 32 | | <u>e.</u> <u>f.</u> | How values in the contract can be accessed. |
| 33 | | <u>f.</u> | The death benefit, if available, and how it will be calculated. |
| 34 | | g. | A summary of the federal tax status of the contract and any |
| 35 | | _ | penalties applicable on withdrawal of values from the contract. |
| 36 | | <u>h.</u> | The impact of any rider, such as a long-term care rider. |
| 37 | <u>(4)</u> | | specific dollar amount or percentage charges and fees with an |
| 38 | | | nation of how they apply. |
| 39 | <u>(5)</u> | · · · · · · · · · · · · · · · · · · · | mation about the current guaranteed rate for new contracts that |
| 40 | | | ins a clear notice that the rate is subject to change. |
| 41 | | | ine terms used in the disclosure statement in language that |
| 42 | | | anding by a typical person within the segment of the public to |
| 43 | which the discl | osure s | tatement is directed. |

"§ 58-60-130. Report to contract owners.

For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least all of the following information:

- (1) The beginning and end date of the current report period.
- (2) The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period.
- (3) The total amounts, if any, that have been credited, charged to the contract value, or paid during the current report period.
- (4) The amount of outstanding loans, if any, as of the end of the current report period."

PART IV. EMPLOYER-OWNED LIFE INSURANCE DISCLOSURE

SECTION 4. G.S. 58-58-75 reads as rewritten:

"§ 58-58-75. Insurable interest in life and physical ability of employee or agent.

- (a) An employer, whether a partnership, joint venture, business trust, mutual association, corporation, any other form of business organization, or one or more individuals, or any religious, educational, or charitable corporation, institution or body, has an insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an employee for the benefit of such employer. Any principal shall have a life insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an agent for the benefit of such principal.
- (b) An employee described in subsection (a) of this section shall be insured for the benefit of an employer described in subsection (a) of this section only if the employee receives written notification from the insurer of the existence of the coverage. The notice shall be provided to the employee within 30 days after the effective date of the coverage and shall include a statement that the employer may maintain the life insurance coverage on the employee even after employment is terminated.
- (c) For nonkey or nonmanagerial employees, the aggregate amount of coverage shall be reasonably related to the benefits provided to the employees in the aggregate.
- (d) With respect to employer-provided pension and welfare plans, the life insurance coverage purchased to finance the plans may only cover the lives of those employees and retirees who, at the time their lives were first insured under the plan, either are participants, or would be eligible to participate, upon the satisfaction of age, service, or similar eligibility criteria in the plan."

PART V. ACTUARIALLY SOUND ASSOCIATION GROUP ACCIDENT AND HEALTH PREMIUM RATES

SECTION 5. G.S. 58-51-80(1a) reads as rewritten:

"(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been

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organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

- a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.
- b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members. The premium rates for each association policy shall be developed, and applied to the certificates thereunder, on an actuarially sound basis.
- c. Repealed by Session Laws 1997-259, s. 8."

PART VI. INDIVIDUAL ACCIDENT AND HEALTH INSURANCE RENEWAL RATE LIMITATIONS

SECTION 6. G.S. 58-51-95 is amended by adding a new subsection to read:

- "(g) For policies subject to this section, an individual health insurer shall not increase an individual's renewal premium for continued health insurance coverage under the terms of the individual's health insurance policy based on any health status-related factors in relation to the individual or a dependent of the individual, including:
 - (1) Health status.
 - (2) Medical condition (including both physical and mental illnesses).
 - (3) Claims experience.
 - (4) Duration from issue.
 - (5) Receipt of health care.
 - (6) Medical history.
 - (7) Genetic information."

PART VII. LARGE GROUP HEALTH INSURANCE SOLE PROPRIETOR EXEMPTION

SECTION 7. G.S. 58-65-60 is amended by adding a new subsection to read:

"(e3) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan

and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

SECTION 7.1. G.S. 58-67-85 is amended by adding a new subsection to read:

"(d1) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(1), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

SECTION 7.2. G.S. 58-51-80(c) reads as rewritten:

The term "employees" as used in this section shall be deemed to include, for "(c) the purposes of insurance hereunder, employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. Employees shall be added to the group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. The term "employer" as used herein may be deemed to include the State of North Carolina, any county, municipality or corporation, or the proper officers, as such, of any unincorporated municipality or any department or subdivision of the State, county, such corporation, or municipality determined by conditions pertaining to the employment. When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

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PART VIII. NEWBORN COVERAGE REINSTATEMENT

SECTION 8. G.S. 58-51-30(b) reads as rewritten:

"(b) Every health benefit plan, as defined in G.S. 58 3-167, G.S. 58-51-115(a)(1), that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the

same basis upon placement in the foster home or placement for adoption. Every health benefit plan shall extend coverage to a foster child or adopted child without requirements for prior notification unless an additional premium charge to add the foster child or adopted child is due. If an additional premium charge is due to cover the foster child or adopted child, the health benefit plan shall cover the foster child or adopted child upon placement in the foster home or placement for adoption if the foster child or adopted child is enrolled within 30 days after the placement in the foster home or placement for adoption."

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PART IX. LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES TECHNICAL CORRECTIONS

SECTION 9. G.S. 58-51-15(a)(2)b. reads as rewritten:

"b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy _____ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." Credit Except for the excepted benefits described in G.S. 58-68-25(b), credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-68-30."

SECTION 9.1. G.S. 58-51-15(h) reads as rewritten:

- "(h) Preexisting Condition Exclusion Clarification. Sub-subdivision (a)(2)b. of this section does not apply to: to
 - (1) Policies policies issued to eligible individuals under G.S. 58-68-60.
 - (2) Excepted benefits as described in G.S. 58-68-25(b)."

PART X. SMALL EMPLOYER HEALTH REINSURANCE POOL BOARD AMENDMENTS

SECTION 10. G.S. 58-50-150(b) reads as rewritten:

"(b) Within 30 days after January 1, 1992, the Commissioner shall give notice to all earriers of the time and place for the initial organizational meeting, which shall take place within 90 days after the notice from the Commissioner. The members shall select the initial Board, subject to the Commissioner's approval. The Board shall consist of nine six members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The voting rights to determine initial Board membership shall be weighted based upon net group health benefit plan premium derived from this State in the previous calendar year. Thereafter, voting Voting rights shall be based on net group health benefit plan premium derived from small employer business. The Board shall at all times, to the extent possible, include at

least one domestic insurance company licensed to transact accident and health insurance, one HMO, one nonprofit hospital or medical service plan. Six Five of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented."

PART XI. EQUITABLE ENROLLMENT PERIOD FOR SUPPLEMENTAL MEDICARE PLANS

SECTION 11. G.S. 58-54-45(a) reads as rewritten:

"(a) In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plans A, C, and J available to persons eligible for Medicare by reason of disability before age 65. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision."

PART XII. REVOCATION AND SUSPENSION TECHNICAL CORRECTION SECTION 12. G.S. 58-3-100(c) reads as rewritten:

- "(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be one of the following:
 - (1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.
 - (2) Payment of the claim.
 - (3) A bona fide written offer of settlement.
 - (4) A written denial of the claim.

A claimant includes an insured, a beneficiary of life or annuity contract, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer, HMO, service corporation, or MEWA. With respect to a claim under an accident, health, or disability policy, if the acknowledgement sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgement includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225."

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PART XIII. HEALTH BENEFIT PLAN TRAVEL EXPENSES COVERAGE

SECTION 13. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-3-270. Insurance coverage for travel expenses associated with obtaining care.

- As used in this section, the terms "health benefit plan" and "insurer" have the (a) meaning as found in G.S. 58-3-167.
- Each health benefit plan shall provide coverage for reasonable transportation, lodging, and boarding expenses incurred by a covered person to access covered health care services when the insurer, through its referral or network contracting arrangements, requires the covered person to travel more than 250 miles from the covered person's residence to obtain those covered health care services from a network provider.
- The coverage specified by this section is limited to transportation, lodging and boarding expenses incurred by a covered person when required by the health plan to travel to access covered health care services as provided in subsection (b) of this section when those health care services are not also available from a network provider who is located within 250 miles of the covered person's residence.
- The coverage required by this section shall be subject to plan requirements including any overall health care benefit plan aggregate limitations and shall last for the duration of the health care benefit plan's coverage of the treatment subject to this section. An insurer may utilize a per diem limit for the expenses specified in subsection (c) of this section as long as the limit reflects the high-low per diem method as annually published by the Internal Revenue Service or the Domestic Per Diem Rate as published annually by the federal General Services Administration in the area where the health care services are being obtained. All travel, lodging, and boarding expenses in excess of the insurer's per diem or the health benefit plan's aggregate limits shall be the responsibility of the covered person.
 - An insurer may require prior approval of all expenses subject to this section. (e)
- The coverage required by this section shall apply only to those travel, (f) lodging, and boarding expenses incurred by the covered person accessing covered health care services in accordance with this section. If the covered person accessing covered health care services in accordance with this section is a minor, the health benefit plan shall also cover the expenses specified in subsection (c) of this section for a parent or guardian who accompanies the minor."

PART XIV. CREDIT INSURANCE AMENDMENTS

- SECTION 14. G.S. 58-57-5 is amended by adding a new subdivision to read:
 - "(5a) "Critical period coverage" means insurance coverage for which benefits are limited to a stated number of payments or the payments end with the expiration of the policy, whichever is less."
 - **SECTION 14.1.** G.S. 58-57-50(b) reads as rewritten:

"(b) The refund of premiums for decreasing term credit life insurance shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy. The refund of premiums for decreasing term credit life insurance in transactions of 60 months duration or less and the refund of premiums for single interest credit property insurance and single interest physical damage insurance shall be equal to the amount computed by the sum of digits formula known as the "Rule of 78." The refund of premiums for decreasing term credit life insurance in transactions of more than 60 months duration shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy. The refund of premiums for level term credit life insurance and dual interest credit property insurance and dual interest physical damage insurance shall be equal to the pro rata unearned gross premiums."

SECTION 14.2. G.S. 58-57-55 reads as rewritten:

"§ 58-57-55. Issuance of policies.

All policies of credit life insurance and credit accident and health insurance shall be issued only by an insurer authorized to do business in this State and shall be issued only through holders of licenses or authorizations issued by the Commissioner. All-With the exception of credit insurance issued in accordance with G.S. 58-57-105, all policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this State only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner. State. The enrollment of debtors under a group policy issued to a creditor and authorized under this Article shall not constitute the issuance of a policy of insurance."

SECTION 14.3. G.S. 58-57-60 is amended by adding a new subsection to read:

- "(d) A claim acknowledgement shall be sent to the claimant within 30 days after receiving written or electronic notice of the claim. Acknowledgement shall include the following:
 - (1) A statement made to the insured or the claimant advising that the claim is being investigated.
 - (2) Payment of the claim.
 - (3) A bona fide written offer of settlement.
 - (4) A written denial of the claim."

SECTION 14.4. G.S. 58-57-110 reads as rewritten:

- "§ 58-57-110. Credit unemployment insurance rate standards; policy provisions.
- (a) Each year the Commissioner shall prescribe a minimum incurred loss ratio standard requirement to develop a premium rate reasonable in relation to the benefits provided by credit unemployment insurance coverage. The following requirements must be met:
 - (1) Coverage is provided or offered, with or without underwriting, to all debtors regardless of age who are working for salary, wages, or other employment income for at least 30 hours per week and have done so for 12 consecutive months;

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- (2) Coverage sets forth a definition of involuntary unemployment as a loss of employment income that may include, but is not limited to, loss caused by layoff, general strike, termination of employment, or lockout:
- (3) Coverage does not contain any exclusion except: debts with irregular monthly payments; voluntary forfeiture of salary, wages, or other employment income; resignation; retirement; sickness, disease, or normal pregnancy; or loss of income due to termination as a result of willful misconduct that is a violation of some established, definite rule of conduct, a forbidden act, or willful dereliction of duty, or criminal misconduct;
- (4) As long as there is no required time period limitation for registration, the insured may be required to register with the State unemployment office in order to qualify for benefit payments under the credit unemployment coverage. Qualification for State unemployment benefits shall not be required in order to qualify for benefit payments under the credit unemployment coverage.
- (b) The Commissioner may approve other policy provisions and coverages consistent with the purposes of unemployment coverage.
- (c) Joint coverage rates for credit unemployment insurance shall be one and two-thirds (1 2/3) times the approved single rate of coverage.
- (d) The refund provision for credit unemployment insurance shall be equal to the pro rata unearned gross premium."

PART XV. MEDICARE SUPPLEMENTAL INSURANCE POLICY CHANGES SECTION 15. G.S. 58-54-25(f) reads as rewritten:

- "(f) No insurer shall use attained age as a structure or methodology for its Medicare supplement insurance <u>rates</u>. rates unless the structure or methodology is fully disclosed to the applicant at the time of application or to the insured at the time of delivery if the purchase is by mail order. All types of solicitation materials shall clearly indicate that the premiums are based on attained age, which means that those premiums will increase each year. The Commissioner shall prescribe by rule the format and content of the attained age rating disclosure notice. The notice shall include:
 - (1) A statement that attained age rating means that rates increase as the insured ages or by the age group in which the insured is.
 - (2) An illustration based on actual attained age that states the dollar amount of premium increase for the insured over a period of not less than 10 policy years and that displays the life expectancy of the insured at the beginning of the period.
 - (3) A statement that premiums for other Medicare supplement policies that are on issue age bases do not increase as the insured ages.
 - (4) A statement that other Medicare supplement policies that are on issue age bases should be compared to policies on attained age bases."

SECTION 15.1 G.S. 58-54-10 reads as rewritten:

"§ 58-54-10. Standards for policy provisions.

- (a) No policy in force in this State shall contain benefits that duplicate benefits provided by Medicare.
- (b) The Commissioner shall adopt rules to establish specific standards for provisions of policies. Such standards shall be in addition to and in accordance with applicable State law. No requirement of State law relating to minimum required policy benefits, other than the minimum standards contained in this Article, applies to policies. The standards may include without limitation to: terms of renewability; initial and subsequent conditions of eligibility; nonduplication of coverage; probationary periods; benefit limitations, exceptions, and reductions; elimination periods; requirements for replacement; recurrent conditions; and definitions of terms.
- (c) The Commissioner may adopt rules that specify prohibited policy provisions not otherwise specifically authorized by State law that, in the opinion of the Commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a policy.
- (d) Notwithstanding any other provision of State law, a policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. A policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.
 - (e) Repealed by Session Laws 1991 (Regular Session, 1992), c. 815, s. 3.
- (f) An insurer shall use issue age as a structure or methodology for its Medicare supplement insurance rates. An insurer not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the Commissioner.
- (g) Except as otherwise provided in this subsection, an insurer shall not file for approval with the Commissioner more than one policy or certificate of each type for each standard policy. An insurer may offer, with the approval of the Commissioner, up to four additional policies or certificates of the same type for the same standard policy, one for each of the following:
 - (1) The inclusion of new or innovative benefits.
 - (2) The addition of either direct response or agent marketing methods.
 - (3) The addition of either guaranteed issue or underwritten coverage.
 - (4) The offering of coverage to individuals eligible for Medicare by reason of disability.

As used in this section, "type" means an individual policy, a group policy, an individual Medicare select policy, or a group Medicare select policy.

- (h) Except as otherwise provided in this subsection, an insurer shall continue to make available for purchase any policy or certificate issued on and after January 1, 2004 that has been approved by the Commissioner. A policy or certificate shall not be considered to be available for purchase unless the insurer has actively offered the policy or certificate for sale in the immediately preceding 12 month period.
- (i) An insurer may discontinue the availability of a policy or certificate if the insurer provides to the Commissioner in writing its decision to discontinue at least 30

- days prior to the effective date of the discontinuance. Upon providing notice to the Commissioner, the insurer shall no longer offer for sale the policy or certificate in this State. An insurer that discontinues the availability of a policy or certificate pursuant to this subsection shall not file for approval a new policy or certificate of the same type for the same standard Medicare supplement policy as the discontinued policy or certificate for a period of five years from the effective date of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate. The following shall be considered a discontinuance under this subsection:
 - (1) The sale or transfer of the insurer's Medicare supplement business to another insurer.
 - (2) A change in the rating structure or methodology of the policy or certificate unless:
 - a. The insurer provides actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating structure or methodology and resultant rates differ from the existing rating structure or methodology and rates, and
 - b. The insurer does not subsequently put into effect a change of rates or rating factors that would cause a change in the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum.

 The Commissioner may approve a change to the differential if the Commissioner finds the change to be in the public interest."

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PART XVI. EFFECT OF HEADINGS, SEVERABILITY, AND EFFECTIVE DATES

SECTION 16. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

SECTION 16.1. 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 16.2. Sections 1 through 8 and Sections 9, 9.1, 13, 14, 14.1, 14.2, 14.3, 14.4, 15, and 15.1 of this act become effective January 1, 2004, and apply to policies or certificates issued or renewed on or after that date. The remainder of this act is effective when it becomes law and applies to policies or certificates issued or renewed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 339 Committee Substitute Favorable 4/24/03

| Short Title: | Life and Health Insurance OmnibusAB | (Public) |
|--------------|-------------------------------------|----------|
| Sponsors: | | |
| Referred to: | | |

March 6, 2003

A BILL TO BE ENTITLED

AN **ACT** TO CONFORM NORTH CAROLINA'S THIRD **PARTY** ADMINISTRATOR ARTICLE TO REVISIONS TO THE NAIC MODEL THIRD PARTY ADMINISTRATOR STATUTE; REQUIRE GROUP INSURERS TO ISSUE INDIVIDUAL CERTIFICATES OF COVERAGE TO EACH ANNUITANT: REORGANIZE ARTICLE 60 OF CHAPTER 58 OF THE **AMEND** GENERAL **STATUTES** AND. CURRENT DISCLOSURE REQUIREMENTS FOR SOLICITATION OF LIFE INSURANCE PRODUCTS AND ANNUITIES: REQUIRE INSURERS TO NOTIFY EMPLOYEES OF THE EXISTENCE OF EMPLOYER-OWNED LIFE INSURANCE POLICIES WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF COVERAGE; REQUIRE THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT EMPLOYER-BASED: LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS' EXPERIENCE TO DEVELOP THE INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE THE FULL-TIME BASIS OR THIRTY-HOUR PROPRIETOR FROM WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES: CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER TO REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP OF INSURERS: TECHNICALLY CORRECT AN OMISSION REGARDING PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; DECREASE THE TOTAL NUMBER OF MEMBERS THAT SERVE ON THE SMALL EMPLOYER REINSURANCE POOL BOARD FROM NINE TO SIX; ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE

| 1 | SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART |
|---|---|
| 2 | B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE; |
| 3 | TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO |
| 4 | INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A |
| 5 | CLAIMANT; MANDATE HEALTH BENEFIT COVERAGE FOR DESIGNATED |
| 6 | TRAVEL EXPENSES WHEN THE REQUIRED DISTANCE TRAVELED |
| | THRESHOLD IS MET; AND MAKE TECHNICAL CORRECTIONS TO THE |
| | CREDIT INSURANCE LAWS. |
| 9 | The General Assembly of North Carolina enacts: |

The General Assembly of North Carolina enacts:

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PART I. THIRD PARTY ADMINISTRATOR ACT REWRITE

SECTION 1. G.S. 58-56-2 is repealed.

SECTION 1.1. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"<u>§ 58-56-3</u>. Definitions.

As used in this Article:

- "Administrator", "third party administrator", and "TPA" mean a person (1) who directly or indirectly underwrites, collects, or charges premiums from, or adjusts or settles claims on, residents of this State in connection with life, annuity, or health coverage offered or provided by an insurer, except any of the following:
 - An employer, or a wholly owned direct or indirect subsidiary of a. an employer, on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer.
 - A union on behalf of its members. b.
 - An insurer that is authorized to transact insurance in this State <u>c.</u> pursuant to Articles 1 through 67 of this Chapter.
 - An insurance producer licensed to sell life, annuity, or health d. . coverage in this State, whose activities are limited exclusively to the sale of insurance.
 - A creditor on behalf of its debtors with respect to insurance e. covering a debt between the creditor and its debtors.
 - <u>f.</u> A trust and its trustees, agents, and employees acting pursuant to a trust established in conformity with 29 U.S.C. § 186.
 - A trust exempt from taxation under section 501(a) of the g. Internal Revenue Code, its trustees and employees acting pursuant to the trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which meets the requirements of section 401(f) of the Internal Revenue Code.
 - A credit union or a financial institution that is subject to <u>h.</u> supervision or examination by federal or State banking authorities, or a mortgage lender, to the extent it collects and

| | remits premiums to licensed insurance producers or to limited |
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| | lines producers or authorized insurers in connection with loan |
| | payments. |
| | i. A credit card issuing company that advances for and collects |
| | insurance premiums or charges from its credit card holders who |
| | have authorized collection. |
| | j. A person who adjusts or settles claims in the normal course of |
| | that person's practice or employment as a licensed attorney and |
| | who does not collect charges or premiums in connection with |
| | life, annuity, or health coverage. |
| | <u>k.</u> An adjuster licensed by this State whose activities are limited to |
| | adjustment of claims. |
| | <u>l.</u> A person licensed as a managing general agent in this State, |
| | whose activities are limited exclusively to the scope of activities |
| | conveyed under the license. |
| | m. An administrator who is affiliated with an insurer and who only |
| | performs the contractual duties (between the administrator and |
| | the insurer) of an administrator for the direct and assumed |
| | insurance business of the affiliated insurer. The insurer is |
| | responsible for the acts of the administrator and is responsible |
| | for providing all of the administrator's books and records to the |
| | Commissioner, upon a request from the Commissioner. |
| <u>(2)</u> | "Affiliate or affiliated" means an entity or person who directly or |
| | indirectly, through one or more intermediaries, controls or is controlled |
| | by, or is under common control with, a specified entity or person. |
| <u>(3)</u> | "Commissioner" means the Commissioner of Insurance of this State. |
| | "Control" means the term as defined in G.S. 58-19-5(2). |
| | "GAAP" means United States generally accepted accounting principles |
| | consistently applied. |
| (6) | "Home state" means the District of Columbia and any state or territory |
| | of the United States in which an administrator is incorporated or |
| | maintains its principal place of business. If neither the state in which |
| | the administrator is incorporated nor the state in which it maintains its |
| | principal place of business has adopted the NAIC Third Party |
| | Administrator Statute, or a substantially similar law governing |
| | administrators, the administrator may declare another state in which it |
| | conducts business to be its "home state". |
| <u>(7)</u> | "Insurance producer" means a person who sells, solicits, or negotiates |
| | a contract of insurance as those terms are defined in this Article. |
| (8) | "Insurer" means an insurance company subject to this Chapter, a |
| | service corporation organized under Article 65 of this Chapter, a health |
| | maintenance organization organized under Article 67 of this Chapter, |
| | and a multiple employer welfare arrangement subject to Article 49 of |
| | this Chapter. |
| | (3) (4) (5) (6) |

- 1 (9) "Negotiate" means the act of conferring directly with, or offering 2 advice directly to, a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, 3 or conditions of the contract, provided that the person engaged in that 4 5 act either sells insurance or obtains insurance from insurers for 6 purchasers. 7 "Nonresident administrator" means a person who is applying for (10)8 licensure or is licensed in any state other than the administrator's home 9 state. 10 <u>(11)</u> "Person" means an individual or a business entity. "Sell" means to exchange a contract of insurance by any means, for 11 (12)money or its equivalent, on behalf of an insurance company. 12 "Solicit" means attempting to sell insurance or asking or urging a 13 (13)
 - (14) "Underwrites" or "underwriting" includes the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer or self-funded plan and also

person to apply for a particular kind of insurance from a particular

(15) "Uniform Application" means the current version of the NAIC Uniform Application for Third Party Administrators."

includes the overall planning and coordinating of a benefits program.

SECTION 1.2. G.S. 58-56-6 reads as rewritten:

"§ 58-56-6. Written agreement necessary.

- (a) No TPA may act as a TPA without a written agreement between the TPA and the insurer. The written agreement shall be retained as part of the official records of both the insurer and the TPA for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by this Article, to the extent those requirements apply to the functions performed by the TPA. except insofar as those requirements do not apply to the functions performed by the TPA.
- (b) The agreement shall include a statement of duties that the TPA is expected to perform on behalf of the insurer and the kinds of insurance the TPA is to be authorized to administer. Ines, classes, or types of insurance for which the TPA is to be authorized to administer. The agreement shall provide for underwriting or other standards pertaining to the business underwritten by the insurer.
- (c) The insurer or TPA may, with written notice, terminate the <u>written</u> agreement for cause as provided in the agreement. The insurer may suspend the underwriting authority of the TPA during the pendency of any dispute regarding the cause for termination of the agreement. The insurer <u>must-shall</u> fulfill any lawful obligations with respect to policies affected by the agreement, regardless of any dispute between the insurer and the TPA."

SECTION 1.3. G.S. 58-56-16 reads as rewritten:

"§ 58-56-16. Records to be kept.

(a) Every TPA shall maintain and make available to the insurer complete books and records of all transactions performed on behalf of the insurer. The books and

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records shall be maintained in accordance with prudent standards of insurance record keeping and must be maintained for a period of at least five years after the date of their creation.

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- (b) The Commissioner shall have access to books and records maintained by a TPA for the purposes of examination, audit, and inspection. The Commissioner shall keep confidential any trade secrets contained in those books and records, including the identity and addresses of policyholders and certificate holders, except that the Commissioner may use the information in any judicial or administrative proceeding instituted against the TPA.
- (c) The insurer shall own the records generated by the TPA pertaining to the insurer, but the TPA shall retain the right to continuing access to books and records to permit the TPA to fulfill all of its contractual obligations to insured parties, claimants, and the insurer.
- (d) In the event the insurer and the TPA cancel their agreement, notwithstanding the provisions of subsection (a) of this section, the TPA may, by written agreement with the insurer, transfer all records to a new TPA rather than retain them for five years. In this case, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA as required in subsection (a) of this section.
- (e) The Commissioner shall have access to books and records maintained by a TPA for the purposes of examination, audit, and inspection. Any documents, materials, or other information in the possession or control of the Commissioner that are furnished by a TPA, insurer, insurance producer, or an employee or agent thereof acting on behalf of the TPA, insurer, or insurance producer, or obtained by the Commissioner in an investigation shall be confidential by law and privileged, shall not constitute a public record as defined by G.S. 132-1, shall not be subject to subpoena, shall not be subject to discovery, and shall not be admissible in evidence in any private civil action. However, the Commissioner is authorized to use such documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.
- (f) Neither the Commissioner nor any person who receives documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (e) of this section.
- (g) <u>In order to assist in the performance of the Commissioner's duties, the Commissioner:</u>
 - (1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (e) of this section, with other State, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates, or its subsidiaries, and with State, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

1 **(2)** May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from 2 3 the National Association of Insurance Commissioners, its affiliates, or 4 its subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as 5 6 confidential or privileged any document, material, or information 7 received with notice or the understanding that it is confidential or 8 privileged under the laws of the jurisdiction that is the source of the 9 document, material, or information; and 10 (3) May enter into agreements governing sharing and use of information 11 consistent with this subsection. No waiver of any applicable privilege or claim of confidentiality in the 12 (h) 13 documents, materials, or information shall occur as a result of disclosure to the 14 Commissioner under this section or as a result of sharing as authorized in subsection (g) 15 of this section. 16 (i) Nothing in this Article shall prohibit the Commissioner from releasing final. 17 adjudicated actions including for-cause terminations that are open to public inspection 18 pursuant to Chapter 132 of the General Statutes or to a database or other clearinghouse 19 service maintained by the National Association of Insurance Commissioners, its 20 affiliates, or its subsidiaries." 21 **SECTION 1.4.** G.S. 58-56-51 is repealed. SECTION 1.5. Article 56 of Chapter 58 of the General Statutes is amended 22 23 by adding a new section to read: 24 "§ 58-56-52. Home state certificate of authority or license. A person shall apply to be a TPA in its home state upon the Uniform 25 (a) Application and shall receive a certificate of authority or license from the Commissioner 26 27 of its home state prior to performing any function of a TPA in this State. Each 28 application shall be accompanied by a nonrefundable filing fee of one hundred dollars 29 (\$100.00). 30 (b) The Uniform Application shall include or be accompanied by the following 31 information and documents: 32 All basic organizational documents of the applicant, including any (1) 33 articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and 34 35 other applicable documents and all amendments to those documents. The bylaws, rules, regulations, or similar documents regulating the 36 <u>(2)</u> 37 internal affairs of the applicant. NAIC Biographical Affidavit for the individuals who are responsible 38 <u>(3)</u> 39 for the conduct of affairs of the applicant, including all members of the 40 board of directors, board of trustees, executive committee, or other 41 governing board or committee; the principal officers in the case of a 42 corporation or the partners or members in the case of a partnership,

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association, or limited liability company; any shareholders or member

holding directly or indirectly ten percent (10%) or more of the voting

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- stock, voting securities, or voting interest of the applicant; and any other person who exercises control or influence over the affairs of the applicant.
- Audited annual financial statements or reports for the two most recent fiscal years that prove that the applicant has a positive net worth. If the applicant has been in existence for less than two fiscal years, the Uniform Application shall include financial statements or reports, certified by an officer of the applicant and prepared in accordance with GAAP, for any completed fiscal years and for any month during the current fiscal year for which the financial statements or reports have been completed. The applicant shall also include any other information the Commissioner requires in order to review the current financial condition of the applicant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include all of the following:
 - <u>a.</u> Amounts shown on the consolidated audited financial report shall be shown on the worksheet.
 - b. Amounts for each entity shall be stated separately.
 - <u>c.</u> Explanations of consolidating and eliminating entries.
- (5) A statement describing the business plan including information on staffing levels and activities proposed in this State and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping, and underwriting.
- (6) Any other pertinent information required by the Commissioner.
- (c) A TPA licensed or applying for licensure under this section shall make available for inspection by the Commissioner copies of all contracts with insurers or other persons utilizing the services of the TPA.
- (d) A TPA licensed or applying for licensure under this section shall produce its accounts, records, and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the Commissioner.
- (e) The Commissioner may refuse to issue a certificate of authority or license if the Commissioner determines that the TPA, or any individual responsible for the conduct of affairs of the TPA, is not competent, trustworthy, financially responsible, or of good personal and business reputation, has had an insurance or an administrator certificate of authority or license denied or revoked for cause by any jurisdiction, or if the Commissioner determines that any of the grounds set forth in G.S. 58-56-72 exists with respect to the TPA.
- (f) A certificate of authority or license issued under this section shall remain valid, unless surrendered, suspended, or revoked by the Commissioner, for so long as the TPA continues in business in this State and remains in compliance with this Article.

(g) A TPA licensed or applying for licensure under this section shall immediately notify the Commissioner of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a certificate of authority or license in this State. The Commissioner shall report any such changes to the producer database maintained by the NAIC or affiliates or subsidiaries of the NAIC."

SECTION 1.6. G.S. 58-56-56 is repealed.

SECTION 1.7. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-57. Registration requirement.

 A person who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this State in connection with life, annuity, or health coverage provided by a self-funded plan shall register with the Commissioner annually, verifying its status as herein described in a format prescribed by the Commissioner."

SECTION 1.8. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-62. Annual report and filing.

- (a) Each TPA licensed under G.S. 58-56-52 shall file an annual report for the preceding calendar year with the Commissioner on or before July 1 of each year or within such extension of time as the Commissioner for good cause may grant. The annual report shall include an audited financial statement performed by an independent certified public accountant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the information required under G.S. 58-56-52(b)(4)a. through c. The report shall be in the form and contain such matters as the Commissioner prescribes and shall be verified by at least two officers of the TPA.
- (b) The annual report shall include the complete names and addresses of all insurers with which the administrator had agreements during the preceding fiscal year.
- (c) At the time of filing its annual report, the administrator shall pay a nonrefundable filing fee of one hundred dollars (\$100.00).
- (d) The Commissioner shall review the most recently filed annual report of each administrator on or before September 1 of each year. Upon completion of its review, the Commissioner shall either:
 - (1) Issue a certification to the administrator that the annual report shows that the administrator has a positive net worth as evidenced by audited financial statements and is currently licensed and in good standing, or noting any deficiencies found in the annual report and financial statements; or
 - (2) Update any electronic database maintained by the National Association of Insurance Commissioners, or its affiliates or subsidiaries, indicating that the annual report shows that the administrator has a positive net worth as evidenced by audited financial statements and is in compliance with existing law, or noting any deficiencies found in the annual report."

SECTION 1.9. G.S. 58-56-66 is repealed.

SECTION 1.10. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-67. Nonresident administrator certificate of authority.

- (a) Unless a TPA has obtained a home state certificate of authority or license in this State under G.S. 58-56-52, any TPA who performs administrator duties in this State shall obtain a nonresident administrator certificate of authority or license in accordance with this section by filing with the Commissioner the Uniform Application accompanied by a letter of certification from the home state of the TPA. In lieu of requiring a TPA to file a letter of certification with the Uniform Application, the Commissioner may verify the nonresident administrator's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.
- (b) A TPA shall not be eligible for a nonresident administrator certificate of authority or license under this section if it does not hold a certificate of authority as a resident in a home state that has adopted the NAIC Third Party Administrator Statute or a substantially similar law governing TPAs.
- (c) Except as provided in subsections (b) and (h) of this section, the Commissioner shall issue to the TPA a nonresident administrator certificate of authority or license promptly upon receipt of a complete application.
- (d) Unless notified by the Commissioner that the Commissioner is able to verify the nonresident TPA's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, or its affiliates or subsidiaries, each nonresident TPA annually shall file a statement that its home state administrator certificate of authority or license remains in force and has not been revoked or suspended by its home state during the preceding year. The statement required by this subsection shall be filed by November 1 each year.
- (e) At the time of filing the statement required under subsection (d) of this section or if the Commissioner has notified the nonresident administrator that the Commissioner is able to verify the nonresident administrator's home state certificate of authority or license status through an electronic database, the nonresident TPA shall pay, no later than November 1, a nonrefundable filing fee of one hundred dollars (\$100.00).
- (f) A TPA licensed or applying for licensure under this section shall produce its accounts, records, and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the Commissioner.
- (g) A nonresident TPA is not required to hold a nonresident administrator certificate of authority or license in this State if the TPA's duties in this State are limited to the administration of a group policy or plan of insurance and no more than a total of 100 persons insured for all plans reside in this State.
- (h) The Commissioner may refuse to issue a nonresident administrator certificate of authority or license, or delay the issuance of a nonresident administrator certificate of authority or license, if the Commissioner determines that, due to events or information

| obtained subsequent to the home state's licensure of the TPA, the nonresident TPA |
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| cannot satisfy the requirements of this Article or that grounds exist for the home state's |
| revocation or suspension of the administrator's home state certificate of authority or |
| license. If the Commissioner refuses to issue a certificate of authority of license |
| pursuant to this section, the Commissioner shall give written notice of its determination |
| to the Commissioner of the home state, and the Commissioner may delay the issuance |
| of a nonresident administrator certificate of authority to the nonresident TPA until the |
| Commissioner determines that the administrator can satisfy the requirements of this |
| Article and that no grounds exist for the home state's revocation or suspension of the |
| administrator's home state certificate of authority or license." |
| SECTION 1.11 Article 56 of Chanter 58 of the General Statutes is amended |

SECTION 1.11. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-56-72. Grounds for denial, suspension, or revocation of certificate of authority.

- (a) The certificate of authority or license of a TPA shall be denied, suspended, or revoked if the Commissioner finds that the TPA:
 - (1) Is in an unsound financial condition;
 - (2) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this State hazardous or injurious to insured persons or the public; or
 - (3) Has failed to pay any judgment rendered against it in this State within 60 days after the judgment has become final.
- (b) The Commissioner may, after notice and opportunity for hearing, deny, suspend, or revoke the certificate of authority or license of a TPA if the Commissioner finds that the TPA:
 - (1) Has violated any lawful rule or order of the Commissioner or any provision of the insurance laws of this State;
 - (2) Has refused to be examined or to produce its accounts, records, and files for examination, or if any individual responsible for the conduct of affairs of the TPA has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination when required by the Commissioner, including:
 - <u>a.</u> <u>Members of the board of directors, board of trustees, executive committee, or other governing board or committee;</u>
 - b. The principal officers in the case of a corporation or the partners or members in the case of a partnership, association, or limited liability company;
 - c. Any shareholder or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities, or voting interest of the TPA; and
 - d. Any other person who exercises control or influence over the affairs of the TPA;
 - (3) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused

| 1 | | covered individuals to accept less than the amount due them or caused |
|----|------------------|---|
| 2 | | covered individuals to employ attorneys or bring suit against the TPA |
| 3 | | to secure full payment or settlement of such claims; |
| 4 | <u>(4)</u> | Fails, at any time, to meet any qualification for which issuance of the |
| 5 | | certificate could have been refused had the failure then existed and |
| 6 | | been known to the Commissioner; |
| 7 | <u>(5)</u> | Or any of the individuals responsible for the conduct of its affairs has |
| 8 | | been convicted of, or has entered a plea of guilty or nolo contendere to |
| 9 | | a felony without regard to whether adjudication was withheld. |
| 10 | | including: |
| 11 | | a. Members of the board of directors, board of trustees, executive |
| 12 | | committee or other governing board or committee; |
| 13 | | b. The principal officers in the case of a corporation or the |
| 14 | | partners or members in the case of a partnership, association, or |
| 15 | | limited liability company; |
| 16 | | c. Any shareholder or member holding directly or indirectly ten |
| 17 | | percent or more of its voting stock, voting securities, or voting |
| 18 | | interest; and |
| 19 | | d. Any other person who exercises control or influence over its |
| 20 | | affairs; |
| 21 | <u>(6)</u> | Is under suspension or revocation in another state; or |
| 22 | <u>(7)</u> | Has failed to timely file its annual report pursuant to G.S. 58-56-62 if a |
| 23 | | resident administrator or its statement and filing fee, as applicable. |
| 24 | | pursuant to G.S. 58-56-67(d) and (e) if a nonresident administrator. |
| 25 | (c) The | Commissioner may, without advance notice or hearing, immediately |
| 26 | | tificate of authority or license of a TPA if the Commissioner finds that |
| 27 | - | the following circumstances exist: |
| 28 | (1) | The TPA is insolvent or impaired. |
| 29 | (2) | A proceeding for receivership, conservatorship, rehabilitation, or other |
| 30 | | delinquency proceeding regarding the TPA has been commenced in |
| 31 | | any state. |
| 32 | <u>(3)</u> | The financial condition or business practices of the TPA otherwise |
| 33 | 1,=_, | pose an imminent threat to the public health, safety, or welfare of the |
| 34 | | residents of this State. |
| 35 | (d) If the | Commissioner finds that one or more grounds exist for the suspension |
| 36 | | f a certificate of authority issued under this part, the Commissioner may |
| 37 | | nsion or revocation, impose a fine upon the TPA." |
| 38 | | FION 1.12. Article 56 of Chapter 58 of the General Statutes is amended |
| 39 | | v section to read: |
| 40 | • | rohibited practices |

No person shall act as, offer to act as, or hold himself or herself out as a TPA in this State without a valid domestic or nonresident administrator certificate of authority

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issued by the Commissioner."

PART II. GROUP ANNUITY CONTRACTS

SECTION 2. G.S. 58-58-145 reads as rewritten:

"§ 58-58-145. Group annuity contracts defined; requirements.requirements; issuance of individual certificates.

- Any policy or contract, except a joint, reversionary or survivorship annuity (a) contract, whereby annuities are payable to more than one person, is a group annuity contract. The person, firm or corporation to whom or to which such contract is issued, as herein provided, is the holder of the contract. The term "annuitant" means any person to whom or which payments are made under the group annuity contract. No authorized insurer shall deliver or issue for delivery in this State any group annuity contract except upon a group of annuitants that conforms to the following: under a contract issued to an employer, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, the stipulated payments on which shall be paid by the holder of such contract either wholly from the employer's funds or funds contributed by him, or partly from such funds and partly from funds contributed by the employees covered by such contract, and providing a plan of retirement annuities under a plan which permits all of the employees of such employer or of any specified class or classes thereof to become annuitants. Any such group of employees may include retired employees, and may include officers and managers as employees, and may include the employees of subsidiary or affiliated corporations of a corporation employer, and may include the individual proprietors, partners and employees of affiliated individuals and firms controlled by the holders through stock ownership, contract or otherwise.
- (b) The insurer of a group annuity contract shall issue to the policyholder, within 30 days of the effective date of the group annuity contract, an individual certificate for delivery to each annuitant which:
 - (1) Identifies the annuity to which the annuitant is entitled.
 - (2) States the name of the person to whom the annuity is payable.
 - (3) Discloses all of the rights and obligations of the insurer, the policyholder, the annuitant, and the persons to whom the annuity is payable with respect to the group annuity contract.
- G.S. 58-3-150 applies to the form of the individual certificate required by this subsection.
- (c) Each group annuity contract shall include a provision that the insurer will issue to the policyholder within 30 days of the effective date of the contract, for delivery to each annuitant, an individual certificate setting forth the information described in subsection (b) of this section."

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PART III. DISCLOSURES FOR ANNUITIES AND LIFE INSURANCE

SECTION 3. The title of Article 60 of Chapter 58 of the General Statutes reads as rewritten:

"Article 60.

Regulation of Life Insurance Solicitation.

Standards of Disclosure for Annuities and Life Insurance."



SECTION 3.1. Article 60 of Chapter 58 of the General Statues is amended by designating G.S. 58-60-1 through G.S. 58-60-35 as:

"Part 1. Regulation of Life Insurance Solicitation."

SECTION 3.2. G.S. 58-60-1 reads as rewritten:

"§ 58-60-1. Purpose of Article. Short title; purpose.

- (a) This Part may be cited as the "Life Insurance Disclosure Act".
- (b) The purpose of this Article-Part is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for their—the buyer's needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and to improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

This Article Part does not prohibit an insurer to use from using additional material which that is not in violation of Articles 1 through 64 of this Chapter nor any other statute or regulation."

SECTION 3.3. G.S. 58-60-5 reads as rewritten:

"§ 58-60-5. Scope of Article; Scope; exemptions.

- (a) Except as otherwise provided in this Article, Part, this Article Part applies to any solicitation, negotiation or procurement of life insurance occurring within this State. This Article Part applies to any issuer of a life insurance contract, including fraternal benefit societies.
 - (b) Unless otherwise specifically included, this Article Part does not apply to:
 - (1) Annuities, Individual group annuity contracts.
 - (2) Credit life insurance, insurance.
 - (3) Group life insurance, insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy).
 - (4) Life insurance policies issued in connection with pension and welfare plans as defined by and that are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).
 - (5) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.
- (c) The policy summary in this Article-Part is not required for policies that are sold subject to rules adopted by the Commissioner for life insurance illustrations."

SECTION 3.4. G.S. 58-60-10(7)k. reads as rewritten:

"k. The date on which the Policy Summary is prepared.

The Policy Summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy

year. Amounts in subparagraph e of this paragraph shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space. If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor, it shall. no later than the first policy anniversary following the revision, advise each affected policy owner residing in this State."

SECTION 3.5. Article 60 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 3. Regulation of Home Service Life Insurance Solicitation.

"§ 58-60-40. Title and reference.

This Part may be cited as the "Home Service Disclosure Act".

"<u>§ 58-60-45.</u> Purpose.

The purpose of this Part is to establish standards that ensure that meaningful information is provided to the purchasers of insurance policies distributed through the home service distribution system.

"§ 58-60-50. Definitions.

As used in this Part:

- "Home service distribution system" means a system in which insurance products are marketed, sold, or serviced by agents in person in the home or business of the insured, owner, or premium payor in assigned territories and may be identified as "debits". The policies are issued on a monthly or more frequent premium payment basis and agents are charged with the responsibilities of servicing the debit, which may include the collection of premium payments in the home or designated location on a monthly or more frequent basis, along with other services normally rendered.
- (2) "Small face amount life insurance policy" means an insurance policy or certificate with a face amount of fifteen thousand dollars (\$15,000) or less.

"§ 58-60-55. General disclosure requirements.

- (a) In accordance with the disclosure simplification standards set forth in G.S. 58-60-80 and at the time an insurance policy is issued through the home service distribution system, the insurer shall disclose:
 - (1) Whether the policyholder is allowed to change the method of premium payment and any conditions for that change;
 - Whether or not at a subsequent date a policyholder may combine multiple policies from the same insurance company, its affiliates, and its subsidiaries into one policy in order to provide like or enhanced coverage at a comparable or reduced premium to eliminate duplicate



administrative costs associated with each policy and, if the option is available:

- a. Whether a policyholder will be subject to underwriting when combining multiple policies into one policy; and
- b. Whether a policyholder will be subject to a new contestable period, waiting periods, etc., when combining multiple policies into one policy.
- (b) In accordance with the disclosure simplification standards set forth in G.S. 58-60-80, an insurer issuing a small face amount life insurance policy through the home service distribution system shall provide the current disclosure included in Appendix A of the NAIC's Home Service Disclosure Model if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy but may be delivered with the policy.
- If, for a particular policy form, the cumulative premiums may exceed the face for some demographic or benefit combination but not for all combinations, the insurer may choose to either:
 - (1) Provide the disclosure only in those circumstances where the premiums may exceed the face amount; or
 - (2) Provide the disclosure for all demographic and benefit combinations.

Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.

If an illustration has been provided that satisfies the requirements of Title 11, Chapter 4, Section .0500 of the North Carolina Administrative Code, the disclosure requirements of subsection (b) of this section are deemed to have been met.

"§ 58-60-60. Disclosure of payment methods.

In accordance with the disclosure simplification standards set forth in G.S. 58-60-80, at the time an insurance policy is issued through the home service distribution system, the insurer shall disclose:

- (1) What premium savings may be realized by a different method or less frequent mode of premium payment.
- (2) That premiums are still due and payable by the person responsible for premium payments even when an agent does not collect the premiums.
- (3) The mailing address for payment of premiums to the company.
- (4) That the consumer is entitled to receive a receipt for premium payments when premium payments are made in cash or in person.

"§ 58-60-65. Evidence of payment.

For every premium collected on a policy of life or disability insurance marketed, sold, or serviced through the home service distribution system in this State, the agent, solicitor, or broker, or any employee acting on the agent, solicitor, or broker's behalf, collecting or receiving the premium in person shall:

(1) Maintain and furnish to the policyholder a receipt indicating payment of premiums, which shall provide the payor with clearly

| 1 | understandable, written evidence of payment at the time the premium |
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| 2 | is collected. At a minimum it shall clearly show: |
| 3 | a. The name of the payor. |
| 4 | b. The name of insured under each policy covered by the |
| 5 | premium. |
| 6 | c. The amount paid. |
| 7 | d. The date paid. |
| 8 | c. The amount paid. d. The date paid. e. The date paid-to-status of the policy. f. The policy number. |
| 9 | <u>f.</u> The policy number. |
| 10 | g. The face amount and type of policy for which the payment will |
| 11 | be credited. |
| 12 | h. The signature of the agent. |
| 13 | h. The signature of the agent.i. The agent's printed name and unique identification number. |
| 14 | j. The name, complete address, and phone number of the insurer. |
| 15 | (2) Remit to the insurer's home office or applicable district office, or |
| 16 | deposit in a fiduciary account, the premium collected on behalf of the |
| 17 | policyholder within 10 days of receipt from the premium payor or |
| 18 | policy owner. In the event that the insurer utilizes an accounting |
| 19 | system based on a monthly list bill, all premiums collected shall be |
| 20 | credited from the date of collection. The premium shall be fully |
| 21 | applied to that particular account. |
| 22 | " <u>§ 58-60-70. Proof of policy delivery.</u> |
| 23 | If an insurance policy marketed, sold, or serviced through the home service |
| 24 | distribution system is delivered by an agent, solicitor, or broker, or an employee acting |
| 25 | on the agent, solicitor, or broker's behalf, a receipt shall be signed by the purchaser and |
| 26 | the agent acknowledging delivery to the purchaser of the policy or contract and the |
| 27 | disclosures required by this Part. The receipt shall contain the name of the purchaser, |
| 28 | the policy or contract number, the amount of the initial premium payment, and the date |
| 29 | the delivery was completed. A policy shall be deemed to have been received six months |
| 30 | after the date of issuance if the insured has paid premiums pursuant to the contract. All |
| 31 | delivery receipts required by this section shall be retained by the company for not less |
| 32 | than three years following delivery and shall be available for inspection upon request of |
| 33 | the Commissioner. |
| 34 | "§ 58-60-75. Company duties. |
| 35 26 | Each insurer engaged in the home service distribution system in this State shall |
| | |

- Established written procedures to audit agencies engaged in the home <u>(1)</u> service system of distribution of policies in this State; and
- <u>(2)</u> Proof of audits conducted periodically that reasonably ensure that the premium payor's records accurately reflect the premium due date and premium paid-to-status of the policy or policies purchased.
- "§ 58-60-80. Minimum disclosure language standards.

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| 1 | All disclosure forms shall comply with the readability standards in Article 38 of this |
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| 2 | Chapter. It is presumed the disclosure form in Appendix A of the NAIC's Home Service |
| 3 | Disclosure Model Act complies with this Part." |
| 4 | SECTION 3.6. Article 60 of Chapter 58 of the General Statutes is amended |
| 5 | by adding a new Part to read: |
| 6 | "Part 3. Regulation of Small Face Amount Life Insurance Solicitation. |
| 7 | "§ 58-60-85. Title and reference. |
| 8 | This Part may be cited as the "Small Face Amount Life Insurance Disclosure Act". |
| 9 | "§ 58-60-90. Purpose; intent; and scope. |
| 10 | (a) The purpose of this Part is to establish standards that ensure meaningful |
| 11 | information is provided to the purchasers of small face amount policies. |
| 12 | (b) This Part applies to any life insurance policy or certificate with an initial face |
| 13 | amount of fifteen thousand dollars (\$15,000) or less. |
| 14 | (c) This Part does not apply to: |
| 15 | (1) Variable life insurance. |
| 16 | (2) <u>Individual and group annuity contracts.</u> |
| 17 | (3) Credit life insurance. |
| 18 | (4) Group or individual policies of life insurance issued to members of an |
| 19 | employer group or other permitted group where: |
| 20 | <u>a.</u> <u>Every plan of coverage was selected by the employer or other</u> |
| 21 | group representative; |
| 22 | b. Some portion of the premium is paid by the group or through |
| 23 | payroll deduction; and |
| 24 | c. Group underwriting or simplified underwriting is used. |
| 25 | (5) Policies and certificates where an illustration has been provided |
| 26 | pursuant to the requirements of Title 11, Chapter 4, Section .0500 of |
| 27 | the North Carolina Administrative Code. |
| 28 | "§ 58-60-95. Disclosure requirements. |
| 29 | (a) An insurer issuing a small face amount policy shall provide the current |
| 30 | disclosure included in Appendix A of the NAIC Disclosure for Small Face Amount Life |
| 31 | Insurance Policies Model Act if at any point in time over the term of the policy the |
| 32 | cumulative premiums paid may exceed the face amount of the policy at that point in |
| 33 | time. The required disclosure shall be provided to the policy owner or certificate holder |
| 34 35 | no later than at the time the policy or certificate is delivered. The disclosure shall not be |
| 35 | attached to the policy but may be delivered with the policy. (b) If for a particular policy form, the sumulative premiums may exceed the face |
| 36 37 | (b) If, for a particular policy form, the cumulative premiums may exceed the face amount for some demographic or benefit combination but not for all combinations, the |
| 3 / | - amount to: some demograpine of dehem combination but not for all combinations. Als |

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(c) Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefits attributable to the riders.

combinations.

premiums may exceed the face amount; or

Provide the disclosure only in those circumstances where the

Provide the disclosure for all demographic and benefit

insurer may choose to either:

(1)

<u>(2)</u>

"§ 58-60-100. Insurer duties.

 The insurer and its producers shall have a duty to provide information to policyholders or certificate holders that ask questions about the disclosure statement."

SECTION 3.7. Article 60 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Regulation of Annuity Solicitation.

"<u>§ 58-60-105</u>. Title and reference.

This Part may be cited as the "Annuity Disclosure Act".

