HOUSE BILL 220*
Committee Substitute Favorable 4/26/19
Senate Commerce and Insurance Committee Substitute Adopted 6/27/19

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

Sponsors:

Referred to:

February 28, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND CLARIFYING CHANGES TO THE INSURANCE LAWS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

PART I. HOLDING COMPANY ACT CHANGES

SECTION 1. G.S. 58-19-10(b) reads as rewritten:

"(b) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under this Chapter, a domestic insurer may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more affiliates or subsidiaries, amounts that do not exceed the lesser of ten percent (10%) of the insurer's admitted assets or fifty percent (50%) of the insurer's policyholders' surplus, provided that after those investments, the insurer's policyholders' surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, investments in domestic or foreign insurance affiliates or subsidiaries and health maintenance organizations shall be excluded, and there shall be included: (i) total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and (ii) all amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;

…

(3) With the approval of the Commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more affiliates or subsidiaries; provided that after such investment the insurer's policyholders' surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs."

PART II. SURPLUS LINES CHANGES

SECTION 2.(a) G.S. 58-21-35(b) reads as rewritten:

"(b) The licensee shall complete and retain a copy of the report in paper or electronic form as required by the Commissioner. The report required by this section ~~and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records~~ is not a public record under G.S. 132-1 or G.S. 58-2-100."

SECTION 2.(b) G.S. 58-21-40(b)(3) is repealed.

SECTION 2.(c) G.S. 58-21-75 reads as rewritten:

"**§ 58-21-75. Records of surplus lines licensee.**

Each surplus lines licensee shall keep in his or her office ~~in this State~~ a full and true record of each surplus lines insurance contract placed by or through the licensee, including a copy of the policy, certificate, cover note, or other evidence of insurance. The record shall include the following items:

(1) Amount of the insurance and perils insured;
(2) Brief description of the property insured and its location;
(3) Gross premium charged;
(4) Any return premium paid;
(5) Rate of premium charged upon the several items of property;
(6) Effective date of the contract, and the terms of the contract;
(7) Name and address of the insured;
(8) Name and address of the insurer;
(9) Amount of tax and other sums to be collected from the ~~insured; and~~insured;
(10) Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the ~~application.~~application; and
(11) Copy of the compliance agreement.

The record of each contract shall be kept open at all reasonable times to examination by the Commissioner without notice for a period not less than five years following termination of the contract."

SECTION 2.(d) G.S. 58-21-80 is repealed.

SECTION 2.(e) G.S. 58-21-95 reads as rewritten:

"**§ 58-21-95. Suspension, revocation or nonrenewal of surplus lines licensee's license.**

The Commissioner may suspend, revoke, or refuse to renew the license of a surplus lines licensee after notice and hearing as provided under G.S. 58-2-70 upon any one or more of the following grounds:

(1) ~~Removal of the surplus lines licensee's office from this State;~~
(2) Removal of the surplus lines licensee's office accounts and records ~~from this State~~ during the period during which such accounts and records are required to be maintained under G.S. 58-21-75;
(3) Closing of the surplus lines licensee's office for a period of more than 30 business days, unless permission is granted by the Commissioner;
(4) Failure to make and file required reports;
(5) Failure to transmit the required tax on surplus lines premiums;
(6) ~~Failure to maintain the required bond;~~Failure to pay the stamping fee to the stamping office;
(7) Violation of any provision of this Article; or
(8) For any other cause for which an insurance license could be denied, revoked, suspended, or renewal refused under the Insurance Law."

PART III. ALIGN STATE LAW WITH NAIC MODEL LAW REGARDING IMMUNITY FOR CONTRACTORS HIRED BY THE DEPARTMENT

SECTION 3.(a) G.S. 58-30-71(a) reads as rewritten:

"(a) ~~For the purposes of this section, the persons~~ Persons entitled to protection under this section are:

(1) All receivers responsible for the conduct of a delinquency proceeding under this Article, including present and former receivers; and

(2) ~~Their employees~~ All of the receiver's employees, meaning all present and former special deputies and assistant special deputies appointed by the Commissioner, staff assigned to the delinquency proceeding employed by the Attorney General's Office, and all persons whom the Commissioner, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding under this Article. ~~Attorneys, accountants, auditors, and other professional persons or firms, who are retained by the receiver as independent contractors and their employees are not employees of the receiver for purposes of this section.~~

(3) All of the receiver's contractors, meaning all persons who are retained by the receiver or the receiver's employees as independent contractors to assist in a delinquency proceeding under this Article, including attorneys, accountants, auditors, and other professional persons or firms and their employees."

