GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

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HOUSE BILL 339

Committee Substitute Favorable 4/24/03

Committee Substitute #2 Favorable 4/30/03

Short Title: Life and Health Insurance Omnibus.-AB (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 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; 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 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 authorities, or a mortgage lender, to the extent it collects and remits premiums to licensed insurance producers or to limited 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.

k. An adjuster licensed by this State whose activities are limited to adjustment of claims.

l. 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.

(2) "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.

(3) "Commissioner" means the Commissioner of Insurance of this State.

(4) "Control" means the term as defined in G.S. 58-19-5(2).

(5) "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".

(7) "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.

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

(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.

(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 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.~~lines, 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 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.**

(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) 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 status of the document, material, or other information;

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

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

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

(i) 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.

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) 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).

(b) The Uniform Application shall include or be accompanied by the following information and documents:

(1) All basic organizational documents of the applicant, including any 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.

(2) The bylaws, rules, regulations, or similar documents regulating the internal affairs of the applicant.

(3) NAIC Biographical Affidavit for the individuals who are responsible for the conduct of affairs of the applicant, including all members of the 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.

(4) 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:

a. 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.

(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:

a. Members of the board of directors, board of trustees, executive committee, or other governing board or committee;

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 covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the TPA to secure full payment or settlement of such claims;

(4) Fails, at any time, to meet any qualification for which issuance of the certificate could have been refused had the failure then existed and been known to the Commissioner;

(5) Or any of the individuals responsible for the conduct of its affairs has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony without regard to whether adjudication was withheld, including:

a. Members of the board of directors, board of trustees, executive committee or other governing board or committee;

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 or more of its voting stock, voting securities, or voting interest; and

d. Any other person who exercises control or influence over its affairs;

(6) Is under suspension or revocation in another state; or

(7) Has failed to timely file its annual report pursuant to G.S. 58-56-62 if a resident administrator or its statement and filing fee, as applicable, pursuant to G.S. 58-56-67(d) and (e) if a nonresident administrator.

(c) The Commissioner may, without advance notice or hearing, immediately suspend the certificate of authority or license of a TPA if the Commissioner finds that one or more of the following circumstances exist:

(1) The TPA is insolvent or impaired.

(2) A proceeding for receivership, conservatorship, rehabilitation, or other delinquency proceeding regarding the TPA has been commenced in any state.

(3) The financial condition or business practices of the TPA otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this State.

(d) If the Commissioner finds that one or more grounds exist for the suspension or revocation of a certificate of authority issued under this part, the Commissioner may, in lieu of suspension 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."

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.**

(a) Any policy or contract, except a joint, reversionary or survivorship annuity 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."

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),~~(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".

"**§ 58-60-45. 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:

(1) "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;

(2) 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 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.
   j. 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

(2) 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.**

All disclosure forms shall comply with the readability standards in Article 38 of this Chapter. It is presumed the disclosure form in Appendix A of the NAIC's Home Service Disclosure Model Act complies with this Part."

SECTION 3.6. Article 60 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 3. Regulation of Small Face Amount Life Insurance Solicitation.

"**§ 58-60-85. Title and reference.**

This Part may be cited as the "Small Face Amount Life Insurance Disclosure Act".

"**§ 58-60-90. Purpose; intent; and scope.**

(a) The purpose of this Part is to establish standards that ensure meaningful information is provided to the purchasers of small face amount policies.

(b) This Part applies to any life insurance policy or certificate with an initial face amount of fifteen thousand dollars ($15,000) or less.

(c) This Part does not apply to:

(1) Variable life insurance.

(2) Individual and group annuity contracts.

(3) Credit life insurance.

(4) Group or individual policies of life insurance issued to members of an employer group or other permitted group where:

a. Every plan of coverage was selected by the employer or other group representative;

b. Some portion of the premium is paid by the group or through payroll deduction; and

c. Group underwriting or simplified underwriting is used.

(5) Policies and certificates where an illustration has been provided pursuant to the requirements of Title 11, Chapter 4, Section .0500 of the North Carolina Administrative Code.

"**§ 58-60-95. Disclosure requirements.**

(a) An insurer issuing a small face amount policy shall provide the current disclosure included in Appendix A of the NAIC Disclosure for Small Face Amount Life Insurance Policies Model Act 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.

(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 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.

(c) Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefits attributable to the riders."

"**§ 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.

"**§ 58-60-105. 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) Immediate and deferred annuities that contain no nonguaranteed elements.

(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.**

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.

(9) "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 element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(10) "Structured settlement annuity" means a "qualified funding asset" as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

"**§ 58-60-120. Standards for the disclosure document and buyer's guide.**

(a) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant, at or before the time of application, shall be given both the disclosure document described in G.S. 58-60-125 and a copy of the buyer's guide.

(b) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the buyer's guide no later than five business days after the completed application is received by the insurer.

(1) With respect to an application received as a result of a direct solicitation through the mail:

a. Providing a buyer's guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the buyer's guide be provided no later than five business days after receipt of the application.

b. Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

(2) With respect to an application received via the Internet:

a. Taking reasonable steps to make the buyer's guide available for viewing and printing on the insurer's web site shall be deemed to satisfy the requirement that the buyer's guide be provided no later than five business days after receipt of the application.

b. Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's web site shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

(3) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the Department for a free annuity buyer's guide. In lieu of the foregoing statement, an insurer may include a statement

that the prospective applicant may contact the insurer for a free annuity buyer's guide.

(c) 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 provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under State law or regulation.

"**§ 58-60-125. Contents of disclosure document.**

At a minimum, all of the following information shall be included in the disclosure document required under this Part:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity.

(2) The insurer's name and address.

(3) A description of the contract and its benefits, emphasizing its long-term nature, including the following, if appropriate:

a. The guaranteed, nonguaranteed, and determinable elements of the contract, and their limitations, if any, and an explanation of how they operate.

b. An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate, and the fact that rates may change from time to time and are not guaranteed.

c. Periodic income options both on a guaranteed and nonguaranteed basis.

d. Any value reductions caused by withdrawals from or surrender of the contract.

e. How values in the contract can be accessed.

f. The death benefit, if available, and how it will be calculated.

g. A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract.

h. The impact of any rider, such as a long-term care rider.

(4) The specific dollar amount or percentage charges and fees with an explanation of how they apply.

(5) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement 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 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:

"(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."

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."

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 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 of conduct, a forbidden act, or willful dereliction of duty, or criminal ~~misconduct.~~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 rates. ~~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 shall 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."

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.