"§ 58-60-110. Purpose; intent; scope.

- (a) The purpose of this Part is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. This Part specifies the minimum information that must be disclosed and the method for disclosing it in connection with the sale of annuity contracts. The goal of this Part is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.
- (b) This Part applies to all group and individual annuity contracts and certificates except:
 - (1) Registered or nonregistered variable annuities or other registered products.
 - (2) <u>Immediate and deferred annuities that contain no nonguaranteed elements.</u>
 - (3) Annuities used to fund:
 - a. An employee pension plan, which is covered by the Employee Retirement Income Security Act (ERISA);
 - b. A plan described by section 401(a), 401(k), or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;
 - c. A governmental or church plan defined in section 414, or a deferred compensation plan of a state or local government or a tax exempt organization under section 457, of the Internal Revenue Code;
 - d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;
 - e. Structured settlement annuities;
 - f. Charitable gift annuities; or
 - g. Funding agreements.
- (c) This Part shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement.

"§ 58-60-115. Definitions. 2 As used in this Part:

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- "Annuity buyer's guide" or "buyer's guide" means the current NAIC (1) Model Buyer's Guide to Fixed Deferred Annuities, including any appendix thereto.
- <u>(2)</u> "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.
- "Contract owner" means the owner named in the annuity contract or <u>(3)</u> certificate holder in the case of a group annuity contract.
- "Determinable elements" means elements that are derived from (4) processes or methods that are guaranteed at issue and not subject to company discretion but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only or from both determinable and guaranteed elements.
- "Disclosure document" means the document the contents of which are **(5)** described in G.S. 58-60-125.
- "Funding agreement" means an agreement for an insurer to accept and **(6)** accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.
- "Generic name" means a short title descriptive of the annuity contract <u>(7)</u> being applied for or illustrated such as "single premium deferred annuity".
- "Guaranteed elements" means the premiums, credited interest rates, (8) including any bonus, benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these, that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.
- <u>(9)</u> "Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these that are subject to company discretion and are not guaranteed at issue. An

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| 1 | | element is considered nonguaranteed if any of the underlying |
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| 2 | | nonguaranteed elements are used in its calculation. |
| 3 | <u>(10)</u> | "Structured settlement annuity" means a "qualified funding asset" as |
| 4 | | defined in section 130(d) of the Internal Revenue Code or an annuity |
| 5 | | that would be a qualified funding asset under section 130(d) but for the |
| 6 | | fact that it is not owned by an assignee under a qualified assignment. |
| 7 | " <u>§ 58-60-120</u> . § | Standards for the disclosure document and buyer's guide. |
| 8 | | e the application for an annuity contract is taken in a face-to-face |
| 9 | | plicant, at or before the time of application, shall be given both the |
| 10 | | ment described in G.S. 58-60-125 and a copy of the buyer's guide. |
| 11 | | e the application for an annuity contract is taken by means other than in |
| 12 | | neeting, the applicant shall be sent both the disclosure document and the |
| 13 | | later than five business days after the completed application is received |
| 14 | by the insurer. | |
| 15 | (1) | With respect to an application received as a result of a direct |
| 16 | | solicitation through the mail: |
| 17 | | a. Providing a buyer's guide in a mailing inviting prospective |
| 18 | | applicants to apply for an annuity contract shall be deemed to |
| 19 | | satisfy the requirement that the buyer's guide be provided no |
| 20 | | later than five business days after receipt of the application. |
| 21 | | b. Providing a disclosure document in a mailing inviting a |
| 22 | | prospective applicant to apply for an annuity contract shall be |
| 23 | | deemed to satisfy the requirement that the disclosure document |
| 24 | | be provided no later than five business days after receipt of the |
| 25 | | application. |
| 26 | <u>(2)</u> | With respect to an application received via the Internet: |
| 27 | | a. Taking reasonable steps to make the buyer's guide available for |
| 28. | | viewing and printing on the insurer's web site shall be deemed |
| 29 | | to satisfy the requirement that the buyer's guide be provided no |
| 30 | | later than five business days after receipt of the application. |
| 31 | | b. Taking reasonable steps to make the disclosure document |
| 32 | | available for viewing and printing on the insurer's web site shall |
| 33 | | be deemed to satisfy the requirement that the disclosure |
| 34 | | document be provided no later than five business days after |
| 35 | | receipt of the application. |
| 36 | <u>(3)</u> | A solicitation for an annuity contract provided in other than a |
| 37 | | face-to-face meeting shall include a statement that the proposed |
| 38 | | applicant may contact the Department for a free annuity buyer's guide. |
| 39 | | In lieu of the foregoing statement, an insurer may include a statement |
| 40 | | that the prospective applicant may contact the insurer for a free annuity |
| 41 | | buyer's guide. |

Where the buyer's guide and disclosure document are not provided at or

before the time of application, a free look period of no less than 15 days shall be

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| 1 | provided for the applicant to return the annuity contract without penalty. This free look | | |
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| 2 | shall run concurrently with any other free look provided under State law or regulation. | | |
| 3 | "§ 58-60-125. Contents of disclosure document. | | |
| 4 | At a minimum, all of the following information shall be included in the disclosure | | |
| 5 | document requi | ired under this Part: | |
| 6 | <u>(1)</u> | The generic name of the contract, the company product name, if | |
| 7 | | different, and form number, and the fact that it is an annuity. | |
| 8 | <u>(2)</u> | The insurer's name and address. | |
| 9 | <u>(3)</u> | A description of the contract and its benefits, emphasizing its | |
| 10 | | long-term nature, including the following, if appropriate: | |
| 11 | | a. The guaranteed, nonguaranteed, and determinable elements of | |
| 12 | | the contract, and their limitations, if any, and an explanation of | |
| 13 | | how they operate. | |
| 14 | | b. An explanation of the initial crediting rate, specifying any | |
| 15 | | bonus or introductory portion, the duration of the rate, and the | |
| 16 | | fact that rates may change from time to time and are not | |
| 17 | | guaranteed. | |
| 18 | | c. Periodic income options both on a guaranteed and | |
| 19 | | nonguaranteed basis. | |
| 20 | | d. Any value reductions caused by withdrawals from or surrender | |
| 21 | | of the contract. | |
| 22 | | e. How values in the contract can be accessed. f. The death benefit, if available, and how it will be calculated. | |
| 23 | | | |
| 24 | | g. A summary of the federal tax status of the contract and any | |
| 25 | | penalties applicable on withdrawal of values from the contract. | |
| 26 | 4.00 | h. The impact of any rider, such as a long-term care rider. | |
| 27 | <u>(4)</u> | The specific dollar amount or percentage charges and fees with an | |
| 28 | (-) | explanation of how they apply. | |
| 29 | <u>(5)</u> | Information about the current guaranteed rate for new contracts that | |
| 30 | | contains a clear notice that the rate is subject to change. | |
| 31 | | all define terms used in the disclosure statement in language that | |
| 32 | | understanding by a typical person within the segment of the public to | |
| 33 | - | osure statement is directed. | |
| 34 | | Report to contract owners. | |
| 35 | | es in the payout period with changes in nonguaranteed elements and for | |
| 36 | | on period of a deferred annuity, the insurer shall provide each contract | |
| 37 | | eport, at least annually, on the status of the contract that contains at least | |
| 38 | 4 | ving information: | |
| 39 | $\frac{(1)}{(2)}$ | The beginning and end date of the current report period. | |
| 40 41 | <u>(2)</u> | The accumulation and cash surrender value, if any, at the end of the | |
| | (2) | previous report period and at the end of the current report period. The total amounts if any that have been aredited aborred to the | |
| 42 43 | <u>(3)</u> | The total amounts, if any, that have been credited, charged to the | |
| 43 | | contract value, or paid during the current report period. | |

(4) The amount of outstanding loans, if any, as of the end of the current report period."

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PART IV. EMPLOYER-OWNED LIFE INSURANCE DISCLOSURE SECTION 4. G.S. 58-58-75 reads as rewritten:

"§ 58-58-75. Insurable interest in life and physical ability of employee or agent.

- (a) An employer, whether a partnership, joint venture, business trust, mutual association, corporation, any other form of business organization, or one or more individuals, or any religious, educational, or charitable corporation, institution or body, has an insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an employee for the benefit of such employer. Any principal shall have a life insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an agent for the benefit of such principal.
- (b) An employee described in subsection (a) of this section shall be insured for the benefit of an employer described in subsection (a) of this section only if the employee receives written notification from the insurer of the existence of the coverage. The notice shall be provided to the employee within 30 days after the effective date of the coverage and shall include a statement that the employer may maintain the life insurance coverage on the employee even after employment is terminated.
- (c) For nonkey or nonmanagerial employees, the aggregate amount of coverage shall be reasonably related to the benefits provided to the employees in the aggregate.
- (d) With respect to employer-provided pension and welfare plans, the life insurance coverage purchased to finance the plans may only cover the lives of those employees and retirees who, at the time their lives were first insured under the plan, either are participants, or would be eligible to participate, upon the satisfaction of age, service, or similar eligibility criteria in the plan."

PART V. ACTUARIALLY SOUND ASSOCIATION GROUP ACCIDENT AND HEALTH PREMIUM RATES

SECTION 5. G.S. 58-51-80(1a) reads as rewritten:

"(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

The policy may insure members of the association or

associations, employees of the association or associations, or

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| 3 | | employees of members, or one or more of the preceding or all |
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| 4 | | of any class or classes for the benefit of persons other than the |
| 5 | | employee's employer. |
| 6 | ŀ | The premium for the policy shall be paid from funds |
| 7 | | contributed by the association or associations, or by employer |
| 8 | | members, or by both, or from funds contributed by the covered |
| 9 | | persons or from both the covered persons and the association, |
| 10 | | associations, or employer members. The premium rates for each |
| 11 | | association policy shall be developed, and applied to the |
| 12 | • | certificates thereunder, on an actuarially sound basis. |
| 13 | C | - 1 11 G 1 Y 100-0-0 0 H |
| 14 | ` | . Repealed by Session Baws 1997 239, 5. 6. |
| 15 | PART VI. IND | IVIDUAL ACCIDENT AND HEALTH INSURANCE |
| 16 | | TE LIMITATIONS |
| 17 | | ON 6. G.S. 58-51-95 is amended by adding a new subsection to read: |
| 18 | | icies subject to this section, an individual health insurer shall not |
| 19 | | dual's renewal premium for continued health insurance coverage under |
| 20 | | ndividual's health insurance policy based on any health status-related |
| 21 | | to the individual or a dependent of the individual, including: |
| 22 | | Health status. |
| 23 | - | Medical condition (including both physical and mental illnesses). |
| 23 24 | - | Claims experience. |
| 2 4 25 | | Duration from issue. |
| 26 | | Receipt of health care. |
| 20 27 | | Medical history. |
| 2 <i>1</i> 28 | | Genetic information." |
| 28 29 | 7.77 | Jeneue information. |
| 29 30 | DADT VII I A I | RGE GROUP HEALTH INSURANCE SOLE PROPRIETOR |
| 30 31 | EXEMPTION | TOE GROUP HEALTH INSURANCE SOLE TROTRIETOR |
| 32 | | ON 7. G.S. 58-65-60 is amended by adding a new subsection to read: |
| 32 33 | | letermining employee eligibility for a large employer, as defined in |
| 33 34 | |), an individual proprietor, owner, or operator shall be defined as an |
| 3 5 | | e purpose of obtaining coverage under the employee group health plan |
| 36 | <u> </u> | eld to a minimum workweek requirement as imposed on other eligible |
| 37 | employees." | nd to a minimum workweek requirement as imposed on other engine |
| 38 | | ON 7.1. G.S. 58-67-85 is amended by adding a new subsection to |
| 39 | read: | or with o.s. so or os is unfolded by dedning a new subsection to |
| 40 | | letermining employee eligibility for a large employer, as defined in |
| 41 | • | an individual proprietor, owner, or operator shall be defined as an |
| 42 | | e purpose of obtaining coverage under the employee group health plan |
| 4 2 | | eld to a minimum workweek requirement as imposed on other eligible |
| 44 | employees." | No to a minimum workweek requirement as imposed on other engine |
| 77 | chipio yees. | |
| | | |

SECTION 7.2. G.S. 58-51-80(c) reads as rewritten:

"(c) The term "employees" as used in this section shall be deemed to include, for the purposes of insurance hereunder, employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. Employees shall be added to the group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. The term "employer" as used herein may be deemed to include the State of North Carolina, any county, municipality or corporation, or the proper officers, as such, of any unincorporated municipality or any department or subdivision of the State, county, such corporation, or municipality determined by conditions pertaining to the employment. When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

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PART VIII. NEWBORN COVERAGE REINSTATEMENT

SECTION 8. G.S. 58-51-30(b) reads as rewritten:

Every health benefit plan, as defined in G.S. 58-3-167, G.S. 58-51-115(a)(1), that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Every health benefit plan shall extend coverage to a foster child or adopted child without requirements for prior notification unless an additional premium charge to add the foster child or adopted child is due. If an additional premium charge is due to cover the foster child or adopted child, the health benefit plan shall cover the foster child or adopted child upon placement in the foster home or placement for adoption if the foster child or adopted child is enrolled within 30 days after the placement in the foster home or placement for adoption."

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"b.

PART IX. LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES TECHNICAL CORRECTIONS

SECTION 9. G.S. 58-51-15(a)(2)b. reads as rewritten:

This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy _____ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." Credit Except for the excepted benefits described in G.S. 58-68-25(b), credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-68-30."

SECTION 9.1. G.S. 58-51-15(h) reads as rewritten:

- "(h) Preexisting Condition Exclusion Clarification. Sub-subdivision (a)(2)b. of this section does not apply to: to
 - (1) Policies policies issued to eligible individuals under G.S. 58-68-60.
 - (2) Excepted benefits as described in G.S. 58-68-25(b)."

PART X. SMALL EMPLOYER HEALTH REINSURANCE POOL BOARD AMENDMENTS

SECTION 10. G.S. 58-50-150(b) reads as rewritten:

"(b) Within 30 days after January 1, 1992, the Commissioner shall give notice to all carriers of the time and place for the initial organizational meeting, which shall take place within 90 days after the notice from the Commissioner. The members shall select the initial Board, subject to the Commissioner's approval. The Board shall consist of nine six members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The voting rights to determine initial Board membership shall be weighted based upon net group health benefit plan premium derived from this State in the previous calendar year. Thereafter, voting Voting rights shall be based on net group health benefit plan premium derived from small employer business. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact accident and health insurance, one HMO, one nonprofit hospital or medical service plan. Six Five of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented."

PART XI. EQUITABLE ENROLLMENT PERIOD FOR SUPPLEMENTAL MEDICARE PLANS

SECTION 11. G.S. 58-54-45(a) reads as rewritten:

"(a) In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plans A, C, and J available to persons eligible for Medicare by reason of disability before age 65. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision."

PART XII. REVOCATION AND SUSPENSION TECHNICAL CORRECTION SECTION 12. G.S. 58-3-100(c) reads as rewritten:

- "(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be one of the following:
 - (1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.
 - (2) Payment of the claim.
 - (3) A bona fide written offer of settlement.
 - (4) A written denial of the claim.

A claimant includes an insured, a beneficiary of life or annuity contract, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer, HMO, service corporation, or MEWA. With respect to a claim under an accident, health, or disability policy, if the acknowledgement sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgement includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225."

PART XIII. HEALTH BENEFIT PLAN TRAVEL EXPENSES COVERAGE

SECTION 13. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-3-270. Insurance coverage for travel expenses associated with obtaining care.

(a) As used in this section, the terms "health benefit plan" and "insurer" have the meaning as found in G.S. 58-3-167.

- (b) Each health benefit plan shall provide coverage for reasonable transportation, lodging, and boarding expenses incurred by a covered person to access covered health care services when the insurer, through its referral or network contracting arrangements, requires the covered person to travel more than 250 miles from the covered person's residence to obtain those covered health care services from a network provider.
- (c) The coverage specified by this section is limited to transportation, lodging and boarding expenses incurred by a covered person when required by the health plan to travel to access covered health care services as provided in subsection (b) of this section when those health care services are not also available from a network provider who is located within 250 miles of the covered person's residence.
- (d) The coverage required by this section shall be subject to plan requirements including any overall health care benefit plan aggregate limitations and shall last for the duration of the health care benefit plan's coverage of the treatment subject to this section. An insurer may utilize a per diem limit for the expenses specified in subsection (c) of this section as long as the limit reflects the high-low per diem method as annually published by the Internal Revenue Service or the Domestic Per Diem Rate as published annually by the federal General Services Administration in the area where the health care services are being obtained. All travel, lodging, and boarding expenses in excess of the insurer's per diem or the health benefit plan's aggregate limits shall be the responsibility of the covered person.
 - (e) An insurer may require prior approval of all expenses subject to this section.
- (f) The coverage required by this section shall apply only to those travel, lodging, and boarding expenses incurred by the covered person accessing covered health care services in accordance with this section. If the covered person accessing covered health care services in accordance with this section is a minor, the health benefit plan shall also cover the expenses specified in subsection (c) of this section for a parent or guardian who accompanies the minor."

PART XIV. CREDIT INSURANCE AMENDMENTS

SECTION 14. G.S. 58-57-5 is amended by adding a new subdivision to read:

"(5a) "Critical period coverage" means insurance coverage for which benefits are limited to a stated number of payments or the payments end with the expiration of the policy, whichever is less."

SECTION 14.1. G.S. 58-57-50(b) reads as rewritten:

"(b) The refund of premiums for decreasing term credit life insurance shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy. The refund of premiums for decreasing term credit life insurance in transactions of 60 months duration or less and the refund of premiums for single interest credit property insurance and single interest physical damage insurance shall be equal to the amount computed by the sum of digits formula known as the "Rule of 78." The refund of premiums for decreasing term credit life insurance in transactions of more than 60 months duration shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy. The refund of premiums for level

term credit life insurance and dual interest credit property insurance and dual interest physical damage insurance shall be equal to the pro rata unearned gross premiums."

SECTION 14.2. G.S. 58-57-55 reads as rewritten:

"§ 58-57-55. Issuance of policies.

All policies of credit life insurance and credit accident and health insurance shall be issued only by an insurer authorized to do business in this State and shall be issued only through holders of licenses or authorizations issued by the Commissioner. All-With the exception of credit insurance issued in accordance with G.S. 58-57-105, all policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this State only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner.—State. The enrollment of debtors under a group policy issued to a creditor and authorized under this Article shall not constitute the issuance of a policy of insurance."

SECTION 14.3. G.S. 58-57-60 is amended by adding a new subsection to read:

- "(d) A claim acknowledgement shall be sent to the claimant within 30 days after receiving written or electronic notice of the claim. Acknowledgement shall include the following:
 - (1) A statement made to the insured or the claimant advising that the claim is being investigated.
 - (2) Payment of the claim.
 - (3) A bona fide written offer of settlement.
 - (4) A written denial of the claim."

SECTION 14.4. G.S. 58-57-110 reads as rewritten:

"§ 58-57-110. Credit unemployment insurance rate standards; policy provisions.

- (a) Each year the Commissioner shall prescribe a minimum incurred loss ratio standard requirement to develop a premium rate reasonable in relation to the benefits provided by credit unemployment insurance coverage. The following requirements must be met:
 - (1) Coverage is provided or offered, with or without underwriting, to all debtors regardless of age who are working for salary, wages, or other employment income for at least 30 hours per week and have done so for 12 consecutive months;
 - (2) Coverage sets forth a definition of involuntary unemployment as a loss of employment income that may include, but is not limited to, loss caused by layoff, general strike, termination of employment, or lockout;
 - (3) Coverage does not contain any exclusion except: debts with irregular monthly payments; voluntary forfeiture of salary, wages, or other employment income; resignation; retirement; sickness, disease, or normal pregnancy; or loss of income due to termination as a result of willful misconduct that is a violation of some established, definite rule

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- of conduct, a forbidden act, or willful dereliction of duty, or criminal misconduct.misconduct:
- As long as there is no required time period limitation for registration, the insured may be required to register with the State unemployment office in order to qualify for benefit payments under the credit unemployment coverage. Qualification for State unemployment benefits shall not be required in order to qualify for benefit payments under the credit unemployment coverage.
- (b) The Commissioner may approve other policy provisions and coverages consistent with the purposes of unemployment coverage.
- (c) Joint coverage rates for credit unemployment insurance shall be one and two-thirds (1 2/3) times the approved single rate of coverage.
- (d) The refund provision for credit unemployment insurance shall be equal to the pro rata unearned gross premium."

PART XV. EFFECT OF HEADINGS, SEVERABILITY, AND EFFECTIVE DATES

SECTION 15. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

SECTION 15.1. 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 15.2. Sections 1 through 8 and Sections 9, 9.1, 13, 14, 14.1, 14.2, 14.3, and 14.4 of this act become effective January 1, 2004, and apply to policies or certificates issued or renewed on or after that date. The remainder of this act is effective when it becomes law and applies to policies or certificates issued or renewed on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

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| EDITION No. | _ | |
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| H. B. No. 337 H339-CSLN-20CV. S. B. No. | | Amendment No (to be filled in by |
| COMMITTEE SUBSTITUTE | _ | Principal Clerk) |
| Rep.) | • | |
| Sen.) | | |
| 1 moves to amend the bill on page | 30 | , line 23 |
| 2 () WHICH CHANGES THE TITLE 3 by Golfing the | = | "shall" between |
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GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2003**

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HOUSE BILL 1152 PROPOSED COMMITTEE SUBSTITUTE H1152-CSRC-29 [v.1]

4/18/2003 5:07:20 PM

| | Short Title: I | nstalling MV Parts and Air Bags. | (Public) | |
|--------|---|--|---------------------|--|
| | Sponsors: | | | |
| | Referred to: | | | |
| | | April 10, 2003 | | |
| 1 | | A BILL TO BE ENTITLED | | |
| 1 2 | ANI ACT DDC | OHIBITING AN INSURER FROM AUTHORIZING | OR REQUIRING | |
| 3 | | E OF NONORIGINAL CRASH REPAIR PARTS | | |
| 4 | | REPAIRS WITHOUT CONSENT FROM THE | | |
| 5 | | IT AND PROHIBITING THE NONREPLACEMENT | | |
| 6 | | Assembly of North Carolina enacts: | | |
| 7 | | CTION 1. Chapter 58 of the General Statutes is ame | ended by adding a | |
| 8 | new section to | * | , , | |
| 9 | "§ 58-36-90. U | Jse of nonoriginal crash repair parts. | | |
| 10 | | used in this section, the following definitions apply: | | |
| 11 | (1) | 'Insurer' includes any person authorized to represe | nt an insurer with | |
| 12 | | respect to a claim. | | |
| 13 | <u>(2)</u> | 'Nonoriginal crash repair part' means a part for a m | otor vehicle made | |
| 14 | | or remanufactured by a company other than the original | ginal manufacturer | |
| 15 | | or a licensed affiliate and is limited only to the | following: metal, | |
| 16 | | fiberglass, or plastic motor vehicle crash repair pa | | |
| 17 | | radiator support; cowl panel; doors; roof; rocker pa | nel; quarter panel; | |
| 18 | | trunk lid; and auto glass including windshields. | | |
| 19 | | insurer may not authorize or require the installation of a | | |
| 20 | | a motor vehicle without first obtaining the written con- | | |
| 21 | | nant. The consent shall be verified by the insured's c | or other claimant's | |
| 22 | | ne repair estimate, appraisal, or work order. | | |
| 23 | | insurer shall provide written notice to the insured of | or claimant that a | |
| 24 | | ash repair part or auto glass has been installed. | | |
| 25 | | insurance fraud for any installer, motor vehicle repair | - | |
| 26 | _ | all a nonoriginal crash repair part on a motor vehicle ar | nd submit a charge | |
| 27 | or invoice for an original repair part. | | | |

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- (e) Any insurer or other person who has reason to believe that a violation of this section has occurred shall report the violation to the Commissioner for further action pursuant to G.S. 58-2-160.
- (f) A violation of the provisions of this section is punishable by a fine of five thousand dollars (\$5,000) per offense."
- **SECTION 2.** Chapter 20 of the General Statutes is amended by adding a new section to read:

"§ 20-136.2. Air bag installation.

- (a) It shall be unlawful for any person, firm, or corporation to knowingly install or reinstall as part of the vehicle inflation restraints system any object in lieu of an air bag that was designed in accordance with federal safety regulations for the make, model, and model year of the motor vehicle.
- (b) Any person, firm, or corporation violating this section shall be guilty of a Class 1 misdemeanor."
- **SECTION 3.** This act becomes effective December 1, 2003, and applies to offenses committed on or after that date.



HOUSE BILL 1152: Installing MV Parts and Air Bags



BILL ANALYSIS

Committee:

House Insurance

Date:

April 28, 2003

Version:

Proposed Committee Substutite

H1152-CSRC-29[v.1]

Introduced by: Representative Cole

Kory J. Goldsmith Summary by:

Committee Counsel

SUMMARY: HB 1152 prohibits an insurer from requiring the installation of nonoriginal crash repair parts without the prior consent of the insurer or other claimant. A motor vehicle repair service that installs nonoriginal crash repair parts and submits an invoice for original repair parts has committed insurance fraud. The bill also makes it a Class 1 misdemeanor to knowingly install any object that isn't the air bag designed for that make, model, and model year of the motor vehicle.

CURRENT LAW: The administrative code prohibits insurers from requiring the use of an after market part in the repair of a motor vehicle unless the after market part is at least equal to the original part in terms of fit, quality, performance and warranty. Insurers requiring the use of an after market part must include in the estimate the costs of any modifications made necessary by the use of the parts. 11 NCAC 4.0425. An after market part is a part made by a manufacturer other than the original manufacturer of a part.

The Administrative code also requires insurers that require or specify the use of after market parts to disclose to the policyholders in writing, either in the policy or on a sticker attached thereto, the following information in no smaller print than ten point type:

IN THE REPAIR OF YOUR COVERED AUTO UNDER THE PHYSICAL DAMAGE COVERAGE PROVISIONS OF THIS POLICY, WE MAY REQUIRE OR SPECIFY THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. THESE PARTS ARE REQUIRED TO BE AT LEAST EQUAL IN TERMS OF FIT, QUALITY, PERFORMANCE AND WARRANTY TO THE ORIGINAL MANUFACTURER PARTS THEY REPLACE.

An insurer must also disclose to a claimant in writing, either on the estimate or on a separate document attached to the estimate, the following information in no smaller print than ten point type: THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUAL IN TERMS OF FIT, QUALITY, PERFORMANCE AND WARRANTY TO THE ORIGINAL MANUFACTURER PARTS THEY ARE REPLACING.

All after market parts installed on a motor vehicle shall be clearly identified on the estimate and invoice for such repair.

BILL ANALYSIS:

Section 1 adds a new section to Chapter 58 of the General Statutes. It prohibits an insurer and any person authorized to represent an insurer, from authorizing or requiring the installation of "nonoriginal crash repair parts" without the insured's or claimant's prior consent. A "nonoriginal crash repair part" is:

HOUSE BILL 1152

Page 2

- a metal, fiberglass, or plastic motor vehicle part;
- made or remanufactured by a company other than the original manufacturer or a licensed affiliate;
- limited to hoods; fenders; radiator supports; cowl panels; doors; roofs; rocker panels; quarter panels; trunk lids; or auto glass including windshields.

The signature of the insured or claimant on the repair estimate, appraisal, or work order may be used to verify prior consent. An insurer must provide written notice any time nonoriginal crash repair parts are installed. It is insurance fraud for a motor vehicle repair service to install nonoriginal crash repair parts and invoice for original parts. Any insurer or other person who has reason to believe that a violation of this section has occurred shall report the violation to the Commissioner of Insurance for investigation. Violations are punishable by a fine of \$5,000.

Section 2 makes it a Class 1 misdemeanor for a person to knowingly install an air bag that is not the air bag designed in accordance with federal safety regulations for the make, model, and model year for that motor vehicle. A Class 1 misdemeanor is punishable by 1 to 120 days of active, intermediate, or community punishment.

H1152-SMRC-001



Anybody can get into an accident. But getting quality collision repairs is no accident. Good communication with your auto insurer, selection of a quality collision repair facility and participation in the parts selection process are factors you can control to help assure your vehicle is repaired to your satisfaction. And your satisfaction is the most important part of the collision repair process. So if you've had the misfortune of being involved in an accident, this brochure is for you.

For Roadside Assistance with your Ford or Mercury vehicle, call 800-241-3673. For Lincoln vehicles, call 800-521-4140. In Canada, call 800-565-3673.





An accident is an upsetting experience and collision repair is often complicated and confusing. Ford Motor Company has developed this brochure to help you better understand key points in the collision repair process.

Your rights as a consumer

As the consumer, you are within your rights to insist on original equipment replacement parts. These genuine parts are made by the manufacturer to meet stringent criteria for fit, finish, structural integrity, corrosion protection and dent resistance, just like the parts that were originally on your vehicle. Insist on genuine Ford replacement parts.

The insurance company

A crucial part of the collision repair process is communication between you and your auto insurer. One call will help you better understand the terms, conditions and limitations of your coverage. Remember, nearly all policies obligate the insurer to return damaged vehicles to "pre-accident condition."

The collision shop

A basic equation: Quality of repair facility = Quality of repair.

Ask family, friends and acquaintances for referrals. Many Ford, Lincoln and Mercury Dealerships offer collision repair services or will recommend a reputable collision repair facility.

Your insurance company also may suggest a collision repair shop.

In the end, you have the final say. Choose the collision repair facility with which you are most comfortable.

The estimate

Collision repair estimates can be difficult to understand. Ask your collision repair professional or your insurer's representative to review the estimate in detail with you. Make sure you understand all abbreviations and acronyms.

If your estimate is prepared at a drive-in claim center and you are immediately offered a check, you may want to review the estimate with a collision repair professional to make sure the check amount covers all required repairs.

The parts

Replacement parts likely will be needed for proper repair of your vehicle. Exterior sheet metal and plastic parts—such as hoods, fenders, doors and bumper components—are known as "crash parts."

Three types and how they differ

All crash parts are not created equal. There are three types and any or all are likely to be specified for repairs.

Make sure you know the differences before signing the repair authorization.

1. Original Equipment Manufacturer (OEM) or genuine crash parts

These parts are made by or for the manufacturer of your vehicle. They are equivalent in all basic quality categories—fit, finish, structural integrity, corrosion protection, dent resistance—to the original parts on your vehicle. In addition, genuine crash parts carry excellent limited warranty coverage. If you lease your vehicle, check to see whether you are required to use genuine crash parts for repairs.

2. New aftermarket crash parts

These are unauthorized copies of genuine crash parts. While generally cheaper, there are questions about the quality of these parts. There also is evidence that use of these parts may reduce your vehicle's resale value. Damage to adjoining parts caused by failure of an aftermarket crash part is not covered by your vehicle's limited warranty.

3. Salvaged crash parts

These are crash parts recovered from "totaled" vehicles. Since it is difficult to determine the source of salvaged parts, there are many quality concerns (hidden damage, improper emoval techniques, unsuitable part storage).

It's not fixed until you're satisfied

The most important fact to remember as you deal with your collision repair is that you should be totally satisfied before accepting your vehicle. Make sure to take a complete walk-around with a representative from the collision repair facility. If damage was extensive, make sure to take a test drive with a representative from the



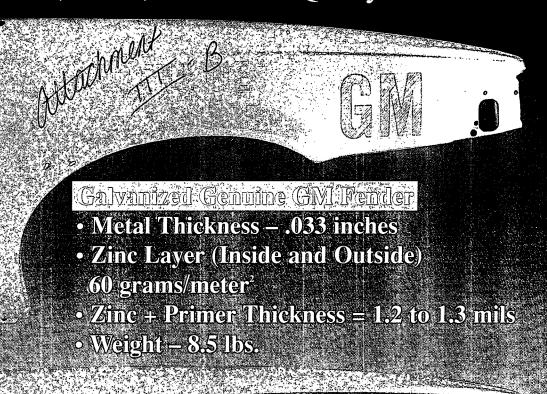
collision repair facility. Remember, your insurance company's obligation is to return your vehicle to "pre-accident condition." You have every right to be satisfied in this regard.

A few words about safety

We recommend only genuine Ford replacement parts be used for repairs to vehicle safety systems—such as airbags, safety belts and structural glass—and components that interact with vehicle safety systems. These parts should be installed using the vehicle manufacturer's recommended procedures. You can be assured genuine Ford replacement parts are the same as those used on new vehicles, which meet Federal Motor Vehicle Safety Standards.

Visual Proof

Solid Evidence Proving Genuine GM Collision Parts are Superior to Foreign Imitation Parts in Corrosion Resistance, Fit, Finish, and Overall Quality.



MITATION CAPA.O

Non= Galvanized Foreign Imitation Fender

- Metal Thickness = .030 inches
- No Zinc Laver (Inside or Outside)
- oPrimer Widdiness 5 to 9 mils
- · Weight-81bs

No Sight of Handle Mark

The American Tron & Steel Institute's Corroston Task Porce deemed the soubsitest used above to be one of the tests
that best represents actual field use performance—These photos show emphreses the of a two-(2) year equivalency
another ests reput offed corrostive environment—Trainness of Test GM9540P (MERRICOD) B) and test decrib provided
approximation request to General Motors—SPO, ISO, IBOX 58115, IDENOTA, MI 43222

Peris

Your Vehicle Represents an Important Investment -- One Worth Protecting.

When your vehicle has been damaged in an accident, or has parts in need of replacement, you want assurances that the work done will restore it to its original condition. Your car, truck or van represents an important investment --- one worth protecting.

The Best Way.

One of the best ways to protect the value of your investment is to insist that your body shop use nothing short of New Genuine GM Replacement Parts. They may cost slightly more initially, but the return can be seen in added resale value, and superior performance for years to come. These are not just words. These are significant objective, measurable differences between New GM and foreign imitation parts. Genuine GM Replacement Parts are manufactured to the same exacting standards as the original parts, and are engineered for the best possible fit, finish and durability.

From the materials used to make them to the packaging used to ship them, Genuine New GM Sheet Metal Replacement Parts stand apart from the cut-rate imitators. That's why we offer a limited lifetime warranty to the owner of record when repairs are made. See warranty form for specifics.

The Best Quality.

We start with thicker metal than that of the competition, producing hoods, fenders and bumper reinforcements that meet the original parts' structural integrity. All Genuine GM sheet metal is made from rust-resistant, two-side galvanized steel to ensure the greatest durability possible. Two-side galvanized steel means a layer of zinc on the outside to resist surface rust, and a layer of-zinc on the inside to prevent holes (which typically start from inside surfaces).

We then coat our parts with a thicker coat of primer than that of the limitators, protecting them from the elements and adding to the corrosion resistance.

New GM parts arrive at the body shop in excellent condition because GM packaging is designed to protect them through the abuses of shipping, delivery and storage. The imitators try to cut corners here, often resulting in parts being damaged during shipping and handling. These parts then must either be returned or repaired – resulting in a longer repair stay, higher labor-costs, and compromised corrosion protection.

The Best Fit.

New GM Parts also are designed to fit exactly – there is no need for adjustments. With imitation parts, repair technicians often have to drill additional holes or contort the part to make it fit properly. One independent researcher observed technicians grinding excess metal from one portion of an imitation part – while another had to use body putty to build up a low spot on a different part. When manipulation like this is necessary, character lines may not match up perfectly, leading to diminished satisfaction with the work, and lower resale value.

The Best in Corrosion Resistance.

And while the quality of New Genuine GM Replacement Parts is apparent at the time of the repair, their true value is found down the road. In test after test, our corrosion resistance is shown to be far superior to that of the imitators.

***** GM IS NOT RESPONSIBLE *****

Using junkyard salvage used parts or foreign imitation parts could lower the value of your vehicle, and will nullify important limited warranties. Using Genuine GM Replacement Parts safeguards you in many ways.

Also, because we have no way of assuring the quality of repairs made with non-new or non-GM remanufactured parts, GM is <u>not</u> responsible for any loss of GM factory or service part warranties, any resulting related liabilities from reduced vehicle performance or occupant safety due to part failure, or any loss of used car, truck or van value at resale or trade-in if you fail to use Genuine GM Parts. More good reasons to keep your GM vehicle all GM.

Protect Your Investment

Your vehicle is an important investment. Protect that investment by insisting on Genuine New GM, or GM Remanufactured Replacement Parts. It's your best assurance of maintaining the original quality, performance, safety, look and value of your GM car, truck or van.



Fa--- # FI 00100400

Ford Motor Company,

STATEMENT

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FORD COLLISION REPAIR POSITION STATEMENTS

(Editor's Note: In response to industry requests, the following represents a collection of all Ford position statements relating to collision repair.)

FORD SUPPORTS OEM BUMPER BEAMS FOR REPAIRS

Light truck and passenger car structural components including, but not limited to, bumper beams and reinforcements. contribute to the proper performance of air bags and other occupant and vehicle protection functions during vehicle collisions. Ford recommends that replacement components be OEM or of like kind and quality.

IMITATION PARTS AND FORD WARRANTY

The use of imitation crash parts to repair collision damaged vehicles raises concerns about warranty and quality.

Imitation crash parts are not covered under the Ford new vehicle limited warranty or any other Ford warranty. In addition, any damage to or failure of a Ford part caused by the installation or improper performance of an imitation part is not covered under the Ford new vehicle limited warranty or any other Ford warranty.

However, the use of imitation crash parts for vehicle repair does not, in itself, void the Ford new vehicle limited warranty. The limited warranty for the rest of the vehicle, excluding the imitation part itself, remains in effect.

Ford believes the interests of vehicle owners and collision repairers are best protected by the use of genuine Ford replacement crash parts to repair collision damage.

SALVAGE PARTS AND FORD WARRANTY

The increasing use of salvage parts to repair collision-damaged vehicles raises concerns about warranty and quality.

Salvage parts are not covered under the Ford new vehicle service part or corrosion warranty or any variety of the Ford Extended Service Plan. In addition, any damage to or failure of a Ford part caused by the installation or improper performance of a salvage part is not covered under the Ford new vehicle limited warranty or any variety of the Ford Extended Service Plan.

However, the use of salvage parts for vehicle repair does not, in itself, void the Ford new vehicle limited warranty. The limited warranty for the rest of the vehicle, excluding the salvage part itself, remains in effect.

Many factors can influence the quality of salvage parts, such as exposure to weather, improper removal or hidden structural damage. In addition, parts salvaged from Ford, Lincoln and Mercury vehicles may not always be genuine Ford parts.

Ford believes the interests of vehicle owners and collision repairers are best protected by the use of genuine Ford replacement crash parts to repair collision damage.

IMITATION CRASH PARTS AND AIR BAG SYSTEMS

Ford Motor Company is confident about the performance of air bag systems it designs and installs in its vehicles. However, Ford cannot be confident that its air bag systems and components will perform properly on vehicles that have been repaired with imitation crash parts.

Testing by Ford has shown imitation crash parts to be substandard in their fit and structural integrity. To our knowledge, no comprehensive testing has been conducted to verify that the performance of imitation

crash parts -- particularly crucial front end parts, such as hoods, bumper reinforcements and header panels -- in front-end crashes will be compatible with Ford air bag systems.

Genuine Ford replacement crash parts are the same as those used on new vehicles, which have been crash tested and meet all Federal Motor Vehicle Safety Standards.

Because so little is known about the effect of imitation parts on airbag system and component integrity, Ford believes genuine Ford crash parts should be used for collision repairs to protect the interests of both collision repairers and vehicle owners.

USE OF SALVAGED AIR BAG SYSTEMS

Ford Motor Company is confident about the performance of air bag systems it designs and installs in its vehicles. However, Ford cannot be confident that air bag systems or components salvaged from other vehicles for re-use will perform properly.

Many factors may influence the integrity of salvaged air bag systems or components, such as weathering and improper removal techniques. In addition, air bag systems are designed for specific vehicles, with changes occurring even within specific vehicle models to accommodate technological advancements. It is possible for an air bag system or an individual air bag component to fit into an inappropriate vehicle, thereby jeopardizing the integrity of the air bag system.

For these reasons. Ford believes that only new air bag systems and components should be used to repair damaged vehicles.

Ford believes the interests of repairers and vehicle owners are best protected when new genuine Ford replacement air bag systems and components are used.

REPAIR AND REPLACEMENT OF SAFETY BELT SYSTEMS

Ford Motor Company recommends that all safety belt assemblies used in vehicles involved in a collision be replaced. However, if the collision was minor and a qualified technician finds that the belts

do not show damage and continue to operate properly, they do not need to be replaced. Safety belt assemblies not in use during a collision should also be inspected and replaced if either damage or improper operation is noted.

Before installing a new safety belt assembly, the safety belt attaching areas must be inspected for damage and distortion. If the attaching points are damaged or distorted, the sheet metal must be reworked back to its original shape and structural integrity. Also, be sure that if new safety belt service parts are needed, they are intended specifically for the vehicle in which they are being installed.

Ford Motor Company describes recommended functional testing procedures for both shoulder harnesses and lap belts and retractors in Ford Technical Service Bulletin 85-2-4, and in Ford service manuals.

#

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WWW.ABRN.COM

GM study blasts CAPA-certified parts

The automaker says non-OEM hoods and fenders for Grand Am don't meet GM standards

By John Yoswick Regional Correspondent

After a recent General Motors Corp. (GM) evaluation of non-OEM crash parts certified by the Certified Automotive Parts Association(CAPA), the automaker concluded that CAPA parts fall short when tested against GM service parts.

In an evaluation of 10 CAPA-certified replacement fenders and hoods made by three different non-OEM parts manufacturers and designed for a 1999-2001 Pontiac Grand Am, none of the CAPA parts tested met minimum GM requirements for fit, finish, material content and assembly characteristics.

GM says that evaluations of material content showed significant differences that affect the parts' performance in resisting minor dents and corrosion. The steel strength of the GM hood was up to 40 percent stronger and 80 percent harder than the tested CAPA hoods. On average, the tested CAPA hoods had 42 percent of the dent resistance compared to the GM hood.

The steel used in the tested CAPA hoods was a different alloy and lower grade than the steel GM specifies for its parts, the study reports. In addition, the study found that the tested CAPA hoods had half or less of the primer thickness of the GM parts and were below GM requirements.

Galvanized coatings on the CAPA hoods did not meet GM's thickness requirements. The GM reports says these differences in coatings could "significantly reduce long-term corrosion performance' of the non-OEM parts.

On average, 23.7 percent of the welds on the CAPA certified hood assemblies reportedly were found to have insufficient weld integrity compared to the GM specification. Hood inner mastic application was on average 29.6 percent below GM standards. GM requirements also call for a continuous adhesive bond between the inner and outer hood panels around the perimeter of the hood; this adhesive was absent in the tested CAPA certified hoods, the research showed.

Inspectors who regularly monitor the surface quality of GM parts said they reviewed the non-OEM parts and found numerous surface defects including buckles, creases, ripples and highs and lows that would be unacceptable on GM products.

Lastly, the CAPA products averaged 33.9 percent out-of-specification measurements when placed on GM OEM checking fixtures used to verify parts dimensions, gaps and contours. The non-OEM hoods in particular fared poorly; all three were high across the front on the driver side, for example, creating an unacceptable gap. "When a customer needs replacement collision parts, they expect the parts to have the same look and performance characteristics as the parts that were originally installed on their vehicle," says Jim Dalton, general product

Service and Parts Operations (SPO). "These [non-OEM] parts would be unacceptable by GM for use as service or production parts."

GM issued a detailed report on the study, outlining its testing procedures and supplementing the results and data with diagrams and color photos.

Jack Gillis, executive director of CAPA, says his organization has not completed its in-depth review of the GM report, but pointed out that the results were on a very small sampling of parts.

"How many parts did they go through

before they found the 10?" Gillis ques-

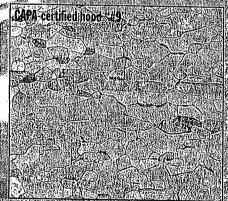
"While their particular choice of parts, tiny sample size, and interpretation of results is questionable, there is no question that GM is desperately trying to protect its monopoly on crash parts.

"The fact is, cars remain among the most complained about, most recalled, and most problematic products we buy," Gillis says. "For GM to hold itself up as the epitome of quality is beyond comprehension. However, when millions and millions of dollars of excess profits are at stake, the car companies will do most anything."

Gillis said part of CAPA's response to the survey, expected to be completed by early this summer, will be to put GM parts through a battery of similar tests.

Offithe Mark?

According to GMs.test.or. 10 CAPA certified replacement fenders and hoods, the steel strength of the GM hood was up to 40 percent stronger and 80 percent harder. GM claims chemical analysis of those hoods proves the CAPA-certified hoods do not use bake hardenable steels grades! which are supposed to provide dent resistence. Viewediat 500x magnification, GM/says the steel in the CAPA hoods does not show the kind of grain structure seen in thake hardenable! steels.



The core structure of one of the CAPA certified hoods tested by GM as seen at 500 times the magnification. The dark areas indicate dark etching ferrite

GM Grand Am hood:

The GM Grand Am outer hood core structure seen at 500-times/the magni-

GM:also claims to have found a variety of other problems with the 10 CAPA-certified parts they tested. They say the also claim to have found the following:

- CAPA centified hoods had an average of 42 percent of the dentiresistance compared to
- CAPA-certified hoods used steel that was different alloy and lower grade than GM.
- CARA-certified boods had half or less of the primer thickness of the GM parts.
- Galvanized coatings on the CAPA noods did not meet GM s thickness requirements.
- An average of 23.7 percent of the welds on hood assemblies had insufficient integrity when compared according to GM specifica
- CAPA-certified:hoodsinner:mastic:application was on average 29:6 percent below GM stan
- CAPA products averaged 33:9 percent out-of specification measurements for dimensions, gaps and contours when placed on GM/0EM. checking fixtures.



GM placed CAPA-certified noods and fenders on GM/s OEM checking fixtures Here; the arrows indicate where GM claims the door line of GAPA-certified RH fender is not flush. GM/s test found that this part was out of specion seven out of 20 probe checks.

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. | | | |
|-----|--|--|--|--|
| | Committee Substitute for 3. 1152 A BILL TO BE ENTITLED AN ACT PROHIBITING AN INSURER FROM AUTHORIZING OR REQUIRING THE USE OF NONORIGINAL CRASH REPAIR PARTS FOR MOTOR VEHICLE REPAIRS WITHOUT CONSENT FROM THE INSURED OR CLAIMANT AND PROHIBITING THE NONREPLACEMENT OF AIR BAGS. | | | |
| | 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) 03/19/03 | | | |

MINUTES

HOUSE INSURANCE COMMITTEE

May 1, 2003

The House Committee on Insurance met at 8:30 AM on May 1, 2003. The following Representatives were present: Hugh Holliman, Lucy Allen, Bobby Barbee, Howard Hunter, Charles Johnson, Linda Johnson, David Lewis, Karen Ray, William Wainwright, and Connie Wilson.

Chair Hugh Holliman called the meeting to order and introduced the pages and the Sergeant-At-Arms. See Attachment I. He then recognized Rep. Warren to explain HB-822-HEALTH INSURANCE COVERAGE/EARLY INTERVENTION. This bill would require all health benefit plans and preferred provider benefit plans that provide benefits for sickness, illness, or disability of a minor child or that provide medical treatment or service to a minor child to provide coverage for medically necessary early intervention services for children ages birth to 36 months. See Attachment:II. Representative Hunter wanted to know who is going to pay for this insurance. Ken Wright said the premiums would go up so the policyholders would pay. Paul Mahoney further explained that small businesses would also be the ones that pa; big companies would be exempt. Rep. Wilson moved to amend the bill on page I, line 19, by rewriting the line to read: 'Health benefit plan has the meaning applied under G.S. 58-3-167, and also includes the Teachers' and State Employees Comprehensive Major Medical Plan." See Attachment VII. Rep. Wilson made the motion to pass the amendment. Amendment passed. Rep. Lewis made the motion to roll the amendment into the bill and refer without prejudice, to the Committee on Appropriations.

Rep. Holliman called on Rep. Wilson to explain HB-l0-66-HEALTH PLANS DISCLOSE FEE SCHEDULES/CODING. See Attachment V. After much discussion about the fee schedules and why legislation is needed a motion is made for a favorable report for the committee sub., unfavorable to the original bill by Rep. Wainwright. The bill passes the committee.

Rep. Wilson then spoke on HB-ll07-UTILIZ. REVIEW 7 GRIEVANCE AMENDMENTS. Rep. Wilson explained that this bill simply cleans up and streamlines the original 1997 patient bill of rights. An amendment was offered by Rep. Wilson and was adopted. See Attachment VI. Rep. Barbee motioned that the PCS be accepted and the motion passed.

The meeting was adjourned at 9:30 AM.

Rep. L. Hugh Holliman, Chair

Rep. Mitchell S. Setzer, Chair

Carol Bowers, Joanna Mills, Chairs

HOUSE INSURANCE COMMITTEE

May 1, 2003 8:30 AM Room 1225 LB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

HB 822 - HEALTH INSURANCE COVERAGE/EARLY INTERVENTION. REPS. ALEXANDER AND WARREN

HB 1066 – HEALTH PLANS DISCLOSE FEE SCHEDULES/CODING. REPS. ALEXANDER AND C. WILSON

HB 1107 – UTILIZ. REVIEW & GRIEVANCE AMENDMENTS. REP. C WILSON

Attachment I

VISITOR REGISTRATION SHEET

HOUSE COMMITTE ON INSURANCE

5-1-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Paul Mahonen | NCAKIP |

VISITOR REGISTRATION SHEET

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VISITOR REGISTRATION SHEET

HOUSE COMMITTE ON INSURANCE

5-1-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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| Barbara Works Buske | NCOOL |
| Frank Folgeg | NCDOI |
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| an Duna | NCAHP |
| Joya Petus | MANGI |
| FRANK FOLGER | Ne DOIT |
| KChesti | NZ-ZC |
| Caul Scheele | NC Medical Society |



HOUSE BILL 822: Health Insurance Coverage/Early Intervention

Committee: House Insurance Committee Introduced by: Representatives Alexander and

Date: April 24, 2003 Warren

Version: House Bill 822 Summary by: Tim Hovis

Committee Counsel

SUMMARY: House Bill 822 would require all health benefit plans and preferred provider benefit plans that provide benefits for sickness, illness, or disability of a minor child or that provide medical treatment or service to a minor child to provide coverage for medically necessary early intervention services for children ages birth to 36 months.

To be eligible for early intervention services, the child must meet the eligibility requirements established by the Department of Health and Human Services.

Coverage under the bill must:

- Provide services that are part of the Individualized Family Services Plan (limited to not more than \$5,000 annually and not more than \$15,000 over the three year eligibility period.).
- Be provided by a certified early intervention specialist.
- Be provided only for those services not covered by Medicaid or other public assistance.