SECTION 3.(b) G.S. 58-30-71(b) reads as rewritten:

"(b) The ~~receiver and his employees have~~ receiver, the receiver's employees, and the receiver's contractors shall have official immunity and are immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property or personal injury or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any employee arising out of or by reason of any of the following:

(1) ~~their~~ Their duties or ~~employment;~~employment.

(2) Any matters that have been subject to review by the Court after notice and opportunity to be heard, provided that the alleged act, error, or omission was not disapproved or disallowed by the Court.

~~provided that nothing~~ Provided, however, that nothing in this section holds the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors immune from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors or for any bodily injury caused by the operation of a motor vehicle."

SECTION 3.(c) G.S. 58-30-71(j) reads as rewritten:

"(j) Nothing in this section deprives the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors of any immunity, indemnity, benefits of law, rights, or any defense otherwise available."

PART IV. CLARIFY CONSENT TO RATE

SECTION 4.(a) G.S. 58-36-30(b) reads as rewritten:

"(b) This subsection applies ~~only~~ to insurance against loss to automobile physical damage and related expenses. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner. An insurer shall give notice to the insured that the rates used to calculate the premium for the policy are greater than those rates that are applicable in the State of North Carolina by including the following language in the policy on page one of the declarations page or on a separate page before the declarations page, in at least 14 point type or in a font size larger than the remainder of the document whichever is larger, bolded, and all capitalized:

NOTICE: THE PREMIUM THAT WE ARE CHARGING FOR AUTOMOBILE PHYSICAL DAMAGE AND RELATED EXPENSES THAT COVERS THE DAMAGE TO YOUR COVERED VEHICLE(S) EXCEEDS THE PREMIUM BASED UPON THE APPROVED RATES IN NORTH CAROLINA, IN ACCORDANCE WITH G.S. 58-36-30(b).

The disclosure statement noted above in this subsection shall be included on any renewal of or endorsement to the policy when the rates charged exceed the approved manual rate. The insurer shall retain consent to rate information for each insured and make this information available to the Commissioner, upon request of the Commissioner. This subsection may also be used to provide motor vehicle liability coverage limits above those required under Article 9A of Chapter 20 of the General Statutes and above those that could be ceded to the North Carolina Reinsurance Facility under Article 37 of this Chapter to persons whose personal excess liability insurance policies require that they maintain specific higher liability coverage limits. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100."

SECTION 4.(b) G.S. 58-36-30(b1) reads as rewritten:

"(b1) This subsection applies only to insurance against loss to residential property with not more than four housing units. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner. An insurer shall give notice to the insured that the rates used to calculate the premium for the policy are greater than those rates that are applicable in the State of North Carolina by including the following language in the policy on page one of the declarations page or on a separate page before the declarations page, in at least 14 point type or in a font size larger than the remainder of the document whichever is larger, bolded, and all capitalized:

NOTICE: IN ACCORDANCE WITH G.S. 58-36-30(b1), THE PREMIUM BASED UPON THE APPROVED RATES IN NORTH CAROLINA FOR RESIDENTIAL PROPERTY INSURANCE COVERAGE APPLIED FOR WOULD BE $____. OUR PREMIUM FOR THIS COVERAGE IS $____.

The disclosure statement noted above in this subsection shall be included on any renewal of or endorsement to the policy when the rates charged exceed the approved manual rate. ~~for any subsequent increase above the.~~ The insurer shall retain consent to rate information for each insured and make this information available to the Commissioner, upon request of the Commissioner. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100."