EFFECTIVE DATE: House Bill 822 becomes effective January 1, 2004 and applies to plans issued or renewed on or after that date.



attachment

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

House Bill 822

| H822-ARG-2 [v.1] | (t | MENDMENT NOo be filled in by Principal Clerk) |
|---|--------------------------|---|
| 11022-ARO-2 [v.1] | . г | Page 1 of 1 |
| | Date | ,2003 |
| Comm. Sub. [NO] Amends Title [NO] First Edition | | |
| Representative | | |
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| morades are reactions a | | wiajor wieurear r ian. |
| | , | |
| SIGNEDAmendment Sponsor | | |
| SIGNEDCommittee Chair if Sen | nate Committee Amendment | |
| ADOPTED | FAILED | TABLED |
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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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1 2

HOUSE BILL 822

| Short Title: | Health Insurance Coverage/Early Intervention. (Publ | ic) |
|--------------------------|---|----------------|
| Sponsors: | Representatives Alexander, Warren (Primary Sponsors); Insko, Wei and Goodwin. | iss, |
| Referred to: | Insurance. | |
| | April 1, 2003 | |
| NECESS | A BILL TO BE ENTITLED O REQUIRE HEALTH BENEFIT PLANS TO COVER MEDICALL SARY EARLY INTERVENTION SERVICES FOR CHILDREN FRO TO THREE YEARS OF AGE WHO ARE COVERED UNDER TH | M |
| The General SI | Assembly of North Carolina enacts: ECTION 1. Article 51 of Chapter 58 of the General Statutes is amended tollowing new section to read: | by |
| | 6. Coverage for early intervention services to children from birth | <u>to</u> |
| | ree years of age. efinitions As used in this section, unless the context clearly requir | res |
| otherwise, th | | .03 |
| (1 | 'Early intervention services' means those services provided for infar and toddlers required by the Individuals with Disabilities Education Act (IDEA), P.L. 105-17, as codified in 20 U.S.C.§ 1400, et seq., as applied and implemented in accordance with rules adopted by the Secretary of the North Carolina Department of Health and Humn Services. | on nd he |
| (<u>2</u> (<u>3</u> | Individuals with Disabilities Education Act (IDEA), P.L. 105-17, codified in 20 U.S.C.§ 1400, et seq., and applied and implemented accordance with rules adopted by the Secretary of the North Caroli Department of Health and Human Services. | as in |
| | otwithstanding G.S. 58-50-63, every health benefit plan issued by | <u>an</u> |
| insurer, and | every preferred provider benefit plan under G.S. 58-50-56 that provid | les |

benefits for any sickness, illness, or disability of any minor child or that provides

| benefits for any medical treatment or service furnished by a health care provider or |
|--|
| institution to any minor child shall provide coverage for medically necessary early |
| intervention services for children ages birth to 36 months who are eligible for these |
| services and who are otherwise covered under the health benefit plan. A child is eligible |
| for early intervention services if the child is between the ages of birth to 36 months and |
| meets the eligibility requirements established in rules adopted by the Secretary of the |
| North Carolina Department of Health and Human Services. Coverage for early |
| intervention services shall be as follows: |
| (4) |

- Services that are not otherwise covered by the health benefit plan and are part of the child's Individualized Family Services Plan. Benefits payable for the services provided under this subdivision may be limited to not more than five thousand dollars (\$5,000) annually and not more than fifteen thousand dollars (\$15,000) over the three-year eligibility period, per child covered. These limits shall be in addition to any annual or lifetime limits applicable under the health benefit plan.
- (2) Covered services shall be provided by a certified early intervention specialist in accordance with rules adopted by the Secretary of the North Carolina Department of Health and Human Services.
- (4) Coverage is required under this section only for those early intervention services not covered by Medicaid or other public assistance program for which the child is eligible."

SECTION 2. G.S. 58-50-155(a) reads as rewritten:

"§ 58-50-155. Standard and basic health care plan coverages.

- (a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:
 - (1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.
 - (2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.
 - (3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.
 - (4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.
 - (5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.
 - (6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

GENERAL ASSEMBLY OF NORTH CAROLINA

| 1 | <u>(7)</u> | Coverage of medically necessary early intervention services for |
|---|------------------|---|
| 2 | | children eligible for these services at least equal to the coverage |
| 3 | | required by G.S. 58-51-36. |
| 4 | | |
| 5 | SECT | TION 3. This act becomes effective January 1, 2004, and applies to |
| 6 | health benefit p | lans and preferred provider plans issued or renewed on and after that |
| 7 | date. | |



Attachmen

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

House Bill 822

| | | AMENDMENT NO | |
|---|----------------------------------|---|--------|
| | | (to be filled in by | |
| H822-ARG-2 [v.1] | , | Principal Clerk) | |
| <u> </u> | | Page | 1 of 1 |
| | Da | ite | ,2003 |
| Comm. Sub. [NO] Amends Title [NO] First Edition | | | |
| Representative | | | |
| | nd: on has the meaning applie | ed under G.S. 58-3-167, and ensive Major Medical Plan." | l also |
| SIGNED | Ulan. | | |
| SIGNED Committee Chair if Senate | e Committee Amendment | | |
| ADOPTED | FAILED | TABLED | |

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
|-----|--|
| | Committee Substitute for 3. 822 A BILL TO BE ENTITLED AN ACT REQUIRE HEALTH BENEFIT PLANS TO COVER MEDICALLY NECESSARY EARLY INTERVENTION SERVICES FOR CHILDREN FROM BIRTH TO THREE YEARS OF AGE WHO ARE COVERED UNDER THE PLAN. |
| | 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 |
| ٠ | title, unfavorable as to (the original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on Appropriately. |
| | With a favorable report as to House committee substitute bill (#), \(\subseteq \) 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) 03/19/03 |
| | |

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

H

HOUSE BILL 1066

1

Short Title: Health Plans Disclose Fee Schedules/Coding. (Public)

Sponsors: Representatives Alexander and C. Wilson (Primary Sponsors).

Referred to: Insurance.

April 10, 2003

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A BILL TO BE ENTITLED

AN ACT TO FACILITATE THE SUBMISSION OF COMPLETE CLAIMS BY PROVIDERS UNDER HEALTH BENEFIT PLANS BY REQUIRING HEALTH BENEFIT PLANS TO DISCLOSE TO CONTRACT PROVIDERS THE PLANS' FEE SCHEDULES AND MEDICAL AND REIMBURSEMENT POLICIES, AND TO PROVIDE NOTICE TO THE PROVIDER PRIOR TO IMPLEMENTING CHANGES TO THE SCHEDULES OR POLICIES.

The General Assembly of North Carolina enacts:

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SECTION 1. G.S. 58-3-225 is amended by adding the following new subsection to read:

11 12 "(n) In order to facilitate submission of complete claims by providers, insurers shall provide to providers the following:

13 14 (1) Notice of changes to the insurer's fee schedule, medical policy, or reimbursement policy, and the effective date of the changes; and

15 16

17

(2) The insurer's fee schedule, medical policy, and reimbursement policy, or
 (3) A statement as to the manner in which claims will be calculated and

18 19 paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis.

20 21 22

The insurer shall provide the information required by this subsection prior to the execution of the contract between the insurer and the provider. The insurer may provide the information required under this subsection by electronic media.

232425

As used in this subsection, the term 'fee schedule' includes, if applicable, CPT, HCPCS, and ICD-9-CM codes and modifiers."

26 27

SECTION 2. This act is effective when it becomes law and applies to provider contracts executed or renewed on and after that date.



HEALTH PLANS DISCLOSE FEE **SCHEDULES/CODING:** House Bill 1066

attachmeni

Committee: House Insurance

April 28, 2003

Version:

Date:

Proposed Committee Substitute

Introduced by: Reps. Alexander and C. Wilson

Summary by:

Kory Goldsmith

Committee Counsel

SUMMARY: House Bill 1066 requires insurers to provide to contract health care providers the insurer's fee schedule for the insurer's top 30 and a description of the insurer's claims submission and reimbursement policies. Insurers would also have to provide advance notice of changes in the fee schedules.

CURRENT LAW: G.S. 58-3-225(b) requires insurers to respond within 30 days of receipt of a claim by either paying the claim or otherwise notify the insured as to the status of the claim. It also specifies the information an insurer must provide to the insured when a claim is denied.

"Insurer" includes an insurance company subject to Chapter 58, a service corporation, a health maintenance organization, or a multiple employer welfare arrangement that writes a health benefit plan.

"Health care provider" means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

BILL ANALYSIS:

Section 1 amends G.S. 58-3-225 by adding a new subsection. It would require insurers to provide health care providers with the insurer's fee schedule for the insurer's top 30 services and procedures most commonly billed by the class of provider. Upon request, the insurer would also have to provide a full fee schedule for services and procedures billed by that class of provider. An insurer would also be required to provide a description of its claims submission and reimbursement policies. Claim submission and reimbursement policies are defined to include claims bundling and down coding of services or procedures.

Insurers would be required to provide notice to contract providers prior to implementing changes to the schedules or policies. An insurer would have to provide the notice within the contractual period but no less than or 30 days from the implementation of the change. Advance notice would not be required if the changes have the effect of increasing fees, expanding benefit coverage, or are made for patient safety considerations. Notice of changes may be made in a medium chosen by the insurer.

If an insurer is offering a contract to a health care provider, the insurer must also provide the insurer's schedule for the fees associated with the top 30 services and procedures most commonly bill by that class of provider and the full fee schedule upon request.

HEALTH PLANS DISCLOSE FEE SCHEDULES/CODING

Page 2

Insurers may require that providers keep the fee information confidential.

Health care providers must submit claims according to the insurers' claim submission and reimbursement policies.

The requirements of this act would not apply to insurance companies, service corporations, health maintenance organizations, or multiple employee welfare arrangements that write stand alone dental insurance.

The requirements (except providing fee schedules) would not apply until January 1, 2005 for an insurer on a claim adjudication system that was implemented prior to January 1, 1982 provided the insurer verifies with the Commissioner that its claim adjudication system qualified under this subsection and the insurer is implement a new claim adjudication software system that will be in place not later that December 31, 2004.

The requirements (except providing fee schedules) would not apply until January 1, 2006 for the Teachers and State Employees' Major Medical Plan.

Section 2 requires that every health benefit plan must annually submit to the Commissioner of Insurance aggregate data on request for reimbursement policies from participating providers and the health benefit plan's responses to those requests.

Most of the act becomes effective January 1, 2004, but the requirement that insurers provide providers with fee schedules and descriptions of the claims submission policies become effective when the bill becomes law for contracts issued, modified or renewed after that date. The provision that exempts certain insurers with antiquated claims adjudication software systems expires January 1, 2005. The provision that exempts the Teachers and State Employees' Major Medical Benefit Plan expires January 1, 2006.

H1066-SMRC-001

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
|-----|--|
| | Committee Substitute for 3. 1066 A BILL TO BE ENTITLED AN ACT TO FACILITATE THE SUBMISSION OF COMPLETE CLAIMS BY PROVIDERS UNDER HEALTH BENEFIT PLANS BY REQUIRING HEALTH BENEFIT PLANS TO DISCLOSE TO CONTRACT PROVIDERS THE PLANS' FEE SCHEDULES AND MEDICAL AND REIMBURSEMENT POLICIES, AND TO PROVIDE NOTICE TO THE PROVIDER PRIOR TO IMPLEMENTING CHANGES TO THE SCHEDULES OR POLICIES. |
| | 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 (# |
| | With a favorable report as to House committee substitute bill (#), \square 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) 03/19/03 |

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

H

D

HOUSE BILL 1066 PROPOSED COMMITTEE SUBSTITUTE H1066-PCS30307-RC-47

| Short Tit | tle: Health Plans Disclose Fee Schedules/Coding. | (Public) |
|--|---|--|
| Sponsors | 3: | |
| Referred | to: | |
| | April 10, 2003 | |
| PROBEN SCH POLI IMPI The Gen | A BILL TO BE ENTITLED T TO FACILITATE THE SUBMISSION OF COMPLETY VIDERS UNDER HEALTH BENEFIT PLANS BY REQUI EFIT PLANS TO DISCLOSE TO CONTRACT PROVIDER EDULES OF FEES AND CLAIMS SUBMISSION AND REIF CIES, AND TO PROVIDE NOTICE TO THE PROVID LEMENTING CHANGES TO THE SCHEDULES OR POLIC eral Assembly of North Carolina enacts: SECTION 1. G.S. 58-3-225 is amended by adding the onto read: In order to facilitate submission of complete claims by provid (1) Insurers shall make available to contracted health ca information listed in subdivision (2) of this subse provide to contracted health care providers advance r to the information listed in subdivision (2) of this subse a change in reimbursement policy shall be given at le to implementing the change. The notice period shall such notices be given less than 30 days prior to provider contract does not include such a terminatio provision, or if a contract requires mutual written schedule of fees changes such notices shall be given days prior to the change. No advance notice must be information in subdivision (2)a. of this subsection if th effect of increasing fees, expanding health benefit pla made for patient safety considerations, in which case | RING HEALTH RS THE PLANS' MBURSEMENT PER PRIOR TO CIES. The following new The description of the changes of the change in a change in a change in a change. If a consent prior to not less than 30 provided for the change has the change has the change has the coverage, or is such notification |
| | days prior to the change. No advance notice must be information in subdivision (2)a. of this subsection if the effect of increasing fees, expanding health benefit pla | provided for the ne change has the an coverage, or is such notification |

available in any medium selected by the insurer, including an

| 1 | | electronic medium, and notice of change may also be provided in the |
|----------------------------------|-------------|--|
| 2 | | medium of the insurer's choosing. Advance notice may be made by |
| 3 | | communicating with contracted providers via an electronic mailing list |
| 4 | | or other electronic means. |
| 5 | <u>(2)</u> | a. An insurer shall make available to contracted providers the |
| 6 | | following: |
| 7 | | 1. The insurer's schedule of fees associated with the top 30 |
| 8 | | services or procedures most commonly billed by that |
| 9 | | class of provider, and, upon request, the full fee schedule |
| 10 | | for services or procedures billed by that class of |
| 11 | | provider; and |
| 12 | | 2. In the case of a contract incorporating multiple classes of |
| 13 | | providers, the insurer's schedule of fees associated with |
| 13 14 | | the top 30 services or procedures most commonly billed |
| 15 | | for each class of provider, and, upon request, the full fee |
| 16 | • | schedule for services or procedures billed for each class |
| 17 | | of provider; and |
| 18 | | 3. A description of the insurer's claim submission and |
| 19 | | reimbursement policies. |
| 20 | | b. In a case where an insurer makes reference to source |
| | | information that is the basis for fees or a reimbursement policy |
| 21 22 23 24 25 26 | | and that source information is outside of the control of the |
| 23 | • | insurer, the insurer's clear identification of the source and |
| 24 | | information on how the provider may readily access the source |
| 25 | | information shall satisfy the requirement to make the fees or |
| 26 | | policy available. |
| 27 | (3) | For providers offered a contract by an insurer, the insurer shall make |
| 28 | | available its schedule of fees associated with the top 30 services or |
| 29 | | procedures most commonly billed by that class of provider, and, upon |
| 30 | | request, the full fee schedule for services or procedures billed by that |
| 31 | | class of provider, or for each class of provider in the case of a contract |
| 32 | | incorporating multiple classes of providers. |
| 33 | <u>(4)</u> | Nothing herein shall prevent an insurer from requiring that providers |
| 34 | | keep confidential, and not disclose to third parties, the fee information |
| 35 | | provided under this subsection. |
| 36 | <u>(5)</u> | Providers shall submit claims in accordance with insurers' claim |
| 37 | | submission and reimbursement policies. |
| 38 | <u>(6)</u> | As used in this subsection, the term 'schedule of fees' includes, if |
| 39 | | applicable, CPT, HCPCS, ICD-9-CM codes, modifiers, and other |
| 40 | | applicable codes for the procedures most commonly billed for that |
| 41 | | class of provider. |
| 42 | <u>(7)</u> | As used in this subsection, the term reimbursement policy means |
| 43 | | information relating to payment and including the following as |
| 44 | | applicable: |

| | a. Policies on claims bundling and other claims editing processes; |
|--------------------|---|
| | b. Policies on recognition or nonrecognition of CPT code |
| | modifiers; |
| | c. Policies on downcoding of services or procedures; |
| | d. Definitions of global surgery periods; |
| | e. Policies on multiple surgical procedures; and |
| | e. Policies on multiple surgical procedures; and f. Policies related to payment based on the relationship of |
| | procedure code to diagnosis code. |
| (8) | As used in this subsection, the term 'insurer' shall not include an |
| | insurance company, service corporation, health maintenance |
| | organization, or multiple employee welfare arrangement that writes |
| | stand alone dental insurance. |
| (9) | Insurers' provider contracts shall indicate the availability of the |
| - 1 | information required to be provided under this subsection. |
| $\frac{1}{2}$ (10) | Except for the notice of changes to schedules of fees in subdivision (1) |
| | and the information required to be provided in subdivision (2)a.1. of |
| | this subsection, this subsection does not apply to claims processed by |
| | an insurer on a claims adjudication system that was implemented prior |
| | to January 1, 1982, provided that the insurer: |
| | a. Verifies with the Commissioner that its claims adjudication |
| | system qualified under this subsection; and |
| | b. Is implementing a new claims adjudication software system as |
| | soon as possible and in any event no later than December 31, |
| | 2004. This subdivision (10) shall expire on January 1, 2005. |
| <u>(11)</u> | Except for the notice of changes to schedules of fees in subdivision (1) |
| | of this subsection, this subsection does not apply to claims processed |
| | by the Teachers' and State Employees' Comprehensive Major Medical |
| | Plan until December 31, 2005. This subdivision shall expire January |
| | <u>1, 2006.</u> " |
| SECT | FION 2. G.S. 58-3-191(b) is amended by adding the following new |
| subdivision to re | |
| | lanaged care reporting and disclosure requirements. |
| | health benefit plan shall annually, on or before the first day of March of |
| • | in the office of the Commissioner the following information for the |
| previous calenda | ar year: |
| ••• | |
| <u>(6)</u> | Aggregate data on requests for schedules of fees and reimbursement |
| | policies from participating providers under G.S. 58-3-225(n) and the |
| | health benefit plans' responses to those requests." |
| | FION 3. Subdivisions (2)a.1. and (2)a.2. of this subsection are effective |
| | ome law for contracts issued, modified, or renewed after that date. The |
| remainder of thi | is act becomes effective January 1, 2004. |
| | (11) SECT subdivision to re "§ 58-3-191. M (a) Each each year, file previous calendary (6) SECT when they become |



VI

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

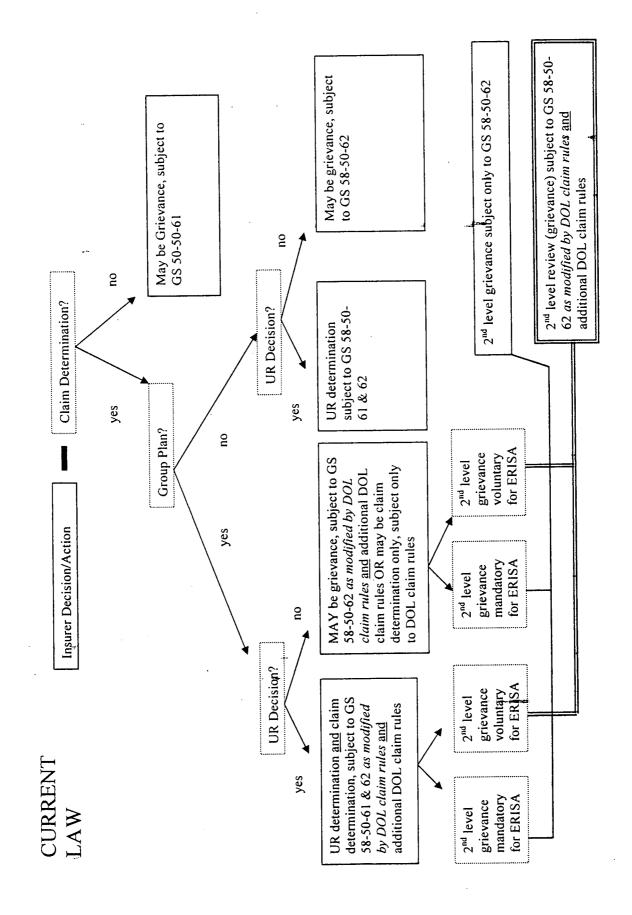
House Bill 1107

| | | AMENDME! | NT NO |
|-------------------------|--|----------------------|--------------------|
| | | (to be filled: | in by |
| H1107-ARC-30 [v.1] | | Principal Cl | lerk) |
| | | | Page 1 of 1 |
| | | Date | ,2003 |
| Comm. Sub. [YES] | | | |
| Amends Title [NO] | | | • |
| H1107-CSRC-46[v.3] | | | |
| Representative C. Wil | son | | |
| " SECTION | ill on page 33, lines 3-4 by rong 18. This act becomes effer in effect, delivered, issued for the state of th | ective March 1, 2004 | and applies to all |
| SIGNEDAmendment Sponsor | Wh | | |
| SIGNED | | | |
| Committee Chair if Se | enate Committee Amendmen | nt . | |
| ADOPTED | FAILED | TABLE | ED |

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NC Department of Insurance April 10, 2003

Insurer Decision/Action

Claim determination (including UR determination) subject to GS 58-50-61 as amended to comply with DOL claim rules. Other matters that are "grievances" are subject to GS 58-50-62, which requires compliance with GS 58-50-61 (i.e., same process as a claim determination)

2nd level grievance mandatory for ERISA

2nd level grievance voluntary for ERISA

2nd level grievance subject only to GS 58-50-62

2nd level review (grievance) subject to GS 58-50-62 as modified by DOL claim rules and

additional DOL claim rules

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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | e following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
|-----|--|
| | Committee Substitute for 3. 1107 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES TO MAKE THEM CONFORM WITH THE UNITED STATES DEPARTMENT OF LABOR CLAIM RULES. |
| | 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) 03/19/03 |

MINUTES

HOUSE INSURANCE COMMITTEE

May 15, 2003

The House Committee on Insurance met at 10:00 AM on May 15, 2003. Representative Setzer was in the chair. The following Representatives were present: Hugh Holliman, John Hall, Lucy Allen, Bobby Barbee, Charles Johnson, Linda Johnson, Drew Saunders, William Wainwright, Connie Wilson and Tom Wright.

Chair Setzer called the meeting to order and introduced the Sergeant-At-Arms. See Attachment I. He recognized Rep. Wainwright to introduce SB-769 (By Senator Thomas)-BEACH PLAN HOMEOWNERS POLICY RATE SETTING. This Senate Bill makes various changes to the statutes governing rate setting for beach plan homeowners. See Attachment II. Rep. Wright stated that he lived in the beach district and wanted to be able to explain the changes to his constituents back home. Mr. Robert Paschal answered his question by stating that the entire industry supports the bill and there is no objection to it at all. Representative Wright made the motion to pass the bill with a favorable report. It was passed unanimously.

Chair Setzer called on Senator Hartsell to introduce SB-471-AMEND SELF-INSURANCE GUARANTY ASSOC. LAWS. See Attachment III. After some discussion, Representative Wainwright made a motion to pass the bill with a favorable report and it passed the committee unanimously.

See Attachment IV for visitors list.

The meeting was adjourned at 10:25 AM.

Ren. Mitchell S. Setzer, Chair

ep. L. Hugh Holliman, Chair

Carol Bowers, Joanna Mills, Clerks

attachment I

House Pages

| 1 | Nama |
|------|------------------------|
| 1. | Name: |
| | County: |
| | Sponsor: |
| 2. | Name: |
| | County: |
| ٠ | Sponsor: |
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| 4. | Name: |
| | County: |
| | Sponsor: |
| 5. | Name: |
| | County: |
| | Sponsor: |
| Sgt- | At-Arms |
| • | Name: Dustr Rhodes |
| 1. | |
| 2. | Name: MAH MYERS |
| 3. | Name: Charles Williams |
| 4. | Name: |



SENATE BILL 769:

Beach Plan Homeowners Policy Rate Setting

Committee: House Insurance Committee

Date:

May 15, 2003

Version:

S769-Second Edition

Introduced by: Senator Thomas

Summary by:

Tim Hovis

Committee Counsel

BACKGROUND: The North Carolina Insurance Underwriting Association was created in Article 45 of the General Statutes, Essential Property Insurance for Beach Area Property, to provide an adequate market for property insurance in the beach and coastal areas of the state. The Association consists of insurers authorized to write property insurance. Members share in the expenses, profits and losses of the Association and receive credit for property insurance written in beach and coastal areas. The Association is popularly known as the Beach Plan.

SUMMARY: Senate Bill 769 makes various changes to the statutes governing rate setting for beach plan homeowners

Section 1 of the bill provides that homeowners' insurance policies under the Beach Plan are subject to underwriting guidelines established by the Association and approved by the Commissioner of Insurance. The guidelines must reflect underwriting standards commonly used in the insurance business.

Section 2 provides that if the Association determines (1) that a property is insurable; (2) that no unpaid premium is due for prior insurance on the property, and (3) that underwriting guidelines established by the Association and approved by the Commissioner are met, then an applicant must be issued a homeowners' policy under the Beach Plan, upon receipt of the premium in whole or in part.

Section 3 authorizes the Association to impose special surcharges to homeowners' policies issued under the Beach Plan, subject to the prior approval of a special surcharge schedule by the Commissioner. Surcharges under this subsection may not be excessive, inadequate or unfairly discriminatory.

EFFECTIVE DATE: Senate Bill 769 is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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SENATE BILL 769 Commerce Committee Substitute Adopted 4/24/03

| Short Title: Beach Plan Homeowners Policy Rate Setting. | | (Public) | |
|---|--|----------|--|
| Sponsors: | | | |
| Referred to: | | | |

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH RATE SETTING AND RATE-APPROVAL METHODS FOR THE BEACH PLAN HOMEOWNERS POLICY, TO PROVIDE INCENTIVES TO BEACH AND COASTAL AREA HOMEOWNERS WHO ESTABLISH AND MAINTAIN RISK PREVENTION AND RISK MITIGATION MEASURES, AND TO EXTEND THE DEADLINE FOR ISSUANCE OF THE HOMEOWNERS POLICY PRODUCT BY THE BEACH PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-45-30(d) reads as rewritten:

As used in this subsection, "homeowners' insurance policy" means a multiperil policy providing full coverage of residential property similar to the coverage provided under an HO-2, HO-3, HO-4, or HO-6 policy under Article 36 of this Chapter. The Association shall issue, for principal residences, homeowners' insurance policies approved by the Commissioner. Homeowners' insurance policies shall be available to persons who reside in the beach and coastal areas who meet the Association's underwriting standards and who are unable to obtain homeowners' insurance policies from insurers that are authorized to transact and are actually writing homeowners' insurance policies in this State. The Association shall file for approval by the Commissioner underwriting standards to determine whether property is insurable. The standards shall reflect underwriting standards commonly used in the voluntary homeowners' insurance business. The terms and conditions of the homeowners' insurance policies available under this subsection shall not be more favorable than those of homeowners' insurance policies available in the voluntary market in beach and coastal counties. Rates for the homeowners' insurance policies authorized by this subsection shall be set pursuant to rate standards set forth in G.S. 58-40-20(a), and the provisions of G.S. 58-45-45(a) shall not apply."

SECTION 2. G.S. 58-45-35 is amended by adding a new subsection to read:

"(b1) If the Association determines that the property, for which application for a homeowners' policy is made, is insurable, that there is no unpaid premium due from the

 applicant for prior insurance on the property, and that the underwriting guidelines established by the Association and approved by the Commissioner are met, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a homeowners' insurance policy."

SECTION 3. G.S. 58-45-45 reads as rewritten:

"§ 58-45-45. Rates, rating plans, rating rules, and forms applicable.

- (a) Except as provided in subsection (b) of this section, the rates, rating plans, rating rules, and forms applicable to the insurance written by the Association 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-Except as provided in subsection (c) of this section, no special surcharge, other than those presently in effect, may be applied to the property insurance rates of properties located in the beach area. and coastal areas.
- (b) The rates, rating plans, and rating rules for the separate policies of windstorm and hail insurance described in G.S. 58-45-35(b) shall be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification. The provisions of Articles 40 and 41 of this Chapter shall govern the filings. Policy deductible plans, consistent with G.S. 58-45-1(b), may be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification.
- (c) Notwithstanding subsection (a) of this section, the Association may, subject to the prior approval of the Commissioner, adopt a schedule of special surcharges relating to homeowners' insurance policies issued by the Association pursuant to G.S. 58-45-30(d). Such schedule may reflect any differences in risk that can be demonstrated to have a probable effect on losses or expenses. Notwithstanding subsections (a) and (b) of this section, the provisions of G.S. 58-36-10(1), 36-15(a), 58-36-20, and 58-36-25 shall apply to such filings."

SECTION 3.1. Section 9 of S.L. 2002-185 reads as rewritten:

"Section 9. Part II of this act becomes effective May-1, 2003. July 1, 2003. Part IV of this act becomes effective January 1, 2003. The remainder of this act is effective when it becomes law."

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



SENATE BILL 471:

Amend Self-Insurance Guaranty Assoc. Laws.

BILL ANALYSIS

Committee: House Insurance

May 14, 2003 Date:

2nd Edition Version:

Introduced by: Senator Hartsell

Summary by:

Kory J. Goldsmith

Committee Counsel

attachmen

SUMMARY: SB471 amends the laws governing the North Carolina Self-Insurance Guaranty Association (NCSIGA) to

- Amend G.S. 97-185 governing security deposits made by self-insurers of workers compensation liability with the Commissioner of Insurance by progressively increasing the minimum amount of the deposit required under the statute. The bill spans the increases over a three year period to 2006, whereby the amount of the deposit will have increased from 25% to 100% of the self-insurer's total outstanding claim liability;
- Allows a member self-insurer with a debt rating of BBB or better to deposit not less than 25% of the self-insurer's total undiscounted outstanding claim liability, but not less than \$500,000, but gives the Commissioner the discretion to require a greater or lesser amount based upon the self-insurer's financial strength;
- Allow the Commissioner to accept irrevocable letters of credit in lieu of cash or a surety bond to meet the deposit requirement under G.S. 97-185;
- Require that surety bonds deposited with the Commissioner are sufficient to allow the NCSIGA to recover its administrative costs, attorney fees and any costs related to the collection of the proceeds of the surety bond:
- Amend the statute governing the NCSIGA's authority to make assessments against the selfinsurer's annual gross premiums by increasing these assessments back to their pre-1997 levels;
- Eliminates the NCSIGA's statutory duty to pay claims against self-insurers that became insolvent before the NCSIGA was created; and
- Amends G.S. 97-141 to allow a 60 day-stay against the running of all time periods pursuant to any proceedings in which an insolvent member of the NCSIGA is a party to begin on the later of the date of notice to the NCSIGA of the insolvency of the member or the date the NCSIGA receives notice of a claim or proceeding after the original notice of the insolvency.

BILL ANALYSIS:

Section 1. G.S. 58-6-25 requires insurance companies to pay a charge at a percentage rate of the company's premium tax liability for the taxable year. This section amends G.S. 97-133(a)(2) to restore the NCSIGA's authority to collect annual assessments from one-quarter of one percent (0.25%) to two percent (2%) of the annual gross workers compensation premiums.

The NCSIGA's rationale for this increase: In 1997 a tax credit was enacted against members' premium tax bills for annual assessments collected to increase the NCSIGA's Guaranty Fund from \$1,000,000 to \$5,000,000. The tax credit was only available for the two years of assessments that were necessary to increase the Guaranty Fund to \$5,000,000. To offset the tax credit, the amount of allowable assessment

SENATE BILL 471

Page 2

was reduced from 2% to 0.25%. Now that the tax credit is no longer available, the amount of the annual assessments available to the NCSIGA is still at the reduced levels and they should be increased to pre-1997 levels.

Section 1 also changes the deadline for annual assessment payments to be made to the NCSIGA from September 15 to May 15. The statute provides that members' assessments must be paid by September 15 of the year in which the assessments are billed. Assessments are for the prior year but cannot be billed until April, after the self-insurers' premium tax returns are filled.

Section 2. G.S. 97-133(a) requires the NCSIGA to pay claims against self-insurers that became insolvent before the NCSIGA was created in 1986. Prior to 1997, the provision included a tax credit for assessments against premiums to pay such claims. This tax credit was deleted in 1997 with the enactment of S.L. 1997-475. SB 471 deletes the requirement to pay the claims since the tax credit is no longer available.

Section 3. Every insurer is required to post a security deposit with the Department of Insurance (DOI) in the form of cash, securities or a surety bond. The deposit or bond is assigned to the NCSIGA by the Department upon the self-insurer's insolvency and is used to pay worker's compensation claims against the insolvent self-insurer before claims are paid from the Guaranty Fund. Any claims paid from the Guaranty Fund result in assessments against all of the other self-insurers in North Carolina that are required, by law to belong to the Guaranty Association. The DOI does not currently accept letters of credit as security deposits. Other states do accept letters of credit.

SB 471 amends G.S. 97-185 to make letters of credit an acceptable form of a security deposit. However, the letter of credit must be in a form acceptable to the Commissioner. The Commissioner may require a bank to reimburse the Commissioner any costs, including attorney fees, incurred in the collection of the proceeds of the letter.

G.S. 97-185 currently requires self-insurers to make a security deposit of 25% of outstanding undiscounted claims liability, as determined by an actuary, or a minimum of \$500,000. The Commissioner is authorized to require a higher deposit depending upon the financial condition of the self-insurer and the self-insurer's outstanding and potential claims liability. According to the NCSIGA, self-insurers that are in financial difficulty have taken advantage of the discretionary nature of the Commissioner's authority and have challenged deposit increases by requesting administrative hearings to delay the loss of their self-insurance authority. Apparently, in some instances the resulting delay has extended into the self-insurer's bankruptcy filing, resulting in more claims to be paid with an inadequate deposit and greater demands on the NCSIGA and remaining self-insurers.

SB 471 would require every self-insurer to post a deposit of 100% of its outstanding claims liability as determined by an actuary. The increase will be phased in over a three-year period.

Also allows a member self-insurer with a debt rating of BBB or better to deposit not less than 25% of the self-insurer's total undiscounted outstanding claim liability, but not less than \$500,000, but gives the Commissioner the discretion to require a greater or lesser amount based upon the self-insurer's financial strength.

Sections 4 through 5 provide for the progressive increases in the percent of claims liability required as a security deposit as explained in Section 3. See Section 7 for explanation of effective dates.

SENATE BILL 471

Page 3

Section 6. G.S. 97-141 provides for a 60-day stay of proceedings in claims against self-insured member employers of the NCSIGA. The 60-day stay begins when the NCSIGA receives notice of insolvency. The purpose of the stay is to suspend pending time deadlines while the NCSIGA investigates, prosecutes, or defend against claims or appeals. Throughout the stay, the NCSIGA is obligated to make weekly compensation payments. According to the NCSIGA, the statute does not adequately address the situation where a claim is asserted against an insolvent former self-insurer long after the NCSIGA was given notice of the insolvency. SB 471 amends G.S. 97-141 to allow the stay to begin on the later of the date of notice of the insolvency or the time the NCSIGA receives notice of a claim after the original notice of the insolvency.

Section 7. This section makes Section 3 (increase in security deposit and letter of credit allowance) effective January 1, 2004. Section 4 is effective January 1, 2005. Section 5 is effective January 1, 2006. Section 6 is effective January 1, 2007. Section 7 (Stay of proceedings) is effective when the bill becomes law and applies to claims filed on or after that date. Section 1 and 2 become effective when the bill becomes law and applies to assessments made on or after that date.

BACKGROUND:

The North Carolina Self-Insurance Guaranty Association (Association) was created by the General Assembly in 1986 to provide mechanisms for the payment of covered claims under self-insurance coverage, to avoid excessive delay in payment, to avoid financial loss to claimants because of insolvency of a self-insurer, and to assist in the detection of self-insurer insolvencies. All self-insurers are required by law to be members of the Association.

Since it was created, the NCSIGA has processed claims from 37 insolvent self-insured companies and 3 insolvent self-insured groups. In 18 of the 20 individual company insolvencies that the NCSIGA considers to be closed, the self-insurer's claim liability exceeded the self-insurers statutory deposit with the DOI.

S471-SMRC-002 Linda Attarian, former member of Research Division Staff, contributed substantially to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

S

SENATE BILL 471 Judiciary II Committee Substitute Adopted 4/24/03

| Short Title. Amend S | elf-Insurance Guaranty Assoc. Laws. | (Public) |
|----------------------|--|--|
| Sponsors: | | |
| Referred to: | | |
| | March 20, 2003 | |
| AN ACT TO AME | A BILL TO BE ENTITLED ND THE LAWS GOVERNING TH | F SELETINGLIDANCE |
| GUARANTY ASSO | | L SELF-INSURANCE |
| | of North Carolina enacts: | |
| | G.S. 97-133(a)(2) reads as rewritten: | |
| | s each member of the Association as follo | ows: |
| a. | Each individual member self-insurer shan amount equal to one-quarter of one percent (2%) of the annual gross produced G.S. 105-228.5(b), (b1), and (c) paid by that member self-insurer for insurance during the prior calendar ye Association shall be made no later than following the close of that calendar assessment is paid based in whole or in annual gross premiums for the prior cabe made in the next year's assessment assessment of such prior year based or gross premiums. Each group member annually assessed an amount equal percent (0.25%)—two percent (2%) premiums, as determined under G.S. (c), of the group member self-insurer dyear; and payment to the Association than September 15—May 15 following the year. Regardless of the size of the Fumonths of membership, no member self-reduce this one-quarter of one percent Assessments paid by members pursuant | emiums, as determined that would have been workers' compensation ear; and payment to the September 15 May 15 year. Where any such a part upon estimates of alendar year, there shall at an adjustment of the nactual audited annual er self-insurer shall be to one-quarter of one of the annual gross 105-228.5(b), (b1), and uring the prior calendar shall be made no later the close of that calendar und, during its first 12 insurer may discount or the (0.25%) assessment. |

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be credited toward the tax paid by self insurers under Article 8B of Chapter 105 of the General Statutes. two percent (2%) assessment. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll information as determined under G.S. 105-228.5(b), (b1) and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.

- b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.
- If a self-insurer is a member of the Association for less than a c. full calendar year, the annual gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.
- d. application of the contribution rates referenced in sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar (\$5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association."

SECTION 2. G.S. 97-133(a)(4) reads as rewritten:

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

SECTION 3. G.S. 97-185 reads as rewritten:

"§ 97-185. Deposits or surety bond. Deposits; surety bonds; letters of credit.

Every self-insurer shall deposit with the Commissioner an amount equal to twenty-five percent (25%) not less than fifty percent (50%) of the self-insurer's total undiscounted outstanding claim liability per the most recent certification from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars (\$500,000), or such other greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the self-insurer and the risk retained by the self-insurer.

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- A self-insurer organized and authorized before the effective date of this (b) section shall have 24 months from the effective date of this section to comply with this section.
- (b1) Notwithstanding subsection (a) of this section, member self-insurers with a debt rating of BBB or better from Standard and Poor's Rating Service, a division of McGraw Hill, Inc., or an equivalent rating from another national rating agency shall deposit with the Commissioner an amount not less than twenty-five percent (25%) of the self-insurer's total undiscounted outstanding claim liability per the most recent certification from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars (\$500,000). The Commissioner shall consider and may, in the Commissioner's discretion, increase or reduce the deposit to a greater or lesser percentage of the member self-insurer's claims liability based on the financial strength of the self-insurer and other financial information submitted by the self-insurer.
- Deposits received, changes to existing deposits, or deposits exchanged after the effective date of this section, shall comprise one or more of the following:
 - Interest-bearing bonds of the United States of America. **(1)**
 - Interest-bearing bonds of the State of North Carolina, or of its cities or (2) counties.
 - Certificates of deposit issued by any solvent bank domesticated in the (3) State of North Carolina that have a maturity of one year or greater.
 - Surety bonds in a form acceptable to the Commissioner and issued by **(4)** a corporate surety. A surety bond deposited pursuant to this subsection shall require that the surety reimburse the Commissioner, or his successors, assigns, or transferees, for any costs incurred in the collection of the proceeds of the surety bond, including reasonable attorneys' fees, and any costs incurred in administering the insolvent self-insurer's workers' compensation claims.
 - Irrevocable letters of credit in a form acceptable to the Commissioner (4a) issued by a bank acceptable to the Commissioner. An irrevocable letter of credit deposited pursuant to this subsection shall require that the bank reimburse the Commissioner, or his successor, assigns, or transferees for any costs incurred in the collection of the proceeds of the letter of credit, including reasonable attorneys' fees.
 - The reimbursement of attorneys' fees and collections cost provided for (4b) in subdivisions (4) and (4a) of this subsection shall be no greater than fifteen percent (15%) of the penal amount of the bond and shall not come from the proceeds of the bond or the letter of credit but shall be in addition to the proceeds of the bond or the letter of credit.
 - Any other investments that are approved by the Commissioner.
- All bonds or securities that are posted as a security deposit shall be valued annually at market value. If market value is less than face value, the Commissioner may require the self-insurer to post additional securities. In making this determination, the Commissioner shall consider the self-insurer's financial condition, the amount by which

market value is less than face value, and the likelihood that the securities will be needed to provide benefits.

- (e) Securities deposited under this section shall be assigned to the Commissioner, the Commissioner's successors, assigns, or trustees, on a form prescribed by the Commissioner in a manner that renders the securities negotiable by the Commissioner. If a self-insurer is deemed by the Commissioner to be in a hazardous financial condition, the Commissioner may sell or collect, or both, such amounts that will yield sufficient funds to meet the self-insurer's obligations under the Act. In the case of a letter of credit, the Commissioner may draw the full amount of a letter of credit if the letter of credit is not renewed within 90 days prior to its expiration or at any time that the bank issuing the letter of credit is no longer acceptable to the Commissioner. Interest accruing on any negotiable security deposited under this Article shall be collected and transmitted to the self-insurer if the self-insurer is not in a hazardous financial condition.
- (f) No judgment creditor, other than a claimant entitled to benefits under the Act, may levy upon any deposits made under this section.
- (g) Securities held by the Commissioner under this section may be exchanged or replaced by the self-insurer with other securities of like nature and amount as long as the self-insurer is not in a hazardous financial condition. No release shall be effectuated until replacement securities or bonds of an equal value have been substituted. Any surety bond may be exchanged or replaced with another surety bond that meets the requirements of this section if 90 days' advance written notice is given to the Commissioner. If a self-insurer ceases to self-insure or desires to replace securities with an acceptable surety bond or bonds, the self-insurer shall notify the Commissioner, and may recover all or a portion of the securities deposited with the Commissioner upon posting instead an acceptable special release bond issued by a corporate surety in an amount equal to the total value of the securities. The special release bond shall cover all existing liabilities under the Act plus an amount to cover future loss development and shall remain in force until all obligations under the Act have been discharged fully.
- (h) If a self-insurer ceases to self-insure, no deposits shall be released by the Commissioner until the self-insurer has discharged fully all of the self-insurer's obligations under the Act.
- (i) An endorsement to a surety bond shall be filed with the Commissioner within 90 days after the effective date of the endorsement."
- **SECTION 4.** Effective January 1, 2005, G.S. 97-185(a), as amended in Section 3 of this act, reads as rewritten:
- "(a) Every self-insurer shall deposit with the Commissioner an amount not less than fifty percent (50%) not less than seventy-five percent (75%) of the self-insurer's total undiscounted outstanding claim liability per the most recent certification from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars (\$500,000), or such other greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the self-insurer and the risk retained by the self-insurer."
- SECTION 5. Effective January 1, 2006, G.S. 97-185(a), as amended in Sections 3 and 4 of this act, reads as rewritten:



"(a) Every self-insurer shall deposit with the Commissioner an amount not less than seventy-five percent (75%) not less than one hundred percent (100%) of the self-insurer's total undiscounted outstanding claim liability per the most recent certification from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars (\$500,000), or such other greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the self-insurer and the risk retained by the self-insurer."

SECTION 6. G.S. 97-141 reads as rewritten:

"§ 97-141. Stay of proceedings.

All <u>claims</u> or proceedings under this Chapter to which the insolvent member self-insurer is a party either before the Industrial Commission or a court in this State and the running of all time periods against either the insolvent member self-insurer or the Association under this Chapter shall be stayed for 60 days from the <u>later of the</u> date of notice to the Association of the insolvency <u>or the date the Association is notified of a claim or proceeding under this Chapter</u> in order to permit the Association to investigate, prosecute, or defend properly any petition, claim, or appeal under this Chapter, provided that the payment of weekly compensation for incapacity is made whenever time periods or proceedings affecting the payment of weekly compensation are stayed."

SECTION 7. Section 3 of this act becomes effective January 1, 2004. Section 4 of this act becomes effective January 1, 2005. Section 5 of this act becomes effective January 1, 2006. Section 6 of this act is effective when this act becomes law and applies to claims filed on or after that date. The remainder of this act is effective when this act becomes law and applies to assessments made on or after that date.



VISITOR REGISTRATION SHEET

attachmen

HOUSE COMMITTE ON INSURANCE

5-15-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|------------------|----------------------------|
| BILL HASE | JORDAN PRICE LAW FIRM |
| The Roll | NCAFOD |
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VISITOR REGISTRATION SHEET

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5-15-03

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|----------------------------|
| John Michellan | MF45 |
| ANN LORE | OV#72 |
| DAVID BARNES | Poyur + Spuill |
| July 18 | JD, AW, PA |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. X Committee Substitute for S.B. 769 A BILL TO BE ENTITLED AN ACT TO ESTABLISH RATE SETTING AND RATE-APPROVAL METHODS FOR THE BEACH PLAN HOMEOWNERS POLICY. TO PROVIDE INCENTIVES TO BEACH AND COASTAL AREA HOMEOWNERS WHO ESTABLISH AND MAINTAIN RISK PREVENTION AND RISK MITIGATION MEASURES, AND TO EXTEND THE DEADLINE FOR ISSUANCE OF THE HOMEOWNERS POLICY PRODUCT BY THE BEACH PLAN. 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) 03/19/03

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | e following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
|-----|---|
| _ | Committee Substitute for 471 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAWS GOVERNING THE SELF-INSURANCE GUARANTY ASSOCIATION. |
| X | 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 Figure . |
| | With a favorable report as to the committee substitute bill (#), \square 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 (#), \square 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) 03/19/03 |

MINUTES

HOUSE INSURANCE COMMITTEE

May 20, 2003

The House Committee on Insurance met at 10:15AM on May 20, 2003. The following Representatives were present: Hugh Holliman, Mitchell Setzer, Lucy Allen, Bobby Barbee, Robert Grady, Charles Johnson, Linda Johnson, David Lewis, Karen Ray, William Wainwright, Thomas Wright and Connie Wilson.

Chair Holliman announced that SB-758 had been removed at the request of DOI.

Chair Holliman called on Senator Thomas to explain SB-771- CREDIT SCORING LIMITATION. He explained credit scoring, adjustments and rates. See Attachment I. Frank Folger, DOI explained the changes in the PCS. See Attachment II. Then Rep. Setzer made a motion to accept the amendment to the PCS. Senator Thomas spoke on the second amendment. Attachment III. Representative Setzer made the motion to adopt the amendment which changes the title of the bill. After much discussion, Rep. Barbee moved for a favorable report and it passed unanimously.

The visitor's sheet is enclosed. See Attachment IV.

Rep L. Hugh Holliman

Rep. Mitchell S. Setzer

Carol Bowers, Joanna Mills, Clerks



SENATE BILL 771: **Credit Scoring Limitation**



BILL ANALYSIS

Committee: House Insurance Committee

Date:

May 20, 2003

Version:

S771-CSRG-189[v.2]

Introduced by: Senator Thomas

Summary by: Tim Hovis

Committee Counsel

SUMMARY: The Proposed Committee Substitute for Senate Bill 771 would regulate the use of "credit scoring" by insurers. Credit scoring is the practice of reducing data from an individual's credit report to a number or rating. The bill prohibits the use of "credit scoring" as the sole basis for terminating or reducing coverage in an existing passenger motor vehicle or residential property policy, or as the sole basis for subjecting a policy to consent to rate. The bill allows the use of credit scoring to discount rates.

The bill also requires insurers to provide notice to applicants or policyholders if a credit report is used to take an "adverse action." Adverse action is defined under the bill as the denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of insurance.

BILL ANALYSIS: Credit score is defined under the bill as "a score that is derived from an individual's credit report in an algorithm, computer program, model, or other process that reduces the data to a number or rating."

The bill specifically prohibits non-commercial private passenger motor vehicle and residential property insurers from using credit scoring as the sole basis to:

- Terminate an existing policy or any coverage in an existing policy.
- Subject a policy to consent to rate. "Consent to rate" is the process by which an insurer may charge a rate in excess of the rate promulgated by the Rate Bureau with the written consent of the insured.

Credit scoring may be used to discount rates.

Senate Bill 771 also provides that, if a credit report is used with other criteria to take an adverse action (as defined above), the insurer must provide an applicant or policyholder with written notice of the action taken. The notification must include the following:

- The reason for the action, including factors primarily influencing a credit score if the action was based upon a credit score.
- The name address, and toll-free telephone of the credit bureau providing the information.
- The fact that the consumer has the right to obtain a free copy of his or her credit report.
- The fact that the consumer has the right to challenge information in his or her credit report.

The bill establishes a 45-day grace period for consumers following disputing of information in a credit report during which time the disputed information cannot be used adversely by the insurer against the consumer.

The Commissioner of Insurance is authorized to investigate violations of and enforce this section.

EFFECTIVE DATE: Senate Bill 771 would become effective January 1, 2004 and would apply to policies issued or renewed on or after that date and to applications made on or after that date.



DEPARTMENT OF INSURANCE

State of North Carolina

P. O. Box 26387 RALEIGH, N. C. 27611 Machine 1

LEGISLATIVE COUNSEL (919) 733-4529

JIM LONG
COMMISSIONER OF INSURANCE

MEMORANDUM

TO:

House Committee on Insurance

FROM:

Frank W. Folger, Legislative Counsel

DATE:

May 20, 2003

Summary of Proposed Committee Substitute for SENATE BILL 771 – CREDIT SCORING LIMITATION

Senate Bill 771 limits the use of credit scoring on the underwriting and rating of insurance coverage for private passenger motor vehicles and residential property.

Section 1 of the bill creates a new statute, G.S.58-36-90, that:

- Prohibits, in underwriting and rating coverage for residential property and **non-commercial** private passenger motor vehicles, use of credit scoring as the sole basis for terminating a policy or coverage or for increasing rates (using the provisions of "consent to rate.") but allows credit scoring to be used as the sole basis for lowering rates.
- Requires an insurer to notify the policyholder or applicant, in writing, when it uses the person's credit report information to take an adverse action with respect to the applicant or policyholder. The notice must:
 - Specify the reason for the adverse action



- If the action is based upon a credit score, describe the factors that were the primary influence on the score;
- Provide contact information for the consumer reporting agency that provided the credit report;
- State the consumer's right to obtain a free credit report from the consumer reporting agency and to challenge information contained in the report.
- □ Establishes a 45-day grace period for consumers following disputing of information in a credit report during which time the disputed information cannot be used adversely by the insurer against the consumer.
- Requires insurers that use credit scoring to file with the Department their credit scoring models but allows them to request treatment of credit scoring data as a trade secret.

Section 2 of the bill make the act effective January 1, 2004, and applicable to policies issued or renewed on or after that date and to applications for coverage made on or after that date.

Summary of Proposed Committee Substitute for SENATE BILL 771 – CREDIT SCORING LIMITATION

Senate Bill 771 limits the use of credit scoring on the underwriting and rating of insurance coverage for private passenger motor vehicles and residential property.

Section 1 of the bill creates a new statute, G.S.58-36-90, that:

- Prohibits, in underwriting and rating coverage for residential property and non-commercial private passenger motor vehicles, use of credit scoring as the sole basis for terminating a policy or coverage or for increasing rates (using the provisions of "consent to rate.") but allows credit scoring to be used as the sole basis for lowering rates.
- Requires an insurer to notify the policyholder or applicant, in writing, when it uses the person's credit report information to take an adverse action with respect to the applicant or policyholder. The notice must:
 - Specify the reason for the adverse action
 - If the action is based upon a credit score, describe the factors that were the primary influence on the score;
 - Provide contact information for the consumer reporting agency that provided the credit report;
 - State the consumer's right to obtain a free credit report from the consumer reporting agency and to challenge information contained in the report.
- □ Establishes a 45-day grace period for consumers following disputing of information in a credit report during which time the disputed information cannot be used adversely by the insurer against the consumer.
- Requires insurers that use credit scoring to file with the Department their credit scoring models but allows them to request treatment of credit scoring data as a trade secret.

Section 2 of the bill make the act effective January 1, 2004, and applicable to policies issued or renewed on or after that date and to applications for coverage made on or after that date.



NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

Senate Bill 771

| S771-ASP-4 [v.1] | (to | MENDMENT NOo be filled in by rincipal Clerk) Page 1 of 1 |
|--|---|---|
| | Date | ,2003 |
| Comm. Sub. [YES] Amends Title [YES] Second Edition | | |
| Senator | | |
| moves to amend the bill on p | age 3, between lines 1 and 2, b | y inserting the following: |
| from and against all liability errors, or omissions of an a scores for an insurer, prov- established by the insurer and | insurer shall indemnify, defending, fees, and costs arising out of gent who obtains or uses creativided the agent follows the discomplies with any applicable and to provide a consumer or other absence of this section."; | of or relating to the actions, dit information or insurance instructions or procedures e law or regulation. Nothing |
| and by relettering the remain | ing subsections accordingly. | |
| | | |
| SIGNEDAmendment Sponsor | | <u> </u> |
| SIGNED Committee Chair if Senate C | committee Amendment | |
| ADOPTED | FAILED | TABLED |

| , | . NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT |
|----|--|
| | (Please type or use ballpoint pen) |
|) | EDITION No |
| • | H. B. No DATE |
| | S. B. No. 77/ S. B. No. 77/ S. B. No. (to be filled in by Principal Clerk) Rep.) Sen.) |
| | moves to amend the bill on page 2 , line $35-43$ |
| 2 | () WHICH CHANGES THE TITLE |
| 3 | by rewriting the lines to read: |
| 4 | "Disputed Oredit Report Information - |
| 5 | "(ch If it is determined through the dispute |
| 6 | resolution process set forth in the Federal |
| 7 | Fair credit Reporting Act, 15 uSC 1681i(a)(5), |
| 8. | that the credit information of a current insured |
| 9 | was incorrect or incomplete and if the insurer |
| 10 | receives notice of such determination from either |
| 11 | the consumer reporting agency or from the insured |
| 12 | the insurer shall reunderwrite or re-rate the |
| 13 | Consumer within 30 days of receiving the notice. |
| 14 | The second of th |
| 15 | inswer shall make any adjustments necessary |
| 16 | consistent with its underwriting quidelines If |
| 17 | an insurer determines the insured has overpaid |
| 18 | premium, the insurer shall refund to the |
| 19 | insured the amount of overpayment cakulated |

ADOPTED______FAILED_____TABLED____

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

| EDITION No. | _ |
|---|---|
| H. B. No | DATE |
| s. B. No. 771 \$711-CSRG-18[v. 2 COMMITTEE SUBSTITUTE Second page Rep.) | Amendment No (to be filled in by Principal Clerk) |
| Sen.) | |
| 1 moves to amend the bill on page | , line |
| 2 () WHICH CHANGES THE TITLE | |
| 3 by hack to the | e shorter of either the last |
| 17 | A |
| 5 12 mon 195 | of coverage or the actual |
| 6 policy pen | |
| 8 | |
| 9 and on pa | ac 2. line 21 |
| 1 | the line to read |
| 10 been in ef | Feet for more than 60 days. " |
| 12 | |
| | 10 1 / Ines 2-14 |
| 14 by rewriting & | the lines to read: |
| 15 "AN ACRT | D CONTROLLE SELECTION ASSESSMENT |
| | PROHIBIT THE USE |
| 16 OF A PER | SON'S CREDIT" |
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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

 \mathbf{S}

Short Title: Credit Scoring Limitation.

SENATE BILL 771 PROPOSED COMMITTEE SUBSTITUTE S771-CSRG-18 [v.2]

 \mathbf{D}

(Public)

| | Sponso | ors: | |
|----------|------------------|------------|--|
| | Referre | ed to: | |
| | | | April 3, 2003 |
| | | | |
| 1 | | | A BILL TO BE ENTITLED |
| 2 | AN A | CT TO | O LIMIT THE USE OF A PERSON'S CREDIT HISTORY FOR |
| 3 | DIS | COUN | ITING RATES ON AUTOMOBILE AND HOMEOWNERS' |
| 4 | INS | URAN | ICE AND TO PROHIBIT THE USE OF A PERSON'S CREDIT |
| 5 | HIS | TORY | AS A SOLE BASIS FOR TERMINATING INSURANCE COVERAGE. |
| 6 | | | ECTING A POLICY TO CONSENT TO RATE. |
| 7 | The Gen | neral A | Assembly of North Carolina enacts: |
| 8 | | SEC | CTION 1. Article 36 of Chapter 58 of the General Statutes is amended by |
| 9 | | new s | section to read: |
| 10 | " <u>§ 58-36</u> | 6-90. | Prohibitions on using credit scoring to rate non-commercial private |
| 11 | () | pass | senger motor vehicle and residential property insurance; exceptions. |
| 12 | <u>(a)</u> | | nitions. – As used in this section: |
| 13 | | (1) | "Adverse action" has the same meaning as in section 1681a(k) of the |
| 14 | | | federal Fair Credit Reporting Act and includes a denial or cancellation |
| 15 16 | | | of, an increase in any charge for, or a reduction or other adverse or |
| 16 17 | | | unfavorable change in the terms of coverage or amount of any |
| 18 | | | insurance, existing or applied for, in connection with the underwriting |
| 19 | | (2) | of insurance. |
| 20 | | <u>(2)</u> | "Credit report" means any written, oral, or other communication of any |
| 21 | | • | information by a consumer reporting agency that bears on a |
| 22 | | | consumer's credit worthiness, credit standing, or credit capacity. Credit report does not include accident or traffic violation records as |
| 23 | • | | maintained by the North Carolina Division of Motor Vehicles or any |
| 24 | | | other law enforcement agency, a property loss report or claims history |
| 25 | | | that does not include information that bears on a consumer's credit |
| 26 | | | worthiness, credit standing, or credit capacity, or any report containing |
| 27 | | | information solely as to transactions or experiences between the |
| 28 | | | consumer and the person making the report. |
| | | | |
| | | | · |

G.S. 58-40-10.

- <u>(3)</u> "Credit score" means a score that is derived by utilizing data from an individual's credit report in an algorithm, computer program, model, or other process that reduces the data to a number or rating. "Non-commercial private passenger motor vehicle" means a "private (4)passenger motor vehicle", as defined by G.S. 58-40-10, that is neither insured under a commercial policy nor used for commercial purposes. б "Private passenger motor vehicle" has the same meaning as set forth in (5)
 - (6) "Residential property" means real property with not more than four housing units located in this State, the contents thereof and valuable interest therein, and insurance coverage written in connection with the sale of that property. It also includes mobile homes, modular homes, townhomes, condominiums, and insurance on contents of apartments and rental property used for residential purposes.
 - (b) Prohibitions; Exceptions. In the rating and underwriting of non-commercial private passenger motor vehicle and residential property insurance coverage, insurers shall not use credit scoring as the sole basis for terminating an existing policy or any coverage in an existing policy or subjecting a policy to consent to rate, as specified in G.S. 58-36-30(b), but insurers may use credit scoring as the sole basis for discounting rates. For purposes of this subsection only, "existing policy" means a policy that has been in effect for 60 days or more.
 - (c) <u>Notification. If a credit report is used to take an adverse action, the insurer shall provide the applicant or policyholder with written notice of the action taken, in a form approved by the Commissioner. The notification shall include, in easily understandable language:</u>
 - (1) The specific reason for the adverse action and, if the adverse action was based upon a credit score, a description of the factors that were the primary influence on the score.
 - (2) The name, address, and toll-free telephone number of the credit bureau that provided the insurer with the credit-based information.
 - (3) The fact that the consumer has the right to obtain a free copy of the consumer's credit report from the appropriate credit bureau.
 - (4) The fact that the consumer has the right to challenge information contained in the consumer's credit report.
 - (d) Disputed Credit Report Information If any item or items of information contained in the credit report for an applicant or policyholder is in dispute pursuant to the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i and the insurer has been informed that the information is in dispute, the insurer, during the 45 day period following the date on which the information was placed in dispute pursuant to such dispute resolution process, shall either not use such disputed item or items in making its underwriting or rating determination for such applicant or insured or shall treat the credit information as neutral with respect to the item or items in dispute.

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| (e) Filing. – Insurers that use insurance scores to underwrite and rate risks sha | al |
|--|-----|
| file their scoring models, or other scoring processes, with the Department. A filing the | na |
| includes insurance scoring may include loss experience justifying the applicab |)l(|
| surcharge or credit. A filer may request that its credit score data be considered a tra- | dí |
| secret, as defined by G.S. 66-152(3), and may designate parts of its filings accordingly | , " |
| CIECTION 3 THE | _ |

SECTION 2. This act becomes effective January 1, 2004, and applies to policies issued or renewed on or after that date and to applications for coverage made on or after that date.

| HOHICE | COMMITTTE | ON INSURANCE | С |
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| HOUSE | COMMITTEE | ON INSULAINC | Ľ |

5-20-03 Date

Name of Committee

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Stella Boswell | NCATL |
| - Duny James | pin GMAC Dusurana |
| Alt Bird | IMNC |
| Suphanie Luryson | NCAR |
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| Win | AUP |
| John Peter | NCINS |
| David Cranford | AIR NC |
| Brod Lamb | NC Consumers Council |
| Portara Monales Boules | NCOCE |
| Andy Ellen | NURMA |
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HOUSE COMMITTE ON INSURANCE

5-20-03

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|---------------|----------------------------|
| Jul ma | NCMAP |
| Willie Burns | M orohead Cty, NC |
| FRED JOYNER | NCAIFA |
| BILL HALE | JORDAN PRICE LAW FIRM |
| SERRY Schill | NC Fisheries Asseinfor |
| BILL SLOGGIN | KCLH |
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| HOUSE COMMITTTE ON INSURANCE | 5-20:03 | |
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| Name of Committee | Date | |

| NAME | FIRM OR AGENCY AND ADDRESS |
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MINUTES

HOUSE INSURANCE COMMITTEE

May 22, 2003

The House Committee on Insurance met at 10:00 on May 22, 2003. The following Representatives were present: Hugh Holliman, Mitchell Setzer, Bobby Barbee, Robert Grady, Charles Johnson, David Lewis, Karen Ray, William Wainwright, Connie Wilson and Tom Wright.

Chair Setzer called on Chair Holliman to bring forth the proposed committee substitute for SB-771-CREDIT SCORING LIMITATION. Then Mr. Holliman asked Tim Hovis to explain the proposed committee substitute. See ATTACHMENT I. Mr. Holliman also had an amendment that would amend the bill on page 2, line 19. See ATTACHMENT II and III. Bobby Barbee made a motion for a favorable report and the amendment passed. Then Rep. Ray made a motion go give the bill a favorable report and it also passed.

Chair Setzer called on Senator Swindell to explain SB-962-REQUIRE AFFIDAVITS OF BAIL BONDSMEN. Senator Swindell explained the bill see ATTACHMENTS IV and V. There was very little discussion. Representative Wainwright made a motion for a favorable report.

Chair Setzer called on Senator Carpenter to explain SB-887-OVARIAN CANCER DET./HIGH RISK WOMEN. See ATTACHMENTS VI and VII. Representative Wainwright made a motion for a favorable and it passed unanimously.

The visitor's sheet is enclosed. See ATTACHMENT VIII.

The meeting was adjourned at 10: 19 AM.

Rep. Hugh Holliman

Rep. Mitchell Setzer

Carol Bowers, Joanna Mills, Clerks

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

S

Short Title: Credit Scoring Limitation.

 \mathbf{D}

(Public)

SENATE BILL 771

Commerce Committee Substitute Adopted 4/23/03 PROPOSED HOUSE COMMITTEE SUBSTITUTE S771-CSRG-19 [v.1]

5/22/2003 8:38:30 AM

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| | Sponsors: | |
| | Referred to: | |
| | | April 3, 2003 |
| 1 | | A BILL TO BE ENTITLED |
| 2 | AN ACT TO | PROHIBIT THE USE OF A PERSON'S CREDIT HISTORY AS A |
| 3 | | SIS FOR TERMINATING INSURANCE COVERAGE OR |
| 4 | | NG A POLICY TO CONSENT TO RATE. |
| 5 | | sembly of North Carolina enacts: |
| 6 | | FION 1. Article 36 of Chapter 58 of the General Statutes is amended by |
| 7 | adding a new se | ection to read: |
| 8 | "§ 58-36-90. P | Prohibitions on using credit scoring to rate non-commercial private |
| 9 | passe | enger motor vehicle and residential property insurance; exceptions. |
| 10 | (a) Defin | uitions. – As used in this section: |
| 11 | <u>(1)</u> | "Adverse action" has the same meaning as in section 1681a(k) of the |
| 12 | | federal Fair Credit Reporting Act and includes a denial or cancellation |
| 13 | | of, an increase in any charge for, or a reduction or other adverse or |
| 14 | | unfavorable change in the terms of coverage or amount of any |
| 15 | | insurance, existing or applied for, in connection with the underwriting |
| 16 | | of insurance. |
| 17 | <u>(2)</u> | "Credit report" means any written, oral, or other communication of any |
| 18 | | information by a consumer reporting agency that bears on a |
| 19 | | consumer's credit worthiness, credit standing, or credit capacity. Credit |
| 20 | | report does not include accident or traffic violation records as |
| 21 | | maintained by the North Carolina Division of Motor Vehicles or any |
| 22 | | other law enforcement agency, a property loss report or claims history |
| 23 | | that does not include information that bears on a consumer's credit |
| 24 | | worthiness, credit standing, or credit capacity, or any report containing |
| 25 | | information solely as to transactions or experiences between the |
| 26 | | consumer and the person making the report. |

- "Credit score" means a score that is derived by utilizing data from an individual's credit report in an algorithm, computer program, model, or other process that reduces the data to a number or rating.

 (4) "Non-commercial private are a second by utilizing data from an individual's credit report in an algorithm, computer program, model, or other process that reduces the data to a number or rating.
 - "Non-commercial private passenger motor vehicle" means a "private passenger motor vehicle," as defined by G.S. 58-40-10, that is neither insured under a commercial policy nor used for commercial purposes.
 - (5) "Private passenger motor vehicle" has the same meaning as set forth in G.S. 58-40-10.
 - "Residential property" means real property with not more than four housing units located in this State, the contents thereof and valuable interest therein, and insurance coverage written in connection with the sale of that property. It also includes mobile homes, modular homes, townhomes, condominiums, and insurance on contents of apartments and rental property used for residential purposes.
 - (b) Prohibitions; Exceptions. In the rating and underwriting of non-commercial private passenger motor vehicle and residential property insurance coverage, insurers shall not use credit scoring as the sole basis for terminating an existing policy or any coverage in an existing policy or subjecting a policy to consent to rate, as specified in G.S. 58-36-30(b), but insurers may use credit scoring as the sole basis for discounting rates. For purposes of this subsection only, "existing policy" means a policy that has been in effect for more than 60 days.
 - (c) Notification. If a credit report is used in conjunction with other criteria to take an adverse action, the insurer shall provide the applicant or policyholder with written notice of the action taken, in a form approved by the Commissioner. The notification shall include, in easily understandable language:
 - (1) The specific reason for the adverse action and, if the adverse action was based upon a credit score, a description of the factors that were the primary influence on the score.
 - (2) The name, address, and toll-free telephone number of the credit bureau that provided the insurer with the credit-based information.
 - (3) The fact that the consumer has the right to obtain a free copy of the consumer's credit report from the appropriate credit bureau.
 - (4) The fact that the consumer has the right to challenge information contained in the consumer's credit report.
 - (d) Disputed Credit Report Information. If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite or re-rate the consumer within 30 days of receiving the notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting guidelines. If an insurer determines the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

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- Indemnification. An insurer shall indemnify, defend, and hold agents (e) harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, omissions of an agent who obtains or uses credit information or insurance scores for an insurer, provided the agent follows the instructions or procedures established by the insurer and complies with any applicable law or regulation. Nothing in this subsection shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this subsection.
- Filing. Insurers that use insurance scores to underwrite and rate risks shall (f) file their scoring models, or other scoring processes, with the Department. A filing that includes insurance scoring may include loss experience justifying the applicable surcharge or credit. A filer may request that its credit score data be considered a trade secret and may designate parts of its filings accordingly."
- SECTION 2. This act becomes effective January 1, 2004, and applies to policies issued or renewed on or after that date and to applications for coverage made on or after that date.

Proposed Amendment to SB 771 – Credit Scoring Limitation. House Insurance Committee; May 22, 2003

(b) Prohibitions; Exceptions. – In the rating and underwriting of non-commercial private passenger motor vehicle and residential property insurance coverage, insurers shall not use credit scoring as the sole basis for terminating an existing policy or any coverage in an existing policy or subjecting a policy to consent to rate, as specified in G.S. 558-36-30(b) without consideration of any other risk factors, but insurers may use credit scoring as the sole basis for discounting rates. For purposes of this subsection only, "existing policy" means a policy that has been in effect for more than 60 days.

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| 1st page Rep.) | , · · · · | | | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |
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NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT.

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| | EDITION No. |
| <u> </u> | H. B. No DATE |
| | S. B. No. 77/ |
| | COMMITTEE SUBSTITUTE (to be filled in by |
| | Second page Rep.) Principal Clerk) |
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| | Sen.) |
| 1 | moves to amend the bill on page, line, |
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| 5 | 12 months of coverage or the actual |
| 6 . | policy period. |
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| 9 _ | and on pare 2, line 21 |
| 10 _ | by recording the line to read |
| 11 | "been in effect for more than 100 due 11. |
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| 13 | and on page 1 lines 2-34 |
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NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

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| | Rep.) Holliman Sen.) | | | |
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| 3 | by rewriting the | line to r | ead: | |
| 4 | <u>"G.S. 38-3</u> | 6-30 (b) | without | - consideration |
| 5 | of any other ri | sk fact | ors but | insurers may |
| 6 | use credit sc | oring as | the sole | basis for |
| 7 | discounting " | <u> </u> | | |
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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

S

SENATE BILL 962

1

Short Title: Require Affidavits of Bail Bondsmen.

(Public)

Sponsors:

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Senators Swindell; Gulley, Metcalf, and Thomas.

Referred to: Judiciary II.

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE BAIL BONDSMEN TO SUBMIT AFFIDAVITS STATING THAT THERE ARE NO PREMIUMS OWED TO FORMER INSURERS AND THAT ALL FORFEITURES OR JUDGMENTS ARE SATISFIED OR DISCHARGED.

The General Assembly of North Carolina enacts:

SECTION 1. Article 71 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-71-141. Appointment of bail bondsmen; affidavit required.

- Prior to receiving an appointment, a surety bondsman shall submit to the (a) Commissioner an affidavit, signed under oath, by the surety bondsman and by any former insurer, stating that the surety bondsman does not owe any premium or unsatisfied judgment to any insurer and that the bondsman agrees to discharge all outstanding forfeitures and judgments on bonds previously written. The affidavit shall be in a form prescribed by the Commissioner. If the surety bondsman does not satisfy or discharge all forfeitures or judgments, the former insurer shall submit a notice, with supporting documents, to the appointing insurer, the surety bondsman, and the Commissioner, which states, under oath, that the surety bondsman has failed to satisfy, in a timely manner, the forfeitures and judgments on bonds written by the surety bondsman and that the former insurer has satisfied the forfeiture or judgment from its own funds. Upon receipt of the notification and supporting documents, the appointing insurer shall immediately cancel the surety bondsman's appointment. The surety bondsman may be reappointed only upon certification by the former insurer that all forfeitures and judgments on bonds written by the surety bondsman have been discharged. The appointing insurer or surety bondsman may, within 10 days of the receipt of notice from the former insurer, appeal to the Commissioner.
- (b) The Commissioner shall adopt rules, including rules regarding the process of appeals and stays of the requirements of this section, to implement this section.

GENERAL ASSEMBLY OF NORTH CAROLINA

| 1 | (c) As used in this section, "former insurer" means the insurer with whom the |
|---|--|
| 2 | surety bondsman had a prior appointment and who is responsible for any outstanding |
| 3 | bonds written by the surety bondsman." |
| 4 | SECTION 2. This act becomes effective October 1, 2003, and applies to all |
| 5 | appointments of bondsmen on or after that date. |

appointments of bondsmen on or after that date.



SENATE BILL 962: Require Affidavits of Bail Bondsmen



BILL ANALYSIS

House Insurance Committee Committee:

Date:

May 22, 2003

Version:

1st Edition

Introduced by: Senator Swindell

Summary by:

Tim Hovis

Committee Counsel

SUMMARY: SB 962 requires a surety bondsman to submit a sworn affidavit to the Commissioner of Insurance stating the bondsman does not owe any premium or unsatisfied judgment to any insurer before the bondsman may receive an appointment to a new insurer.

A "surety bondsman" is a person who is licensed by the Commissioner, and is appointed by an insurer to execute bail bonds for the insurer. Insurers are required to provide the Commissioner annually with a list of the surety bondsmen appointed by the insurer. Upon terminating an appointment, the insurer must file a written notice with the Commissioner as well as the clerk of superior court of any county in the State in which the insurer has been obligated on bail bonds through the surety bondsman. The surety bondsman is required to register his or her current license with the clerk of superior court in the county where the bondsman resides as well as any county where he or she writes bail bonds. The Commissioner may suspend, revoke or refuse to renew a bondsman license for, among other things, failing to pay any judgment or decree rendered on any forfeited undertaking and any fraudulent or dishonest practice in the conduct of business.

BILL ANALYSIS: SB962 adds a new section to Article 71 of Chapter 58. It provides that a surety bondsman must file an affidavit with the Commissioner before being appointed by a new insurer. The affidavit must state that the bondsman does not owe any premium or unsatisfied judgment to any insurer and the bondsman agrees to discharge all outstanding forfeitures and judgments on bonds previously written. If those obligations are not satisfied, the former insurer shall notify the Commissioner and the new appointing insurer that the bondsman has failed to satisfy the outstanding obligations. The new insurer is supposed to revoke any appointment until the former insurer certifies that the obligations have been satisfied.

The Commissioner is directed to adopt rules to implement the act.

"Former insurer" means the insurer with whom the surety bondsman had a prior appointment and who is responsible for any outstanding bonds written by the surety bondsman.

The act is effective October 1, 2003 and applies to appointments of surety bondsmen made on and after that date.

This summary was contributed to by Kory J. Goldsmith, Staff Attorney, Research Division.

S962-SMRC-001



SENATE BILL 887: Ovarian Cancer Det./High Risk Women



Committee: House Insurance

Date: Version: May 21, 2003

Second Edition

Introduced by: Senators Carpenter, Dannelly,

Purcel1

Summary by: Sandra Alley

Committee Counsel

SUMMARY: SB887 would require every health benefit plan and every standard health care plan for small employers to include coverage for surveillance tests for women age 25 and older who are at risk of ovarian cancer. The act becomes effective January 1, 2004 and applies to all health benefit plans delivered, issued for delivery, or renewed on and after that date.

CURRENT LAW: There is no current statutory requirement that health plans include coverage for surveillance tests for ovarian cancer. However, the standard health plan for small employers is required to include coverage for Mammograms, pap smears, prostate-specific antigen tests and colorectal cancer examinations and laboratory tests. Health benefit plans as defined under G.S. 58-3-167 are required to include coverage for colorectal cancer examinations and laboratory tests for cancer.

A health benefit plan as defined in G.S. 58-3-167 means an accident and health insurance policy; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract, a plan provided by a multiple employer welfare arrangement, or a plan provided by another benefit arrangement, to the extent permitted by the ERISA. It does not include any plan implemented or administered by the State of North Carolina or the United States Department of Health and Human Services.

The standard health care plan for small employers is a health benefit plan developed under Article 50, Part 5 of Chapter 58. A small employer is an employer that employs no more than 50 eligible employees, the majority of whom are employed within North Carolina.

BILL ANALYSIS:

Section 1 requires health benefit plans as defined in G.S. 58-3-167 to provide coverage for surveillance tests for women age 25 and older who are at risk of ovarian cancer. Surveillance tests means annual screening using transvaginal ultrasound and rectovaginal pelvic examination. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan would apply to coverage for transvaginal ultrasound and rectovaginal pelvic examination.

A woman is at risk for ovarian cancer if she has a family history of ovarian cancer or she tests positive for hereditary ovarian cancer syndrome. A women has a family history of ovarian cancer if she has at least one first –degree relative with ovarian cancer and at least one first-degree or second-degree relative with breast, ovarian, or nonpolyposis colorectal cancer. The bill does not define "herediatary ovarian cancer syndrome." However, medical literature identifies three hereditary syndromes that predispose to ovarian cancer: 1. the breast-ovarian cancer syndrome due to mutations in the tumor suppressor genes BRCA1 and BRCA2, 2. Lynch syndrome II, and 3. hereditary site specific ovarian cancer.

Section 2 requires that the standard health plan for small employers provide coverage for surveillance tests for women at risk for ovarian cancer. The same terms and requirements of Section 1 would apply.

SENATE BILL 887

Page 2

SB887 does not apply to the State Health Plan because the definition of "health benefit plan" in G.S. 58-3-67 does not include the State Health Plan.

BACKGROUND: Five to ten percent of individuals who develop ovarian cancer have an inherited genetic susceptibility to the disease. Generally, the risk of developing ovarian cancer increases as the number of family members affected by ovarian cancer increases. Having a first-degree relative affected by ovarian cancer (for example, a mother or a sister) increases a woman's lifetime risk from 1.4% to 3.1%. Those at greatest risk for inherited genetic susceptibility have a personal or family history of ovarian and/or breast cancer.

EFFECTIVE DATE: January 1, 2004S887

Kory Goldsmith, Staff Attorney, contributed significantly to this report.

S887-SMSP-001

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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SENATE BILL 887 Commerce Committee Substitute Adopted 4/23/03

| | Short Title: Ovarian Cancer Det./High Risk Women | n. (Public) |
|----|---|--------------------------------------|
| | Sponsors: | |
| | Referred to: | |
| | April 3, 2003 | |
| 1 | A BILL TO BE ENTIT | CLED |
| 2 | | GE FOR SURVEILLANCE TESTS |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | · · · · · · · · · · · · · · · · · · · | amended by adding the following |
| 7 | • | |
| 8 | | omen at risk for ovarian cancer. |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 | | ther: |
| 13 | a. Having a family history: | |
| 14 | | first-degree relative with ovarian |
| 15 | - | |
| 16 | 2. At least one first-deg | ree or second-degree relative with |
| 17 | breast, ovarian, or nor | polyposis colorectal cancer; or |
| 18 | b. Testing positive for a heredit | ary ovarian cancer syndrome. |
| 19 | (2) 'Surveillance tests' mean annual scre | eening using: |
| 20 | <u>a.</u> <u>Transvaginal ultrasound; and </u> | |
| 21 | b. Rectovaginal pelvic examina | tion. |
| 22 | (b) The same deductibles, coinsurance, and o | ther limitations as apply to similar |
| 23 | | |
| 24 | rectovaginal pelvic examinations required to be cover | red under this section." |
| 25 | SECTION 2. G.S. 58-50-155 reads as rev | vritten: |
| 26 | 5 "§ 58-50-155. Standard and basic health care plan | ı coverages. |
| 27 | (a) Notwithstanding G.S. 58-50-125(c), the s | tandard health plan developed and |
| 28 | approved under G.S. 58-50-125 shall provide coverage | ge for all of the following: |

GENERAL ASSEMBLY OF NORTH CAROLINA

| 1 | (1) | Mammograms and pap smears at least equal to the coverage required |
|----|-------------------|---|
| 2 | | by G.S. 58-51-57. |
| 3 | (2) | Prostate-specific antigen (PSA) tests or equivalent tests for the |
| 4 | | presence of prostate cancer at least equal to the coverage required by |
| 5 | | G.S. 58-51-58. |
| 6 | (3) | Reconstructive breast surgery resulting from a mastectomy at least |
| 7 | | equal to the coverage required by G.S. 58-51-62. |
| 8 | (4) | For a qualified individual, scientifically proven bone mass |
| 9 | | measurement for the diagnosis and evaluation of osteoporosis or low |
| 10 | | bone mass at least equal to the coverage required by G.S. 58-3-174. |
| 11 | (5) | Prescribed contraceptive drugs or devices that prevent pregnancy and |
| 12 | | that are approved by the United States Food and Drug Administration |
| 13 | | for use as contraceptives, or outpatient contraceptive services at least |
| 14 | | equal to the coverage required by G.S. 58-3-178, if the plan covers |
| 15 | | prescription drugs or devices, or outpatient services, as applicable. The |
| 16 | | same exceptions and exclusions as are provided under G.S. 58-3-178 |
| 17 | | apply to standard plans developed and approved under G.S. 58-50-125. |
| 18 | (6) | Colorectal cancer examinations and laboratory tests at least equal to |
| 19 | | the coverage required by G.S. 58-3-179. |
| 20 | <u>(7)</u> | Surveillance tests at least equal to coverage required by G.S. 58-3-266. |
| 21 | | pealed by Session Laws 1999-197, s. 2. |
| 22 | | thstanding G.S. 58-50-125(c), in developing and approving the plans |
| 23 | | 0-125, the Committee and Commissioner shall give due consideration to |
| 24 | cost-effective as | nd life-saving health care services and to cost-effective health care |
| 25 | providers." | |
| 26 | | TION 3. This act becomes effective January 1, 2004, and applies to all |
| 27 | | ans that are delivered, issued for delivery, or renewed on and after that |
| 28 | | rposes of this act, renewal of a health benefit plan is presumed to occur |
| 29 | | sary of the date on which coverage was first effective on the person or |
| 30 | persons covered | by the health benefit plan. |

| HOUSE COMMITTE ON INSURANCE |
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5-2203

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|-------------------|----------------------------|
| BILL HALE | JURDAN PRICE LAWFIRM |
| an Dunen | NUAHP |
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| John McMillan | MFAS |
| Barban Caroli | |
| Steve Woodson | IK Tem Buren |
| Camile Stell | KCLH |
| David Stoller | SPAKE FARM |
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| Stephanie Simpson | NCAR |
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| <u>HOUSE COMMITTTE ON INSURANCE</u> |
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5-2203

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Mask Blace | ncoaa |
| Will Ween | NEGHA |
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| 1. | Name: KC Immler | Re conside |
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| 2. | Name: | |
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| 4. | Name: | |
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| 5. | Name: | |
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| | Sponsor: | : |

Name: OR. FAANUS POUE

Name: JACKSON STANCIL

Name: CHARLES WILLAMS

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. | |
|--|---|
| S.E | Committee Substitute for 962 A BILL TO BE ENTITLED AN ACT TO REQUIRE BAIL BONDSMEN TO SUBMIT AFFIDAVITS STATING THAT THERE ARE NO PREMIUMS OWED TO FORMER INSURERS AND THAT ALL FORFEITURES OR JUDGMENTS ARE SATISFIED OR DISCHARGED. |
| Ą | 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 (#), \(\subseteq \) 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) 03/19/03 |

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. S.B. 887 A BILL TO BE ENTITLED AN ACT TO MANDATE INSURANCE COVERAGE FOR SURVEILLANCE TESTS FOR WOMEN AGE TWENTY-FIVE AND OLDER AND AT RISK FOR OVARIAN CANCER. 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 # 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)

03/19/03

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. Committee Substitute for A BILL TO BE ENTITLED AN ACT TO LIMIT THE USE OF A PERSON'S S.B. 771 CREDIT HISTORY FOR DISCOUNTING RATES ON AUTOMOBILE AND HOMEOWNERS' INSURANCE AND TO PROHIBIT THE USE OF A PERSON'S CREDIT HISTORY AS A SOLE BASIS FOR TERMINATING INSURANCE COVERAGE OR SUBJECTING A POLICY TO CONSENT TO RATE. 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 # recommendation that the committee substitute bill #) be re-referred to the Committee on .) With a favorable report as to House committee substitute bill (#-), Twhich 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) 03/19/03

MINUTES

HOUSE INSURANCE COMMITTEE

MAY 27, 2003

Chair Holliman called the meeting to order at 10:00 AM on Tuesday, May 27, 2003. The following members were present: Hugh Holliman, Mitchell Setzer, Lucy Allen, Bobby Barbee, Howard Hunter, Charles Johnson, David Lewis, Karen Ray, Drew Saunders, William Wainwright and Connie Wilson.

Chair Holliman called on Representative Barbee to bring forth the proposed committee substitute. The committee voted in favor of the PCS. Chair Holliman called on Senator Dalton to explain SB-775- PRELITIGATION MEDIATION OF INSURANCE CLAIMS. SB-775 would establish a method for an injured party to obtain information on policy limits from an insurance company prior to litigation in exchange for the injured party being willing to enter into mediation on the claim prior to filing suit. See Attachment I. Rep. Connie Wilson brought forth an amendment. See Attachment II. The amendment passes and Rep. Wilson made a motion for a favorable report. The motion carries.

Chair Holliman called on Senator Hartsell to explain SENATE BILL 469-UNFAIR TRADE PRACTICES/LIFE INSURANCE SALES. He explained what's unfair or deceptive about this bill. Ron Gibson, Attorney from Charlotte spoke on how this bill affects independent agencies. After much discussion and due to the time restraints the meeting was adjourned.

See attachment V for the visitors.

Chair Hugh Holliman

Chair Mitchell Setzer

Carol Bowers, Joanna/Mills, Clerks



SENATE BILL 775: Prelitigation Mediation of Insurance Claims

BILL ANALYSIS

Committee: House Insurance

Date:

May 19, 2003

Version:

S775-CSSP-12[v.1/2

Introduced by: Sen. Dalton

Summary by:

Sandra Alley

Committee Counsel

Senate Bill 775 would establish a method for an injured party to obtain information on SUMMARY: policy limits from an insurance company prior to litigation in exchange for the injured party being willing to enter into mediation on the claim prior to filing suit.

The PCS to S775 eliminated language that would have required insurers to provide information regarding policy provisions to injured parties who requested that information. A party must make the request regarding policy limits to the insurance company's home office and the company has fifteen days to reply, rather than the five allowed in the original version. In addition, the effective date was changed from October 1, 2003 to January 1, 2004.

Currently an insurance company is not required to disclose policy limits to a third **CURRENT LAW:** party to the policy who may have a liability claim against the policyholder, prior to a lawsuit being filed. There is also no current law that allows an insurer to initiate a mediation process with a person claiming against the insured's policyholder.

Section 1 of the bill requires an insurer to furnish information concerning the **BILL ANALYSIS:** policy limits to a person who claims to have been injured or damaged by another covered by the insurance policy provided that the injured person agrees to participate in mediation of the claim prior to litigation, authorizes release to the insurance company of the person's medical records for the prior three years, and submits a copy of the accident report containing the financial responsibility information of the insurer's policyholder. Once the injured person has submitted this information to the insurer, the insurer is required to furnish the information about the policy within 30 days.

The information the insurer is required to provide under Section 1 would be discoverable by a party to a lawsuit after the lawsuit is filed under current law. Even though the information is disclosed, either under this bill or through discovery, the insurance information is not admissible in evidence in a trial by reason of this disclosure, and generally is not admissible in personal injury or property damages cases. This section does not apply in medical malpractice claims.

Section 2 establishes the procedures for prelitigation mediation of insurance claims. The insurer initiates the mediation after having provided the insurance information to the injured party as required under Section 1 of the bill. The costs of mediation are to be paid by the insurer. The mediation shall be conducted in accordance with the standard mediation procedures for civil cases in accordance with rules adopted by the Supreme Court to carry out this law. Once the mediation is concluded, the mediator files a certification on the mediation with the clerk. Time periods, including any statutes of limitation, are suspended during the mediation and for a period of 30 days after the mediation concludes. The mediation procedure provided for under this section does not apply to malpractice claims.

SENATE BILL 775

Page 2

EFFECTIVE DATE: This bill becomes effective January 1, 2004, and applies to injuries and property damage that occurs on or after the effective date.

Walker Reagan, Staff Attorney, contributed significantly to this report.

S775-SMSP-001



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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(Public)

SENATE BILL 775

Commerce Committee Substitute Adopted 4/14/03 PROPOSED HOUSE COMMITTEE SUBSTITUTE S775-CSSP-12 [v.2]

5/27/2003 9:47:30 AM

Short Title: Prelitigation Mediation of Insurance Claims.

| Sponsors: |
|---|
| Referred to: |
| April 3, 2003 |
| A BILL TO BE ENTITLED |
| AN ACT TO CONDITIONALLY REQUIRE INSURERS TO PROVID |
| INFORMATION REGARDING POLICY LIMITS PRIOR TO LITIGATIO |
| WHEN REQUESTED IN WRITING BY THE PERSONS WHO HAVE CLAIM |
| OTHER THAN MEDICAL MALPRACTICE CLAIMS, SUBJECT TO NON |
| FLEET PRIVATE PASSENGER AUTOMOBILE INSURANCE POLICIES AN |
| TO GIVE THESE INSURERS THE OPTION OF INITIATING PRELITIGATIO |
| MEDIATION OF THE CLAIMS. |
| 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: |
| "§ 58-3-33. Insurer conditionally required to provide information. |
| (a) A person who claims to have been physically injured or to have incurred |
| property damage where such injury or damage is subject to a policy of non-fleet priva |
| passenger automobile insurance may request by certified mail directed to the insurance |
| company at its last known principal place of business that the insurance compar |
| provide information regarding the policy's limits of coverage under the applicab |
| policy. Upon receipt of such a request, which shall include the policyholder's name, ar |
| if available, policy number, the insurance company shall notify that person with |
| fifteen business days, on a form developed by the Department, that the insurer |

required to provide this information prior to litigation only if the person seeking the

The person seeking the information submits to the insurer the person's

written consent to the person's physicians to release to the insurer the

person's medical records for the three years prior to the date on which

information satisfies all of the following conditions:

the claim arose.

(1)

- (2) The person seeking the information submits to the insurer the person's written consent to participate in mediation of the person's claim under G.S. 7A-38.3A.
- (3) The person seeking the information submits to the insurer a copy of the accident report required under G.S. 20-166.1 and a description of the events at issue with sufficient particularity to permit the insurer to make an initial determination of the potential liability of its insured..

- (b) Within 30 days of receiving the person's written documents required under subsection (a) of this section, the insurer shall provide the policy limits and a copy of the policy to that person.
- (c) <u>Disclosure of the policy limits under this section shall not constitute an</u> admission that the alleged injury or damage is subject to the policy.
- (d) This section does not apply to claims seeking recovery for medical malpractice or claims for which an insurer intends to deny coverage under any policy of insurance."

SECTION 2. Article 5 of Chapter 7A of the General Statutes is amended by adding a new section to read:

"§ 7A-38.3A. Prelitigation mediation of insurance claims.

(a) Initiation of Mediation. – Prelitigation mediation of an insurance claim may be initiated by an insurer that has provided the policy limits in accordance with G.S. 58-3-33 by filing a request for mediation with the clerk of superior court in a county in which the action may be brought. The insurer also shall mail a copy of the request by certified mail, return receipt requested, to the person who requested the information under G.S. 58-3-33.

(b) Costs of Mediation. – Costs of mediation, including the mediator's fees, shall be borne by the insurer. When an attorney represents a party to the mediation, that party shall pay his or her attorneys' fees.

(c) Mediation Procedure. – Except as otherwise expressly provided in this section, mediation under this section shall be conducted in accordance with the provisions for mediated settlement of civil cases in G.S. 7A-38.1 and G.S. 7A-38.2, and rules and standards adopted pursuant to those sections. The Supreme Court may adopt additional rules and standards to implement this section, including an exemption from the provisions of G.S. 7A-38.1 for cases in which mediation was attempted under this section.

(d) Certification That Mediation Concluded. – Upon the conclusion of mediation, the mediator shall prepare a certification stating the date on which the mediation was concluded and the general results of the mediation, including, as applicable, that an agreement was reached, that mediation was attempted but an agreement was not reached, or that one or more parties, to be specified in the certification, failed or refused without good cause to attend one or more mediation meetings or otherwise participate in the mediation. The mediator shall file the original of the certification with the clerk and provide a copy to each party. Each party to the mediation has satisfied the requirements of this section upon the filing of the certification, except any party specified in the certification as having failed or refused to attend one or more mediation meetings or

mediation conducted under this section.

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Time Periods Tolled. - Time periods relating to the filing of a claim or the taking of other action with respect to an insurance claim, including any applicable statutes of limitations, shall be tolled upon the filing of a request for mediation under this section, until 30 days after the date on which the mediation is concluded as set forth in the mediator's certification or, if the mediator fails to set forth such date, until 30 days after the filing of the certification under subsection (d) of this section.

otherwise participate. The sanctions in G.S. 7A-38.1(g) do not apply to prelitigation

Medical Malpractice Claims Excluded. - This section does not apply to claims seeking recovery for medical malpractice."

SECTION 3. This act becomes effective January 1, 2004, and applies to claims regarding physical injury or property damage that arise on or after that date.

Attachment II



NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

Senate Bill 775

| | AMENDMENT I | |
|---|----------------------------|-----------------|
| | (to be filled in by | · |
| S775-ASP-5 [v.1] | Principal Clerk) | |
| | | Page 1 of 1 |
| · | Date | ,2003 |
| Comm. Sub. [NO] Amends Title [NO] S775-CSSP-12[v.1] | | |
| Representative C. Wilson | | |
| moves to amend the bill on page 2, line 26 by rew | vriting that line to read: | |
| "be borne by the insurer and claimant equally." the mediation, that party". | When an attorney represe | ents a party to |
| | | |
| SIGNED Conne Whi | | |
| Amendment Sponsor | | |
| SIGNED | | |
| Committee Chair if Senate Committee Amendme | nt | |
| ADOPTED FAILED | TABLED | |

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SENATE BILL 469: Unfair Trade Practices/Life Insurance Sales

Committee:

House Insurance

Date:

May 23, 2003

Version:

2nd Edition

Introduced by: Senator Hartsell

Summary by:

Kory J. Goldsmith

Committee Counsel

SUMMARY: Senate Bill 469 would provide that certain conditions placed on the sale of life insurance policies and financial services are unfair and deceptive trade practices.

Article 63 of Chapter 58, Unfair Trade Practices, regulates unfair methods of competition and trade practices in the business of insurance.

Senate Bill 469 would provide that requiring nonemployee, exclusive agents to sell (1) a specified number of policies in relation to the sale of property or casualty insurance or (2) a specific level of financial services, as a condition of continuing an exclusive contract, is an unfair trade practice.

Under current law, the Commissioner of Insurance is authorized to investigate and issue a cease and desist order for persons violating the provisions of this Chapter. Persons violating a cease and desist order are subject to a penalty of not less than \$1,000 nor more than \$5,000 for each violation.

EFFECTIVE DATE: Senate Bill 469 is effective October 1, 2003.

S469-SMRC-002

Tim Hovis contributed substantially to this summary.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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SENATE BILL 469 Commerce Committee Substitute Adopted 4/17/03

| | Short Title: Unfair Trade Practices/Life Insurance Sales. | (Public) |
|----|---|-----------------------------|
| | Sponsors: | |
| | Referred to: | |
| | March 20, 2003 | |
| 1 | A BILL TO BE ENTITLED | |
| 2 | AN ACT TO PROVIDE THAT CERTAIN CONDITIONS PLACED OF | NEXCLUSIVE |
| 3 | AGENCY CONTRACTS FOR THE SALE OF LIFE INST | URANCE OR |
| 4 | FINANCIAL SERVICES ARE UNFAIR METHODS OF COMPE | ETITION AND |
| 5 | UNFAIR OR DECEPTIVE TRADE PRACTICES. | |
| 6 | The General Assembly of North Carolina enacts: | |
| 7 | SECTION 1. G.S. 58-63-15 is amended by adding a new | subdivision to |
| 8 | read: | |
| 9 | "(14) Sale of Life Insurance or Financial Services. | Requiring |
| 10 | nonemployee, exclusive agents who have exclusive ag | gency contracts |
| 11 | or agreements with an insurer as of January 1, 2002 to | sell either (i) a |
| 12 | specified number of life and health insurance policies in | n relation to the |
| 13 | sale of property and casualty insurance or (ii) a sp | pecific level of |
| 14 | financial services, as a condition of continuing the ex | clusive agency |
| 15 | contract or agreement. This subdivision does not app | ly to insurance |
| 16 | agents who do not offer property or casualty lines of ins | surance." |
| 17 | SECTION 2. This act becomes effective October 1, 2003. | |

Attachment I

VISITOR REGISTRATION SHEET

'HOUSE INSURANCE COMMITTEE

May 27, 2003

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
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| andhum | |
| Allen Janes | NCAHP |
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'HOUSE INSURANCE COMMITTEE

May 27, 2003

Name of Committee

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'HOUSE INSURANCE COMMITTEE

May 27, 2003

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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May 27, 2003

Name of Committee

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House Pages

| 1. | Name: Tiffany Correll | |
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| | County: Forsyth | |
| | Sponsor: <u>Parmon</u> | |
| 2. | Name: Courtney Courty | |
| | County: GASTON | |
| | Sponsor: DEBBIE Clarect | |
| 3. | Name: Qua'Shonda Patterson | |
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| Sgt- | -At-Arms | |
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| 2. | Name: ChARLES Williams | м |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. Committee Substitute for S.B. 775 A BILL TO BE ENTITLED AN ACT TO CONDITIONALLY REQUIRE INSURERS TO PROVIDE INFORMATION REGARDING POLICY PROVISIONS AND POLICY LIMITS PRIOR TO LITIGATION WHEN REQUESTED IN WRITING BY THE PERSONS WHO HAVE CLAIMS, OTHER THAN MEDICAL MALPRACTICE CLAIMS, SUBJECT TO INSURANCE POLICIES AND TO GIVE THESE INSURERS THE OPTION OF INITIATING PRELITIGATION MEDIATION OF THE CLAIMS. 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 With a favorable report as to House committee substitute bill-(#___ 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)

MINUTES

HOUSE INSURANCE COMMITTEE

May 29, 2003

Representative Setzer called the meeting to order at 10:05 AM on May 29, 2003 and introduced the pages and Sgt. At Arms and the visitors. See Attachments I & 2. The members is attendance were: Reps. Holliman, Setzer, Allen, Barbee, Wainwright, Saunders, Grady, Lewis, Johnson, L. Johnson, Hunter and Rick Eddins.

Chair Setzer called on Rep. Martha Alexander to explain HB-654-MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY. See Attachments 3 & 4.

John Tote and B. J. McMillian spoke in support of this legislation. George Teague, Paul Mahoney, Robert Paschal, Julie Woodson and Joyce Peters spoke against this legislation. See attached notes from these speakers.

Rep. Holliman spoke in favor if this bill and ask the committee to consider passing this bill. Rep. Saunders motioned for adjournment due to time restraints and that the members need more time to discuss this bill. The meeting was adjourned at 11:45 AM.

Chair Hugh Holliman

Chair Mitchell Setzer

Carol Bowers & Joanna Mills, Clerks

Attachment

VISITOR REGISTRATION SHEET

| HOUSE COMMITTE ON INSURANCE | May 29, 2003 | |
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| Name of Committee | Date | |

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Jernifor U. Sulivan | NASO NC/Coolur 200 |
| Jennifer Mahan | MHAINC |
| John Toteth | MHA.NC |
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VISITOR REGISTRATION SHEET

HOUSE COMMITTE ON INSURANCE

May 29, 2003

Name of Committee

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| Don Willis | DMH DDS ME |
| Julie Wooden | NCCBL |
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| Paula A. Wolf. | Covenant W/Wc's Children |
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HOUSE COMMITTE ON INSURANCE

May 29, 2003

Name of Committee

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House Pages

| 1. | Name Cherrelle Dunoton |
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| | Sponsor: Stan-Foxx |
| 2. | Name: Tiffany Correll |
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| | Sponsor: Parmon |
| 3. | Name: Kolonya Stanlay (Klena |
| | County: Cherohee |
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| Søt- | At-Arms |
| | Maril D |
| 1. | |
| 2. | Name: CHARIES GRAdy |
| 3. | Name: FRANCIS POOLE |
| 4. | Name: CHARIES Williams |



MENTAL HEALTH/CHEMICAL **DEPENDENCY PARITY:** House Bill 654



BILL ANALYSIS

Committee: House Insurance

Date:

May 29, 2003

Version:

H654-PCS30323-LN-23

Introduced by: Reps. Alexander, Insko,

Hackney, Wainwright

Summary by:

Sandra Alley

Committee Counsel

SUMMARY OF ORIGINAL BILL: House Bill 808 would mandate coverage of mental illness and chemical dependency and require that the coverage would be at full parity with covered benefits for physical illness. Health benefit plans must provide the same day and visit limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits and nay other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. The bill allows insurers to impose utilization management measures on covered benefits for mental illness and chemical dependency, even if those measures are not placed on covered benefits for physical illness. The act becomes effective January 1, 2004.

The PCS does 3 things:

- (1) Requires that if a health plan provides coverage for mental illness or chemical dependency, then the benefits for the care and treatment of mental illness and chemical dependency must be no less favorable than the benefits for physical illness generally.
- (2) Requires the Commissioner of Insurance to conduct a study and analysis of the impact of providing mental health benefits at parity with benefits for physical illness generally.
- (3) Requires that every insurer that provides health plan benefits for mental illness/chemical dependency shall provide written notice upon initial issuance or renewal of health benefit plans stating that State law requires parity among benefits for mental illness/chemical dependency and physical illness generally.

CURRENT LAW: Chemical Dependency: Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. If the group policyholder accepts the coverage, the benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than \$8,000 in total annual benefits for all illnesses under the policy, it must also provide chemical dependency coverage of at least \$8,000 per year and at least \$16,000 over the lifetime of the policy.

Mental illness: Insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans.

Self-funded plans: Plans governed by ERISA are subject to the federal Mental Health Parity Act of 1996. The Act prohibits these plans from imposing annual or lifetime dollar limits on reimbursement ceilings

MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY

Page 2

for mental health benefits that are more restrictive than those applied to care for physical illness. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement

BILL ANALYSIS:

- (1) Requires that if a health plan provides coverage for mental illness or chemical dependency, then the benefits for the care and treatment of mental illness and chemical dependency must be no less favorable than the benefits for physical illness generally. Benefits for mental illness/chemical dependency must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as apply to physical illness generally. In providing parity for covered benefits for mental illness/chemical dependency, an insurer may use a case management program to evaluate and determine medically necessary and medically appropriate care and treatment for each patient. A health plan may manage benefits through common methods, including preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage only to services deemed to be medically necessary. Benefits for chemical dependency treatment shall be payable for specified providers in both facilities and in outpatient settings. Sections 1 and 2 make statutory changes to this effect for group health plans. Sections 3 and 4 make statutory changes to this effect for group subscriber contracts. Sections 5 and 6 make statutory changes to this effect for Health Maintenance Organizations. Section 7 makes statutory changes to this effect for small employer plans.
- (2) Requires the Commissioner of Insurance to conduct a study and analysis of the impact of providing mental health benefits at parity with benefits for physical illness generally. The study must address: (i) whether there is a decrease in the number of health benefit plans that offer coverage for mental health and chemical dependency treatment, (ii) the cost providing mental health/chemical dependency treatment in terms of premium costs and claims payments; and (iii) the scope of coverage provided by health benefit plans for mental illness/chemical dependency. The Commissioner must report his findings on January 15, 2005 and again on May 1, 2006.
- (3) Requires that every insurer that provides health plan benefits for mental illness/chemical dependency shall provide written notice upon initial issuance or renewal of health benefit plans stating that State law requires parity among benefits for mental illness/chemical dependency and physical illness generally.

Provisions remaining from the original bill:

Cost Control Provisions:

Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case. Plans will meet the parity requirements in the bill if at least one of the patient's choices of treatment options within the patient's policy meets the parity requirement.

MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY

Page 3

Definitions of Mental Illness and Chemical Dependency:

Chemical Dependency:

Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as the "pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal." Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines "chemically dependent" in the same manner, but the bill adds a requirement that the dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions).

Mental Illness:

Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MH/DD/SA Act defines "mental illness" as follows: "(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment. "(GS 122C-3(21)).

The act becomes effective January 1, 2004.

BACKGROUND: According to a study conducted by Medstat Group for the Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD, 56% of the funding for mental health and substance abuse treatment in 1997 was paid by the public sector, up from 53% in 1987. According to the same study, spending for mental health and substance abuse treatment nationwide reached \$85.3 billion in 1997. There has been a decline in private insurers' real spending for substance abuse services between 1987 and 1997 of 0.6%.

Gann Watson, Drafting Division Staff Attorney, and Linda Attarian, former Research Division Staff Attorney, contributed substantially to this summary.