SECTION 4.(c) G.S. 58-36-30(c) reads as rewritten:

"(c) ~~Any approved rate under subsection (b) of this section with respect~~ This subsection applies only to workers' compensation and employers' liability insurance written in connection ~~therewith shall be furnished to the Bureau.~~therewith. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner."

SECTION 4.(d) G.S. 58-36-30(e) reads as rewritten:

"(e) Each insurer shall collect the following consent to rate data for nonfleet private passenger motor vehicle physical damage and homeowners residential property ~~(all forms excluding HO4 and HO6)~~ with not more than four housing units (all forms, excluding HO4 and HO6) and transmit the data electronically for each policy to the Commissioner on a semi-annual basis in a format prescribed and designated by the Commissioner:

…."

SECTION 4.(e) The Commissioner may adopt temporary rules to implement this section.

PART V. FAST ACT CONFORMING CHANGE

SECTION 5. G.S. 58-39-26**(**a) reads as rewritten:

"(a) Disclosure Required. – In addition to the notice requirements of G.S. 58-39-25, an insurance institution or agent shall provide, to all applicants and policyholders no later than (i) before the initial disclosure of personal information under G.S. 58-39-75(11) or (ii) the time of

the delivery of the insurance policy or certificate, a clear and conspicuous notice, in written or electronic form, of the insurance institution or agent's policies and practices with respect to:

(1) Disclosing nonpublic personal information to affiliates and nonaffiliated third parties, consistent with section 502 of Public Law 106-102, including the categories of information that may be disclosed.

(2) Disclosing nonpublic personal information of persons who have ceased to be customers of the financial institution.

(3) Protecting the nonpublic personal information of consumers.

These disclosures shall be made in accordance with the regulations prescribed under section ~~505~~ 504 of Public Law 106-102.

(b) Information to Be Included. – The disclosure required by subsection (a) of this section shall include:

(1) The policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the insurance institution or agent, consistent with section 502 of Public Law 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided under section 502(e) of Public Law 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(2) The categories of nonpublic personal information that are collected by the insurance institution or agent.

(3) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with section 501 of Public Law 106-102.

(4) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In the case of a policyholder, the notice required by this section shall be provided not less than annually during the continuation of the policy. As used in this subsection, "annually" means at least once in any period of 12 consecutive months during which the policy is in effect.

(d) Exception to Annual Notice Requirement. – An insurance institution or agent is not required to provide the privacy notice annually as required under subsection (c) of this section if all of the following apply:

(1) The insurance institution or agent provides nonpublic personal information only in accordance with the provisions of sections 502(b)(2) or 502(e) of Public Law 106-102 or regulations prescribed under section 504(b) of Public Law 106-102.

(2) The insurance institution or agent has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with this section.

If, at any time, subdivision (1) or (2) of this subsection no longer applies to an insurance institution or agent, then the insurance institution or agent shall be required to provide the annual privacy notice required under subsection (c) of this section."

PART VI. STREAMLINE EXPEDITED EXTERNAL REVIEW PROCESS

SECTION 6.(a) G.S. 58-50-82(a) reads as rewritten:

"(a) Except as provided in subsection (g) of this section, a covered person may file a request for an expedited external review with the Commissioner at the time the covered person ~~receives:~~receives any of the following:

(1) A noncertification decision under G.S. 58-50-61(f) ~~if:~~if all of the following conditions apply:

a. The covered person has a medical condition where the time frame for completion of an expedited review of an appeal involving a noncertification set forth in G.S. 58-50-61(*l*) 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~~function.

b. The covered person has filed a request for an expedited appeal under G.S. 58-50-61(*l*).

(2) An appeal decision under G.S. 58-50-61(k) or ~~(l)~~ G.S. 58-58-61(*l*) upholding a noncertification ~~if:~~if all of the following conditions apply:

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) 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~~function.

b. The covered person has filed a request for an expedited second-level grievance review of a noncertification as set forth in ~~G.S. 58-50-61(i); or~~ G.S. 58-50-62(i).