H654-SMSP-003

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 654 PROPOSED COMMITTEE SUBSTITUTE H654-PCS30323-LN-23

| Short Title: Mental Health/Chemical Dependency Parity. | (Public) |
|---|--|
| Sponsors: | |
| Referred to: | The second secon |
| March 25, 2003 | |
| A BILL TO BE ENTITLED | |
| AN ACT TO PROVIDE THAT HEALTH INSURANCE POLICI | ES THAT COVER |
| MENTAL ILLNESS AND CHEMICAL DEPENDENCY P | |
| WITH COVERAGE FOR PHYSICAL ILLNESS GENERAL | |
| SAME POLICY. | |
| 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) As used in this section, the term "chemical dependency" n | neans-term: |
| (1) 'Chemical dependency' means the pathological use | or abuse of alcohol |
| or other drugs in a manner or to a degree that prod | luces an impairment |
| in personal, social or occupational functioning a | nd which may, but |
| need not, include a pattern of tolerance and withdra | wal. |
| (2) 'Health benefit plan' has the same meaning as in G. | <u>S. 58-3-167.</u> |
| (3) 'Insurer' has the same meaning as in G.S. 58-3-167. | 1 |
| (b) Every insurer that writes a policy or contract of group | p or blanket health |
| insurance or group or blanket accident and health insurance that is | |
| amended on or after January 1, 1985, shall offer to its insured | s benefits provides |
| coverage for the necessary care and treatment of chemical depender | * |
| the benefits for the necessary care and treatment of chemical depe | • |
| less favorable than benefits for physical illness generally. Exc | |
| subsection (c) of this section, benefits Benefits for treatment of ch | _ |
| shall be subject to the same durational limits, dollar limits, deductible | |
| factors as are benefits for physical illness generally. An insure | |
| management program for chemical dependency treatment benefit | |
| determine medically necessary and medically appropriate care and | |
| patient, provided that the program complies with rules adopted by | |
| Nothing in this section prohibits a group health benefit plan t | from managing the |

provision of benefits through common methods, including, but not limited to, 1 preadmission screening, prior authorization of services, or other mechanisms designed 2 3 to limit coverage only to services for chemical dependency treatment that are deemed 4 medically necessary. 5 Every group policy or group contract of insurance that provides benefits for (c) 6 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: 7 8 The policy or contract shall-provide, for each 12-month period, a 9 minimum benefit of eight thousand dollars (\$8,000) for the necessary 10 care and treatment of chemical dependency. 11 $\left(2\right)$ The policy or contract shall provide a minimum benefit of sixteen 12 thousand dollars (\$16,000) for the necessary care and treatment of 13 chemical dependency for the life of the policy or contract. 14 Provisions for benefits for necessary care and treatment of chemical (d) 15 dependency in group policies or group contracts of insurance shall provide benefit 16 payments for the following providers of necessary care and treatment of chemical 17 dependency: The following units of a general hospital licensed under Article 5 of 18 (1) 19 General Statutes Chapter 131E: Chapter 131E of the General Statutes: 20 Chemical dependency units in facilities licensed after October 21 1, 1984; licensed facilities; Medical units: 22 b. Psychiatric units: and 23 c. 24 **(2)** The following facilities or programs licensed after July 1, 1984, under 25 Article 2 of General Statutes Chapter 122C:under Article 2 of Chapter 26. 122C of the General Statutes: 27 Chemical dependency units in psychiatric hospitals; a. 28 b. Chemical dependency hospitals: Residential chemical dependency treatment facilities; 29 c. 30 d. Social setting detoxification facilities or programs: 31 Medical detoxification or programs; and e. Duly licensed physicians and duly licensed practicing psychologists 32 (3) and certified professionals working under the direct supervision of 33 such physicians or psychologists in (i) facilities described in 34 subdivisions (1) and (2) of this subsection, above and in (ii) day/night 35 programs or outpatient treatment facilities licensed after July 1, 1984, 36 under Article 2 of General Statutes Chapter 122C. under Article 2 of 37 Chapter 122C of the General Statutes, or (iii) outpatient practice 38 39 settings: and Duly licensed clinical social workers, duly certified substance abuse 40 <u>(4)</u> professionals, licensed marriage and family therapists, and licensed 41 42 professional counselors working within the scope of practice in (i) facilities described in subdivisions (1) and (2) of this subsection, (ii) 43

44

day/night programs or outpatient treatment facilities licensed under

| 1 | | Article 2 of Chapter 122C of the General Statutes, or (iii) outpatient |
|----|--------------------------|---|
| 2 | | practice settings. |
| 3 | Provided, ho | wever, that nothing in this subsection shall prohibit any policy or contract |
| 4 | of insurance | from requiring the most cost effective treatment setting to be utilized by the |
| 5 | person under | going necessary care and treatment for chemical dependency. |
| 6 | (e) Ce | verage for chemical dependency treatment as described in this section shall |
| 7 | not be applied | cable to any group policy holder or group contract holder who rejects the |
| 8 | coverage in v | |
| 9 | SE | CTION 2. G.S. 58-51-55 reads as rewritten: |
| 10 | "§ 58-51-55 | - |
| 11 | | pendent. dependent individuals. |
| 12 | (a) De | finitions. – As used in this section, the term: |
| 13 | (1) | 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); |
| 14 | | and G.S. 122C-3(21), with a mental disorder defined in the Diagnostic |
| 15 | | and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent |
| 16 | | edition published by the American Psychiatric Association, except |
| 17 | | those mental disorders coded in the DSM-IV or subsequent edition as |
| 18 | | substance-related disorders (291.0 through 292.9 and 303.0 through |
| 19 | | 305.9) and those coded as 'V' codes. |
| 20 | (2) | 'Chemical dependency' has the same meaning as defined in G.S. |
| 21 | | 58-51-5058-51-50, with a mental disorder defined in the Diagnostic |
| 22 | | and Statistical Manual of Mental Disorders, DSM-IV, or subsequent |
| 23 | | editions of this manual. |
| 24 | with a diagn | nosis found in the Diagnostic and Statistical Manual of Mental Disorders |
| 25 | DSM-3-R or | the International Classification of Diseases ICD/9/CM, or a later edition of |
| 26 | those manua | |
| 27 | (b) Co | overage of Physical Illness No insurance company licensed in this State |
| 28 | under this C | hapter shall, solely because an individual to be insured has or had a mental |
| 29 | illness or che | emical dependency: |
| 30 | (1 | Refuse to issue or deliver to that individual any policy that affords |
| 31 | | benefits or coverages for any medical treatment or service for physical |
| 32 | | illness or injury; |
| 33 | (2 |) Have a higher premium rate or charge for physical illness or injury |
| 34 | | coverages or benefits for that individual; or |
| 35 | (3 | · · · · · · · · · · · · · · · · · · · |
| 36 | | individual. |
| 37 | (b1) C | overage of Mental Illness. A policy that covers both physical illness or |
| 38 | injury and n | nental illness may not impose a lesser lifetime or annual dollar limitation or |
| 39 | the mental l | nealth benefits than on the physical illness or injury benefits, subject to the |
| 40 | following: | |
| 41 | (1 | A lifetime limit or annual limit may be made applicable to all benefits |
| 42 | | under the policy, without distinguishing the mental health benefits. |
| 43 | (2 | If the policy contains lifetime limits only on selected physical illness |
| 44 | | and injury benefits, and these benefits do not represent substantially al |
| | | " |

| 1 | (2) | The certificate or contract shall provide a minimum benefit of sixteen |
|----|------------------|--|
| 2 | (2) | thousand dollars (\$16,000) for the necessary care and treatment of |
| 3 | | chemical dependency for the life of the certificate or contract. |
| 4 | (d) Pro | ovisions for benefits for necessary care and treatment of chemical |
| 5 | | in group certificates or group contracts shall provide for benefit payments |
| | | ving providers of necessary care and treatment of chemical dependency: |
| 6 | | |
| 7 | (1) | |
| 8 | | General Statutes Chapter 131E: Chapter 131E of the General Statutes: |
| 9 | | a. Chemical dependency units in facilities licensed after October |
| 10 | • | 1, 1984; licensed facilities; |
| 11 | | b. Medical units; |
| 12 | (0) | c. Psychiatric units; and |
| 13 | (2) | |
| 14 | | Article 2 of General Statutes Chapter 122C: under Article 2 of Chapter |
| 15 | | 122C of the General Statutes: |
| 16 | | a. Chemical dependency units in psychiatric hospitals; |
| 17 | | b. Chemical dependency hospitals; |
| 18 | | c. Residential chemical dependency treatment facilities; |
| 19 | | d. Social setting detoxification facilities or programs; |
| 20 | | e. Medical detoxification facilities or programs; and |
| 21 | (3) | |
| 22 | | and certified professionals working under the direct supervision of |
| 23 | • | such physicians or psychologists in (i) facilities described in |
| 24 | | subdivisions (1) and (2) of this subsection, above and in (ii) day/night |
| 25 | | programs or outpatient treatment facilities licensed after July 1, 1984, |
| 26 | | under Article 2 of General Statutes Chapter 122C. under Article 2 of |
| 27 | | Chapter 122C of the General Statutes, or (iii) outpatient practice |
| 28 | • | settings; and |
| 29 | <u>(4</u>) | Duly licensed clinical social workers, duly certified substance abuse |
| 30 | | professionals, licensed marriage and family therapists, and licensed |
| 31 | | professional counselors working within the scope of practice in (i) |
| 32 | | facilities described in subdivisions (1) and (2) of this subsection, (ii) |
| 33 | | day/night programs or outpatient treatment facilities licensed under |
| 34 | | Article 2 of Chapter 122C of the General Statutes, or (iii) outpatient |
| 35 | | practice settings. |
| 36 | Provided, he | owever, that nothing in this subsection shall prohibit any certificate or |
| 37 | contract from | n requiring the most cost effective treatment setting to be utilized by the |
| 38 | person under | rgoing necessary care and treatment for chemical dependency. |
| 39 | (e) C | overage for chemical dependency treatment as described in this section shall |
| 40 | not be appli | cable to any group certificate holder or group subscriber contract holder |

SECTION 4. G.S. 58-65-90 reads as rewritten:

who rejects the coverage in writing."

No discrimination against the mentally ill and chemically "§ 58-65-90. dependent.dependent individuals.

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42

43

| 1 | (a) | Defin | nitions. – As used in this section, the term: |
|----|-----------------|----------------|---|
| 2 | () | (1) | 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); |
| 3 | | () | and G.S. 122C-3(21), with a mental disorder defined in the Diagnostic |
| 4 | | | and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent |
| 5 | | | edition published by the American Psychiatric Association, except |
| 6 | | | those mental disorders coded in the DSM-IV or subsequent edition as |
| 7 | | | substance-related disorders (291.0 through 292.9 and 303.0 through |
| 8 | | | 305.9) and those coded as 'V' codes. |
| 9 | | (2) | 'Chemical dependency' has the same meaning as defined in G.S. |
| 10 | | (-) | 58-65-7558-65-75, with a mental disorder defined in the Diagnostic |
| 11 | | | and Statistical Manual of Mental Disorders, DSM-IV, or subsequent |
| 12 | | | editions of this manual. |
| 13 | with a d | iaanosi | is found in the Diagnostic and Statistical Manual of Mental Disorders |
| 14 | | _ | E International Classification of Diseases ICD/9/CM, or a later edition of |
| 15 | those ma | | of international Classification of Diseases 12D/7/21vi, of a fater cartion of |
| 16 | (b) | | rage of Physical Illness No service corporation governed by this |
| 17 | ` , | | olely because an individual to be insured has or had a mental illness or |
| 18 | chemical | | • |
| 19 | Cilcillical | (1) | Refuse to issue or deliver to that individual any individual or group |
| 20 | | | subscriber contract in this State that affords benefits or coverage for |
| 21 | | | medical treatment or service for physical illness or injury; |
| 22 | | (2) | Have a higher premium rate or charge for physical illness or injury |
| 23 | | (2) | coverages or benefits for that individual; or |
| 24 | | (3) | Reduce physical illness or injury coverages or benefits for that |
| 25 | | (3) | individual. |
| 26 | (b1) | Cove | rage of Mental Illness. A subscriber contract that covers both physical |
| 27 | ` ' | | and mental illness may not impose a lesser lifetime or annual dollar |
| 28 | | | e mental health benefits than on the physical illness or injury benefits, |
| 29 | subject to | | |
| 30 | subject it | (1) | A lifetime limit or annual limit may be made applicable to all benefits |
| 31 | | (*) | under the subscriber contract, without distinguishing the mental health |
| 32 | | | benefits. |
| 33 | | (2) | If the subscriber contract contains lifetime limits only on selected |
| 34 | | (-) | physical illness or injury benefits, and these benefits do not represent |
| 35 | | | substantially all of the physical illness and injury benefits under the |
| 36 | | | subscriber contract, the service corporation may impose a lifetime |
| 37 | | | limit on the mental health benefits that is based on a weighted average |
| 38 | | | of the respective lifetime limits on the selected physical illness and |
| 39 | | | injury benefits. The weighted average shall be calculated in |
| 40 | | | accordance with rules adopted by the Commissioner. |
| 41 | | (3) | If the subscriber contract contains annual limits only on selected |
| 42 | | • • | physical illness and injury benefits, and these benefits do not represent |
| 43 | | | substantially all of the physical illness and injury benefits under the |
| 44 | | | 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.

 Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or
 - (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.
 - Coverage of Mental Illness. A subscriber contract that covers the necessary (c1) care and treatment of mental illness shall ensure that the benefits for the necessary care and treatment of mental illness are not 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 deductibles, coinsurance factors, co-payments, durational limits. out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services. A subscriber contract 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. Nothing in this section prohibits a subscriber contract 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 only to services for mental illness that are deemed medically necessary."

SECTION 5. G.S. 58-67-70 reads as rewritten:

"§ 58-67-70. Coverage for chemical dependency treatment.

H654-PCS30323-LN-23

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(a) 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.

- On and after January 1, 1985, every Every health maintenance organization that writes a health care plan on a group basis and that is subject to this Article shall offer that provides benefits for the necessary care and treatment of chemical dependency shall ensure that coverage under the health care plan provides benefits 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. 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 ensure only 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. 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 only to services for chemical dependency treatment 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

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- (2) 1 The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:under Article 2 of Chapter 2 3 122C of the General Statutes: Chemical dependency units in psychiatric hospitals; 4 5 Chemical dependency hospitals; b. 6 Residential chemical dependency treatment facilities; c. 7 Social setting detoxification facilities or programs: d. 8 Medical detoxification facilities or programs; and e. 9 (3) Duly licensed physicians and duly licensed practicing psychologists 10 and certified professionals working under the direct supervision of such physicians or psychologists in (i) facilities described in 11 12 subdivisions (1) and (2) of this subsection, above and in (ii) day/night 13 programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C. under Article 2 of 14 Chapter 122C of the General Statutes, or (iii) outpatient practice 15 16 settings; and 17 (4) Duly licensed clinical social workers, duly certified substance abuse professionals, licensed marriage and family therapists, and licensed 18 professional counselors working within the scope of practice in (i) 19 facilities described in subdivisions (1) and (2) of this subsection, (ii) 20 21 day/night programs or outpatient treatment facilities licensed under 22 Article 2 of Chapter 122C of the General Statutes, or (iii) outpatient 23 practice settings. Provided, however, that nothing in this subsection shall prohibit any plan from requiring 24 the most cost effective treatment setting to be utilized by the person undergoing 25 26 necessary care and treatment for chemical dependency. 27 (e) Coverage for chemical dependency treatment as described in this section shall 28 not be applicable to any group that rejects the coverage in writing. 29

 - 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 6. G.S. 58-67-75 reads as rewritten:

58-67-75. No discrimination against the mentally ill and chemically dependent.dependent individuals.

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

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| 1 | | | substance-related disorders (291.0 through 292.9 and 303.0 through |
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| 2 | | | 305.9) and those coded as 'V' codes. |
| 3 | | (2) | 'Chemical dependency' has the same meaning as defined in G.S. |
| 4 | | ` ' | 58-67-70G.S. 58-67-70, with a mental disorder defined in the |
| 5 | | | Diagnostic and Statistical Manual of Disorders, DSM-IV, or |
| 6 | | | subsequent editions of this manual. |
| 7 | with a di | iagnos: | is found in the Diagnostic and Statistical Manual of Mental Disorders |
| 8 | | - | e International Classification of Diseases ICD/9/CM, or a later edition of |
| 9 | those ma | | \cdot |
| 10 | (b) | Cove | erage of Physical Illness No health maintenance organization governed |
| 11 | by this (| | er shall, solely because an individual has or had a mental illness or |
| 12 | chemical | _ | |
| 13 | | (1) | Refuse to enroll that individual in any health care plan covering |
| 14 | | | physical illness or injury; |
| 15 | | (2) | Have a higher premium rate or charge for physical illness or injury |
| 16 | | ` , | coverages or benefits for that individual; or |
| 17 | | (3) | Reduce physical illness or injury coverages or benefits for that |
| 18 | | | individual. |
| 19 | (b1) | Cove | erage of Mental-Illness. A health care plan that covers both physical |
| 20 | illness or | r injur | y and mental illness may not impose a lesser lifetime or annual dollar |
| 21 | limitation | 1 on t h | ne mental health benefits than on the physical illness or injury benefits, |
| 22 | subject to | the fo | ollowing: |
| 23 | | (1) | A lifetime limit or annual limit may be made applicable to all benefits |
| 24 | | | under the plan, without distinguishing the mental health benefits. |
| 25 | | (2) | If the plan contains lifetime limits only on selected physical illness and |
| 26 | | | injury benefits, and these benefits do not represent substantially all of |
| 27 | | | the physical illness and injury benefits under the plan, the HMO may |
| 28 | | | impose a lifetime limit on the mental health benefits that is based on a |
| 29 | | | weighted average of the respective lifetime limits on the selected |
| 30 | | | physical illness and injury benefits. The weighted average shall be |
| 31 | | | calculated in accordance with rules adopted by the Commissioner. |
| 32 | | (3) | If the plan contains annual limits only on selected physical illness and |
| 33 | | | injury benefits, and these benefits do not represent substantially all of |
| 34 | | | the physical illness and injury benefits under the plan, the HMO may |
| 35 | | | impose an annual limit on the mental health benefits that is based on a |
| 36 | | | weighted average of the respective annual limits on the selected |
| 37 | | | physical illness and injury benefits. The weighted average shall be |
| 38 | | | calculated in accordance with rules adopted by the Commissioner. |
| 39 | | (4) | Except as otherwise provided in this section, the plan may distinguish |
| 40 | | | between mental illness benefits and physical injury or illness benefits |
| 41 | | | with respect to other terms of the plan, including coinsurance, limits on |
| 42 | | | provider visits or days of coverage, and requirements relating to |
| 43 | | | medical necessity. |

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- 1 (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.
 - Coverage of Mental Illness. A health maintenance organization health care plan subject to this Article that covers the necessary care and treatment of mental illness shall ensure that the benefits for the necessary care and treatment of mental illness are not 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. A health maintenance organization 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. 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 only to services for mental illness that are deemed medically necessary."

SECTION 7. 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.

Page 12 House Bill 654 H654-PCS30323-LN-23

- (4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.
 - (5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.
 - (6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.
 - (7) If the standard health plan provides coverage for chemical dependency and mental illness, then the coverage for the treatment of chemical dependency and mental illness shall be at least equal to the coverage required by G.S. 58-51-50 and G.S. 58-51-55. The plan may use a case management program in accordance with G.S. 58-51-50 and G.S. 58-51-55.
 - (a1), (a2) Repealed by Session Laws 1999-197, s. 2.
 - (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 8. The Commissioner of Insurance shall conduct a study and analysis of the impact of providing mental health benefits at parity with benefits for physical illness as required by this act. The study and analysis shall address the following:

- (1) To the extent ascertainable, whether there is a decrease in the number of health benefit plans that offer coverage for mental health and chemical dependency treatment due to the parity requirement enacted in this act.
- (2) The cost of providing mental health and chemical dependency treatment benefits in terms of premium costs and claims payments.
- (3) On average, the scope of coverage for mental health and chemical dependency treatment provided by health benefit plans.
- (4) Other issues at the discretion of the Commissioner.

The Commissioner of Insurance shall report the findings and recommendations of the study and analysis to the standing committees on insurance of the House of Representatives and the Senate not later than January 15, 2005, and again on May 1, 2006. At the time of submitting the report, the Commissioner shall provide a copy of the reports to the chairs of the Joint Legislative Health Care Oversight Committee and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

SECTION 9. Every insurer shall provide written notice to employers and the insured upon initial issuance or renewal of the health benefit plan stating that State law requires health benefit plans that cover mental health and chemical dependency treatment to provide such coverage that is not less favorable than the coverage provided under the health benefit plan for physical illness generally. The notice shall further state whether the health benefit plan being issued or renewed provides mental health and chemical dependency treatment that is not less favorable than coverage under the health benefit plan for physical illness generally. The Commissioner of Insurance shall adopt rules pertaining to the notice required under this section.

SECTION 10. This act becomes effective January 1, 2004, 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. To the extent this act is in conflict with G.S. 58-50-63, this act prevails.

B, J, McMillean ADONC

"The Truth About Parity"

What is Parity?

In 1996, The federal Mental Health Parity Act imposed a minimum benefit standard for mental health benefits on employer-sponsored health insurance for the first time. In 1997, twelve states enacted parity laws that required more generous Mental Health and Substance Abuse benefits then the federal mandate required. Parity is the concept the mental illness (including substance abuse) benefits should be comparable to physical illness benefits and offered as part of a basic benefits package. Research indicates that providing full parity for mental illness and substance abuse services would not have an enormous effect of premium costs and would result in saving North Carolina billions of dollars each year.

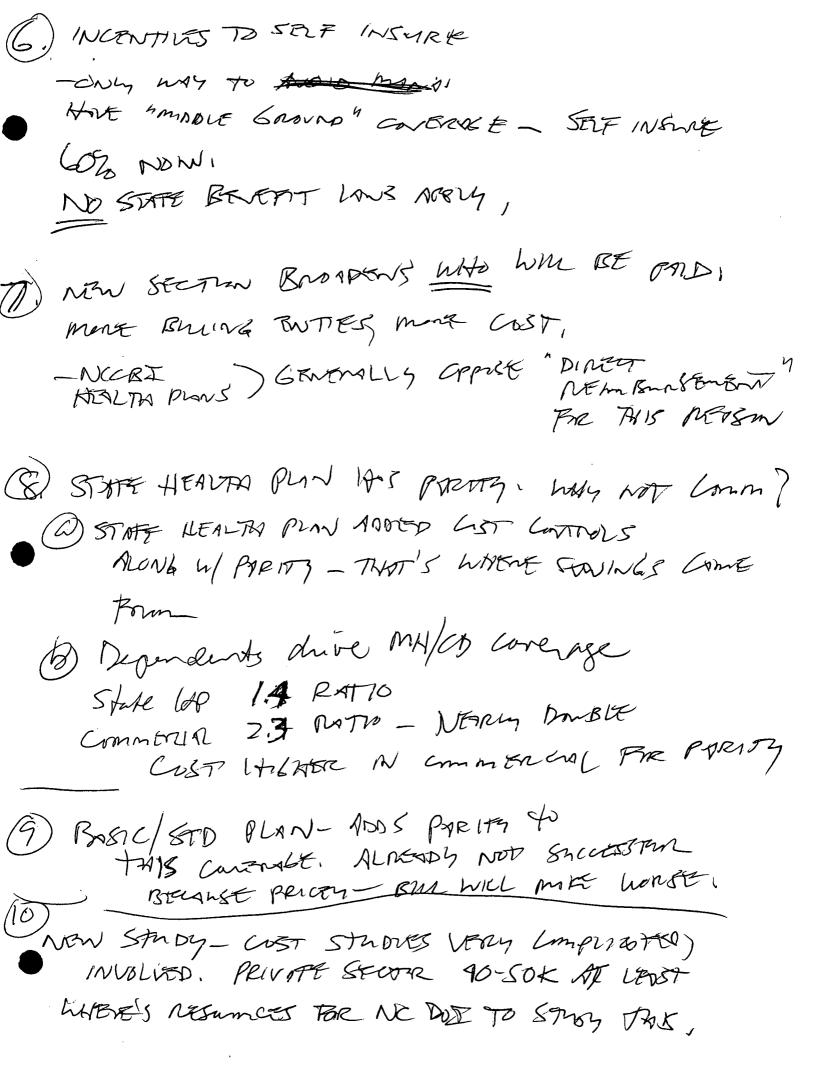
#9 Billion

- Addiction disease currently costs North Carolina 8 billion dollars per year.
- Providing parity for drug and alcohol treatment services WILL NOT increase health insurance premiums significantly. The premiums would only increase by less than one percent (\$1.35 per month).
- * Approximately **750,000** North Carolinians will be affected directly by addiction disease in their lifetime. There are currently 343,000 adults actively in need of treatment and between **25,000 50,000** children. ²
 - ❖ Seven dollars are saved for every dollar spent on employee rehabilitation. ³
 - Parity for drug and alcohol treatment services dramatically reduces hospital visits one year after treatment was received. For example, **fifty percent** reduction for medical services, **sixty percent** reduction for psychiatric services, **thirty percent** reduction in emergency medical admissions, **fifty percent** reduction for psychiatric admissions and **seventy-five** percent reduction in admissions for detoxification services. ⁴
 - * Sixty-five percent of emergency room visits are drug and alcohol related. Eighty-five percent of people in the prison system test positive for drugs/alcohol. 5

Addiction disease is the most serious health problem, affecting every community, whether urban and rural and the need for effective and affordable treatment is the greatest need of our society today and with parity, treatment is included in the basic health care benefits package.

1. Millian & Roberston, Inc. 1997) 2. Duke Epidemiological Catchment Area Study and Substance Use and Need for Comprehensive Treatment and Services in North Carolina's Adult Household Population: 1995, RTI, 1997 Chevron Corporation, 1998 4. Harrison, P.A. and Hoffman 1997) 5. President's Commission on Model State Drug Laws, 1996).

(1) LAST MINTE PCS CHOTSING CONSTANT (EVEL IN ATTER) -7 YEAR DESTIE ON THIS ISSUE - ALMAS LAST MINUTE CHONDES; NO TIME TO ANALYZE (2) FUBBLITY! - WELL PAST (ROJSONERZ -NO 5 NUR VOD PISCAL NOTE 50 - was tribible? - CAUSSALEZ PULES MENNBLESS W/ ANS PRECEDENT (3) PCS STILL A MANDETE - ALL OR NOTHING CHUILE PENCISO - Business Now CHOUSE MIDDIE GROUND - RASINGS WILL DROP ALL MN/CD-D EMPLOYEES SUPFER 4) ADVERSE SELECTION - ONLY GOOD THING ABOUT BRINEPIT MONNETZ, SPREADS RISKS, THIS BU DOBY THE GRASTIE. - DNLy THATE MOST LIKERY TO LISE STRUKE HOPT - Motes Go Up; WEALUITIER GROUPS DROP: NOTES GO UP LAIGHTER DEATH SPIRAL (5) HOSPITALS WILL LOSE IN TONS "MIDDLE GREVED = 30-My INPATIENT SERVINS moun (LLMESS Drop Coverise = 0. HOSPITALS WILL SET RISE IN LNUMPENSTATED GORT ALREGOY SMAN GROVE PRESIONS - EP, PURL ANDS



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COMMITTEE MEETINGS

(Three digit rooms = Legislative Office Building - Four digit rooms = Legislative Building)

| Thursday, May | ROOM | <u>TIME</u> | |
|---------------|---|-------------|----------|
| FINANCE | | 544 | 8:30 am |
| | ase Three New Prisons (For Discussion Only) | | |
| INSURANCE | | 544 | 10:00 am |
| HB 654 | Mental Health/Chemical Dependency Parity. | | |
| JUDICIARY I | | 1228 | 10:00 am |
| SB 925 | Strengthen Security Fraud Enforcement Laws. | | |
| JUDICIARY II | | 421 | 10:00 am |
| HB 915 | Manufactured Home Leasehold Estate Financing. | | |
| HB 1006 | Manufactured Housing. | | |
| SB 774 | Liability at Public Skateboard Parks. | | |
| SB 995 | School Construction/Repair Flexibility. | | |
| SB 996 | ABC-Sexually Explicit Conduct Banned. | | |

Julie Woodson

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HOUSE CALENDAR 70th Legislative Day Thursday, May 29, 2003 House Convenes at 11:00 am

Richard T. Morgan, Presiding Speaker

James B. Black, Speaker

LOCAL FOR CONCURRENCE

HB Senate Committee Substitute - Weiss, Røss and Miner (Primary Sponsors) - RALEIGH/WAKE CLEAR-CUTTING. (Senate Committee Substitute) (4th Edition)

CALENDAR

LOCAL BILLS

SECOND AND THIRD READINGS

SB 292 Stevens - RALEIGH ELECTRONIC NOTICE. (Local Government II) (1st Edition)

PUBLIC BILLS

SECOND READING - ROLL CALL

SB 214 Committee Substitute - Gulley RESEARCH AND PRODUCTION SERVICE DISTRICT DEANNEXATION. (Finance) (2nd Edition)

SECOND AND THIRD READINGS

- SB 38 House Committee Substitute Gulley DOT SAFETY AND LOGO SIGNS. (Transportation) (2nd Edition)
- SB 629 House Committee Substitute Clodfelter CLARIFY SUBORDINATION AGREEMENT REQUIREMENTS. (Judiciary 1) (3rd Edition)
- SB 887 Committee Substitute Carpenter OVARIAN CANCER DETECTION/HIGH RISK WOMEN. (Insurance) (2nd Edition)

MINUTES

HOUSE INSURANCE COMMITTEE

June 3, 2003

Chair Mitchell Setzer called the meeting together at 10:00 in room 544. He introduced the pages and the Sgt. At Arms. See Attachment I. The members who were present were: Holliman; Setzer; Hall; Allen; Barbee; Grady; Hunter; C. Johnson; L. Johnson; Lewis, Miner, Ray; Saunders; Wainwright; and Wilson. He thanked the visitors for attending the meeting. See Attachment II.

Chair Setzer called on Representative Martha Alexander to explain the new PCS on HB-654-MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY. See Attachment III and IV. Rep. Hunter made a motion to withdraw the PCS from the last meeting and to bring forth the new PCS. The motion carried. Chair Holliman made a motion for a favorable report and explained why he is in favor of passing this bill. After much discussion a roll call vote was taken. The PCS failed 13 to 2. See Attachment V. The meeting was adjourned at 10:50 AM.

Chair Hugh Holliman

Chair Mitchell Setzer

Carol Bowers; Joanna Mills, Clerks

6-3-02
Date

VISITOR REGISTRATION SHEET

Name of Committee

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

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June 3, 2003 Insurence

attachment

House Pages

| 1. | Name: Adam Edgertun |
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| | County: Johnston |
| | Sponsor: Leo Daughtry |
| 2. | Name: Krystle Wiggins |
| | County: Gates |
| | Sponsor: Bill Culpepper |
| 3. | Name: Jennifer Carpenter |
| | County: Wake |
| | Sponsor: Jim Black |
| 4. | Name: Travis Thrmpron |
| | County: Wake |
| | Sponsor: Don Munford |
| 5. | Name: |
| | County: |
| | Sponsor: |
| ~ | |
| Sgt-A | At-Arms |
| 1. | Name: Charles Williams |
| 2 | Name: Francis Poole |
| 3. | Name: Charles Grady |
| 4. | Name: |



MENTAL HEALTH/CHEMICAL **DEPENDENCY PARITY:**

House Bill 654



Committee: House Insurance

Date:

June 3, 2003

Version:

H654-CSLN-12 [v.1]

Introduced by: Reps. Alexander, Insko,

Hackney, Wainwright

Summary by:

Sandra Alley

Committee Counsel

SUMMARY OF ORIGINAL BILL: House Bill 808 would mandate coverage of mental illness and chemical dependency and require that the coverage would be at full parity with covered benefits for Health benefit plans must provide the same day and visit limits, deductibles, physical illness. coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits and any other dollar limits or fees for covered services prior to reaching any maximum out-of-pocket limit. The bill allows insurers to impose utilization management measures on covered benefits for mental illness and chemical dependency, even if those measures are not placed on covered benefits for physical illness. The act is effective on January 1, 2004.

THE PROPOSED COMMITTEE SUBSTITUTE adds clinical social workers, certified substance abuse counselors and licensed professional counselors to the list of providers to whom benefit payments must be made for necessary care and treatment for chemical dependency treatment as required under the Act.

CURRENT LAW: Chemical Dependency: Under current law, insurers, service corporations (Blue Cross), and HMOs must offer coverage for chemical dependency to all group and blanket policyholders that is no less favorable than the coverage provided under the policy for physical benefits generally. If the group policyholder accepts the coverage, the benefits must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as benefits for physical illness generally. If the policy provides more than \$8,000 in total annual benefits for all illnesses under the policy, it must also provide chemical dependency coverage of at least \$8,000 per year and at least \$16,000 over the lifetime of the policy.

Mental illness: Insurers, service corporations and HMOs are not required to provide or offer mental health benefits in their plans.

Self-funded plans: Plans governed by ERISA are subject to the federal Mental Health Parity Act of 1996. The Act prohibits these plans from imposing annual or lifetime dollar limits on reimbursement ceilings for mental health benefits that are more restrictive than those applied to care for physical illness. Thus, both insured and self-funded group plans in North Carolina are covered by the limited mental parity requirement

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BILL ANALYSIS:

Coverage and Parity Requirements:

The proposed bill requires all insurers to cover chemical dependency benefits and mental illness benefits. Group plans are required to be in full parity with benefits for physical illness generally under the policy. The plan cannot provide for lower annual and lifetime dollar limits, different deductibles, copayments, or coinsurance factors, lower maximum out-of-pocket limits, or for more restrictive day and visit limits for mental illness and chemical dependency benefits than it provides for physical benefits generally under the policy

Cost Control Provisions:

Insurers can use case management programs in conjunction with their coverage of chemical dependency and mental illness benefits. Case management programs, which must comply with rules adopted by the Commissioner of Insurance, are used to evaluate and determine medically necessary and medically appropriate care for each patient. In addition, the bill provides that insurers can use common managed care procedures, such as pre-admission screening and prior authorization, to determine whether treatment for mental illness or chemical dependency is medically necessary in a particular case. Plans will meet the parity requirements in the bill if at least one of the patient's choices of treatment options within the patient's policy meets the parity requirement.

Definitions of Mental Illness and Chemical Dependency:

Chemical Dependency:

Chemical dependency, for purposes of the chemical dependency parity requirement, is defined as the "pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal." Another section of the current law, which prohibits insurers from discriminating against mentally ill or chemically dependent individuals in the issuance of policies providing physical benefits, defines "chemically dependent" in the same manner, but the bill adds a requirement that the dependency be accompanied by a mental disorder recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or subsequent editions).

• Mental Illness:

Mental illness, for purposes of both the parity requirement and the anti-discrimination requirement, is defined under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, with the additional requirement that it be accompanied by a recognized mental disorder also. The MH/DD/SA Act defines "mental illness" as follows: "(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is need of treatment. "(GS 122C-3(21)).

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Exclusions:

- Mental disorders coded in the DSM-IV as substance abuse related disorders (291.0 through 292.9 and 303.0 through 305.9). This list of exclusions consists of numerous disorders that fall into the categories of alcohol-related disorders, amphetamine and amphetamine-like related disorders, caffeine-related disorders, cannabis-related disorders, cocaine-related disorders, hallucinogen-related disorders, inhalant-related disorders, nicotine-related disorders, opiod-related disorders, phencyclidine-related disorders, sedative-hypnotic, or anxiolytic-related disorders, polysubstance-related disorders, and other (unknown) substance-related disorders.
- Mental disorders coded as "V" codes. This includes relational problems, problems related to abuse or neglect (if the focus of attention is on a person other than the victim), and certain additional conditions such as academic problems, bereavement, and antisocial behavior.

Effective Date: January 1, 2004.

BACKGROUND: According to a study conducted by Medstat Group for the Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD, 56% of the funding for mental health and substance abuse treatment in 1997 was paid by the public sector, up from 53% in 1987. According to the same study, spending for mental health and substance abuse treatment nationwide reached \$85.3 billion in 1997. There has been a decline in private insurers' real spending for substance abuse services between 1987 and 1997 of 0.6%.

Linda Attarian, former Research Division Staff Attorney, contributed substantially to this summary.

H654-SMSP-002

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

Attachment

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HOUSE BILL 654 PROPOSED COMMITTEE SUBSTITUTE H654-PCS60292-LNf-12

| | Short Title: Mental Health/Chemical Dependency Parity. | (Public) |
|----|--|---------------------------------------|
| | Sponsors: | · · · · · · · · · · · · · · · · · · · |
| | Referred to: | |
| | March 25, 2003 | |
| 1 | A BILL TO BE ENTITLED | |
| 2 | AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE | COVERAGE FOR |
| 3 | MENTAL ILLNESS AND CHEMICAL DEPENDENCY. | |
| 4 | The General Assembly of North Carolina enacts: | |
| 5 | SECTION 1. G.S. 58-51-50 reads as rewritten: | |
| 6 | "§ 58-51-50. Coverage for chemical dependency treatment. | |
| 7 | (a) <u>Definitions</u> – As used in this section, the term "chemical | term: |
| 8 | (1) 'Chemical dependency' means the pathological us | |
| 9 | or other drugs in a manner or to a degree that pro | |
| 10 | in personal, social or occupational functioning | |
| 11 | need not, include a pattern of tolerance and withdr | awal. |
| 12 | (2) 'Health benefit plan' has the same meaning as in G | S. 58-3-167. |
| 13 | (3) 'Insurer' has the same meaning as in G.S. 58-3-167 | <u>7.</u> |
| 14 | (b) Every insurer that writes a policy or contract of grou | up or blanket health |
| 15 | insurance or group or blanket accident and health insurance that is | s issued, renewed, or |
| 16 | amended on or after January 1, 1985, shall offer to its insureds s | shall provide in each |
| 17 | group health benefit plan benefits for the necessary care and tr | eatment of chemical |
| 18 | dependency that are not less favorable than benefits for physic | |
| 19 | Except as provided in subsection (c) of this section, benefits Ben | efits for treatment of |
| 20 | chemical dependency shall be subject to the same durational | |
| 21 | deductibles, and coinsurance factors limits as are benefits for physical | |
| 22 | For purposes of this subsection, 'limits' includes durational | limits, deductibles, |
| 23 | coinsurance factors, co-payments, maximum out-of-pocket limits, | |
| 24 | dollar limits, and any other dollar limits or fees for covered services | |
| 25 | (b1) Weighted Average. – If a group health benefit plan co | |
| 26 | lifetime limits, co-payments, deductibles, or coinsurance only | |
| 27 | illness and injury benefits, and these benefits do not represent su | |
| 28 | 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.
 - 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 <u>licensed facilities</u>; 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

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- (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.
 - (4) Duly licensed clinical social workers, duly certified substance abuse professionals, and licensed professional counselors working within the scope of practice in facilities described in subdivisions (1) and (2) of this subsection and in day/night programs or outpatient treatment facilities licensed under Article 2 of Chapter 122C of the General Statutes

Provided, however, that nothing in this subsection shall prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

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

SECTION 2. G.S. 58-51-55 reads as rewritten:

"§ 58-51-55. No discrimination against the mentally ill and chemically dependent dependent individuals.

- (a) Definitions. As used in this section, the term:
 - '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.
 - 'Chemical dependency' has the same meaning as defined in G.S. 58-51-5058-51-50, 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) <u>Definition.</u> 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, benefitsBenefits for chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinstance 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.
 - 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.

| 1 | (d) Provis | sions for benefits for necessary care and treatment of chemical |
|----|-------------------|--|
| 2 | dependency in g | croup certificates or group contracts shall provide for benefit payments |
| 3 | for the following | g providers of necessary care and treatment of chemical dependency: |
| 4 | (1) | The following units of a general hospital licensed under Article 5 of |
| 5 | `, | General Statutes Chapter 131E: Chapter 131E of the General Statutes: |
| 6 | | a. Chemical dependency units in facilities licensed after October |
| 7 | | 1, 1984; licensed facilities; |
| 8 | | b. Medical units; |
| 9 | | c. Psychiatric units; and |
| 10 | (2) | The following facilities or programs licensed after July 1, 1984, under |
| 11 | () | Article 2 of General Statutes Chapter 122C:under Article 2 of Chapter |
| 12 | | 122C of the General Statutes: |
| 13 | | a. Chemical dependency units in psychiatric hospitals; |
| 14 | | b. Chemical dependency hospitals; |
| 15 | | c. Residential chemical dependency treatment facilities; |
| 16 | | d. Social setting detoxification facilities or programs; |
| 17 | | e. Medical detoxification facilities or programs; and |
| 18 | (3) | Duly licensed physicians and duly licensed psychologists and certified |
| 19 | , | professionals working under the direct supervision of such physicians |
| 20 | | or psychologists in facilities described in (1) and (2) above and in |
| 21 | | day/night programs or outpatient treatment facilities licensed after July |
| 22 | | 1, 1984, under Article 2 of General Statutes Chapter 122C.under |
| 23 | | Article 2 of Chapter 122C of the General Statutes. After January 1, |
| 24 | | 1995, "duly licensed psychologist Duly licensed psychologist shall be |
| 25 | | defined as means licensed psychologists who hold permanent licensure |
| 26 | | and certification as health services provider psychologist issued by the |
| 27 | | North Carolina Psychology Board. |
| 28 | <u>(4)</u> | Duly licensed clinical social workers, duly certified substance abuse |
| 29 | | professionals, and licensed professional counselors working within the |
| 30 | | scope of practice in facilities described in subdivisions (1) and (2) of |
| 31 | | this subsection and in day/night programs or outpatient treatment |
| 32 | | facilities licensed under Article 2 of Chapter 122C of the General |
| 33 | | Statutes. |
| 34 | Provided, how | ever, that nothing in this subsection shall prohibit any certificate or |
| 35 | contract from 1 | requiring the most cost effective treatment setting to be utilized by the |
| 36 | person undergo | ing necessary care and treatment for chemical dependency. |
| 37 | (e) Cove | erage for chemical dependency treatment as described in this section shall |
| 38 | | ble to any group certificate holder or group subscriber contract holder |
| 39 | | coverage in writing." |
| 40 | SEC | TION 5. G.S. 58-65-90 reads as rewritten: |

Page 7

dependent.dependent individuals.

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

No discrimination against the mentally ill and chemically

"§ 58-65-90.

(a)

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- '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. 58-65-7558-65-75, 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 1 injury benefits. The weighted average shall be calculated in 2 accordance with rules adopted by the Commissioner. 3 Except as otherwise provided in this section, the subscriber contract (4) 4 may distinguish between mental illness benefits and physical injury or 5 illness benefits with respect to other terms of the subscriber contract, 6 including coinsurance, limits on provider visits or days of coverage, 7 and requirements relating to medical necessity. 8 If the service corporation offers two or more benefit package options 9 (5) under a subscriber contract, each package must comply with this 10 subsection. 11 This subsection does not apply to a subscriber contract if the service (6) 12 corporation can demonstrate to the Commissioner that compliance will 13 increase the cost of the subscriber contract by one percent (1%) or 14 more. 15 This subsection expires October 1, 2001, but the expiration does not (7)16 affect services rendered before that date. 17 Mental Illness or Chemical Dependency Coverage Not Required. Nothing 18 in this section requires a service corporation to offer coverage for mental illness or 19 chemical dependency, except as provided in G.S. 58-65-75. 20 Applicability. Subsection (b1) of this section applies only to subscriber 21 (d) contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 22 50 employees. The remainder of this section applies only to group contracts covering 20 23 or more employees." 24 **SECTION 6.** G.S. 58-67-70 reads as rewritten: 25 "§ 58-67-70. Coverage for chemical dependency treatment. 26 <u>Definition</u>. – As used in this section, the term 'chemical dependency' means 27 the pathological use or abuse of alcohol or other drugs in a manner or to a degree that 28 produces an impairment in personal, social or occupational functioning and which may, 29 but need not, include a pattern of tolerance and withdrawal. 30 Chemical Dependency Requirement. - On and after January 1, 1985, 31 everyEvery health maintenance organization that writes a health care plan on a group 32 basis and that is subject to this Article shall offer provide benefits for the necessary care 33 and treatment of chemical dependency that are not less favorable than benefits under the 34 health care plan generally. Except as provided in subsection (c) of this section, benefits 35 Benefits for chemical dependency shall be subject to the same durational limits, dollar 36 limits, deductibles, and coinsurance factors limits as are benefits under the health care 37 plan generally. For purposes of this subsection, 'limits' includes durational limits, 38 deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual 39 and lifetime dollar limits, and any other dollar limits or fees for covered services. 40 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

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| average c | or the re | espective annual, lifetime, co-payment, deductible, or coinsurance limits |
| on the so | <u>elected</u> | physical illness and injury benefits. The weighted average shall be |
| calculated | d in acc | cordance with rules adopted by the Commissioner. |
| <u>(b2)</u> | Case | Management. – A health maintenance organization may use a case |
| managen | ient pr | rogram for chemical dependency treatment benefits to evaluate and |
| determin | <u>e medi</u> | cally necessary and medically appropriate care and treatment for each |
| patient, r | provide | d that the program complies with rules adopted by the Commissioner. |
| These ru | les sha | Il only ensure that case management programs are not designed to avoid |
| the requi | rement | ts of this section concerning parity between the benefits for chemical |
| · - | icy trea | atment and those for physical illness generally. |
| <u>(b3)</u> | Medi | cal Necessity. – Nothing in this section prohibits a health maintenance |
| organizat | tion fr | om managing the provision of benefits through common methods, |
| including | g, but n | not limited to, preadmission screening, prior authorization of services, or |
| | | sms designed to limit coverage to services for chemical dependency |
| treatmen | t only t | to those that are deemed medically necessary. |
| (c) | Ever | y group health care plan that provides benefits for chemical dependency |
| treatmen | t and | that provides total annual benefits for all illnesses in excess of eight |
| thousand | l dollar | s (\$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) | Prov | isions for benefits for necessary care and treatment of chemical |
| depende | ncy in | group health care plans shall provide for benefit payments for the |
| followin | g provi | iders 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; |

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Medical detoxification facilities or programs; and

Duly licensed physicians and duly licensed practicing psychologists

and certified professionals working under the direct supervision of

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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.

Duly licensed clinical social workers, duly certified substance abuse professionals, and licensed professional counselors working within the scope of practice in facilities described in subdivisions (1) and (2) of this subsection and in day/night programs or outpatient treatment facilities licensed 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:
 - '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.
 - 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70G.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:

Refuse to enroll that individual in any health care plan covering (1) 1 physical illness or injury; 2 Have a higher premium rate or charge for physical illness or injury (2) 3 coverages or benefits for that individual; or 4 Reduce physical illness or injury coverages or benefits for that 5 (3) 6 individual. Coverage of Mental Illness. A health care plan that covers both physical 7 illness or injury and mental illness may not impose a lesser lifetime or annual dollar 8 limitation on the mental health benefits than on the physical illness or injury benefits, 9 subject to the following: 10 A lifetime limit or annual limit may be made applicable to all benefits 11 (1)under the plan, without distinguishing the mental health benefits. 12 If the plan contains lifetime limits only on selected physical illness and 13 $\left(2\right)$ injury benefits, and these benefits do not represent substantially all of 14 the physical illness and injury benefits under the plan, the HMO may 15 impose a lifetime limit on the mental health benefits that is based on a 16 weighted average of the respective lifetime limits on the selected 17 physical illness and injury benefits. The weighted average shall be 18 calculated in accordance with rules adopted by the Commissioner. 19 If the plan contains annual limits only on selected physical illness and $\left(3\right)$ 20 injury benefits, and these benefits do not represent substantially all of 21 the physical illness and injury benefits under the plan, the HMO may 22 impose an annual limit on the mental health benefits that is based on a 23 weighted average of the respective annual limits on the selected 24 physical illness and injury benefits. The weighted average shall be 25 calculated in accordance with rules adopted by the Commissioner. 26 Except as otherwise provided in this section, the plan may distinguish (4) 27 between mental illness benefits and physical injury or illness benefits 28 with respect to other terms of the plan, including coinsurance, limits on 29 provider visits or days of coverage, and requirements relating to 30 medical necessity. 31 If the HMO offers two or more benefit package options under a plan, 32 (5) each package must comply with this subsection. 33 This subsection does not apply to a health benefit plan if the HMO can 34 (6) demonstrate to the Commissioner that compliance will increase the 35 cost of the plan by one percent (1%) or more. 36 This subsection expires October 1, 2001, but the expiration does not 37 (7) affect services rendered before that date. 38 Mental Illness or Chemical Dependency Coverage Not Required. Nothing 39 in this section requires an HMO to offer coverage for mental illness or chemical 40 dependency, except as provided in G.S. 58-67-70.

contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than

Applicability. Subsection (b1) of this section applies only to group

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 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) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.
 - (7) 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.
 - (a1), (a2) Repealed by Session Laws 1999-197, s. 2.
- (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, 2004, 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. To the extent this act is in conflict with G.S. 58-50-63, this act prevails.

| | | ROLL C | ALL V | OTE | |
|------------------------|-------------|----------------------------|-------------|------------|----------------------|
| $\frac{2}{\text{YES}}$ | | $\frac{3}{0} = 15$ (TOTAL) | | | HB# <u>65</u> SB# |
| | SE STAI | NDING COMMITTEE ON | | _ | |
| House | Subcor | nmittee on | | | |
| YES | NO | MEMBER (last name) | YES | NO | MEMBER (last name) |
| <u> </u> | | Holliman, Chair | | | |
| | <u>x</u> | Setzer, Chair | | | |
| | <u>_x</u> _ | Hall, Vice-Chair | | | |
| | | · | | | |
| | <u>x</u> | Allen | | | |
| | <u>_x_</u> | Barbee | | | |
| | <u>×</u> | Grady | | | |
| | <u>x</u> | Hunter | | | |
| | <u> </u> | C. Johnson | | | |
| | <u> </u> | L. Johnson | | | |
| | | Lewis | | | |
| | | Miner | | | |
| | | Ray | | | |
| | | Saunders | | | |
| <u>x</u> | | Wainwright | | | |
| | <u> </u> | Wilson | | <u></u> . | |
| | <u> </u> | Wright | | | |
| | | | | | |
| | | Ex-Officio Members: | | | |

Brubaker

Culpepper Cunningham

Eddins

MINUTES

HOUSE INSURANCE COMMITTEE

June 4, 2003

Chair Holliman called the meeting to order, introduced the pages and the Sgt. At Arms. See Attachment I. The following Representatives were present: Holliman; Setzer; Allen; Barbee; C. Johnson; L. Johnson; Ray; Saunders; and Wainwright. Rep. Holliman turned the meeting our to Rep. Setzer in order for him to explain HB-l049-LICENSED PSYCH. ASSOC./INSURANCE PAYMENTS. See Attachments II and III. Mary Ann Olsen, speaking for the North Carolina Association of Professional Psychologist spoke in favor of the bill. See Attachment IV Carol Lawler and Sally Cameron also spoke in favor of the bill. See Attachment IV. C. Johnson made a motion for a favorable report to the PCS and it was re-referred to Finance.

Rep. Holliman called on Rep. Setzer to present the changes made by the Senate, Section 27 on HB-276-INSURANCE FINANCIAL AMENDMENTS OMNIBUS-AB. See Attachment V. Rep. Barbee moved for a favorable report to concur with the Senate. Motion carries.

Frank Folger, from DOI was called on to speak on SB-966 in Senator Dalton's request. Mr. Folger explained language changes in the PCS. See Attachments VI and VII. Rep. Saunders motioned for a favorable report, unfavorable to original bill. The motion carries

The meeting was adjourned at II: 45. See Attachment VIII for the visitors in attendance.

Rep. Hugh Holliman

Rep. Mitchell Setzer

Carol Bowers, Joanna/Mills, Clerks

House Pages

| 1. | Name: Laura Buckley |
|----|-------------------------|
| • | County: Cabarrus |
| | Sponsor: L. Johnson |
| ว | |
| 2. | Name: Amanda Shearin |
| | County: Woke |
| | Sponsor: J. Weiss |
| 3. | Name: Adam Edgerton |
| | County: Johnston |
| | Sponsor: Leo Dayshtry |
| 4. | Name: Clint C. Starnes |
| | County: Caldwell |
| | Sponsor: Edgar Starnes |
| 5. | Name: |
| | County: |
| | Sponsor: |
| | |
| | At-Arms |
| | Name: Brian Doherty 1 |
| | Name: JAMES WORTH |
| 3. | Name: JAMES Womack |
| 4. | Name: Philip Schreibman |
| | Charles Williams |



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

H

D

HOUSE BILL 1049 PROPOSED COMMITTEE SUBSTITUTE H1049-CSRC-63 [v.5]

6/3/2003 5:18:47 PM

| | Short Ti | tle: L | Licensed Psych. Assoc./Insurance Payments. (Public) | | |
|----|--------------|-----------------|--|--|--|
| | Sponsors: | | | | |
| | Referred to: | | | | |
| | | | April 10, 2003 | | |
| 1 | | | A BILL TO BE ENTITLED | | |
| 2 | AN ACT | Γ TO A | ALLOW LICENSED PSYCHOLOGICAL ASSOCIATES TO RECEIVE | | |
| 3 | PAY | MENT | FOR SERVICES FROM INSURERS AND TO INCREASE THE FEE | | |
| 4 | | | HOLOGY BOARD MAY CHARGE FOR A TEMPORARY LICENSE. | | |
| 5 | | | ssembly of North Carolina enacts: | | |
| 6 | | | TION 1. G.S. 58-50-30(b) reads as rewritten: | | |
| 7 | "(b) | For t | he purposes of this section, a "duly licensed psychologist" is a a: | | |
| 8 | | (1) | licensed psychologist who holds permanent licensure and certification | | |
| 9 | | as a | health services provider psychologist issued by the North Carolina | | |
| 10 | | Psyc | hology Board. <u>Board; or</u> | | |
| 11 | | <u>(2)</u> | a licensed psychological associate who holds permanent licensure." | | |
| 12 | | SEC | TION 2. G.S. 135-40.7B(c) reads are rewritten: | | |
| 13 | "(c) | Notv | vithstanding any other provisions of this Part, the following providers | | |
| 14 | and no | others | may provide necessary care and treatment for mental health under this | | |
| 15 | section: | | | | |
| 16 | | (1) | Psychiatrists who have completed a residency in psychiatry approved | | |
| 17 | | | by the American Council for Graduate Medical Education and who are | | |
| 18 | | | licensed as medical doctors or doctors of osteopathy in the state in | | |
| 19 | | | which they perform and services covered by the Plan; | | |
| 20 | | (2) | Licensed or certified doctors of psychology; | | |
| 21 | | (3) | Certified clinical social workers and licensed clinical social workers; | | |
| 22 | | (3a) | Licensed professional counselors; | | |
| 23 | | (4) | Certified clinical specialists in psychiatric and mental health nursing; | | |
| 24 | | (4a) | Nurses working under the employment and direct supervision of such | | |
| 25 | | | physicians, psychologists, or psychiatrists; | | |
| 26 | | (5) | Repealed by Session Laws 1997-512, s. 14. | | |
| 27 | | (6) | Psychological associates with a masters degree in psychology under | | |
| 28 | | | the direct employment and supervision of a licensed psychiatrist or | | |

| 1 | | | | sea or certified doctor or psychology Licensed psychological |
|----------|--------------|------------|----------|--|
| 2 | | | assoc | <u>iates;</u> |
| 3 | | (7) | , (8) I | Repealed by Session Laws 1997-512, s. 14. |
| 4 | | (9) | Certi | fied fee-based practicing pastoral counselors; |
| 5 | | (10) | Licen | sed physician assistants under the supervision of a licensed |
| 6 | | | psych | niatrist and acting pursuant to G.S. 90-18.1 or the applicable laws |
| 7 | | | | ules of the area in which the physician assistant is licensed or |
| 8 | | | | ied; and |
| 9 | | (11) | | sed marriage and family therapists. |
| 10 | | SEC | | 3. G.S. 135-40.7B(c1) reads as rewritten: |
| 11 | "(c1) | | | ding any other provisions of this Part, the following providers |
| 12 | | | | vide necessary care and treatment for chemical dependency under |
| 13 | this section | | J P U | and and and another the common depositions, and |
| 14 | | (1) | The f | following providers with appropriate substance abuse training and |
| 15 | | (-) | | rience in the field of alcohol and other drug abuse as determined |
| 16 | | | _ | he mental health case manager, in facilities described in |
| 17 | | | _ | vision (b)(2) of this section, in day/night programs or outpatient |
| 18 | | | | nent facilities licensed after July 1, 1984, under Article 2 of |
| 19 | | | | ter 122C of the General Statutes or in North Carolina area |
| 20 | | | _ | ams in substance abuse services are authorized to provide |
| 21 | | | | nent for chemical dependency under this section: |
| 22 | | | a. | Licensed physicians including, but not limited to, physicians |
| 23 | | | a. | who are certified in substance abuse by the American Society of |
| 24 | | | | · · · · · · · · · · · · · · · · · · · |
| 25 | | | b. | Addiction Medicine (ASAM); |
| 26 | | | | Licensed or certified psychologists; Psychiatrists; |
| 27 | | | c. d. | · |
| 28 | | | u. | Certified substance abuse counselors working under the direct |
| 29 | • | | | supervision of such physicians, psychologists, or psychiatrists; Psychological associates with a masters degree in psychology |
| 30 | | | e. | |
| 31 | | | | working under the direct supervision of such physicians, psychologists, or psychiatrists Licensed psychological |
| 32 | | | | psychologists, or psychiatrists Licensed psychological associates; |
| 33 | | | f. | |
| 34 | | | 1. | Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists; |
| 35 | | | ~ | Certified clinical social workers and licensed clinical social |
| 36 | | | g. | |
| | | | h | workers; |
| 37 38 | | | h. | Certified clinical specialists in psychiatric and mental health |
| 39 | | | i. | nursing; |
| | | | | Licensed professional counselors; |
| 40 | | | j. | Certified fee-based practicing pastoral counselors; |
| 41 | | | k. | Substance abuse professionals certified under Article 5C of |
| 42 | | | 1 | Chapter 90 of the General Statutes; and |
| 43 | | | ı. | Licensed marriage and family and therapists. |

GENERAL ASSEMBLY OF NORTH CAROLINA

| 1 | (2) | The follow | ring providers with appropriate substance abuse training and |
|----|------------------|--------------|---|
| 2 | . , | | in the field of alcohol and other drug abuse as determined |
| 3 | | - | ntal health case manager are authorized to provide treatment |
| 4 | | - | al dependency in outpatient practice settings: |
| 5 | | | ensed physicians including, but not limited to, physicians |
| 6 | • | | are certified in substance abuse by the American Society of |
| 7 | | | liction Medicine (ASAM); |
| 8 | | | ensed or certified psychologists; |
| 9 | | | chiatrists; |
| 10 | | • | tified substance abuse counselors working under the direct |
| 11 | | | ervision of such physicians, psychologists, or psychiatrists; |
| 12 | | - | chological associates with a masters degree in psychology |
| 13 | | • | king under the direct supervision of such physicians |
| 14 | | | chologists, or psychiatrists Licensed psychological |
| 15 | | | ociates; |
| 16 | | | ses working under the direct supervision of such physicians |
| 17 | | | chologists, or psychiatrists; |
| 18 | | ~ | tified clinical social workers and licensed clinical social |
| 19 | | _ | kers; |
| 20 | | | tified clinical specialists in psychiatric and mental health |
| 21 | | | sing; |
| 22 | | | ensed professional counselors; |
| 23 | | | |
| | | j. Cen | tified fee-based practicing pastoral counselors; |
| 24 | | 1. | Substance abuse professionals certified under Article 50 |
| 25 | | :1 T.: | of Chapter 90 of the General Statutes; |
| 26 | | • | ensed marriage and family and therapists; and |
| 27 | | | the absence of meeting one of the criteria above, the Menta |
| 28 | | | lth Case Manager could consider, on a case-by-case basis, a |
| 29 | | | vider who supplies: |
| 30 | | 1. | Evidence of graduate education in the diagnosis and |
| 31 | | 2 | treatment of chemical dependency, and |
| 32 | | 2. | Supervised work experience in the diagnosis and |
| 33 | | | treatment of chemical dependency (with supervision by |
| 34 | | _ | an appropriately credentialed provider), and |
| 35 | | 3. | Substantive past and current continuing education in the |
| 36 | | | diagnosis and treatment of chemical dependency |
| 37 | | | commensurate with one's profession. |
| 38 | • | • | t nothing in this subsection shall prohibit the Plan from |
| 39 | | | ffective treatment setting to be utilized by the persor |
| 40 | undergoing neces | ssary care a | nd treatment for chemical dependency." |

SECTION 4. G.S. 90-270.18 reads as rewritten: "§ 90-270.18. Disposition and schedule of fees.

(a) All Except as provided in subdivision (b)(2) of this section, all fees derived from the operation of this Article shall be deposited with the State Treasurer to the

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credit of a revolving fund for the use of the Board in carrying out its functions. All fees 1 2 derived from the operation of this Article shall be nonrefundable. 3 Fees for activities specified by this Article are as follows: (b) 4 Application fees for licensed psychologists and licensed psychological (1)associates per G.S. 90-270.11(a) and (b)(1), or G.S. 90-270.13, shall 5 not exceed one hundred dollars (\$100.00). 6 7 Fees for the national written examination shall be the cost of the (2) examination to the Board as set by the vender plus an additional fee 8 9 not to exceed fifty dollars (\$50.00). The Board may require applicants to pay the fee directly to the vendor. 10 Fees for additional examinations shall be as prescribed by the Board. (3) 11 Fees for the renewal of licenses, per G.S. 90-270.14(a)(1), shall not 12 **(4)** exceed two hundred fifty dollars (\$250.00) per biennium. This fee 13 14

- may not be prorated. (5) Late fees for license renewal, per G.S. 90-270.14(a)(1), shall be
- twenty-five dollars (\$25.00). Fees for the reinstatement of a license, per G.S. 90-270.15(f), shall not (6)
- exceed one hundred dollars (\$100.00).
- Fees for a duplicate license, per G.S. 90-270.14(b), shall be **(7)** twenty-five dollars (\$25.00).
- Fees for a temporary license, per G.S. 90-270.5(f) and 90-270.5(g), (8) shall be twenty five thirty-five dollars (\$25.00 \$35.00).
- Application fees for a health services provider certificate, per G.S. (9) 90-270.20, shall be fifty dollars (\$50.00).
- The Board may specify reasonable charges for duplication services, materials, and returned bank items in its rules."

SECTION 5. This act becomes effective January 1, 2004 and applies to services rendered by psychological associates on and after that date.

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HOUSE BILL 1049: Licensed Psych. Assoc./Insurance Payments



BILL ANALYSIS

Committee: House Insurance

Date:

June 3, 2003

Version:

Proposed Committee Substitute

H1049-CSRC-63[v.5]

Introduced by: Representative Holliman

Summary by: Kory J. Goldsmith

Committee Counsel

SUMMARY: The Proposed Committee Substitute for H1049 would allow psychological associates to be reimbursed directly from health insurance plans and the State Health Plan for services rendered. The bill also increases the fee the Psychology Board may charge for a temporary license.

The act would become effective January 1, 2004 and would apply to services rendered by psychological associates on and after that date.

The Proposed Committee Substitute contains a fee increase and must be re-referred to House Finance.

CURRENT LAW: See Bill Analysis below.

BILL ANALYSIS:

Section 1 -Current Law - G.S. 58-50-30(a1) provides that if a health benefit plan or policy of insurance under a Health Maintenance Organization provides coverage or payment for any service that is within the practice of a duly licensed psychologist, then the insured persons are entitled to coverage and the duly licensed psychologist is entitled to be paid or reimbursed for the services renders.

The Proposed Committee Substitute expands the definition of a duly licensed psychologist to include licensed psychological associates.

Sections 2 and 3 - Current Law - G.S. 135-40.7B provides the types of benefits for the treatment of mental illness and chemical dependency are covered under the State Health Plan. psychological associate may not provide necessary care and treatment for mental health unless under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology. A licensed psychological associate may not provide necessary care and treatment for chemical dependency unless the psychological associate has received the appropriate substance abuse training and experience and is working under the direct supervision of physicians, psychologist, or psychiatrists at the facility.

The Proposed Committee Substitute would remove the supervision requirements and allow licensed psychological associates to receive payment for necessary care and treatment of mental health and chemical dependency treatment under the State Health Plan.

Section 4 – Current Law - G.S. 90-270.18 provides the fees the Psychology Practice Board may charge to carryout its functions. The Board may charge the cost of the national written exam plus \$50, and \$25 for a temporary license.

The Proposed Committee Substitute - would allow the Board to have the fee for the national exam be set by the vendor and remitted directly to the vendor by the applicants. The PCS also allows a \$10 increase in the fee for temporary licenses (from \$25 to \$35).

HOUSE BILL 1049

Page 2

BACKGROUND: Article 18A of Chapter 90 is the Psychology Practice Act. It governs the qualifications and licensure of persons who practice psychology in North Carolina.

The practice of psychology is defined as he observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior or of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, or mental health. It includes: psychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; diagnosis, including etiology and prognosis, and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological and neuropsychological aspects of physical illness, accident, injury, or disability; and psychoeducational evaluation, therapy, remediation, and consultation.

In order to obtain licensure as a psychologist, an individual must be at least 18 years old, have good moral character, have received a doctoral psychology degree, have at least two years of supervised experience, and pass a licensure exam.

In order to obtain licensure as a psychological associate, an individual must be at least 18 years old, have good moral character, have received a master's psychology degree and pass a licensure exam. Under rules adopted by the Psychology Board, psychological associates must receive at least one hour per month of supervision from a licensed psychologist or other qualified professional.

As a general rule, insurance companies will not directly reimburse psychological associates for services rendered unless the psychological associate is employed and directly supervised by a psychologist or other professional.

· Manyann Olsen

I want to thank the members of this committee for your attention, and, in particular Chairman Holliman and Representatives Johnson and Allen who offered their interest, time and direct assistance in developing this FESA. Speaking for the North Carolina Association of Professional Psychologists, we urge your favorable consideration of HB 1049. consider this bill a potential remedy to a situation in the law that deprives our citizens of freedom of choice in mental health treatment providers by omitting one group of mental health professionals from inclusion in relevant insurance statutes. Unlike clinical social workers, professional counselors. psychiatric nurses, pastoral care counselors, and substance abuse counselors - who are all professionals licensed with training at the master's graduate level and referenced in Freedom of Choice and State Health Plan

legislation, — WE, 2 licensed psychological associates, who are psychologists with equal or superior master's graduate credentials, are omitted from reference in Chapters 135 and 58. The effect of this omission is to limit options for consumers and deny legitimate mental health providers reimbursement from insurance benefits.

If you would allow a brief personal illustration: I am a psychologist who works with families experiencing problems with very children. In this capacity, it is advantageous to families if I conduct observations and child's the natural assessments in environments and provide consultation and helpful strategies in homes, day cares, and preschools. I spent last evening with such a family in their home observing and consulting with two frustrated parents worried about their Because I am not eligible for young sons.

insurance reimbursement, I adjust my fees to something families can afford. Rather than the typical \$100-\$120 an hour fee, I charge \$50. The reality is that one-half of that goes to income and payroll taxes. And with costs of travel to the home and other business expenses, as much as I value my work, I could not maintain a practice solely on this compensation rate. I am also employed as a psychologist with Wake County Human But when mental health reform Services. mandates outsourcing of all public mental health services - as it soon will across this state - to continue to offer psychological services, I will need to be eligible for insurance, MCO, Medicaid reimbursement on par with all other master's trained mental health treatment professionals in Carolina.

The subcommittee members, who included.

representatives of this committee, and the North Carolina Association of Professional **Psychologists** and the North Carolina Psychological Association, worked together to reach a compromise that we all hope will successfully resolve this dilemma and is one that you can support. If enacted, but proves inadequate, we will need to regroup and search for alternative solutions. For, if we cannot receive reimbursement for provision of psychological services, we cannot survive to offer our expertise and experience to consumers who seek our help. further information, the amendments to the Psychology **Practice** Act are changes requested and supported by the North Carolina Psychology Board. We appreciate your support of HB 1049 as it now stands and I am happy to answer any questions you might have.

Carale Frender

That you Mr. Chairman, Ladies and Jentlever of the committee, my name is Carole Lawler and I repused the North Carolina Projessional Psychologists, also Mown as NCAP. NCAP is an assertion Organization Comprised of licersed pagethologies psychological associates. These masters level psychologists have worked lay and hard to obtain the ability to reive diect insurance windersents was the been by one g the subcommittee of these egats and that to that lep. aller and lep. Johnson joint beitand reach. I would also like to comund lip Holisma zon delle lis egets on the 15004. US 649. Can accoringto LPAS have traditionally provided ale 80% of services to public agencies and Shep Center make up approximately 40% & are data, psychologists in North Carolina. Their confined availability is greatly needed. Consideration and to vote yes on House Beil 1049.

That you & Very much.



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 276

Committee Substitute Favorable 4/14/03 Senate Commerce Committee Substitute Adopted 5/28/03 Fourth Edition Engrossed 5/29/03

| Short Title: | Insurance Financial Amendments OmnibusAB | (Public) |
|--------------|--|----------|
| Sponsors: | | |
| Referred to: | | |
| | March 6, 2002 | |

March 6, 2003

1 A BILL TO BE ENTITLED 2 AN ACT TO MAKE SUBSTANTIVE AND TECHNICA

AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMENTS IN THE LAWS CONCERNING INSURANCE COMPANY SOLVENCY AND TO PROHIBIT OFFICERS AND EMPLOYEES OF THE STATE AND ITS POLITICAL SUBDIVISIONS FROM REQUIRING CONSTRUCTION CONTRACT BIDDERS TO OBTAIN SURETY BONDS FROM SURETIES OR PRODUCERS DESIGNATED BY THE OFFICERS AND EMPLOYEES.

The General Assembly of North Carolina enacts:

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

"§ 58-5-5. Amount of deposits required of foreign or alien fire and/or marine insurance companies.

Unless otherwise provided in this Article, every fire, marine, or fire and marine insurance company chartered by any other state or foreign government shall make and maintain deposits of securities with the Commissioner in the amount of twenty-five thousand dollars (\$25,000) one hundred thousand dollars (\$100,000) market value."

SECTION 2. G.S. 58-5-10 reads as rewritten:

"§ 58-5-10. Amount of deposits required of foreign or alien fidelity, surety and casualty insurance companies.

Unless otherwise provided in this Article, every fidelity, surety or casualty insurance company chartered by any other state or foreign government shall make and maintain deposits of securities with the Commissioner in the amount of fifty thousand dollars (\$50,000) two hundred thousand dollars (\$200,000) market value."

SECTION 3. G.S. 58-5-50 reads as rewritten:

"§ 58-5-50. Deposits of foreign life insurance companies.

In addition to other requirements of Articles 1 through 64 of this Chapter, all foreign life insurance companies shall deposit securities, as specified in G.S. 58-5-20, having a market value of one hundred thousand dollars (\$100,000) four hundred thousand dollars

| 1 | (\$400,000) as a pr | erequisite of doing business in this State. All foreign life insurance | | | |
|----|---------------------|---|--|--|--|
| 2 | | ompanies shall deposit an additional one hundred thousand dollars (\$100,000) two | | | |
| 3 | · · | dollars (\$200,000) where such companies cannot show three years of | | | |
| 4 | | ins prior to admission. Foreign life insurance companies that are | | | |
| 5 | | re the effective date of this section shall have one year from that date | | | |
| 6 | to comply with this | | | | |
| 7 | . • | ON 4. G.S. 58-7-162(2) reads as rewritten: | | | |
| 8 | | vestments, securities, properties, and loans acquired or held in | | | |
| 9 | | cordance with this Chapter, and in connection therewith the | | | |
| 10 | | llowing items: | | | |
| 11 | a. | Interest due or accrued on any bond or evidence of indebtedness | | | |
| 12 | | that is not in default. | | | |
| 13 | b. | Declared and unpaid dividends on stock and shares, unless that | | | |
| 14 | | amount has otherwise been allowed as an asset. | | | |
| 15 | e. | Interest due or accrued upon a collateral loan in an amount not | | | |
| 16 | | to exceed one year's interest thereon. | | | |
| 17 | d. | • | | | |
| 18 | | and loan associations, and trust companies, and interest due or | | | |
| 19 | | accrued on other assets, if the interest is, in the Commissioner's | | | |
| 20 | | judgment, a collectible asset. | | | |
| 21 | e. | Interest due or accrued on a current mortgage loan, in an | | | |
| 22 | | amount not-exceeding in any event the amount, if any, of the | | | |
| 23 | | excess of the value of the property less delinquent taxes thereon | | | |
| 24 | | over the unpaid principal; but in no event shall interest accrued | | | |
| 25 | | for a period in excess of 90 days be allowed as an asset. | | | |
| 26 | £. | Rent due or accrued on real property if the rent is not in arrears | | | |
| 27 | | for more than three months, and rent more than three months in | | | |
| 28 | | arrears if the payment of the rent is adequately secured by | | | |
| 29 | | property held in the tenant's name and conveyed to the insurer | | | |
| 30 | | as collateral and the underlying collateral is admissible under | | | |
| 31 | | this Chapter. | | | |
| 32 | g. | The unaccrued portion of taxes paid before the due date on real | | | |
| 33 | | property. | | | |
| 34 | | hapter." | | | |
| 35 | SECTIO | N 5. G.S. 58-7-162(5) and G.S. 58-7-162(7) are repealed. | | | |
| 36 | | N 6. G.S. 58-7-162(12) reads as rewritten: | | | |
| 37 | | ectronic and mechanical machines, including operating and system | | | |
| 38 | | ftware constituting a management information system, if the cost of | | | |
| 39 | | e system is at least twenty-five thousand dollars (\$25,000) but not | | | |
| 40 | m | ore than two percent (2%) of total admitted assets; the cost shall be | | | |

SECTION 7. G.S. 58-7-163 reads as rewritten:

amortized in full over a period not to exceed seven calendar

"§ 58-7-163. Assets not allowed.

years.system."

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In addition to assets impliedly excluded by the provisions of G.S. 58-7-162, the following expressly shall not be allowed as assets in any determination of the financial condition of an insurer:

- (1) Goodwill, trade names, and other like intangible assets.
- (2) Advances (other than policy loans) to officers, directors, and controlling stockholders, whether secured or not, and advances to employees, agents, and other persons on personal security only.
- (3) Stock of the insurer or any material equity therein or loans secured thereby, or any material proportionate interest in the stock acquired or held through the ownership by the insurer of an interest in another firm, corporation, or business unit.
- (4) Furniture, fixtures, other equipment, safes, vehicles, libraries, stationery, literature, and supplies, other than data processing and accounting systems authorized under G.S. 58-7-162(12), except in the case of title insurers the materials and plants which G.S. 58-7-182 expressly authorizes the insurer to invest in, and except, in the case of any insurer, any personal property that the insurer is permitted to hold under this Chapter, or that is acquired through forcolosure of chattel mortgages acquired under G.S. 58-7-180, or that is reasonably necessary for the maintenance and operation of real estate that the insurer uses for a home office, branch office, and similar purposes.
- (5) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value of the investments as determined under this Chapter.
- (6) Bonds, notes, or other evidences of indebtedness that are secured by mortgages or deeds of trust that are in default, to the extent of the cost or carrying value that is in excess of the value as determined pursuant to other provisions of this Chapter.
- (7) Prepaid and deferred expenses.
- (8) Certificates of eontribution contribution, surplus notes, or other similar evidences of indebtedness. indebtedness, to the extent that admission of these investments results in the double counting of these investments in the reporting entity's balance sheet.
- (9) Any asset that is encumbered in any manner unless the asset is authorized under G.S. 58-7-187 or G.S. 58-7-162(13)."

SECTION 8. G.S. 58-7-192 reads as rewritten:

"§ 58-7-192. Valuation of securities and investments.

(a) All securities, investments, and evidences of debt, other than those for which valuation methodologies are specifically set forth in this Chapter, that are held by an insurer shall be valued at their market values, at their appraised values, or at prices determined by the insurer as representing their fair market values, subject to the Commissioner's approval.



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- (b) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, in the Commissioner's discretion and in accordance with a method of valuation that the Commissioner approves.
- (c) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of its net value as based upon those assets only of the subsidiary that would be eligible under this Chapter and G.S. 58-19-10 for investment of the funds of the insurer direct.
- (d) No valuations under this section shall be greater than any applicable valuation or method contained in the latest edition of the NAIC publications entitled "Valuations of Securities" "Purposes and Procedures Manual of the NAIC Securities Valuation Office" or the "Accounting Practices and Procedures Manual", unless the Commissioner determines that another valuation method is appropriate when it results in a more conservative valuation.
- (e) All-bonds or fully secured indebtedness having a stated term and a rate of interest that are held by an insurer shall be valued in accordance with the procedures and instructions contained in the NAIC publication entitled "Valuations of Securities", unless the Commissioner determines that a more conservative valuation is appropriate."

SECTION 9. G.S. 58-7-193 reads as rewritten: "§ 58-7-193. Valuation of property.

- (a) Real property acquired pursuant to a mortgage loan or contract for sale shall be valued at the net realizable value, but in no event shall the property be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of the acquisition and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.
- (b) Other real property held by an insurer shall not be valued at an amount in excess of fair-market value as determined by recent appraisal and as approved by the Commissioner. If valuation is based on an appraisal more than three years old, the Commissioner may call for and require a new appraisal in order to determine fair value.
- (c) Personal property acquired pursuant to chattel mortgages made in accordance with G.S. 58-7-180 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at the date of acquisition, or the fair market value of the property, whichever amount is less.
- (d) If the Commissioner and an insurer do not agree on the value of real or personal property of an insurer, in carrying out the Commissioner's responsibilities under this section, the Commissioner may retain the services of a qualified real or personal property appraiser. The insurer shall reimburse the Commissioner for the costs of the services of any appraiser incurred with respect to the Commissioner's responsibilities under this section."

SECTION 10. G.S. 58-7-195 is repealed.

SECTION 11. G.S. 58-7-179(d) reads as rewritten:

"(d) In the case of a purchase money mortgage given to secure the purchase price of real estate sold by the insurer, the amount lent or invested shall not exceed the unpaid part of the purchase price and shall be valued in accordance with G.S. 58-7-195.price."







SECTION 12. G.S. 58-23-26(c) reads as rewritten:

"(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-175, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and Articles 13, 19, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

SECTION 13. G.S. 58-47-80 reads as rewritten:

"§ 58-47-80. Assets and invested assets.

Funds shall be held and invested by the board under G.S. 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-178, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-195, 58-7-197, 58-7-200, and 58-19-10."

SECTION 14. G.S. 58-8-15 reads as rewritten:

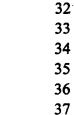
"§ 58-8-15. Directors in mutual companies.

Every mutual insurance company shall elect by ballot a board of not less than seven directors, who shall manage and conduct its business and hold office for one year or for such term as the bylaws provide and until their successors are qualified. The directors need not be residents of this State or members of the company. In companies with a guaranty capital, no more than one half one-half of the directors shall be ehosen elected by and from the stockholders holders of guaranty capital, except where guaranty capital holders are policyholders. Policyholders which are holders of guaranty capital shall be entitled to one vote for each policy that person holds and one vote for each unit of guaranty capital that person holds."

SECTION 15. G.S. 58-8-20 reads as rewritten:

"§ 58-8-20. Mutual companies with a guaranty capital.

- (a) A mutual insurance company formed as provided in Articles 1 through 64 of this Chapter, in lieu of the contributed surplus required for the organization of mutual companies under the provisions of G.S. 58-7-75, or a mutual insurance company now existing, may, with the prior approval of the Commissioner, establish tender a guaranty capital offering of not less than fifty thousand dollars (\$50,000), divided into shares units of one hundred dollars (\$100.00) each, which shall be invested in the same manner as is provided in this Chapter for the investment of the capital stock of insurance companies.
- (a1) Guaranty capital may be issued by an existing domestic mutual insurance company only under the following terms and conditions:
 - (1) To aid and assist a financially troubled domestic mutual insurance company which otherwise faces rehabilitation or liquidation by this Department; or



(2) For any other reason as presented in a petition to the Commissioner and which is found by the Commissioner to be reasonable, justifiable, and in the best interest of all the policyholders of the company.

Guaranty capital issued under subdivision (2) of this subsection shall require written notification of the action proposed by the board of directors of the company to be mailed to the policyholders of the company not less than 30 days before the meeting when the action may be taken. The written notification shall be advertised in two newspapers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before the meeting. The written notification to policyholders shall include a proxy statement to allow policyholders to vote on the proposed action without personal attendance at the meeting, and the Commissioner shall approve both the written notification and the proxy statement. The proposed action shall be effected by a vote of two-thirds of the policyholders voting thereon in person or by proxy.

- (b) The board of directors of a company may declare and pay dividends to the stockholders of the guaranty capital of a company, subject to the notification requirements of G.S. 58-19-25(d) and the prior approval requirements of G.S. 58-19-30(c). distribute interest to the holders of guaranty capital in accordance with the guaranty capital filing approved by the Department.
- (c) The guaranty Guaranty capital shall be applied to the payment of losses only when the company has exhausted its cash in hand and the invested assets, exclusive of uncollected premiums, and when thus impaired, the directors may make good the whole or any part of it by assessments upon the contingent funds of the company at the date of such impairment. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.
- (d) Shareholders and members of such companies are subject to the same provisions of law in respect to their right to vote as apply respectively to shareholders in stock companies and policyholders in mutual companies. Guaranty capital holders are entitled to one vote per unit of guaranty capital. Guaranty capital holders who are not policyholders are not entitled to participate in the policyholder votes prescribed under subdivision (a1)(2) and subsection (e) of this section.
- (e) This guaranty Guaranty capital may be reduced or retired by vote of the policyholders of the company and the assent of the Commissioner, if the net assets of the company above its reserve and all other claims and obligations, exclusive of guaranty capital, for two years immediately preceding and including the date of its last annual statement, is not less than twenty-five percent (25%) of the guaranty capital. Due notice of such proposed action on the part of the company must be mailed to each policyholder of the company not less than 30 days before the meeting when the action may be taken, and must also be advertised in two papers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before such meeting. No insurance company with a guaranty capital







which has ceased to do new business, shall divide to its stockholders any part of its assets or guaranty capital, except income from investments, until it has performed or canceled its policy obligations. In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the certificate holders to the extent that the guaranty capital had been contributed together with accrued income as specified in the certificate. Any amounts in excess shall be for the benefit of the policyholders.

- (f) No insurance company with guaranty capital shall distribute to its holders of guaranty capital its assets, except as provided in the guaranty capital filing as approved by the Commissioner.
- (g) In the event of a merger, demutualization, or other event where the entity ceases to exist, guaranty capital shall only be returned or repaid to the holders of guaranty capital to the extent that the guaranty capital has been contributed together with accrued interest as specified in the filing approved by the Commissioner."

SECTION 16. G.S. 58-8-50 reads as rewritten:

"§ 58-8-50. Guaranty against assessments prohibited.

If any director, officer, or agent of a mutual insurance company, either officially or privately, shall give gives a guarantee to a policyholder thereof of the company against an assessment to which such that policyholder would otherwise be liable, he the director, officer, or agent shall be punished by a fine not exceeding one hundred dollars (\$100.00) one thousand dollars (\$1,000) for each offense."

SECTION 17. G.S. 58-65-1 reads as rewritten:

"§ 58-65-1. Regulation and definitions; application of other laws; profit and foreign corporations prohibited.

(a) Any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, unless otherwise provided.

The term "hospital service plan" as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations or any other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association or the American Medical Association.

The term "medical service plan" as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical or any other professional services authorized or permitted to be furnished by a duly licensed physician or other provider listed in G.S. 58-50-30. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be



 furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article and Article 66 of this Chapter includes contracting for the payment 20f of fees toward, or furnishing of dental or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The term "hospital service corporation" as used in this Article and Article 66 of this Chapter—is intended to mean any nonprofit corporation operating a hospital or medical or dental service plan, as defined in this section. Any corporation organized and subject to the provisions of this Article and Article 66 of this Chapter, Article, the certificate of incorporation of which authorizes the operation of either a hospital or medical or dental service plan, or any or all of them, may, with the approval of the Commissioner—of Insurance, Commissioner, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Article. Except to the extent prohibited either by G.S. 58-65-140 or by rules promulgated adopted by the Department of Insurance Commissioner not inconsistent with this Article and Article 66 of this Chapter, Article, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

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- (b) through (c) Repealed by Session Laws 2001-297.
- licensed licensed Social Work and Licensure
- (d) No foreign or alien hospital or medical or dental service corporation as herein defined shall be authorized to do business in this State."

SECTION 18. G.S. 58-65-95(a) reads as rewritten:

"(a) No corporation Corporations subject to this Article shall invest in any securities other than securities or hold only those assets permitted by Article 7 of this Chapter for the investment of assets of life and health insurance companies."

SECTION 19. G.S. 58-67-5(i) reads as rewritten:

"(i) "Net worth" means the excess of total assets over the total liabilities and may include borrowed funds that are repayable only from the net earned income of the health maintenance organization and repayable only with the advance permission of the Commissioner. For the purposes of this subsection, "assets" means (i) tangible assets and (ii) other investments permitted under G.S. 58-67-60; provided, however, that the



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depreciated cost of office furniture and equipment in the principal office shall not exceed ten percent (10%) of a health maintenance organization's net worth. G.S. 58-67-60."

SECTION 20. G.S. 58-67-40 is repealed.

SECTION 21. G.S. 58-67-110 reads as rewritten:

"§ 58-67-110. Protection against insolvency.

- (a) The Commissioner shall require deposits in accordance with the provisions of G.S. 58-67-25.
- Each full service medical-health maintenance organization shall maintain a minimum net worth of not less than one million dollars (\$1,000,000), which shall be increased by the amount of the contingency reserves calculated annually in accordance with the provisions of G.S. 58-67-40. The net worth calculation shall be computed in accordance with statutory accounting principles generally recognized in the regulation of health maintenance organizations and the Commissioner may promulgate such regulations as he deems appropriate to carry out the provisions of this section. If a health maintenance organization fails to comply with the net worth requirement of this subsection or subsections (e) or (d) of this section, the Commissioner is authorized to take appropriate action to assure that the continued operation of the health-maintenance organization will not be hazardous to its enrollees. equal to the greater of one million dollars (\$1,000,000) or the amount required pursuant to the risk-based capital provisions of Article 12 of this Chapter. Each single service health maintenance organization shall maintain a minimum net worth equal to the greater of fifty thousand dollars (\$50,000) or that amount required pursuant to the risk-based capital provisions of Article 12 of this Chapter.
- (c) The minimum net worth for a health maintenance organization authorized to operate on July 17, 1987, and having a net worth of less than one million dollars (\$1,000,000) shall be as follows:
 - (1) \$150,000 by December 31, 1987
 - (2) \$300,000 by December 31, 1988
 - (3) \$450,000 by December 31, 1989
 - (4) \$750,000 by December 31, 1990
 - (5) \$1,000,000 by December 31, 1991

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.

- (d) Notwithstanding any other provision of this Article, a health maintenance organization authorized to offer only a single health care service plan providing a single health care service must have a minimum net worth of fifty thousand dollars (\$50,000). The minimum net worth for such plan authorized to operate on July 17, 1987, and having a net worth of less than fifty thousand dollars (\$50,000) shall be as follows:
 - (1) Twenty-five thousand dollars (\$25,000) by December 31, 1987; and
 - (2) Fifty thousand dollars (\$50,000) by December 31, 1988;

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 58-67-40.



| | | · |
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| 1 | (e) Every | full service medical health maintenance organization shall have and |
| 2 | maintain at all ti | mes an adequate plan for protection against insolvency acceptable to |
| 3 | the Commissione | er. In determining the adequacy of such a plan, the Commissioner may |
| 4 | consider: | • |
| 5 | (1) | A reinsurance agreement preapproved by the Commissioner covering |
| 6 | , , | excess loss, stop loss, or catastrophes. The agreement must provide |
| 7 | | that the Commissioner will be notified no less than 60 days prior to |
| 8 | | cancellation or reduction of coverage. |
| 9 | | A conversion policy or policies that will be offered by an insurer to the |
| 10 | | enrollees in the event of the health maintenance organization's |
| 11 | | insolvency. |
| 12 | | Any other arrangements offering protection against insolvency that the |
| 13 | • • | Commissioner may require." |
| 14 | | ON 22. G.S. 58-67-140(a)(3) reads as rewritten: |
| 15 | "(3) | No longer maintains the financial reserve specified in G.S. 58-67-40 or |
| 16 | | is Is no longer financially regnonsible and may reasonable be expected |
| 17 | | is <u>Is</u> no longer financially responsible and may reasonably be expected |
| 18 | | to be unable to meet its obligations to enrollees or prospective enrollees." |
| 19 | | ON 23. G.S. 58-67-140(a)(7) reads as rewritten: |
| 20 | | |
| 21 | | Has knowingly published or made to the Department or to the public |
| 22 | | any false statement or report, including any report or any data that |
| 23 | | serves as the basis for any report, required to be submitted under G.S. |
| .s 24 | | 58-3-210.G.S. 58-3-191." |
| 25 | SECTI | ON 24. G.S. 58-47-65(a) reads as rewritten: |
| .5 26 | "(a) No gro | up shall self-insure its workers' compensation liabilities under the Act |
| .0 27 | annly to a group of | sed by the Commissioner under this Part. This subsection does not |
| 28 | July 1 1005 and | that was organized and approved under the North Carolina law before |
| .o !9 | | whose authority to self-insure its workers' compensation liabilities |
| .9 .0 | | not terminated after that date." |
| | | ON 25. G.S. 97-170(a) reads as rewritten: |
| 1 | "(a) No emp | oloyer shall self-insure its workers' compensation liabilities under the |
| 2 3 | not apply to an ex | censed by the Commissioner under this Article. This subsection does |
| | | mployer authorized to self-insure its workers' compensation liabilities |
| 4 | under the Act pri | or to December 1, 1997, whose authority to self-insure its workers' |
| 5 | | collities under the Act has not terminated after that date." |
| 6 | | ON 26.(a) G.S. 58-3-100 reads as rewritten: |
| 7 | | rance company licensing provisions. |
| 8 | (a) The Co | ommissioner may, after notice and opportunity for a hearing, revoke, |
| 9 | | or refuse to renew or restrict the license of any insurer if: |
| 10 | | The insurer fails or refuses to comply with any law, order or rule |
| 1 | | applicable to the insurer. |
| 2 | | The insurer's financial condition is unsound, or its assets above its |
| 3 | ŀ | iabilities, exclusive of capital, are less than the amount of its capital or |

required minimum surplus.



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The insurer has published or made to the Department or to the public (3) any false statement or report.

- The insurer or any of the insurer's officers, directors, employees, or **(4)** other representatives refuse to submit to any examination authorized by law or refuse to perform any legal obligation in relation to an examination.
- The insurer is found to make a practice of unduly engaging in (5) litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.
- Any suspension, revocation or refusal to renew suspension or revocation of (b) an insurer's license under this section may also be made applicable to the license or registration of any individual regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section."

SECTION 26.(b) G.S. 58-4-15 reads as rewritten:

"§ 58-4-15. Revocation or suspension of license.

The Commissioner may suspend, revoke, or refuse to renew suspend or revoke the license of any insurer failing to file its financial statement when due or within any extension of time that the Commissioner, for good cause, may have granted."

SECTION 26.(c) G.S. 58-6-7 reads as rewritten:

"§ 58-6-7. Licenses; perpetual licensing; annual license continuation Annual license fees for insurance companies.

In order to do business in this State, an insurance company shall apply for and obtain a license from the Commissioner by March 1 of each year. Commissioner. The license shall be perpetual and become effective the following July 1 and shall remain in effect for one year. shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with this Chapter and subject to any other applicable provision of the insurance laws of this State. Except as provided in subsection (b) of this section, the insurance company shall pay an annual a fee for each <u>year</u> the license is in effect, as follows:

For each domestic farmer's mutual assessment fire insurance company......\$ 25.00 For each fraternal order......100.00 For each of all other insurance companies, except mutual burial associations taxed under G.S. 105-121.1......1,000.00 The fees levied in this subsection are in addition to those specified in G.S. 58-6-5.

- When the paid-in capital stock or surplus, or both, of an insurance company, other than a farmer's mutual assessment company or a fraternal order, does not exceed one hundred thousand dollars (\$100,000), the fee levied in this section shall be one-half the amount specified.
- Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety

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companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars (\$100.00) for each such additional classification of business done. All fees and charges collected by the Commissioner under this Chapter are nonrefundable.

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

SECTION 26.(d) G.S. 58-6-15 reads as rewritten:

"§ 58-6-15. Licenses run from July 1. Annual license continuation fee definition; requirements.

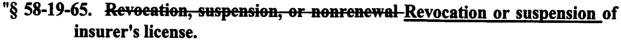
The license required of insurance companies shall continue, continue for the next ensuing 12 months after July 1 of each year, unless revoked as provided in Articles 1 through 64 of this Chapter. Application for renewal of the company license For purposes of this Chapter only, "annual license continuation fee means" the fee specified in G.S. 58-6-7 submitted to the Commissioner for each year the license is in effect after the company's year of initial licensing. The annual license continuation fee must be submitted on or before the first day of March on a form to be supplied by the Commissioner. Commissioner each year the license is to remain in effect. If the Commissioner is satisfied Upon satisfying himself that the company has met all requirements of law and appears to be financially solvent he shall forward the renewal license to the company. Any company which does not qualify for a renewal license before July 1 shall cease to do business in the State of North Carolina as of July 1, unless its license is sooner revoked by the Commissioner. solvent, the Commissioner shall not revoke or suspend the license of the company, and the company shall be authorized to do business in this State, subject to all other applicable provisions of the insurance laws of this State. Nothing contained in this section shall be interpreted as applying to licenses issued to individual representatives of insurance companies."

SECTION 26.(e) G.S. 58-6-30 reads as rewritten: "§ 58-15-30. License, surplus, and deposit requirements.

- (a) No reciprocal shall engage in any insurance transaction in this State until it has obtained a license to do so in accordance with the applicable provisions of Articles 1 through 64 of this Chapter. Such The license shall continue in full force and effect, subject to timely payment of an annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State.expire on the last day of June of each year.
- (b) No domestic or foreign reciprocal shall be licensed in this State unless it has a surplus to policyholders of at least eight hundred thousand dollars (\$800,000); and no alien reciprocal shall be licensed unless it has a trusteed surplus of at least eight hundred thousand dollars (\$800,000).
- (c) Each domestic, foreign, or alien reciprocal licensed in this State must maintain a minimum deposit with the Commissioner of at least one hundred thousand dollars (\$100,000) in cash or in value of securities of the kind specified in G.S. 58-5-15, which shall be subject to the same conditions as contained in Article 5 of this Chapter."

SECTION 26.(f) G.S. 58-19-65 reads as rewritten:





Whenever it appears to the Commissioner that any person has committed a violation of this Article that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an opportunity to be heard, suspend, revoke, or refuse to renew suspend or revoke such insurer's license to do business in this State for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law."

SECTION 26.(g) G.S. 58-24-130 reads as rewritten:

"§ 58-24-130. Annual-Perpetual license.

Societies which are now authorized to transact business in this State may continue such business until the 30th day of June next succeeding January 1, 1988. The authority of such societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the 30th day of the succeeding June. However, a license so issued Subject to timely payment of the annual license continuation fee and subject to any other applicable provisions of the insurance laws of this State, a license, other than a preliminary license, to a fraternal benefit society under this Article shall continue in full force and effect until the new license be issued or specifically refused. effect. For each such-license or renewal the society shall pay the Commissioner the fee specified in G.S. 58-6-5. The society shall pay the Commissioner, as an annual license continuation fee and a condition of the continuation of the license, the fee specified in G.S. 58-6-7 on or before the first day of March on a form to be supplied by the Commissioner. A duly certified copy or duplicate of suchthe license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of Articles 1 through 64 of this Chapter."

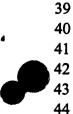
SECTION 26.(h) G.S. 58-26-10 reads as rewritten: "§ 58-26-10. Financial statements and licenses required.

Title insurance companies are subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-165, 58-2-180, and 58-6-5. The Commissioner may require title insurance companies to separately report their experience in insuring titles and in insuring closing services. The license to do business in this State issued to a title insurance company shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State. The Commissioner shall annually license such companies and their agents the agents of title insurance companies."

SECTION 26.(i) G.S. 58-30-62 reads as rewritten:

"§ 58-30-62. Administrative supervision of insurers.

(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



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requests; continues to transact the business of insurance after its license has been revoked, suspended, or not renewed revoked or suspended 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."

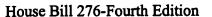
SECTION 26.(j) G.S. 58-65-55 reads as rewritten:

"§ 58-65-55. Issuance of certificate. and continuation of license.

- (a) Before issuing or continuing any such license or certificate the Commissioner may make such an examination or investigation as the Commissioner deems expedient. The Commissioner shall issue a certificate of authority or license upon the payment of an annual a fee of one thousand dollars (\$1,000) and upon being satisfied on the following points:
 - (1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.
 - (2) The rates charged and benefits to be provided are fair and reasonable.
 - (3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and hospital and medical and/or dental expenses and such reserve as the Department deems adequate, as provided hereinafter.
 - (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.
- (b) The license shall continue in full force and effect, subject to payment of an annual license continuation fee of one thousand dollars (\$1,000), subject to all other provisions of subsection (a) of this section and subject to any other applicable provisions of the insurance laws of this State."

SECTION 26.(k) G.S. 58-65-125 reads as rewritten:

- "§ 58-65-125. Revocation, suspension, and refusal to renew Revocation and suspension of license; unfair trade practices.
- (a) The Commissioner may revoke, suspend, or refuse to renewrevoke or suspend the license of any service corporation if:
 - (1) The service corporation fails or refuses to comply with any law, order, or rule applicable to the service corporation.
 - (2) The service corporation's financial condition is unsound.
 - (3) The service corporation has published or made to the Department or to the public any false statement or report.



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- The service corporation refuses to submit to any examination **(4)** authorized by law.
- The service corporation is found to make a practice of unduly (5) engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.
- Any suspension, revocation, or refusal to renew suspension or revocation of a (b) service corporation's license under this section may also be made applicable to the license or registration of any natural person regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.
- Article 63 of this Chapter applies to service corporations and their agents and representatives."

SECTION 26.(1) G.S. 58-67-140 reads as rewritten:

"§ 58-67-140. Suspension or revocation of license.

- The Commissioner may suspend, revoke, or refuse to renew suspend or revoke an HMO license if the Commissioner finds that the HMO:
 - Is operating significantly in contravention of its basic organizational (1) document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-67-10, unless amendments to such submissions have been filed with and approved by the Commissioner.
 - Issues evidences of coverage or uses a schedule of premiums for health **(2)** care services that do not comply with G.S. 58-67-50.
 - No longer maintains the financial reserve specified in G.S. 58-67-40 or (3) is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
 - Has itself or through any person on its behalf advertised or **(4)** merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.
 - Is operating in a manner that would be hazardous to its enrollees. **(5)**
 - Knowingly or repeatedly fails or refuses to comply with any law or (6) rule applicable to the HMO or with any order issued by the Commissioner after notice and opportunity for a hearing.
 - Has knowingly published or made to the Department or to the public **(7)** any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210."

SECTION 26.(m) G.S. 58-67-160 reads as rewritten: "§ 58-67-160. Fees.

Every health maintenance organization subject to this Article shall pay to the Commissioner a fee of two hundred fifty dollars (\$250.00) for filing an application for a license and a-an annual license continuation fee of one thousand dollars (\$1,000) for each license renewal. license. The license shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State."

SECTION 26.(n) G.S. 58-67-20 reads as rewritten:

"§ 58-67-20. Issuance of certificate. and continuation of license.

- (a) Before issuing <u>or continuing</u> any such <u>certificate</u>, <u>license</u>, the Commissioner of Insurance may make such an examination or investigation as he deems expedient. The Commissioner of Insurance shall issue a <u>certificate of authority license</u> upon the payment of the application fee prescribed in G.S. 58-67-160 and upon being satisfied on the following points:
 - (1) The applicant is established as a bona fide health maintenance organization as defined by this Article;
 - (2) The rates charged and benefits to be provided are fair and reasonable;
 - (3) The amounts provided as working capital are repayable only out of earned income in excess of amounts paid and payable for operating expenses and expenses of providing services and such reserve as the Department of Insurance deems adequate, as provided hereinafter;
 - (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the eertificate—license—and that the health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. Such working capital shall initially be a minimum of one million five hundred thousand dollars (\$1,500,000) for any full service medical health maintenance organization. Initial working capital for a single service health maintenance organization shall be a minimum of one hundred thousand dollars (\$100,000) or such higher amount as the Commissioner shall determine to be adequate.
- (b) In making the determinations required under this section, the Commissioner shall consider:
 - (1) The financial soundness of the health care plan's arrangements for health care services and the schedule of premiums used in connection therewith;
 - (2) The adequacy of working capital;
 - (3) Any agreement with an insurer, a hospital or medical service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of alternative coverage in the event of discontinuance of the plan;
 - (4) Any agreement with providers for the provision of health care services; and
 - (5) Any firm commitment of federal funds to the health maintenance organization in the form of a grant, even though such funds have not been paid to the health maintenance organization, provided that the health maintenance organization certifies to the Commissioner that such funds have been committed, that such funds are to be paid to the



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health maintenance organization with a current fiscal year and that such funds may be used directly for operating purposes and for the benefit of enrollees of the health maintenance organization.

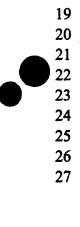
(c) A certificate of authority license shall be denied only after compliance with the requirements of G.S. 58-67-155."

SECTION 27. Article 31 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-31-66. Public construction contract surety bonds.

- (a) Neither the State nor any county, city, or other political subdivision of the State, or any officer, employee, or other person acting on behalf of any such entity shall, with respect to any public building or construction contract, require any contractor, bidder, or proposer to procure a bid bond, payment bond, or performance bond from a particular surety, agent, producer, or broker.
- (b) Nothing in this section prohibits an officer or employee acting on behalf of the State or a county, city, or other political subdivision of the State from:
 - (1) Approving the form, sufficiency, or manner of execution of the surety bonds furnished by the surety selected by the bidder to underwrite the bonds.
 - (2) <u>Disapproving</u>, on a reasonable, nondiscriminatory basis, the surety selected by the bidder to underwrite the bonds because of the financial condition of the surety.
- (c) A violation of this section renders the public building or construction contract void ab initio."

SECTION 28. Sections 26(a) through (n) become effective January 1, 2004, and apply to all company licenses issued or otherwise eligible for renewal or continuation after that date. The remainder of this act becomes effective October 1, 2003.



CONCURRENCE IN SENATE CHANGE TO HB 276

THE LAST SECTION (SECTION 27) OF HB 276, ADDED BY THE SENATE, WOULD PROHIBIT PUBLIC OFFICIALS FROM **REQUIRING BIDDERS ON PUBLIC** CONSTRUCTION CONTRACTS TO GET THEIR SURETY BONDS FROM SPECIFIC SURETY COMPANIES OR SPECIFIC SURETY AGENTS OR BROKERS. THIS HAS BEEN A PROBLEM IN OTHER STATES, AND 34 OF THEM HAVE STOPPED THE PRACTICE WITH LEGISLATION SIMILAR TO SECTION 27. NORTH CAROLINA PUBLIC CONTRACT LAW MIGHT POSSIBLY DISALLOW THIS PRACTICE, BUT IT IS NOT CLEAR ENOUGH. IN THE PROPOSED LANGUAGE, THE PUBLIC OFFICIAL COULD STILL REJECT A SURETY COMPANY BECAUSE OF ITS FINANCIAL CONDITION. THERE IS NO **OPPOSITION TO SECTION 27, AND THE** DEPARTMENT OF INSURANCE AND THE SURETY INDUSTRY HAVE ENDORSED IT.