(3) A second-level grievance review decision under ~~G.S. 58-60-62(h) or (i)~~ G.S. 58-50-62(h) or G.S. 58-50-62(i) upholding a ~~noncertification:~~noncertification if all of the following conditions apply:

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~~function.

b. If the second-level grievance 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."

SECTION 6.(b) G.S. 58-50-82(b) reads as rewritten:

"(b) Within two days after 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 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. 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.~~review.

(3) If the request is eligible for external review and the covered person's treating provider requesting the service that is the subject of the external review has

certified the request on a form prescribed by the Commissioner, then one of the following shall apply:

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~~ section, the request ~~should~~ shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-61(l) 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, at a minimum, the insurer's internal appeal process under G.S. 58-50-61(l) before making another request for an external review with the Commissioner.~~notified.

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~~ section, the request ~~should~~ shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-62 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 process under G.S. 58-50-62 before making another request for an external review with the Commissioner.~~notified.

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~~ section, the request ~~should~~ shall 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 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.~~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."

SECTION 6.(c) G.S. 58-50-89 reads as rewritten:

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

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

SECTION 6.(d) Subsections (a) and (b) of this section become effective October 1, 2019, and apply to requests for expedited review submitted on or after that date.

PART VII. BAIL BONDSMAN CHANGES

SECTION 7.(a) G.S. 58-71-1 is amended by adding a new subdivision to read:

"(6a) Premium. – An amount of money paid in exchange for a bail bondsman's services in writing a bail bond."

SECTION 7.(b) G.S. 58-71-45 reads as rewritten:

"**§ 58-71-45. Terms of licenses.**

A license issued to a bail bondsman or to a runner authorizes the licensee to act in that capacity until the license is lapsed, suspended or revoked. ~~Upon the suspension or revocation of a license, the~~ The licensee shall return the license to the ~~Commissioner.~~ Commissioner within 10 working days of the lapse, suspension, or revocation of the license. A license of a bail bondsman and a license of a runner shall be renewed in accordance with G.S. 58-71-75. After notifying the Commissioner in writing, a professional bondsman who employs a runner may cancel the runner's authority to act for the professional bondsman."

SECTION 7.(c) G.S. 58-71-165(a) reads as rewritten:

"(a) Each professional bail bondsman shall file with the Commissioner a written report in a form prescribed by the Commissioner regarding all bail bonds on which the bondsman is liable

as of the first day of each month showing (i) each individual bonded, (ii) the date the bond was given, (iii) the principal sum of the bond, (iv) the ~~State or local official to whom given, and~~ court file or docket number for the principal's court obligation, (v) the fee charged for the bonding service in each ~~instance.~~instance, and (vi) the certificate seal number for each bond issued."

SECTION 7.(d) G.S. 58-71-167 reads as rewritten:

"**§ 58-71-167. Portion of bond premium payments deferred.**

(a) In any case where the agreement between principal and surety calls for some portion of the bond premium payments to be deferred or paid after the defendant has been released from custody, a written memorandum of agreement between the principal and surety shall be kept on file by the surety with a copy provided to the ~~principal, upon request.~~ principal. The memorandum shall contain the following information:

(1) The amount of the premium payment deferred or not yet paid at the time the defendant is released from jail.

(2) The method and schedule of payment to be made by the defendant to the bondsman, which shall include the dates of payment and amount to be paid on each date.

(3) That the principal ~~is, upon the principal's request,~~ is entitled to a copy of the memorandum.

(b) The memorandum must be signed by the defendant and the bondsman, or one of the bondsman's agents, and dated at the time the agreement is made. Any subsequent modifications of the memorandum must be in writing, signed, dated, and kept on file by the surety, with a copy provided to the ~~principal, upon request.~~principal."

PART VIII. CLARIFY RULE-MAKING AUTHORITY FOR STATE FIRE AND RESCUE COMMISSION

SECTION 8. G.S. 58-78-5(a) is amended by adding a new subdivision to read:

"(a) The Commission shall have the following powers and duties:

…

(17) To adopt, modify, or repeal any rules and regulations necessary for the purpose of carrying out the provisions of this Article."