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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SENATE BILL 966 PROPOSED HOUSE COMMITTEE SUBSTITUTE S966-CSRG-24 [v.1]

6/4/2003 9:16:14 AM

| | Short Title: Insurance Personal Info. Safeguards. (Public) | |
|----------|---|--|
| | Sponsors: | |
| | Referred to: | |
| | April 3, 2003 | |
| - 1 | A BILL TO BE ENTITLED | |
| 2 | AN ACT TO REQUIRE INSURERS TO IMPLEMENT SAFEGUARDS FOR THE | |
| 3 | PROTECTION OF CUSTOMER INFORMATION, PURSUANT TO THE | |
| 4 | PROVISIONS OF THE GRAMM-LEACH-BLILEY ACT. | |
| 5 | The General Assembly of North Carolina enacts: | |
| 6 | SECTION 1. The heading for Article 39 of Chapter 58 of the General | |
| 7 | Statutes reads as rewritten: | |
| 8 | "Article 39. | |
| 9 | Insurance Information and Privacy Protection Act. | |
| 10 | Consumer and Customer Information Privacy." | |
| 11 | SECTION 2. Article 39 of Chapter 58 of the General Statutes is amended | |
| 12 | by: | |
| 13 | (1) Designating G.S. 58-39-1 through G.S. 58-39-76 as: | |
| 14 | "Part 1. Insurance Information and Privacy Protection." | |
| 15 | (2) Designating G.S. 58-39-80 through G.S. 58-39-125 as: | |
| 16 | "Part 2, Enforcement, Sanctions, Remedies, and Rights." and | |
| 17 | (3) Recodifying G.S. 58-39-70 as G.S. 58-39-125. | |
| 18 | SECTION 3. G.S. 58-39-1 reads as rewritten: | |
| 19 | "§ 58-39-1. Short title.titles. | |
| 20 | This Article may be cited as the Consumer and Customer Information Privacy Act. | |
| 21 | Part 1 of this Article may be cited as the Insurance Information and Privacy Protection | |
| 22 | Act. Part 3 of this Article may be cited as the Customer Information Safeguards Act." | |
| 23 | SECTION 4. Article 39 of Chapter 58 of the General Statutes is amended by | |
| 24 25 | adding a new Part to read: "Part 3. Customer Information Safeguards. | |
| | | |
| 26 27 | "§ 58-9-130. Purpose. The purpose of this Part is to establish standards for developing and implementing | |
| 28 | administrative, technical, and physical safeguards to protect the security, confidentiality, | |

- and integrity of customer information, as required by sections 501, 505(b) and 507 of 1 2 the federal Gramm-Leach-Bliley Act (Public Law 106-102), codified as 15 U.S.C. §§6801, 6805(b), and 6807. The purpose of this Part is also to provide privacy and security protection consistent with federal regulations governing the privacy and 4 security of medical records when this Part is consistent with those federal regulations. In 5 those instances in which this Part and the federal regulations are inconsistent and this 6 Part provides privacy and security protection beyond that offered by the federal 7 regulations, the purpose of this Part is to provide that additional privacy and security 8 9 protection.
 - "§ 58-39-135. Scope.

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The safeguards established under this Part apply to all customer information, as defined in G.S. 58-39-135.

"§ 58-39-140. Definitions."

As used in this Part, in addition to the definitions in G.S. 58-39-15:

- (1) 'Customer' means an applicant with or policyholder of a licensee.
- (2) 'Customer information' means nonpublic personal information about a customer, whether in paper, electronic or other form that is maintained by or on behalf of the licensee.
- (3) 'Customer information systems' means the electronic or physical methods used to access, collect, store, use, transmit, protect, or dispose of customer information.
- (4) 'Licensee' means any producer, as defined in G.S. 58-33-10(7), insurer, MEWA, HMO, or service corporation governed by this Chapter. 'Licensee' does not mean:
 - a. An insurance-support organization.
 - b. A licensee who is a natural person operating within the scope of the licensee's employment by or affiliation with an insurer or producer.
 - c. A surplus lines insurer or licensee under Article 21 of this Chapter.
- (5) 'Service provider' means a person that maintains, processes, or otherwise is permitted access to customer information through its provision of services directly to the licensee and includes an insurance support organization.

"§ 58-39-145. Information security program.

Each licensee shall implement a comprehensive written information security program that includes administrative, technical, and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

"§ 58-39-150. Objectives of information security program.

A licensee's information security program shall be designed to:

(1) Ensure the security and confidentiality of customer information:

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| | GENERAL AS | SSEMBLY OF NORTH CAROLINA SESSION 2003 |
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| 1 | (2) | Protect against any anticipated threats or hazards to the |
| 2 | | security or integrity of the information; and |
| 3 | (3) | Protect against unauthorized access to or use of the |
| 4 | ` , | information that could result in substantial harm or inconvenience to |
| 5 | | any customer. |
| 6 | "§58-39-155. F | Rules. |
| 7 | The Commi | ssioner may adopt rules that the Commissioner deems necessary to carry |
| 8 | out the purpose | es of this Part, including rules that govern licensee oversight of service |
| 9 | providers with | which it contracts or has a relationship. |
| 10 | " <u>§ 58-39-160. N</u> | Violation. |
| 11 | A violation | of G.S. 58-39-140 or G.S. 58-39-145 subjects the violator to Part 2 of |
| 12 | this Article. | • |
| 13 | " <u>§ 58-39-165.</u> | Effective date. |
| 14 | Each license | ee shall establish an information security program, including appropriate |
| 15 | policies and sys | stems, under this Part by April 1, 2005." |
| 16 | SEC | TION 5. This act is effective when it becomes law. |



SECTION-BY-SECTION SUMMARY of the Proposed Committee Substitute for SENATE BILL 966 – INSURANCE CUSTOMER INFORMATION SAFEGUARDS ACT (6/4/03)

Senate Bill 966 requires a licensee, as defined in the legislation (insurance producer, insurer, MEWA, HMO, or service corporation – but not an individual agent, insurance support organization, or surplus lines insurer or licensee), to implement a program to safeguard customer information of individuals required to be protected under the federal Gramm-Leach-Bliley Act (GLBA). This legislation is needed in order for the State of North Carolina to be GLBA-compliant. The language in Senate Bill 966 mirrors substantially the language in the model regulation on this topic adopted by the National Association of Insurance Commissioners (Standards for Safeguarding Customer Information Model Regulation).

Section 1. Renames the title of Article 39 to be "Consumer and Customer Information Privacy" to reflect the expanded purview of the Article brought about by the substantive provisions in the bill.

Section 2. Restructures Article 39 into Parts:

- Part 1. Insurance Information and Privacy Protection.
- Part 2. Enforcement, Sanctions, Remedies and Rights.

Section 3. Amends G.S. 58-39-1 to conform to the changes in the title and the reorganization of the Article into Parts.

Section 4. Adds a new Part 3 to Article 39 of Chapter 58 that:

- States that the purpose of the new Part is to establish standards for developing and implementing customer information safeguard programs to protect information requiring protection under GLBA and to provide privacy and security protection consistent with the federal regulations governing the privacy and security of medical records.
- Is applicable to all customer information of individuals requiring protection under GLBA.
- Defines key terms used in the Part: "customer"; "customer information"; "customer information systems"; "licensee" and "service provider".
- Mandates that each licensee implement a comprehensive written information security program that includes administrative, technical, and physical safeguards for the protection of customer information. The safeguards in the program must be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

- Establishes that the program be designed to ensure the security and confidentiality of the protected information, guard against anticipated threats to its security or integrity, and protect against harmful unauthorized access.
- Subjects a violator of this Part to the enforcement provisions in Part 2 of Article 39.
- Sets a deadline of April 1, 2005, for implementation of the customer information security program, and its accompanying policies and procedures.

Section 5. Makes the act effective when it becomes law.

VISITOR REGISTRATION SHEET

INSURANCE Name of Committee

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

| MAME | FIRM OR AGENCY |
|------------------|-----------------|
| 111.17 | MICAHP |
| Anita MA mond | AKA |
| Rosa W. Small | AKA |
| Queen L'agurence | AKA |
| Bettye Jones | AKA |
| Meday s. Car | MEPA |
| Sally Camera | NCPsychological |
| BILL HAZE | JORDAN PRICE |
| (and Lauler | ECHS |
| Mary an Olsen | NCAPP |
| Flora Duntar | NIAPP |
| Canala Dean | NCAPP |
| You'd Couthard | NCAPP |
| Amy Ross | Sen. Dalton |
| Shirk will | NCAITP |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer (Chair) for the Committee on INSURANCE. Senate Committee Substitute for H.B. 276 A BILL TO BE ENTITLED AN ACT TO MAKE SUBSTANTIVE AND TECHNICAL AMENDMENTS IN THE LAWS CONCERNING INSURANCE COMPANY SOLVENCY AND TO PROHIBIT OFFICERS AND EMPLOYEES OF THE STATE AND ITS POLITICAL SUBDIVISIONS FROM REQUIRING CONSTRUCTION CONTRACT BIDDERS TO OBTAIN SURETY BONDS FROM SURETIES OR PRODUCERS DESIGNATED BY THE OFFICERS AND EMPLOYEES. 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 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)

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | e following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer (Chairs) for the Committee on INSURANCE. |
|-----|--|
| н.н | Committee Substitute for 3. 1049 A BILL TO BE ENTITLED AN ACT AUTHORIZING THE NORTH CAROLINA PSYCHOLOGY BOARD TO ALLOW LICENSED PSYCHOLOGICAL ASSOCIATES TO ENGAGE IN THE PRACTICE OF PSYCHOLOGY WITHOUT SUPERVISION AFTER ACHIEVING A CERTAIN LEVEL OF EXPERIENCE IN THE FIELD AND INCREASING THE MEMBERSHIP ON THE BOARD FROM SEVEN TO EIGHT. |
| | 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 . |
| Ø. | With a favorable report as to the committee substitute bill (#), \(\substitute \) 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 \(\substitute \) in \(\substitute |
| | 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) 03/19/03 |

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | e following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer (Chairs) for the Committee on INSURANCE. |
|----------|--|
| | Committee Substitute for 966 A BILL TO BE ENTITLED AN ACT TO REQUIRE INSURERS TO IMPLEMENT SAFEGUARDS FOR THE PROTECTION OF PERSONAL INFORMATION, PURSUANT TO THE PROVISIONS OF THE GRAMM-LEACH-BLILEY ACT. |
| | With a favorable report. |
| | With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations Finance . |
| | With a favorable report, as amended. |
| | With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations Finance |
| X | 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 the committee of the co |
| | 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) 03/19/03 |

MINUTES

HOUSE INSURANCE COMMITTEE

June 12, 2003

Chair Hugh Holliman called the meeting to order at 10:10 and introduced the pages and Sergeant-At-Arms. See Attachment I. He thanked the visitors for coming. See Attachment II.

The following Representatives were present: Holliman, Allen, Barbee, Hunter, C. Johnson, Lewis, Miner, Ray, Saunders, Wainwright, Connie Wilson and Rep. Brubaker, Ex-officio member.

Senate Bill 469-UNFAIR TRADE PRACTICES/LIFE INSURANCE SALES was taken off the calendar.

Chair Holliman presented Rep. Lucy Allen and Rep. Charles Johnson a Certificate of Appreciation for perfect attendance to the Insurance Committee meetings. The meeting adjourned.

Rep. Hugh Holliman

Rep. Mitchell Setzer

Carol Bowers/Joanna Mills, Clerks

House Pages

| 1. | Name: Brian Hyder |
|-----|--------------------------|
| | County: Henderson |
| | Sponsor: C. Justus |
| 2. | Name: Josh Richardson |
| | County: Gaston |
| | Sponsor: D. Clan |
| 3. | Name: Damia |
| • | County: Wake |
| | Sponsor: ROSS |
| 4. | Name: Cisha |
| | County: Walf |
| | Sponsor: WOUNWIGHT |
| 5. | Name: |
| | County: |
| | Sponsor: |
| C , | |
| | At-Arms |
| l. | Name: Ph. / p Schreibman |
| 2. | Name: Brian Doherty |
| 3. | Name: Charles Williams |
| 4. | Name: |

VISITOR REGISTRATION SHEET /2

| HOUSE COMMITTE ON INSURANCE |
|-----------------------------|
|-----------------------------|

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
|----------------|--|
| JAMES FISH | NATIONAL Association of Professional Allstate Agents St. Louis, Mo. |
| Nancy Fish | National Association of Prof Misterte Agents St Louis MC |
| David Spoller | STATE FARM J.WS. |
| Sper Woodson | NC Farm Bureau |
| JERRANDYKE | BST |
| Dan Stant | SABOMI |
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| Frank Folga | 1001 |
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| John Peterson | NCINS |
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VISITOR REGISTRATION SHEET

June 9, 2,

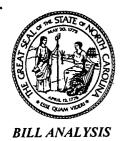
HOUSE COMMITTE ON INSURANCE

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Joes monie | MFOS |
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| Barbara Cansler | MFS-S |
| Barbar Cansler M. N | WAA |
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SENATE BILL 469: Unfair Trade Practices/Life Insurance Sales

Committee: House Insurance

Date:

May 23, 2003

Version:

2nd Edition

Introduced by: Senator Hartsell

Summary by:

Kory J. Goldsmith Committee Counsel

SUMMARY: Senate Bill 469 would provide that certain conditions placed on the sale of life insurance policies and financial services are unfair and deceptive trade practices.

Article 63 of Chapter 58, Unfair Trade Practices, regulates unfair methods of competition and trade practices in the business of insurance.

Senate Bill 469 would provide that requiring nonemployee, exclusive agents to sell (1) a specified number of policies in relation to the sale of property or casualty insurance or (2) a specific level of financial services, as a condition of continuing an exclusive contract, is an unfair trade practice.

Under current law, the Commissioner of Insurance is authorized to investigate and issue a cease and desist order for persons violating the provisions of this Chapter. Persons violating a cease and desist order are subject to a penalty of not less than \$1,000 nor more than \$5,000 for each violation.

EFFECTIVE DATE: Senate Bill 469 is effective October 1, 2003.

S469-SMRC-002

Tim Hovis contributed substantially to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

S

SENATE BILL 469 Commerce Committee Substitute Adopted 4/17/03

| | Short Title: Unfair Trade Practices/Life Insurance Sales. (Publi | c) |
|----|---|-----------|
| | Sponsors: | |
| | Referred to: | |
| | March 20, 2003 | |
| 1 | A BILL TO BE ENTITLED | |
| 2 | AN ACT TO PROVIDE THAT CERTAIN CONDITIONS PLACED ON EXCLUSIV | E |
| 3 | AGENCY CONTRACTS FOR THE SALE OF LIFE INSURANCE OF | R |
| 4 | FINANCIAL SERVICES ARE UNFAIR METHODS OF COMPETITION AND | D |
| 5 | UNFAIR OR DECEPTIVE TRADE PRACTICES. | |
| 6 | The General Assembly of North Carolina enacts: | |
| 7 | SECTION 1. G.S. 58-63-15 is amended by adding a new subdivision to | to |
| 8 | read: | |
| 9 | "(14) Sale of Life Insurance or Financial Services Requiring | ıg |
| 10 | nonemployee, exclusive agents who have exclusive agency contract | _ |
| 11 | or agreements with an insurer as of January 1, 2002 to sell either (i) | |
| 12 | specified number of life and health insurance policies in relation to the | _ |
| 13 | sale of property and casualty insurance or (ii) a specific level of | |
| 14 | financial services, as a condition of continuing the exclusive agence | |
| 15 | contract or agreement. This subdivision does not apply to insurance | - |
| | | <u>,C</u> |
| 16 | agents who do not offer property or casualty lines of insurance." | |
| 17 | SECTION 2. This act becomes effective October 1, 2003. | |

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SHORT SESSION 2003-2004

ATTENDANCE

HOUSE INSURANCE COMMITTEE

| DATES | 7,01 | 6 | 7-1-6 | 7 | 7.8. | | | | | · | | | | · |
|----------------------------------|----------|---|----------|------------|-----------|---|---|----------|---|---|----------|---|------|---|
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| Rep. Hugh Holliman, Chair | V | V | V | V | $\sqrt{}$ | | | | | | | | | |
| Rep. Mitchell Setzer, Chair | ✓ | V | V | V | V | | ! | | | - | | | | |
| Rep. John Hall, Vice-Chair | 1 | | V | | V | | | | | | | | | |
| | | | <u> </u> | <i>z</i> 1 | | | | | | | | | | |
| Rep. Lucy Allen | | V | V | J | V | | | · · | | | | | | |
| Rep. Bobby Barbee | <u></u> | | V | V | | | | ļ | ļ | | | | | |
| Rep. Robert Grady | | ļ | | | | | | | | | | | | |
| Rep. Howard Hunter | | | V | ļ., | | | | | | ļ | | | | |
| Rep. Charles Johnson | V | V | | <u> </u> | V | | ļ | ļ | | | | | | |
| Rep. Linda Johnson | V | V | V | V | V | | | <u> </u> | | | | | | |
| Rep. David Lewis | ✓ | ļ | V | | V | | | | ļ | ļ | | | | |
| Rep. David Miner | | ļ | | | | | | | | | | | | |
| Rep. Karen Ray | V | V | <u> </u> | V | V | | _ | | | ļ | | | | |
| Rep. Drew Saunders | V | V | V | 1/ | | | | | | | | | | |
| Rep. William Wainwright | | ļ | V | V, | | | | | | ļ | ļ | | | |
| Rep. Connie Wilson | V | ļ | V | <u>/</u> | | | _ | | | ļ | | | | |
| Rep. Tom Wright | | | ļ | V | | | | ļ | · | | ļ | | | |
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| Rep. Harold Brubaker, Ex-officio | | | ļ | 1 | | , | | | | | | ļ | | |
| Rep. Bill Culpepper, Ex-officio | | | <u> </u> | ļ | | | | | | | | | | |
| Rep. Pete Cunningham, Ex-officio | | | V | | | | | | | | | | | |
| Rep. Rick Eddins, Ex-officio | | | | | | | | | | | | | | |
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HOUSE COMMITTEE ON INSURANCE

| MOVIBER | <u>ASSISTANT</u> | PHONE | OFFICE | <u>SEAT</u> |
|-------------------------|--------------------|--------------|---------------|-------------|
| Holliman, Hugh, Chair | Carol Bowers | 5-0873 | 1213 | 55 |
| Setzer, Mitchell, Chair | Joanna Mills | 3-4948 | 1204 | 42 |
| Hall. John, Vice-Chair | Delta Prince | 3-5878 | 611 | 60 |
| Allen, Lucy | Melissa Riddle | 3-5860 | 1307 | 92 |
| Barbee, Bobby | Rosa Murray | 3-5908 | 1025 | 52 |
| Grady, Robert | Neta Grady | 5-9644 | 302A | 4 |
| Hunter, Howard | Barbara Phillips | 3-2962 | 613 | 68 |
| Johnson, Charles | Sally Gillis | 5-3021 | 416A | 116 |
| Johnson, Linda | Debbie Gorman | 3-5861 | 1006 | 28 |
| Lewis, David | Marie Strickland | 5-3015 | 509 | 73 |
| er, David | Susan Phillips | 3-5934 | 2204 | 6 |
| Ray, Karen | Mary Ann Norwood | 3-5741 | 1315 | 75 |
| Saunders, Drew | Ruth Fish | 3-5606 | 2217 | 48 |
| Wainwright, William | Blinda Edwards | 3-5995 | 532 | 8 |
| Wilson, Connie | Chris Floyd | 3-5849 | 503 | 37 |
| Wright, Tom | Clarestene Stewart | 3-5754 | 528 | 19 |
| Ex-Officio Members: | | | | |
| Brubaker, Harold | Cindy Coley | 5-4946 | 1229 | 2 |
| Culpepper, Bill | Dot Crocker | 5-3028 | 404 | 36 |
| Cunningham, Pete | Valerie Rustin | 3-5778 | 541 | 7 |
| Eddins, Rick | Dorie Monroe | 3-5828 | 1002 | 26 |
| | | | | |

<u>Legislative Staff</u>:

Pescearch – 733-2578 - Tim Hovis, Linda Attarian and Kori Goldsmith

NORTH CAROLINA GENERAL ASSEMBLY HOUSE INSURANCE COMMITTEE 2003–2004 SESSION



Rep. Hugh Holliman Chair



Rep. Mitchell Setzer Chair



Rep. John Hall Vice-Chair



Rep. Lucy Allen



Rep. Bobby Barbee



Rep. Robert Grady



Rep. Howard Hunter



Rep. Charles Johnson



Rep. Linda Johnson



Rep. David Lewis



Rep. David Miner



Rep. Karen Ray



Rep. Drew Saunders



Rep. William Wainwright



Rep. Connie Wilson



Rep. Tom Wright



Rep. Harold Brubaker Ex-officio



Rep. Bill Culpepper Ex-officio



Rep. Pete Cunningham Ex-officio



Rep. Rick Eddins Ex-officio

MINUTES

HOUSE INSURANCE COMMITTEE

June 2, 2004

Chairman Setzer called the meeting to order at 10: 00 AM on Wednesday, June 02, 2004. The following members were present: Hugh Holliman, Mitchell Setzer, John Hall, Bobbie Barbee, Charles Johnson, Linda Johnson, David Lewis, Karen Ray, Drew Saunders and Connie Wilson.

Chairman Setzer introduced and thanked the pages and Sergeant-At-Arms for their assistance. See attachment 1. He also thanked the visitors and speakers. See attachment II.

Chairman Setzer called on Rep. Connie Wilson to explain House Bill 1463. She explained that this bill is coming out of two study commissions. See attachment III and IV. Representative Wilson called on David Dunn, Asst. to the Chancellor at UNCC, and Rebecca Ballard, from Moore County with First Health in the Carolinas to speak in support of the bill. Representative Wilson said there would be no cost to the general funds; all funds would come from grants. Representative Holliman asked for a favorable report. Bill passes unanimously.

Representative Hall made a motion for a House Committee substitute on SB-486 to be heard by the committee. See attachment V & VI. Representative Holliman explained how this is a consumer protection bill and he called on Susan Valauri, Nationwide Insurance to explain the bill. She pointed out that beginning in 2005 through Choice Point there would be no charge to order a report.

Stephanie Simpson with NCAR spoke against this legislation and explained NCAR's objections. Daschal Propes, with DOI explained the language changes in Section I, Part B from the original bill. Representative Holliman asked for a favorable report. Chairman Setzer asked for a motion for committee substitute favorable, unfavorable to original bill. The motion passes unanimously. The meeting was adjourned at 10:33.

Chair Mitchell Setzer

Chair Hugh Holliman

Carol Bowers, Joanna Mills, Clerks

HOUSE INSURANCE COMMITTEE

June 2, 2004 10:00 AM Room 424 LOB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

Senate Bill 486- Amber Alert Sponsor: Sen. Queen

House Bill 1463 – Health Insurance Innovations Commission Sponsor: Rep. C. Wilson 6-2-04

House Pages

| 1. | Name: Jason Thomas |
|------|-------------------------|
| | County: Cleveland |
| | Sponsor: Moore |
| 2. | Name: Alyssia Blalock |
| | County: Wake |
| | Sponsor: R. Allen |
| 3. | Name: Heather Honeycutt |
| | County: Wayne |
| | Sponsor: L. Pate |
| 4. | Name: Kalle Wlast |
| | County: Lincoln |
| | Sponsor: J. KISCY |
| 5. | Name: |
| | County: |
| | Sponsor: |
| | |
| Sgt- | <u>At-Arms</u> |
| 1. | Name: Charles Williams |
| 2. | Name: Paul Rucho |
| 3. | Name: Dusty Rhodes |
| | Name: JAMES WILLIAMS |

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VISITOR REGISTRATION SHEET

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HOUSE COMMITTE ON INSURANCE

June 2, 2004

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

| NAME | - FIRM OR AGENCY AND ADDRESS | | | | |
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| John Mothel | GOU OATT | | | | |
| Bill Hester | Alliel Durocq | | | | |
| Chris Valauvi | NC Beer & Wine Association | | | | |
| Paul Folleren | Then The. | | | | |
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VISITOR REGISTRATION SHEET

HOUSE COMMITTE ON INSURANCE

Name of Committee

June 2, 2004

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|-------------------|----------------------------|
| BILL SCOGGIN | KCLH |
| PERRI MORGAN | NFIB |
| Suptranie Simpson | NCAR |
| John Bowdish | artia genera |
| Barbara Cansler | BSCER |
| Mari Luts | 6St. |
| Tere Keene | NC Medical Society |
| SUSAN Valauri | Nationurole Isurani |
| Robert PASILAP | Young, Moorer |
| Steve Happa | AP |
| Male Johnson | The Charlotte Observer |
| | |

VISITOR REGISTRATION SHEET

HOUSE COMMITTE ON INSURANCE

June 2, 2004

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
|-----------------|--|
| DAVID STOLLER | STATE FARM INS. COS. |
| DAVID PUNN | UNC CHAPLOTTE |
| John McMillan | MES |
| Papmanno | State of the state |
| ANN WIRE | DU 125 |
| PDP | NC FB |
| Mary leanidas | NCANA - Nurse of/the Bay. |
| ginette Archiva | CART JAMILY HEATHCARE "DOGOR of the DAY" |
| Grilenan | NMRS |
| Hu6A TILGOD | NCHA |
| R. Jand W. hans | NCABA |

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 1463*

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Short Title: Health Insurance Innovations Commission. (Public)

Sponsors: Representatives C. Wilson, LaRoque, Church (Primary Sponsors); Allred, Bordsen, Daughtridge, Decker, Jones, Warner, Barnhart, Glazier, Gorman, and Steen.

Referred to: Insurance.

May 17, 2004

AND ACT TO ECTADI

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE INNOVATIONS COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. Findings and Purpose. – The General Assembly finds that a crisis exists in the availability and affordability of adequate health insurance coverage for small business owners and employees in this State. These findings indicate that greater than fifty percent (50%) of the statewide workforce is employed by small business, that there are 1,154,000 North Carolinians who are not covered by health insurance, and that more than sixty percent (60%) of these citizens either own or work for a small business, or are the dependent of a small business owner or employee. The findings further indicate that 16 health insurance carriers left the North Carolina small group health coverage market in 2001, an all-time high, that virtually no small group health insurance carriers have entered the North Carolina market in the last two years, and that dramatic increases in premium rates is the primary reason for the alarming decrease in availability of health insurance coverage for small business. The purpose of this act is to quickly and effectively address this crisis through the collaborative efforts of persons involved in and affected by the declining availability of health insurance for the State's small employer workforce. It is the intent of the General Assembly to achieve this purpose through the establishment of the North Carolina Health Insurance Innovations Commission in accordance with this act.

SECTION 2. Commission Established. – There is established the North Carolina Health Insurance Innovations Commission. The Commission shall consist of 24 members, appointed as follows:

(1) Twelve members appointed by the General Assembly, six upon the recommendation of each of the Speakers of the House of

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Representatives. Upon appointment each speaker shall designate a cochair.

(2) Twelve members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate. Upon appointment, the President Pro Tempore shall designate a cochair.

The appointing authorities shall ensure that members of the Commission are representative of the following: three who represent health insurers, three physicians licensed to practice in this State, three who represent hospitals located in this State, two who represent businesses with fewer than 50 fifty employees, two who represent businesses with 50 fifty employees or more, one who represents insurance brokers or agents, and one who represents health researchers and policy experts. The appointing authorities shall also ensure that appointments reflect representation among the regions of the State.

SECTION 3.(a) Commission Duties and Responsibilities. – The Commission shall do the following:

- (1) Adopt procedures and implement other administrative requirements necessary to carry out its duties under this act.
- (2) Identify and evaluate comprehensively the problems small employers face when they attempt to obtain health insurance coverage for themselves and their employees, and consider the impact these problems have for large employees and the communities they serve.
- (3) Initiate regional demonstration projects to pilot innovative health care plans and products to address the problems identified. Innovative products may include piloted community education programs targeted at top illnesses in an effort to increase early detection of these illnesses. Innovative plans may also include piloted programs targeted at increasing the demand for health insurance coverage by both employers and employees through the use of policy incentives. Innovative plans and products are subject to the approval of the Commissioner of Insurance as provided in Section 5 of this act.
- (4) Develop clear and substantive recommendations for actions that must be taken by health insurance carriers, health care providers, government, small business employers, large business employers, consumers and consumer groups, in order to improve the availability and affordability of small employer health insurance coverage within the next three years.
- (5) Provide a report on the Commission's activities to the 2005 General Assembly, Regular Session 2006, upon its convening. Reports to the General Assembly shall include proposed legislation necessary to carry out the purposes of this act.

SECTION 3.(b) The Commission shall consider the following issues and strategies in developing regional demonstration projects and other approaches to address the rising cost of health care:

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- (1) Feasibility of establishing chronic disease management programs similar to those that are working successfully in this State and other states.
- (2) The cost-effectiveness of existing and proposed health insurance coverage mandates.
- (3) Promoting collaboration among providers, insurers, government agencies, and consumers to improve health care affordability.
- (4) Promoting consumer education about available insurance products and promoting education of small business owners about the available insurance products, available services to assist them in understanding and selecting appropriate insurance plans, and current small business tax benefits regarding health insurance deductions.
- (5) Review and evaluate "consumer driven" benefit plans.
- (6) Increasing efforts and resources to educate and motivate consumers to use health care resources appropriately.
- (7) Rewarding technological innovation based in quality and evidence-based outcomes that provide increased value to consumers over existing treatments.
- (8) Encourage case management of high utilizers.
- (9) Promoting evidence-based medicine.

SECTION 4. Meetings; Staff; Funding. - Members shall serve an initial two-year term and may be reappointed for an additional two-year term. The Commission shall secure federal or private funds to conduct meetings, hire professional staff, support demonstration plans and products, and cover any other costs incurred by the Commission in carrying out its duties under this act. The Department of Insurance shall, at the request of the Commission, provide technical assistance in the preparation of grant proposals for federal and other non-State funding to support the work of the Commission, in the preparation of forms, and in other related matters. The Commission may meet in the Legislative Building or the Legislative Office Building, as approved by the Legislative Services Commission, or at any other location deemed appropriate by the Health Insurance Innovations Commission. The Commission may enter into agreements and allocate federal or private funds obtained by the Commission with the University of North Carolina at Charlotte and other public or private entities to provide meeting space, professional services and support staff, and other services necessary for the Commission to carry out its duties and responsibilities under this act.

SECTION 5. Waiver of Rules. – The Commissioner of Insurance shall review all pilot programs and innovative plans and products proposed by the North Carolina Health Insurance Innovations Commission. If the Commissioner determines that the proposed programs, plans, or products are in the interest of the citizens of this State and are not contrary to the public policy of this State, then the Commissioner may approve them. If the approved programs, plans, or products are in conflict with or contrary to rules adopted by the Commissioner, the Commissioner may waive the rules adopted by the Commissioner to allow implementation of the programs, plans, or

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products. Waivers granted by the Commissioner under this section shall expire three years from the date the waiver is granted or December 31, 2008, whichever occurs first.

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SECTION 6. Funds obtained by the North Carolina Health Innovations Commission for operations and programs of the Commission shall be deposited with the State Treasurer for credit to the Legislative Services Office. The Legislative Services Office shall allocate these funds for reimbursement to the Commission for operation and program costs incurred.

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SECTION 7. Nothing in this act obligates the General Assembly to appropriate funds to implement this act. This act becomes effective July 1, 2004.



HEALTH INSURANCE INNOVATION **COMMISSION:**

House Bill 1463

Committee:

House Insurance

Date:

May 27, 2004

Version:

First Edition

Introduced by: Rep. C. Wilson, Laroque,

Church

Summary by: Sandra Alley

Committee Counsel

SUMMARY: HB 1463 establishes the North Carolina Health Insurance Innovations Commission to study the problems small employers face when seeking health insurance coverage for themselves and their employees, to initiate programs to pilot innovative health care plans and products, and to develop recommendations for insurance providers, health care providers, government, business employers, consumers, and consumer groups to improve the availability and affordability of small employer health insurance within the next three years.

BILL ANALYSIS: Section 1 of the bill sets out the findings and purpose for the bill.

Section 2 of the bill establishes the North Carolina Health Insurance Innovations Commission.

Section 3. (a) of the bill identifies Commission member duties and responsibilities.

Section 3.(b) of the bill directs the Commission to consider certain issues and strategies in developing regional demonstration projects and other attempts to address the rising cost of health care. These issues and strategies include chronic disease management programs, health insurance mandates, collaboration among providers, insurance companies and consumers, consumer education, "consumer driven" benefit plans, technological innovation, case management for high utilizers, and the use of promoting evidencebased medicine.

Section 4 of the bill establishes two year terms for Commission members. The Commission shall secure federal or private funds to support the work of the Commission. The Department of Insurance shall provide technical assistance to the Commission to seek grants for federal and other non-State funding.

Section 5 of the bill directs the Commissioner of Insurance to review all pilot programs, plans, and products proposed by the Commission. The Commissioner may approve programs, plans, and products if they are of interest to the citizens of NC and not contrary to public policy. If approved programs, plans, or products conflict with DOI rules, the Commissioner may waive the rules to allow implementation of programs, plans, or products. Waivers shall expire three years from the date of the waiver or December 31, 2008, whichever occurs first.

Section 6 of the bill directs the Commission to deposit funds obtained by the Commission for operations and programs with the State Treasurer for credit to the Legislative Services Office. The Legislative Services Office shall allocate these funds for reimbursement to the Commission for operations and program costs.

Section 7 of the bill states that the General Assembly is not obligated to appropriate funds to implement the bill and that the bill becomes effective July 1, 2004

Effective Date: The bill becomes effective July 1, 2004.

HEALTH INSURANCE INNOVATIONS COMMISSION

Page 2

BACKGROUND:

Over 50% of North Carolina's workforce is employed by small business employers. More than 60% North Carolina's 1,154,000 uninsured either own or work for a small business. In 2001, sixteen health insurance carriers left the North Carolina small group market and no new small group health insurance carriers have entered the market for the past two years. Dramatic increases in premium rates are the primary reason for the decrease in availability of health insurance coverage for small businesses.

The House Select Committee on the Rising Cost of Health Care recommended a bill similar to HB 1463. The Committee recommendation resulted in part from a presentation by Ches Gwinn of the Metrolina Health Initiative (MHI) in Charlotte, NC. Mr. Gwinn described MHI, which takes on partnership approach toward lowering health care costs and improving the ability of small employers to afford health insurance for their employees. He recommended a commission that would seek to improve access to insurance for small businesses and reduce the volume of the most frequent and high cost illnesses. Toward that end he recommended forming a state commission like the one set up in HB 1463.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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SENATE BILL 486

Judiciary II Committee Substitute Adopted 4/14/03 PROPOSED HOUSE COMMITTEE SUBSTITUTE S486-CSRG-30 [v.5]

6/2/2004 9:03:24 AM

| Short Title: Customer Inquiries/Insurance Coverage. | (Public) |
|--|-----------------|
| Sponsors: | |
| Referred to: | |
| March 20, 2003 | |
| | |
| A BILL TO BE ENTITLED | |
| AN ACT TO PROHIBIT INSURANCE COMPANIES FROM USING | |
| INQUIRIES TO TERMINATE A POLICY, TO REFUSE TO ISSUE | OR RENEW |
| A POLICY, OR TO SUBJECT A POLICY TO CONSENT TO RATE. | |
| The General Assembly of North Carolina enacts: | |
| SECTION 1. Article 36 of Chapter 58 of the General Statutes is | s amended by |
| adding a new section to read: | |
| "§ 58-36-115. Prohibitions on using inquiries to terminate a policy, re | fuse to issue |
| or renew a policy or to subject a policy to consent to rate. | |
| (a) Insurers writing residential real property insurance subject to this | Article shall |
| not use an inquiry of an insured that does not result in a claim to terminate | te an existing |
| policy or any coverage under an existing policy, to refuse to write a policy | y, to refuse to |
| renew a policy, or to subject a policy to consent to rate as specified in G.S. | 58-36-30(b). |
| Any termination attempted or made that is not in compliance with this s | section is not |
| effective. | |
| (b) For the purposes of this section, an inquiry by a policyhold | ler about the |
| provisions of a property insurance contract is not a claim, unless the policy | |
| third party files a claim or reports a loss, incident, or accident cover | ed under the |
| contract. | |
| (c) Nothing in this section shall preclude an insurer from acting in | response to a |
| substantial increase in the risk assumed by and unknown to the insurer sin | ice the policy |
| was issued." | |
| SECTION 2. This act becomes effective October 1 2004 at | nd applies to |

policies issued or renewed on or after that date.



Charlotte • com

Posted on Sat, May. 15, 2004

OBSERVER WATCHDOG

State Legislative Building RALEIGH, NC 27601-1096 -9191733-5827 (919) 754-3180 FAX E-Mail: hughh@ncleg.net



37TH DISTRICT

HOME ADDRESS 103 Sapona Road Lexington, N.C 27295 (336) 956-1385

Home insurance question? Don't ask

Queries to insurance companies can raise your rates

MARK JOHNSON Raleigh Bureau

Charlotte lawyer Spencer Alridge woke up to the sound of his toilet overflowing and, later, to the fact that insurance companies are penalizing customers just for asking a question.

It's a practice that N.C. and S.C. state lawmakers want to rein in.

Alridge's middle-of-the-night spillover, caused by a failing flush valve, put water on the floor and dripped a small amount through a light fixture in the room below in their Lake Park house, in Union County. His wife, Denise, called their insurance agent the next morning to ask what their options were.

The spill turned out to be harmless. No claim was filed. No work was done. No adjuster visited the house. No money was paid.

That was a couple of years ago.

Last summer, the couple sold their house and, 10 days before the closing, the buyer's broker called with a snag. The buyer was told that homeowner's insurance would cost much more than anticipated because of the "water damage" at the house.

"I asked what the heck she was talking about," Alridge said.

His wife's phone call to the insurance agent had been recorded in a database that contains 90 percent of the insurance claims filed in the United States and is used throughout the insurance industry. It's called CLUE, Comprehensive Loss Underwriting Exchange. The Alridges were listed as having filed a claim but without any money being paid out.

Not every insurance company handles questions that way, but the practice of recording inquiries as claims is "widespread," according to Chrissy Pearson, spokeswoman for the N.C. Insurance Department.

"That's where it starts getting ugly for consumers. It starts getting unfair for consumers," Pearson said. "It seems like the companies are getting a bit greedy with that."

Mark Dombrowski, spokesman for Erie Insurance Group, which held Alridge's policy, didn't address that specific case, but said the company must react when they get a call.

"If a policy holder calls and reports the possibility of a claim, it triggers action on our part," Dombrowski said. "In other words, we have to consider there may be a loss. We have to reserve funds.... We're tracking the activities on our part. I think that's a pretty standard practice."

Alridge said Erie deleted the claim after he threatened to handle his own lawsuit against them.

Neither the N.C. nor S.C. insurance departments have any kind of list of which companies or agents have reported inquiries as claims.

S.C. legislators, at the urging of the insurance department, proposed legislation earlier this year prohibiting insurance companies from denying renewal of a policy that is in any way based on inquiries. That bill is still in committee.

In North Carolina, Rep. Hugh Holliman, D-Davidson, who co-chairs the House Insurance Committee, denounced the use of the database to record questions. He said this year's "short" General Assembly session did not allow time for dealing

with much more than the budget, but he wants to take on the issue when lawmakers return in January.

"The industry...should not be abusing consumers in this fashion," said Sen. Marc Basnight, president pro tem of the N.C. Senate. He said his office is researching solutions. "We're going to discover how to fix it," he said.

The company that maintains the CLUE database, ChoicePoint, in Alpharetta, Ga., knows about the inaccurate reports.

"That has become a problem," said spokesman Chuck Jones. "Many companies were in fact recording mere inquiries into the database."

Last year, the firm dispatched a letter to insurance companies warning that "Claims information should *not* be reported when a customer merely asks questions about their coverage or deductible."

The N.C. Insurance Department still gets three or four complaints a month about the CLUE system, but has not yet established a separate category for those problems in order to keep a more exact count.

How insurers handle questions from customers "varies from company to company and from agent to agent," said Ray Evans, general manager for the N.C. Rate Bureau, a partnership of insurance companies, created by law, that proposes rates for insurance in North Carolina subject to the commissioner's approval.

Alridge's insurance agency, Allen Insurance Group, said they work hard to avoid the confusion.

"We try to make it clear, `Do you want to file a claim or are you just trying to get information?' " said Fenn Allen, the agency's owner.

Insurance industry officials said the 10-year-old database, when used properly, helps insurers weed out fraud and set premiums. CLUE holds records for an estimated 170 million auto claims and 40 million homeowner claims that go back five years. Before the database, insurers did not regularly exchange information about customers and had no easy way of knowing whether a prospective customer had a lengthy history of claims.

A scam artist, for example, may have filed claims for stolen jewelry from five different companies in five years. Jones, of ChoicePoint, said insurance is priced based on risk, and it's not fair to charge everybody the same.

"Somebody who rarely files a claim ought to pay less of a premium than someone who frequently files claims," he said.

The related, but equally unpleasant, surprise consumers run into with CLUE is that insurers now are using the database to examine a house or a building as much as the individual who owns it. Home buyers may be about to close a deal and then find that they can't get insurance, or it's prohibitively expensive, because the current owner or a previous owner filed claims.

This is especially true of water damage, given the recent trend of lawsuits over exposure to mold in buildings.

Realtors "have not been aware of these issues," said Stuart Powell, vice president of the Independent Insurance Agents of North Carolina. "Realtors are beginning to get the idea of having the seller produce a CLUE report."

Mark Johnson: (704) 358-5941 or mjohnson@charlotteobserver.com.

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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| | By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
|-------------|---|
| H.B | Committee Substitute for 1. 1463 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE INNOVATIONS COMMISSION. |
| \boxtimes | 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 (#), \(\subseteq \) 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) |

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. Committee Substitute for S.B. 486 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAW REGARDING THE NORTH CAROLINA CHILD ALERT NOTIFICATION (NC CAN) SYSTEM AND TO RENAME THAT SYSTEM THE AMBER ALERT SYSTEM. With a favorable report. With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations Finance With a favorable report, as amended. With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations Finance House which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill #recommendation that the committee substitute bill.# -) be re-referred to the Committee 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)

03/19/03

MINUTES

HOUSE INSURANCE COMMITTEE

June 17, 2004

Chairman Setzer called the meeting to order at 8:35 AM on Thursday, June 17, 2004. The following members were present: Chairman Setzer, Chairman Holliman, Rep. Lucy Allen, Rep. Charles Johnson, Rep. Linda Johnson, Rep. Karen Ray, Rep. Saunders and Rep. C. Wilson.

Chairman Setzer introduced the pages. See attachment I. Visitors, see attachment II.

Rep. Setzer called on Rep. L. Coates to introduce HB-1424. She explained that this bill came from the Joint Transportation Oversight Committee for a technical correction. See attachment III & IV. Rep. Ray made a motion for a favorable report; passed unanimously.

Chairman Setzer called on Chairman Holliman to introduce SB-486. Rep. Holliman ask for the adoption of the Committee Substitute. Adoption passes. Rep. Holliman explained how the insurance companies, DOI and realtors compromised on the language changes. Jeffrey Skelton of Choice Point was introduced to clarify the clue database. See attachment V. After some discussion, Rep. Saunders ask for a favorable report for SB 486- Proposed House Committee Substitute. See attachment VI, and VII. Motion passes.

The committee adjourned at 9:10 AM.

Chair Mitchell Setzer

Chair Hugh Holliman

Joanna Mills & Carol Bowers, Clerks

att: I

HOUSE COMMITTEE ON INSURANCE

June 17, 2004 8:30 AM Room 424 LOB

Pages:

| Name (please print) | County | Representative |
|--|-------------------------|----------------|
| Kai Toshumbar | Davidson | Holliman |
| Saran Hill | Davidson | Holliman |
| Ben Yancey | wave | speaker Black |
| Craig Franklin | Burke | Church |
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VISITOR REGISTRATION SHEET

HOUSE COMMITTE ON INSURANCE

June 17, 2004

Name of Committee

Date

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VISITOR REGISTRATION SHEET

HOUSE COMMITTE ON INSURANCE

June 17, 2004

Name of Committee

Date

| NAME | FIRM OR AGENCY AND ADDRESS |
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| Robert Paschal | Yony, Moore |
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| David Stoller | STATE FARM |
| Ken Kinion | A. TG, |
| JEFFREY SKELTON | CHOICE POINT |
| Susan Valouri | Nationurde |
| PRANK W. FOLGER | NCDOJ |
| Jim Lowry | Ne Utility Contrations ASSN |
| John Reterson | NCINS |
| Jaya Polis | JP ALGO |

VISITOR REGISTRATION SHEET

| HOUSE COMMITTE ON INSURANCE |
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June 17, 2004

Name of Committee

Date

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

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HOUSE BILL 1424*

| Short Title: Public Construction Surety Bonds. (Public |) |
|---|---|
| Sponsors: Representatives Coates; Cole, Crawford, and Pate. | |
| Referred to: Insurance. | |
| May 13, 2004 | |
| A BILL TO BE ENTITLED | |
| AN ACT TO AMEND THE PUBLIC CONSTRUCTION CONTRACT SURETY | 7 |
| BOND STATUTE. | |
| The General Assembly of North Carolina enacts: | |
| SECTION 1. G.S. 58-31-66 reads as rewritten: | |
| "§ 58-31-66. Public construction contract surety bonds. | |
| (a) Neither the State nor any county, city, or other political subdivision of the | |
| State, or any officer, employee, or other person acting on behalf of any such entity shall, | |
| with respect to any public building or construction contract, require any contractor, | |
| bidder, or proposer to procure a bid bond, payment bond, or performance bond from a | l |
| particular surety, agent, producer, or broker. | _ |
| (b) Nothing in this section prohibits an officer or employee acting on behalf of | ŧ |
| the State or a county, city, or other political subdivision of the State from: | |
| (1) Approving the form, sufficiency, or manner of execution of the surety | |
| bonds furnished by the surety selected by the bidder to underwrite the | , |
| bonds. | |
| (2) Disapproving, on a reasonable, nondiscriminatory basis, the surety | |
| selected by the bidder to underwrite the bonds because of the financial | ł |
| condition of the surety. | |
| (c) A violation of this section renders the public building or construction contract | E |
| void ab initio." SECTION 2. This not becomes affective July 1, 2004 | |



HOUSE BILL 1424: Public Contruction Surety Bonds



Committee: House Insurance

Date:

June 17, 2004

Version:

First Edition

Introduced by: Rep. Coates

Summary by: Sandra Alley

Committee Counsel

SUMMARY: HB 1424 would delete language in G.S. 58-31-66 that would void any contract entered into that is in violation of the statute.

CURRENT LAW: G.S. 58-31-66, as enacted in Section 27 of House Bill 276 (S.L. 2003-212), prohibits state and local government officials from telling public construction bidders that they have to deal with particular surety companies for their bid, payment, and performance bonds. This is referred to in the industry as "directed suretyship". The main prohibition appears in G.S. 58-31-66(a), which would remain in place if HB 1424 is enacted.

BILL ANALYSIS: HB 1424 is recommended by the Joint Legislative Transportation Oversight Committee. The bill would delete G.S. 58-31-66(b) and G.S. 58-31-66(c). G.S. 58-31-66(b) stated that nothing in the section prohibited an officer or employee of the State, a county, city or other political subdivision from approving the form, sufficiency or manner of execution of the Surety bonds or from disapproving, on a reasonable, nondiscriminatory basis, the surety selected by the bidder because of the surety's financial condition.

BACKGROUND: At the request of the Department of Transportation, the language is G.S. 58-31-66(b) and (c) was studied by the Joint Legislative Transportation Oversight Committee. The Committee recommended that these subsections be removed from the statute.

HB1424-SMSP-01



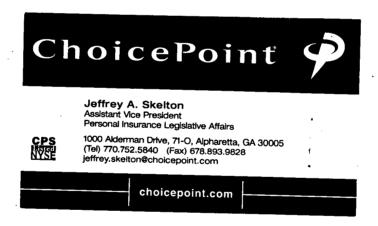
existing policy, to refuse to write a policy, to refuse to renew a policy, or to subject a policy to consent to rate as specified in G.S. 58-36-30(b). Any termination attempted or made that is not in compliance with this section is not effective.

- (b) For the purposes of this section, an inquiry by a policyholder about the provisions of a property insurance contract is not a claim, unless the policyholder or a third party files a claim or reports a loss, incident, or accident covered under the contract.
- (c) Nothing in this section shall preclude an insurer from acting in response to a substantial increase in the risk assumed by and unknown to the insurer since the policy was issued."

SECTION 2. This act becomes effective October 1, 2004, and applies to policies issued or renewed on or after that date.

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C. L. U. E,

reserve

New business only product

Why developed >10 yrs report 5 yrs updated monthy FCRA - FTC

Paid

no-pay - denial

loss adj. perse expense

adverse action lotters

5 challenges per 1,000 requests

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2003**

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SENATE BILL 486

Judiciary II Committee Substitute Adopted 4/14/03 PROPOSED HOUSE COMMITTEE SUBSTITUTE S486-CSRG-32 [v.6]

| Short Title: Customer Inquiries/Insurance Coverage. | (Public) |
|---|------------------------|
| Sponsors: | |
| Referred to: | |
| March 20, 2003 | |
| A BILL TO BE ENTITLED | |
| AN ACT TO PROHIBIT INSURANCE COMPANIES FROM USING | CUSTOMER |
| INQUIRIES TO TERMINATE A POLICY, TO REFUSE TO ISSU | E OR RENEW |
| A POLICY, OR TO SUBJECT A POLICY TO CONSENT TO RATE | 3. |
| The General Assembly of North Carolina enacts: | |
| SECTION 1. Article 36 of Chapter 58 of the General Statutes | is amended by |
| adding a new section to read: | |
| "§ 58-36-115. Prohibitions on using inquiries to terminate a policy, | <u>refuse to issue</u> |
| or renew a policy, or to subject a policy to consent to rate. | |
| An insurer writing residential real property insurance subject to this A | |
| terminate an existing policy or any coverage under an existing policy, re | |
| policy, refuse to renew a policy, or subject a policy to consent to rate | as specified in |
| G.S. 58-36-30(b) based solely on either of the following: | |
| (1) An inquiry about policy provisions that does not result | |
| (2) A claim that was closed-without—payment, provided th | |
| that was the subject of the claim was only an inquiry re | |
| provisions and no claim for payment was requested by | the insured or a |
| third party." | |
| SECTION 2. This act becomes effective October 1, 2004, | and applies to |

policies issued or renewed on or after that date.



SENATE BILL 486: Customer Inquiries/Insurance Coverage

BILL ANALYSIS

Committee:

House Insurance Committee

Date:

June 16, 2004

Version:

Proposed Committee Substitute

S486-CSRG-32[v.6]

Introduced by:

Summary by:

Tim Hovis

Committee Counsel

BACKGROUND: Databases of property loss or claims history are used by insurers to track an insured's insurance history and provide or rate coverage according to that history. These databases include the Comprehensive Loss Underwriting Exchange (CLUE) and the Automated Property Loss Underwriting System (A-PLUS). Recent reports have indicated that an inquiry by an insured may be included in these databases and, in some cases, may have a negative impact on an insured's ability to obtain or continue coverage, even if the insured did not file a claim.

SUMMARY: The Proposed Committee Substitute for Senate Bill 486 would prohibit residential real property insurers from terminating a policy or any coverage under the policy, refusing to write or renew a policy, or subjecting a policy to a consent to rate based solely on either of the following:

- (1) An inquiry concerning coverage that did not result in a claim; or
- (2) A claim that was closed and not paid by the insurer, provided the notice of the loss was only an inquiry regarding coverage under the provisions of the policy and no claim for payment was made by the insured or a third party.

The Proposed Committee Substitute for Senate 486 would become effective October 1, 2004 and applies to policies issued or renewed on or after that date.

HOUSE INSURANCE COMMITTEE

June 17, 2004 8:30 AM Room 424 LOB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

Senate Bill 486- Customer Inquiries/Insurance Coverage Sponsor: Rep. Holliman

House Bill 1424 – Public Construction Surety Bonds Sponsor: Rep. Coates

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| | following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. |
|-------------|--|
| ☐ (H.B | Committee Substitute for 1424 A BILL TO BE ENTITLED AN ACT TO AMEND THE PUBLIC CONSTRUCTION CONTRACT SURETY BOND STATUTE. |
| \boxtimes | With a favorable report. The last the second of the second |
| | 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 Financ |
| | With a favorable report as to the committee substitute bill (#), \(\subseteq \) which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill #), \((and \(\subseteq \) recommendation that the committee substitute bill #) be re-referred to the Committee |
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| | With an unfavorable report. |
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| | With recommendation that the House concur; committee believes bill to be material. |
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| | Without prejudice. The statistic transfer on the state of |
| | With an indefinite postponement report. |
| | With an indefinite postponement report, with a Minority Report attached. |
| | With recommendation that it be adopted. (HOUSE RESOLUTION ONLY) 03/19/03 |

FOR JOURNAL USE ONLY

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| | Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of | |
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| | the state of the s | |
| . A. Santanana ——————————————————————————————— | 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 | 7.1. |
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| | On motion of (Rep) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on | |
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| | 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. | : |
| 40 pm | 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). San adopted; (by EV. 2004). San adopted; (by EV. 2004). | e |
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| | On motion of Rep, Committee Amendment No.(s) is/ar adopted (by EV). | e |
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| · | 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,) | e · |
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| | 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,) 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. | |
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2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. Committee Substitute for S.B. 486 A BILL TO BE ENTITLED AN ACT TO PROHIBIT INSURANCE COMPANIES FROM USING CUSTOMER INQUIRIES TO TERMINATE A POLICY, TO REFUSE TO ISSUE OR RENEW A POLICY, OR TO SUBJECT A POLICY TO CONSENT TO RATE. 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 (# 2), which changes the title, unfavorable as to Senate committee substitute bill. ## 1 House 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)

03/19/03

FOR JOURNAL USE ONLY

| Pursuant to Rule 36(b), the bill/resolution 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 |
| 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, |
| 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 hill is ordered enrolled. |

MINUTES HOUSE INSURANCE COMMITTEE July 1, 2004

Chairman Hugh Holliman called the Insurance Committee to order at 10:08 AM. The following Representatives were present: Hugh Holliman, Mitchell Setzer, John Hall, Lucy Allen, Bobby Barbee, Howard Hunter, Linda Johnson, David Lewis Karen Ray, Drew Saunders, William Wainwright, Connie Wilson and Ex-officio, Rep. Pete Cunningham.

Chair Holliman introduced the pages (Attachment I & II) and thanked them for their assistance in our meeting. He also thanked the Sergeant-At-Arms (Attachment I) and welcomed the visitors (Attachment III).

Representative Saunders was called on to explain HB-1370 (Attachment IV), which came from the Transportation Oversight Committee and has a companion bill SB-l081. Representative Saunders explained how this bill was filed on May 10 and was referred to Rules then sent to Insurance.

Charlie Dill, President of the N.C. Truckers Association spoke in support of the bill and the need for this legislation. Representative McComas spoke on the independent truckers verses leasing trucks and how this legislation would affect those drivers. Dick Taylor, NC Assoc. of Trial Lawyers and Laura Mavretic, NC Industrial Commission, James Andrews, President of AFLCIO spoke against the bill. (See Attachment V).

After much discussion and concerns from some committee members wanting to hear from independent truckers, Chairman Holliman recommended that HB-l370 be put back on the calendar for a meeting on Tuesday, July 6, 2004.

The meeting was adjourned at 11:35AM...

Rep. L. Hugh Holliman, Chair

Rep. Mitchell S. Setzer, Chair

Carol Bowers & Joanna Mills, Committee Clerks

HOUSE INSURANCE COMMITTEE

July 1, 2004 10:00 AM Room 544 LOB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

HB 1370 – WORKERS' COMP./ TRUCKING. REP. SAUNDERS

House Pages

| 1. | Name: Byan Ryba |
|------|-----------------------------|
| | County: Wake |
| | Sponsor: Russell Gpgs |
| 2. | Name: Morty Wadsworth |
| | County: Lincoln(C) |
| | Sponsor: Noie Kiser |
| 3. | Name: Brandon Rasbury |
| | County: Lenoir |
| | Sponsor: William Wagneright |
| 4. | Name: Brandon Taklitsch |
| | County: Mecklenburg. |
| | Sponsor: Speaker Black |
| 5. | Name: Holly Stiles |
| · | County: Cherokee |
| | Sponsor: Rodge West |
| | |
| Sgt- | -At-Arms |
| 1. | Name: PAUL CURRY |
| 2. | Name: JAMES Womack |
| | Name: PAUL Rucho |
| 4. | Name: FRANK Prevo |

CHARLES WILLIAMS

Name: A mas Miltr Wake B. Allen

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| | Sponsor: Rick Folding | |
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| | Sponsor: WAINWright | |
| 4. | Name: Alizaboth Johnson | |
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| | Sponsor: Joe Kiser | |
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attachment 11

VISITOR REGISTRATION SHEET

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| / NSUPANE | 07/01/04 |
| Name of Committee | Date |

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

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| NAME | FIRM OR AGENCY |
| Partara levire | NCIC |
| Laura Mauretic | NC Industrial Commission |
| Macon | NMIZS |
| Charlie Dirk | Ne Trucking Association |
| Angie Haur | Maupa Tayla |
| BERRY JENKINS | CAROLINAS AGC |
| Drill Tale | MCATZ |
| Victor Farak | AHX |
| Harry Dallan | NCAHP |
| Dave Home | SAGONI |
| Harl fully | NCATL |
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| BILL HALE | ACLI |
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GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2003**

H

HOUSE BILL 1370*

(Public)

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Sponsors:

Short Title: Workers' Comp./Trucking. Representatives Saunders;

Crawford, Cunningham, Gillespie, Hilton,

Stiller, and K. Williams.

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

May 11, 2004

A BILL TO BE ENTITLED

AN ACT TO AMEND THE APPLICATION OF THE WORKERS' COMPENSATION LAW TO CERTAIN MOTOR CARRIERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-19.1 reads as rewritten:

"§ 97-19.1. Truck, tractor, or truck tractor trailer driver's status as employee or independent contractor.

An individual in the interstate or intrastate carrier industry who operates a truck, tractor, or truck tractor trailer licensed by a governmental motor vehicle regulatory agency may be an employee or an independent contractor under this Article dependent upon the application of the common law test for determining employment status.status and any individual found to be an employee shall be subject to workers' compensation coverage pursuant to G.S. 97-93 unless otherwise exempt.

Any interstate or intrastate motor carrier shall be considered the contractor in relation to any individual driver found to be an independent contractor who shall be considered as the subcontractor, and their relationship shall be subject to the provisions of G.S. 97-19.

A contractor and subcontractor may agree in writing that the contractor shall cover the subcontractor, or the subcontractor and the subcontractor's employees, under a blanket insurance policy of the contractor to allow the contractor to chargeback the cost of the coverage to the subcontractor.

Any principal contractor, intermediate contractor, or subcontractor, irrespective of whether such contractor regularly employs three or more employees, who contracts with an individual in the interstate or intrastate carrier industry who operates a truck, tractor, or truck tractor trailer licensed by a governmental motor vehicle regulatory agency and who has not secured the payment of compensation in the manner provided for employers set forth in G.S. 97-93 for himself personally and for his employees and subcontractors, if any, shall be liable as an employer under this Article for the payment

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of compensation and other benefits on account of the injury or death of the independent contractor and his employees or subcontractors due to an accident arising out of and in the course of the performance of the work-covered by such contract.

The principal contractor, intermediate contractor, or subcontractor may insure any and all of his independent contractors and their employees or subcontractors in a blanket policy, and when insured, the independent contractors, subcontractors, and employees will be entitled to compensation benefits under the blanket policy.

A principal contractor, intermediate contractor, or subcontractor may include in the governing contract with an independent contractor in the interstate or intrastate carrier industry who operates a truck, tractor, or truck tractor trailer licensed by a governmental motor vehicle regulatory agency an agreement for the independent contractor to reimburse the cost of covering that independent contractor under the principal contractor's, intermediate contractor's, or subcontractor's coverage of his business."

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



HOUSE BILL 1370: Workers' Comp./Trucking



BILL ANALYSIS

Committee: House Insurance Committee

Date: July 1, 2004

Version: First Edition

Introduced by:

Summary by: Tim Hovis

Committee Counsel

SUMMARY: HB 1370 would amend the existing G.S. 97-19.1 to provide that an individual truck driver providing service to an interstate or intrastate motor carrier shall be considered a subcontractor to the carrier, who shall be considered the contractor. The bill specifically provides that the carrier and driver are subject to the provisions of G.S. 97-19, as discussed below.

BACKGROUND: G.S. 97-19 provides that a principal contractor must obtain an Industrial Commission or Department of Insurance certificate from a subcontractor stating that the subcontractor has complied with the Workers Compensation Act. If the contractor fails to obtain the certificate, the contractor is liable for injuries to the subcontractor under the Act. Once the contractor has the certificate, he or she is not liable to the subcontractor or the subcontractor's employees for workers compensation benefits. A copy of the statute is attached.

Prior to the enactment of G.S. 97-19.1 during the 2003 Session, a ruling by the North Carolina Supreme Court controlled the relationship of independent drivers and carriers. Specifically, this ruling, <u>Brown v. L.H. Bottoms Truck Lines, Inc.</u>, 227 N.C. 299 (1947), held that an independent truck driver was considered to be an employee of the carrier or trucking company. As such, the carrier was required to provide workers compensation insurance for the trucker.

EXISTING LAW: In the 2003 Regular Session, the General Assembly enacted G.S. 97-19.1. This statute required independent truckers to provide workers compensation insurance. Under the existing law, carriers were also given the option of providing coverage and charging the costs of the coverage to the independent trucker.

BILL ANALYSIS: HB 1370 amends the current G.S. 97-19.1 to provide that an individual truck driver providing service to an interstate or intrastate motor carrier shall be considered a subcontractor to the carrier, who is considered the contractor. The bill provides further that G.S. 97-19 shall govern the relationship between the driver and the carrier.

G.S. 97-19 provides that a principal contractor must obtain an Industrial Commission or Department of Insurance certificate from a subcontractor stating that the subcontractor has complied with the Workers Compensation Act. If the contractor fails to obtain the certificate, the contractor is liable for injuries to the subcontractor under the Act. Once the contractor has the certificate, he is not liable to the subcontractor or the subcontractor's employees for workers compensation benefits.

As with current law, the bill provides that the carrier may cover the trucker under a blanket insurance policy and charge the costs of the coverage to the trucker.

House Bill 1370 would become effective when it becomes law.

HOUSE BILL 1370

Page 2

§ 97-19. Liability of principal contractors; certificate that subcontractor has complied with law; right to recover compensation of those who would have been liable; order of liability.

Any principal contractor, intermediate contractor, or subcontractor who shall sublet any contract for the performance of any work without requiring from such subcontractor or obtaining from the Industrial Commission a certificate, issued by a workers' compensation insurance carrier, or a certificate of compliance issued by the Department of Insurance to a self-insured subcontractor, stating that such subcontractor has complied with G.S. 97-93 hereof, shall be liable, irrespective of whether such subcontractor has regularly in service fewer than three employees in the same business within this State, to the same extent as such subcontractor would be if he were subject to the provisions of this Article for the payment of compensation and other benefits under this Article on account of the injury or death of any employee of such subcontractor due to an accident arising out of and in the course of the performance of the work covered by such subcontract. If the principal contractor, intermediate contractor or subcontractor shall obtain such certificate at the time of subletting such contract to subcontractor, he shall not thereafter be held liable to any employee of such subcontractor for compensation or other benefits under this Article.

Any principal contractor, intermediate contractor, or subcontractor paying compensation or other benefits under this Article, under the foregoing provisions of this section, may recover the amount so paid from any person, persons, or corporation who independently of such provision, would have been liable for the payment thereof.

Every claim filed with the Industrial Commission under this section shall be instituted against all parties liable for payment, and said Commission, in its award, shall fix the order in which said parties shall be exhausted, beginning with the immediate employer.

The principal or owner may insure any or all of his contractors and their employees in a blanket policy, and when so insured such contractor's employees will be entitled to compensation benefits regardless of whether the relationship of employer and employee exists between the principal and the contractor. (

Dich Taylor. Trial Lauryers H1370 EXCLUDES TRUCK DRIVERS FROM WORKERS COMP



For 57 years, individuals driving trucks in North Carolina under the license of interstate trucking carriers have been covered by workers compensation, whether the individual was an employee or independent contractor. The NC Supreme Court said in 1947 that if a trucking company placed its license plates on a truck and authorized the truck to operate under that license, the driver was an employee for purposes of worker compensation and the carrier must pay comp premiums.

For several legislative sessions, the trucking industry sought to reverse the court decision and remove the responsibility to cover drivers who were independent contractors. Those efforts were rejected by the General Assembly.

In 2003, an agreement was reached between all parties, including the trucking industry, organized labor, and the plaintiff's bar, and H892 was enacted.

H892 reversed the court decision and said employment status would be decided on a case by case basis, but that drivers would continue to be covered whether employees or contractors, and that if the driver was a contractor and not an employee, the carrier could require that the driver pay for his or her coverage.

Now the trucking industry is asking the General Assembly to reverse the deal struck just a year ago and remove the protections of the comp system from truck drivers. H1370 would change North Carolina law fundamentally to the effect that independent contractor drivers for big carriers would not be covered by comp for the first time in 57 years.

The 2003 legislation allowed the trucking industry to pass on all costs for coverage of independent contractor drivers to the drivers – that legislation did not increase cost to the industry.

If there is an increased cost to the industry, it is because the industry is now complying with the law which was clarified by the General Assembly in 2003.

The consequences of H1370 would be to place the burden for medical costs and disability for injured truck drivers on the state and government programs.

For more information --- Dick Taylor 8352800, Paul Pulley 8805777, Bill Wilson 8352809

MINUTES

HOUSE INSURANCE COMMITTEE

July 7, 2004

Chairman Holliman called the meeting to order at 10:07AM. He introduced the pages and thanked the Sgt.-At-Arms for assisting with the meeting. See Attachments I, II, & III.

The following members were present: Chairman Holliman and Setzer, Representative Lucy Allen, Rep. Bobby Barbee, Rep. Charles Johnson, Rep. Linda Johnson, Rep. Drew Saunders; Rep. Wainwright, Rep. Connie Wilson, Rep. Tom Wright, Ex-officio Harold Brubaker and Ex-officio Pete Cunningham.

Chair Holliman called on Rep. Saunders to speak on HB-1370 that was continued from our meeting of July 1, 2004. Susan Smith spoke for herself and her husband who are independent/owner operated truckers. She explained that if this legislation were approved, they would be forced out of business. She talked about the expense of liability insurance, registration fees and fuel tax.

Paul Pulley, Academy of Trial Lawyers introduced Victor Farah, Attorney with Journigan Law Firm. He explained that he specializes in Workman's Compensation and talked about the "bright line test", and how the owner would be the employer.

Representative Holliman recognized Representative McComas as an "Honoree Member" of the Insurance Committee. See Attachment VI. Rep. McComas spoke for this legislation and explained how being an independent trucker works, and how this legislation compares to other independent small businesses. And how these regulations will affect independent truckers. After much discussion, Rep. Holliman called for a vote with a show of hands. HB-1370 passed with a favorable report with an 8 to 3 vote.

Representative Holliman called on Bill Hale, Attorney with Jordan, Price a Proposed Committee Substitute being drafted by Tim Hovis, Staff Attorney. The discussion on this legislation will continue at a later date. See Attachment VII.

Chairman Holliman adjourned at 10: 55 AM.

Chair Hugh Holliman

Chair Mitchell Setzer

Carol Bowers, Joanna Mills, Clerks

HOUSE INSURANCE COMMITTEE

July 7, 2004 10:00 AM Room 544 LOB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

HB 1370 – WORKERS' COMP./ TRUCKING. REP. SAUNDERS

House Pages

| 1. | Name: Andrew E Austin |
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| | County: Walle |
| | Sponsor: Sam Ellis |
| 2. | Name: <u>Fie Greige</u> |
| | County: Mecklen-burg |
| | Sponsor: Beverly Earle |
| 3. | Name: Geofficy Edmonds |
| | County: Cumberland |
| | Sponsor: Rick Glazier |
| 4. | Name: David Acosta |
| | County: Cumberland |
| | Sponsor: Rick Glazier |
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| Sgt- | At-Arms |
| 1. | Name: Frank Prevo |
| 2. | Name: Philip Schreibman |
| | Name: ChARLES WILLIAMS |
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VISITOR REGISTRATION SHEET

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| R. Jan Wilms | NCMBA |
| Chris Fitzsimon | ne Policy Watch |
| David STOLLER | STATE FALM |
| Robert Paschar | Young, hoone |
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VISITOR REGISTRATION SHEET

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112 S. Blount St., Ste. 102 Raleigh, NC 27601 (919) 833-2070 (ph) info@ncpirg.org www.ncpirg.org (919) 839-0767 (fx)

Revised "Stormwater" Bill, S 1210, Won't Protect Water Quality

The federal Clean Water Act requires state and local governments to control stormwater pollution from new developments in rapidly urbanizing cities and counties. The revised version of SB 1210, Phase II Stormwater Management, does not control polluted runoff in the parts of the state where development pressure will be heaviest.

Q: S 1210 will control stormwater pollution in and around 123 cities. Why are you saying this won't protect water quality?

A: The essence of the Phase II stormwater program, as prescribed by the federal Clean Water Act, is to apply stormwater controls to *future* development. The program does not apply to existing development, or even to projects that are vested before the local programs go into effect. The bill covers 123 cities, 1-3 mile buffers around them, and a handful of outlying census tracts considered urbanized in 2000. The earliest the program will go into effect is between 2006 and 2008. North Carolina loses 383 acres of forests and farmland each day, the majority in and around urbanizing areas. By the time the program goes into effect, development pressures will be well outside the boundaries drawn by S 1210; none of the new development between 2000 (when the census was taken) and 2006 will be covered by this legislation. No additional municipalities will be covered until 2010 at the earliest.

The bill also fails to protect sensitive waters, such as shellfish waters. The final Environmental Management Commission rules would have protected shellfish waters by using a science-based density trigger for structural stormwater controls, but this legislation does not. The expected result will be the closures of more shellfish waters to commercial harvest.

Q: Are you saying this bill won't protect water quality in already-developed areas?

A: Yes. In addition to requiring post-construction stormwater controls on new developments, the Clean Water Act requires 5 minimum measures of local governments: public education; public involvement; illicit discharge control; good housekeeping, and sedimentation and erosion control from construction sites. Most communities are already implementing these five other measures, with or without the passage of S 1210.

Q: If this bill doesn't protect water quality in municipalities, why do the municipalities want it?

A: The municipalities want the security of a state-sanctioned program that includes the measures detailed above. The original version of the bill provided this security and much more adequately protected water quality; the revised version does not.

Q: Why should rural counties like Alexander have to implement these types of controls countywide?

¹Losing Our Natural Heritage, NCPIRG Educational Fund, North Carolina's Disappearing Open Spaces, September 2003. According to the Natural Resource Conservation Service's Natural Resource Inventory data, the areas with the greatest total acres developed from 1982-2002 are Rural Piedmont Counties (353,300 acres) the Triangle Area (301,500 acres) and the Charlotte Area (301,500 acres).

Q: Why should rural counties like Alexander have to implement these types of controls county-wide?

A: Stormwater pollution is the largest source of water pollution in the state.² Ideally, any development anywhere in the state over one acre would be required to control its stormwater pollution; the technology to do so is available and affordable. The original version of S1210/H 1585 was a compromise from this ideal; it only required standards in a third of the state's counties. Environmental interests offered a further compromise, suggesting allowing counties like Alexander to "opt-out" of requirements; but our proposals were not incorporated into the version of the bill adopted by the Senate or considered in committee.

Q: Other areas can be petitioned in and covered by the stormwater controls, isn't that sufficient? A: The agency responsible for handling and responding to any incoming petitions, the Department of Environment and Natural Resources, is understaffed and overworked. Permittees in water quality programs alone already outnumber inspectors 500 to 1.3 DENR is not proposing additional staffing to implement the Phase II program; it is difficult to see how the agency, despite its best intentions, would be able to efficiently process new petitions. The petitioning process also requires modeling and other resources that local governments and citizen organizations do not have. Finally, newly petitioned areas would not be covered until 2008, 2010, 2013 or beyond—too far in the future to protect water quality in these areas to keep pace with new development.

² Assessed by DENR in their 303(d) Impaired Waters List, prepared for US EPA under the federal Clean Water Act. See http://h2o.enr.state.nc.us/tmdl/General_303d.htm#Downloads. See also, See Streamlines, Vol. 2, No. 2, May 1997.

³ North Carolina Department of Environment and Natural Resources Environmental Regulatory Compliance Activity in Calendar Year 2000, Kari Barsness, Jimmy Carter, November 14, 2001. Available at http://www.enr.state.nc.us/assets/applets/compliancereport2000.pdf.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

H

HOUSE BILL 1370*

| • | Short Title: | Workers' Comp./Trucking. | | | | (Public) |
|---|--------------|--|---------------|-------------|------------|----------|
| | Sponsors: | Representatives Saunders; Stiller, and K. Williams. | Crawford, | Cunningham, | Gillespie, | Hilton, |
| | Referred to: | Rules, Calendar, and Operati | ions of the H | ouse. | | |

May 11, 2004

1 2 AN ACT TO A

A BILL TO BE ENTITLED

AN ACT TO AMEND THE APPLICATION OF THE WORKERS' COMPENSATION LAW TO CERTAIN MOTOR CARRIERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-19.1 reads as rewritten:

"§ 97-19.1. Truck, tractor, or truck tractor trailer driver's status as employee or independent contractor.

An individual in the interstate or intrastate carrier industry who operates a truck, tractor, or truck tractor trailer licensed by a governmental motor vehicle regulatory agency may be an employee or an independent contractor under this Article dependent upon the application of the common law test for determining employment status.status and any individual found to be an employee shall be subject to workers' compensation coverage pursuant to G.S. 97-93 unless otherwise exempt.

Any interstate or intrastate motor carrier shall be considered the contractor in relation to any individual driver found to be an independent contractor who shall be considered as the subcontractor, and their relationship shall be subject to the provisions of G.S. 97-19.

A contractor and subcontractor may agree in writing that the contractor shall cover the subcontractor, or the subcontractor and the subcontractor's employees, under a blanket insurance policy of the contractor to allow the contractor to chargeback the cost of the coverage to the subcontractor.

Any principal contractor, intermediate contractor, or subcontractor, irrespective of whether such contractor regularly employs three or more employees, who contracts with an individual in the interstate or intrastate carrier industry who operates a truck, tractor, or truck tractor trailer licensed by a governmental motor vehicle regulatory agency and who has not secured the payment of compensation in the manner provided for employers set forth in G.S. 97-93 for himself personally and for his employees and subcontractors, if any, shall be liable as an employer under this Article for the payment

of compensation and other benefits on account of the injury or death of the independent contractor and his employees or subcontractors due to an accident arising out of and in the course of the performance of the work covered by such contract.

The principal contractor, intermediate contractor, or subcontractor may insure any and all of his independent contractors and their employees or subcontractors in a blanket policy, and when insured, the independent contractors, subcontractors, and employees will be entitled to compensation benefits under the blanket policy.

A principal contractor, intermediate contractor, or subcontractor may include in the governing contract with an independent contractor in the interstate or intrastate carrier industry who operates a truck, tractor, or truck tractor trailer licensed by a governmental motor vehicle regulatory agency an agreement for the independent contractor to reimburse the cost of covering that independent contractor under the principal contractor's, intermediate contractor's, or subcontractor's coverage of his business."

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



HOUSE BILL 1370:Workers' Comp./Trucking



BILL ANALYSIS

Committee: House Insurance Committee

Date: July 1, 2004

Version: First Edition

Introduced by:

Summary by: Tim Hovis

Committee Counsel

SUMMARY: HB 1370 would amend the existing G.S. 97-19.1 to provide that an individual truck driver providing service to an interstate or intrastate motor carrier shall be considered a subcontractor to the carrier, who shall be considered the contractor. The bill specifically provides that the carrier and driver are subject to the provisions of G.S. 97-19, as discussed below.

BACKGROUND: G.S. 97-19 provides that a principal contractor must obtain an Industrial Commission or Department of Insurance certificate from a subcontractor stating that the subcontractor has complied with the Workers Compensation Act. If the contractor fails to obtain the certificate, the contractor is liable for injuries to the subcontractor under the Act. Once the contractor has the certificate, he or she is not liable to the subcontractor or the subcontractor's employees for workers compensation benefits. A copy of the statute is attached.

Prior to the enactment of G.S. 97-19.1 during the 2003 Session, a ruling by the North Carolina Supreme Court controlled the relationship of independent drivers and carriers. Specifically, this ruling, <u>Brown v. L.H. Bottoms Truck Lines</u>, Inc., 227 N.C. 299 (1947), held that an independent truck driver was considered to be an employee of the carrier or trucking company. As such, the carrier was required to provide workers compensation insurance for the trucker.

EXISTING LAW: In the 2003 Regular Session, the General Assembly enacted G.S. 97-19.1. This statute required independent truckers to provide workers compensation insurance. Under the existing law, carriers were also given the option of providing coverage and charging the costs of the coverage to the independent trucker.

BILL ANALYSIS: HB 1370 amends the current G.S. 97-19.1 to provide that an individual truck driver providing service to an interstate or intrastate motor carrier shall be considered a subcontractor to the carrier, who is considered the contractor. The bill provides further that G.S. 97-19 shall govern the relationship between the driver and the carrier.

G.S. 97-19 provides that a principal contractor must obtain an Industrial Commission or Department of Insurance certificate from a subcontractor stating that the subcontractor has complied with the Workers Compensation Act. If the contractor fails to obtain the certificate, the contractor is liable for injuries to the subcontractor under the Act. Once the contractor has the certificate, he is not liable to the subcontractor or the subcontractor's employees for workers compensation benefits.

As with current law, the bill provides that the carrier may cover the trucker under a blanket insurance policy and charge the costs of the coverage to the trucker.

House Bill 1370 would become effective when it becomes law.

HOUSE BILL 1370

Page 2

§ 97-19. Liability of principal contractors; certificate that subcontractor has complied with law; right to recover compensation of those who would have been liable; order of liability.

Any principal contractor, intermediate contractor, or subcontractor who shall sublet any contract for the performance of any work without requiring from such subcontractor or obtaining from the Industrial Commission a certificate, issued by a workers' compensation insurance carrier, or a certificate of compliance issued by the Department of Insurance to a self-insured subcontractor, stating that such subcontractor has complied with G.S. 97-93 hereof, shall be liable, irrespective of whether such subcontractor has regularly in service fewer than three employees in the same business within this State, to the same extent as such subcontractor would be if he were subject to the provisions of this Article for the payment of compensation and other benefits under this Article on account of the injury or death of any employee of such subcontractor due to an accident arising out of and in the course of the performance of the work covered by such subcontract. If the principal contractor, intermediate contractor or subcontractor shall obtain such certificate at the time of subletting such contract to subcontractor, he shall not thereafter be held liable to any employee of such subcontractor for compensation or other benefits under this Article.

Any principal contractor, intermediate contractor, or subcontractor paying compensation or other benefits under this Article, under the foregoing provisions of this section, may recover the amount so paid from any person, persons, or corporation who independently of such provision, would have been liable for the payment thereof.

Every claim filed with the Industrial Commission under this section shall be instituted against all parties liable for payment, and said Commission, in its award, shall fix the order in which said parties shall be exhausted, beginning with the immediate employer.

The principal or owner may insure any or all of his contractors and their employees in a blanket policy, and when so insured such contractor's employees will be entitled to compensation benefits regardless of whether the relationship of employer and employee exists between the principal and the contractor. (

----Original Message----

From: Jerry Pope [mailto:jerrypope@portcitytrans.com]

Sent: Thursday, October 30, 2003 1:45 PM

To: dmccomas@mcotransport.com

Subject: Fw: NC LAW.doc

Danny,

This has created some serious repercussion. I cannot believe this has happened. If it weren't difficult enough to try to comply with all the regulations we are faced with, we now have this! If it were not difficult enough for Owner Operators to make a living, they now just have to pay more for no better benefits.

Hep. Mc Comas) Attachment

For Motor Carriers who do use Owner Operators and are based in North Carolina, it appears that our best bet is to move our base of operations outside North Carolina so that our operations outside N.C. are not adversely affected as well. What have we accomplished with this law?

Jerry Pope

---- Original Message -----

From: Lefton, Mark To: 'Jerry Pope'

Sent: Wednesday, October 29, 2003 3:15 PM

Subject: NC LAW.doc

SCOPELITIS, GARVIN, LIGHT & HANSON

PROFESSIONAL CORPORATION ATTORNEYS AT LAW

INDIANAPOLIS
CHICAGO • WASHINGTON, D.C. • SAN FRANCISCO • KANSAS CITY

10 W. Market Street, Suite 1500 Indianapolis, Indiana 46204 fax (317) 687-2414

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GREGORY M. FEARY MANAGING PARTNER gfeary@scopelitis.com

MEMORANDUM

Fr: Greg Feary - Managing Partner, Scopelitis, Garvin, Light & Hanson

DT: October 17, 2003

RE: North Carolina Owner-Operator Law

Section 97-19.1 - Comments and Observations

The following comments and observations are made to provide general guidance to trucking companies attempting to understand their rights and obligations under the new provision of North Carolina's Workers' Compensation Act that took effect on October 1, 2003. It is not to be relied on as legal advice for any specific circumstance and cannot be relied on as applicable to any set of specific circumstances. With regard to the resolution of any legal questions or specific problems, counsel should be specifically retained to review the facts and circumstances and provide a written legal opinion to resolve the issue.

Section 97-19.1 of North Carolina's Workers' Compensation Act (the "Owner-Operator Law") provides a very useful resolution to one important issue but may also create confusion with respect to other critical issues. Specifically, the Owner-Operator Law authorizes a motor carrier's "charge back" of workers' compensation coverage to an owner-operator. In the absence of a specific statute authorizing such charge back, many states' insurance laws may interpret the coverage of an owner-operator under a motor carrier's workers' compensation policy (and the charge back associated therewith) as creating a group workers' compensation policies. Many states' laws determine group workers' compensation policies to be in violation of insurance laws. Consequently, this "charge back" authorization is quite helpful to motor carriers that are willing to offer workers' compensation coverage to owner-operators under the motor carrier's policy.

Nevertheless, two critical questions remain ambiguous or possibly contrary to the original intent of those trucking industry interests within the State of North Carolina attempting to lobby its enactment. The following two issues will require further resolution:

1. Does the new Owner-Operator Law in North Carolina require a sole proprietor owner-operator to obtain workers' compensation coverage even if he does not have employees? Simply stated, the Owner-Operator law appears to require sole proprietor owner-operators to secure workers' compensation coverage. Despite the fact that the first paragraph of the Owner-Operator Law indicates that a determination of "employee or independent contractor" will be "dependent upon the application of the common law test for determining employment status," the second paragraph of the Owner-Operator Law effectively eliminates the practical application of the first paragraph or its underlying purpose (I would also observe that the common law in North Carolina is substantially predisposed toward finding owner-operators to be employees).

The second paragraph specifically requires the owner-operator "for himself personally" to obtain workers' compensation coverage or the motor carrier will be liable for such coverage. This creates an apparent conflict in the law in North Carolina given that sole proprietors are deemed by North Carolina statute not to be employees of their own businesses and thus not obligated to be covered under a workers' compensation policy. Unfortunately, rules of statutory construction require that a specific statute controls over more general statutes and I would expect this apparent conflict between the two statutory provisions in North Carolina's Workers' Compensation Act to be resolved in favor of the new Owner-Operator Law. This means that sole proprietor owner-operators are a special class of sole proprietors in the State of North Carolina that are required to purchase workers' compensation coverage for themselves. Yet, a fundamental legal issue remains regarding the intent of the North Carolina Workers' Compensation Act to only apply to employees.

2. How does North Carolina law determine jurisdiction over a motor carrier? Section 97-36 of North Carolina's Workers' Compensation Act addresses jurisdiction. The most troubling aspect of this statute is that if a North Carolina trucking company with a principal place of business in North Carolina has owner-operators outside of North Carolina, North Carolina may exercise jurisdiction over any of these owner-operators regardless of whether those owner-operators travel to or from North Carolina. Consequently, all North Carolina trucking companies may need to be concerned about the scope and reach of this law to all owner-operators under contract with such trucking companies.

As is generally true in many jurisdictions, in addition to the above-referenced "employer's place of business" jurisdictional element, North Carolina may exercise jurisdiction over owner-operators whose work is principally localized in North Carolina or who enter into a contract of hire in North Carolina.

It is my view that a legislative solution may need to be applied to the problems created by the Owner-Operator Law. While I believe the trucking industry interests in North Carolina launched an extremely well-meaning attempt to resolve preexisting problems in the law (and to some extent provided some useful solutions), the end result of this statute is not as advantageous to the trucking industry as other similar statutes in other states.

North Carolina ACADEMY of TRIAL LAWYERS

Protecting People's Right

FEBRUARY 2004

FOCUS

President's Column. Let's Fly Together

Rules of the Road: Understanding the Federal Motor Carrier Safety Regulations

The Safety Expert's Guide to Thoroughly Investigating a Trucking Collision

The Critical Role of the Accident Reconstructionist in Trucking Cases

Gathering Evidence in Commercial Truck Cases

Handling Tractor-Trailer Wrecks: A Step-by-Step Approach

How to Try and Win a Trucking Case

ent Killer on the Highway

DEPARTMENTS

Telling the Story: Tristin Lewis: A Life Like Nothing We Can Imagine

Machinery

PROPOSED COMMITTEE SUBSTITUTE FOR SB 469

A BILL TO BE ENTITLED

AN ACT TO REQUIRE NOTIFICATION TO EMPLOYEES OF THE EXISTENCE OF EMPLOYER-OWNED LIFE INSURANCE POLICIES WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF COVERAGE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-58-75 reads as rewritten:

"§ 58-58-75. Insurable interest in life and physical ability of employee or agent.

(a) An employer, whether a partnership, joint venture, business trust, mutual association, corporation, any other form of business organization, or one or more individuals, or any religious, educational, or charitable corporation, institution or body, has an insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an employee for the benefit of such employer. Any principal shall have a life insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an agent for the benefit of such principal.

(b) The insurable interest specified in subsection (a) of this section exists only if the employee receives written notification of the existence of the coverage. The notice shall be provided to the employee within 30 days after the effective date of the coverage and shall include a statement that the employer may maintain the life insurance coverage on the employee even after employment is terminated.

(c) For non-key or non-managerial employees, the aggregate amount of coverage shall be reasonably related to the benefits provided to the employees in the aggregate.

(d) With respect to employer-provided pension and welfare plans, the life insurance coverage purchased to finance the plans may only cover the lives of those employees and retirees who, at the time their lives were first insured under the plan, either are participants, or would be eligible to participate, upon the satisfaction of age, service, or similar eligibility criteria in the plan."

SECTION 2. This act becomes effective October 1, 2004.

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

| The | The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. | | |
|-------------|--|--|--|
| _ | Committee Substitute for 1. 1370 A BILL TO BE ENTITLED AN ACT TO AMEND THE APPLICATION OF THE WORKERS' COMPENSATION LAW TO CERTAIN MOTOR CARRIERS. | | |
| \boxtimes | 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) | | |

MINUTES

HOUSE INSURANCE COMMITTEE

July 8, 2004

Chair Setzer called the meeting to order at l2: 11. We had no pages for the meeting because The Appropriations Committee was still meeting. The Sergeant-At-Arms is listed on Attachment I. The visitors were welcomed. See Attachment II.

The members in attendance were: Representative Setzer, Rep. Holliman, Rep. Hall, Rep. Lucy Allen, Rep. Charles Johnson, Rep. Linda Johnson, Rep. David Lewis and Rep. Karen Ray.

Chair Setzer called on Frank Folger, Legislative Liaison, to explain HB-ll07 for concurrence to HB-l751. He explained the bill and answered questions from Rep. Hall. See Attachments III, IV, and V. Rep. David Lewis made a motion to concur and the motion carried unanimously.

Chair Setzer made the announcement that we had three bill left in the Insurance Box which needed to be postponed. Rep. David Lewis made a motion to postpone these bills indefinitely: HB-596, HB-654 and HB-1121. The motion carried and the meeting was adjourned at 12:33.

Chairman Mitchell Setzer

Chairman Hugh Holliman

Joanna Mills & Carol Bowers, Clerks

HOUSE INSURANCE COMMITTEE

July 8, 2004 12:00 PM Room 544 LOB

Chairs

Rep. Hugh Holliman Rep. Mitchell Setzer

Vice Chair

Rep. John Hall

AGENDA

HB 1107 - FORTIFY AGAINST UNAUTHORIZED INSURANCE.
REPRESENTATIVE WILSON

SB 758 - MORE SM. EMPLOYER HEALTH INS. AVAILABLE. SENATOR RAND

House Pages

| 1. | Name: |
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| Sgt- | At-Arms |
| 1. | Name: JAMES WilliAms |
| 2. | Name: Philip Schreibnan |
| 3. | Name: Martha tourish |
| 4. | Name: |

Attachment 11

VISITOR REGISTRATION SHEET

| | 7-8-04 |
|-------------------|--------|
| Name of Committee | Date |

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

| NAME | FIRM OR AGENCY |
|-----------------|------------------------|
| Mary Gurganus | NC Bar Assoc. |
| lock and Hovers | LA+A |
| David Cranford | AlA North Carolina |
| Million | PMRS |
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FORTIFY AGAINST UNAUTHORIZED 777 **INSURANCE:**

Summary by:

House Bill 1107

Committee:

Introduced by: Representative Connie Wilson

Kory J. Goldsmith

Attachment

Date:

July 2, 2004

Version:

3rd Edition

SUMMARY: The 3rd Edition of HB1107 clarifies and increases the penalties for an insurance agent who solicits or sells insurance for an unauthorized insurer. It also puts stricter limits on which entities may sell insurance directly to a person in this State.

The act becomes effective December 1, 2004 and applies to acts committed on or after that date.

CURRENT LAW:

G.S. 58-33-95 provides that any person representing an insurer is personally liable on all contracts of insurance unlawfully made by that person for a company that is not authorized to do business in North Carolina. It also provides that it is a Class 1 misdemeanor for that person to solicit or negotiate an insurance contract for an insurance company that is not licensed to do business in North Carolina. The sentence for a Class 1 misdemeanor for a person with no prior convictions is 1-45 days of community punishment.

G.S. 58-28-45(a) provides that it is unlawful for any person to act as agent, negotiate for or place insurance coverage for any insurer not authorized to transact business in this State. An unauthorized insurer is an insurer that is not licensed by the Commissioner of Insurance or otherwise permitted to transact insurance business in the State. A violation of this provision is a Class 3 misdemeanor with a mandatory fine of not less than \$1,000 and not more than \$5,000. The sentence for a Class 3 misdemeanor for a person with no prior convictions is 1-10 days of community punishment.

G.S. 58-33-46(a)(2) authorizes the Commissioner of Insurance to place on probation, suspend, revoke, or refuse to renew any insurance agent's license for a violation of the any insurance law.

As a general rule, an insurance company may not sell insurance in North Carolina without a license. There are two exceptions to this general rule. An unlicensed insurer may sell insurance in this State as a surplus lines insurer if it meets certain eligibility requirements. Even then, the insurer may only sell coverage for a risk if the applicant is unable to procure coverage from a licensed insurer. The other exception is known as 'direct procurement' and involves the sale of insurance without any agent or broker and allows an individual to directly procure insurance from an 'unauthorized insurer' which does not have to meet any statutory requirements.

BILL ANALYSIS:

Section 1 of the bill rewrites G.S. 58-33-95. It makes it clear that an agent is strictly liable, i.e., liable regardless of the presence or absence of negligence, for any losses or claims that are unpaid by an unauthorized insurer. It makes a violation a Class 1 misdemeanor if the insurance agent did not know the insurer is an unauthorized insurer. It makes it a Class H felony if the insurance agent knew or should have known the insurer was an unauthorized insurer. The presumptive sentence for a Class H felony for a person with no prior convictions is 5-6 months of community, intermediate or active punishment.

FORTIFY AGAINST UNAUTHORIZED INSURANCE

Page 2

Section 2 makes soliciting, negotiating, or selling insurance for an unauthorized insurer grounds to revoke an insurance agent's license, regardless of whether the agent knew that the insurer was an unauthorized insurer.

Section 3 clarifies that the higher penalties of G.S. 58-33-95 apply when a person solicits or negotiates an insurance contract for an unauthorized insurer.

Section 4 amends G.S. 58-28-5(b) to restrict which entities may directly sell insurance to a person in this State. It would require that only eligible surplus line insurers would qualify for this exception.

BACKGROUND: The bill comes at the request of the Department of Insurance and in response to a recent incident in which a group of North Carolina physicians procured professional liability insurance from an unauthorized insurer that did not have the financial resources to pay claims.

H1107-SMRC-004

attachment

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2003

H

HOUSE BILL 1107

Committee Substitute Favorable 5/1/03 Senate Commerce Committee Substitute Adopted 7/1/04

| Short Title: | Fortify Against Unauthorized Insurance. | (Public) |
|--------------|---|----------|
| Sponsors: | | |
| Referred to: | | |

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE CIVIL LIABILITY AND INCREASE THE CRIMINAL PENALTY FOR PERSONS WHO REPRESENT UNAUTHORIZED INSURERS AND TO PROVIDE THAT SUCH ACTIVITY IS GROUNDS FOR REVOCATION OF THE LICENSE OF THE INSURANCE AGENT OR BROKER; AND TO LIMIT DIRECT PROCUREMENT OF INSURANCE ONLY THROUGH ELIGIBLE SURPLUS LINES INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-95 reads as rewritten:

"§ 58-33-95. Agents personally liable; representing unlicensed company prohibited; penalty.

- (a) Any person representing an insurer is personally liable on all contracts of insurance unlawfully made by or through him, directly or indirectly, for any company not authorized to do business in the State. A person or citizen of the State who fills up or signs any open policy, certificate, blank or coupon of, or furnished by, an unlicensed company, agent, broker or limited representative, the effect of which is to bind any insurance in an unlicensed company on property in this State, is the representative of such company, and personally liable for all licenses and taxes due on account of such transaction. If any person shall unlawfully solicit, negotiate for, collect or transmit a premium for a contract of insurance or act in any way in the negotiation or transaction of any unlawful insurance with an insurance company not licensed to do an insurance business in North Carolina, he shall be guilty of a Class 1 misdemeanor. or entity who solicits, negotiates, or sells insurance in this State for an unauthorized insurer:
 - Is the representative of that insurer and shall be strictly liable for any losses or unpaid claims if an unauthorized insurer fails to pay in full or in part any claim or loss within the provisions of any insurance contract sold, directly or indirectly, by or through that person or entity on behalf of the unauthorized insurer.

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- Shall be guilty of a Class 1 misdemeanor if the person or entity does not know that the insurer is an unauthorized insurer. Each solicitation, negotiation, or sale shall constitute a separate offense.
 - (3) Shall be guilty of a Class H felony if the person or entity knew or should have known that the insurer is an unauthorized insurer. Each solicitation, negotiation, or sale shall constitute a separate offense.
 - (b) A civil action may be filed or a license revocation proceeding may be initiated under this section regardless of whether a criminal action is brought or a criminal conviction is obtained for the act alleged in the civil action or revocation proceeding.
 - (c) As used in this section, the terms "negotiate", "sell", and "solicit" shall have the meanings set forth in G.S. 58-33-10. As used in this section, the status of an entity or person as an "unauthorized insurer" shall be determined in accordance with Article 28 of this Chapter and, if applicable, Article 49 of this Chapter."

SECTION 2. G.S. 58-33-46(a) is amended by adding a new subdivision to read:

"(12a) Soliciting, negotiating, or selling insurance in this State for an unauthorized insurer, regardless of whether the licensee or applicant knew that the insurer was unauthorized. As used in this section, the terms "soliciting", "negotiating", and "selling" shall have the meaning of "solicit", "negotiate", and "sell", respectively, set forth in G.S. 58-33-10."

SECTION 3. G.S. 58-28-45(h) reads as rewritten:

"(h) Any—Except as provided in G.S. 58-33-95, any person, corporation, association or partnership violating any of the provisions of this section shall be guilty of a Class 3 misdemeanor and shall only be fined not less than one thousand dollars (\$1,000) nor more than five thousand dollars (\$5,000)."

SECTION 4. G.S. 58-28-5(b) reads as rewritten:

Any person in this State may directly procure or directly renew insurance with an unlicensed insurer eligible surplus lines insurer, as defined in G.S. 58-21-10(3), without the involvement of an agent, broker, or surplus lines licensee, on a risk located or to be performed, in whole or in part, in this State. The person shall, within 30 days after the date the insurance is procured or renewed, file a written report with the Commissioner on forms prescribed by the Commissioner. The report must contain the name and address of the insured; name and address of the insurer; the subject of insurance; a general description of the coverage; the amount of premium currently charged; and any additional information requested by the Commissioner. The report must also contain an affidavit of the insured that states that the full amount or kind of insurance cannot be obtained from insurers that are admitted-licensed to do business in this State; and that the insured has made a diligent search among the insurers that are admitted-licensed to transact and are actually writing the particular kind and class of insurance in this State. Gross premiums charged for the insurance, less any return premiums, are subject to a tax at the rate of five percent (5%). At the time of filing the report required by this subsection, the insured shall pay the tax to the Commissioner.

4

General Assembly of North Carolina

Session 2003

- The Commissioner has the powers specified in G.S. 58-21-90 with respect to the tax levied by this subsection."
- SECTION 5. This act becomes effective December 1, 2004, and applies to acts committed on or after that date.

Ottachment

NORTH CAROLINA GENERAL ASSEMBLY LEGISLATIVE FISCAL NOTE

BILL NUMBER: House Bill 1107 (Third Edition) REVISED

SHORT TITLE: Utiliz. Review & Grievance Amendments.

SPONSOR(S): Representative C. Wilson

FISCAL IMPACT

Yes ()

No ()

No Estimate Available (X)

FY 2004-05 FY 2005-06 FY 2006-07 FY 2007-08 FY 2008-09

REVENUES:

EXPENDITURES:

POSITIONS:

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Insurance.

EFFECTIVE DATE: December 1, 2004

BILL SUMMARY:

Section 1. (Amending G.S. 58-33-95): Clarifies that an agent is strictly liable for any losses or claims unpaid if the agent sells or offers to sell insurance for an unauthorized insurer and the insurer fails to pay, in full or in part, any valid claim or loss.

- Specifically provides that selling or offering to sell insurance for an unauthorized insurer is grounds for revocation of the agent's license.
- Increases to a Class H felony the criminal penalty for an agent who *knowingly* sells insurance for an unauthorized insurer. Under existing law, it is a Class 1 misdemeanor to sell insurance for an unauthorized insurer, regardless of the agent's knowledge.

Section 2. Makes conforming changes to G.S. 58-28-45(h).

Section 3. (Amending G.S. 58-28-5) More strictly limits which entities may directly sell insurance to a person in this State. In general, an insurance company cannot sell insurance in this State without a license. However, an unlicensed insurer may sell insurance in this State as a surplus lines insurer if it meets certain eligibility requirements. Even then, such insurers may only sell coverage for a risk if the applicant is unable to procure coverage from a licensed insurer. One exception to these laws involves the sale of insurance without the use of an agent or broker ("direct procurement"). Currently, a person can directly procure from any "unauthorized insurer". Under

this exception, a person can directly buy "insurance" from an entity that does not even have to meet any statutory requirements. The opportunity for rogue entities to enter this arena is substantial. The proposed change would shut down this avenue for possible fraud by limiting direct procurement only to eligible surplus lines insurers, which must, at least, meet financial and other standards in Article 21 of Chapter 58.

July 2, 2004

House Commerce committee substitute changes the nature of the felony offense. It had read that it would be a Class F if the agent "knows" the company is unauthorized. The committee changed that to "knew or should have known"

ASSUMPTIONS AND METHODOLOGY: This bill requires a fiscal note because it includes criminal penalties. Any bill with a potential impact on the state's prison population must have a fiscal note. For this memorandum, the bill's impact on judicial and prison resources will be the focus; the Department of Insurance feels that this bill's requirements are within their current resources.

Judicial Department

The Administrative Office of the Courts currently does not have an offense code for GS 58-33-95, an indicator that relatively few charges occur. We have no data from which to estimate the number of additional charges that would arise from this amendment. We expect the enhancement in punishment to be accompanied in some cases by a more vigorous defense and prosecution, resulting in more court time and costs to dispose of these cases. The attached costs sheets indicate a \$3,000 difference in cost between a Class H felony trial and a Class 1 misdemeanor trial, and a \$76 difference in cost between a Class H felony plea and a Class 1 misdemeanor plea. AOC has no data from which to estimate the number of new civil actions or license revocation proceedings that would arise from this provision. Depending on the number and complexity of these cases, the impact on the court system could be substantial.

These amendments can be expected to increase the workload of district and superior court judges, district attorneys, clerks, and court reporters. There would also be an increase in expenses for jury fees and indigent defense.

This bill expands current GS 58-33-46(a) by adding to this list of violations the act of soliciting, negotiating, or selling insurance for an unauthorized insurer, regardless of whether the licensee knew that the insurer was unauthorized.

This provision can be expected to result in increased enforcement and court actions appealing enforcement actions. AOC has no data from which to estimate the number of such matters or the impact on the courts. Depending on the number and complexity of such proceedings, the court impact could be significant.

Department of Correction

Since this bill creates a new offense, the Sentencing Commission does not have any historical data from which to estimate its impact on the prison population. It is not known how many offenders

might be convicted and sentenced for the proposed offense. If, for example, there were three Class H convictions under this proposed bill per year, the combination of active sentences and probation revocations would result in the need for one additional prison bed the first year and two additional prison beds the second year.

This bill retains the current Class 1 misdemeanor under G.S. 58-33-95 but limits it to if the person does not know the insurer is not authorized to do business in North Carolina. The Administrative Office of the Courts (AOC) currently does not have a specific offense code for violations of G.S. 58-33-95. The lack of an AOC offense code is some indication that this offense is infrequently charged and/or infrequently results in convictions.

SOURCES OF DATA: Administrative Office of the Courts; NC Sentencing and Policy Advisory - Commission.

TECHNICAL CONSIDERATIONS:

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Douglas Holbrook

Official

Fiscal Research Division
Publication

APPROVED BY: James D. Johnson, Director

Fiscal Research Division

DATE: July 6, 2004

Signed Copy Located in the NCGA Principal Clerk's Offices

HOUSE COMMITTEE ON INSURANCE July 7, 2004

The following bills remain in the Insurance Committee and no action has been taken:

HB 596 – MOTOR VEHICLE INSURANCE RATES. REP. STARNES

HB 654 – MENTAL HEALTH/CHEMICAL DEPENDENCY PARITY.
REPS. ALEXANDER, INSKO, HACKNEY, AND WAINWRIGHT

HB 1121 – HEALTH CARE PROVIDER PROF. LIAB. INS. CHANGES. REPS. ALEXANDER, EARLE, INSKO, AND MOORE

Need a motion to postpone these bills indefinitely.

Motion by Rep.

Second by Rep.

2003 COMMITTEE REPORT HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented: By Representatives Holliman and Setzer, (Chairs) for the Committee on INSURANCE. X Committee Substitute for A BILL TO BE ENTITLED AN ACT TO CLARIFY THE CIVIL LIABILITY H.B. 1107 AND INCREASE THE CRIMINAL PENALTY FOR PERSONS WHO REPRESENT UNAUTHORIZED INSURERS AND TO PROVIDE THAT SUCH ACTIVITY IS GROUNDS FOR REVOCATION OF THE LICENSE OF THE INSURANCE AGENT OR BROKER; AND TO LIMIT DIRECT PROCUREMENT OF INSURANCE ONLY THROUGH ELIGIBLE SURPLUS LINES INSURERS.. 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) 03/19/03

2003-2004 Standing Committees

| Box | Box Conte | nts |
|-----|-------------------------------|-----|
| 6 | 2003-2004 House Judiciary I | |
| | 2003-2004 House Judiciary II | |
| | 2003-2004 House Judiciary III | |
| | 2003-2004 House Judiciary IV | |

2003-2004 House Local Government I