PART IX. PREPAID HEALTH PLAN LICENSING ACT CLARIFYING AND TECHNICAL CHANGES

SECTION 9.(a) G.S. 58-93-20(c) reads as rewritten:

"(c) Any person that is already a licensed health organization in this State under this Chapter shall be recognized as a PHP under this Article and shall be issued a PHP license upon the licensed health organization's demonstration to the Commissioner of its compliance with this Article. A licensed health organization shall not be required to file a PHP application, pay a PHP application fee, or provide the notice required by subsection (d) of this section as a condition of receipt of a PHP license. Unless otherwise exempted, a licensed health organization shall be subject to the remaining requirements of this Article, including deposit, minimum capital and surplus, and working capital requirements."

SECTION 9.(b) G.S. 58-93-30 reads as rewritten:

"**§ 58-93-30. Fees.**

The Commissioner shall ~~establish~~ charge an application fee ~~not to exceed~~ of two thousand dollars ($2,000) for entities filing an application to be licensed as a PHP under this Article. The Commissioner shall ~~establish~~ charge an annual PHP license continuation fee ~~not to exceed~~ of five thousand dollars ($5,000). The PHP license shall continue in full force and effect subject to timely payment of the annual PHP license continuation fee in accordance with G.S. 58-6-7(c) and subject to any other provisions of this Chapter applicable to PHPs."

SECTION 9.(c) G.S. 58-93-60 reads as rewritten:

"**§ 58-93-60. Examinations.**

The Commissioner may make an examination of the affairs of any PHP as often as the Commissioner determines it to be necessary for the protection of the interests of the enrollees or the State but not less frequently than once every five years. The Commissioner shall notify DHHS prior to any examination of a PHP and shall provide DHHS with the results of an examination in accordance with G.S. 58-93-5(e). Examinations shall otherwise be conducted under G.S. 58-2-131 through G.S. 58-2-134."

SECTION 9.(d) G.S. 58-93-90 reads as rewritten:

"**§ 58-93-90. Rehabilitation or liquidation of PHP.**

(a) Any rehabilitation or liquidation of a PHP shall be deemed to be the rehabilitation or liquidation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to Article 30 of this Chapter. The Commissioner may apply for an order directing the rehabilitation or liquidation of a PHP upon one or more grounds set out in Article 30 of this Chapter or when it is the opinion of the Commissioner that the continued operation of the PHP would be hazardous either to the enrollees or to the State. Priority shall be given to DHHS's claims over all other claims in G.S. 58-30-220, except for claims in G.S. 58-30-220(1).

(b) To the greatest extent possible, the Commissioner shall provide notice to DHHS prior to seeking an application for an order to rehabilitate or liquidate a PHP under this section. If prior notice is not possible, the Commissioner shall provide the notice to DHHS as soon as possible after seeking the order."

SECTION 9.(e) G.S. 58-93-95(a) reads as rewritten:

"(a) When the Commissioner has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, notification shall be given to the PHP in ~~writing.~~ writing and a copy of the notice shall be provided to DHHS. This notice shall specifically state the grounds for denial, suspension, or revocation and shall set a date for a hearing on the matter at least 30 days after notice is given."

SECTION 9.(f) G.S. 58-93-120(16) reads as rewritten:

"(16) G.S. 58-7-26, Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of ~~G.S. 58-7-121.~~G.S. 58-7-21."

PART X. CLARIFY WHEN APPLICATION SENT TO NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION

SECTION 10. G.S. 97-170(b) reads as rewritten:

"(b) An applicant for a license as a self-insurer shall file with the Commissioner the information required by subsection (d) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. No application is complete until the Commissioner has received all required information. A copy of the application ~~must~~ shall also be filed with the North Carolina Self-Insurance Security Association ~~at least 90 days before the proposed licensing date.~~at the same time the application is filed with the Commissioner."

PART XI. MEDICARE SUPPLEMENT CHANGES

SECTION 11.(a) G.S. 58-54-45 reads as rewritten:

"**§ 58-54-45. By reason of disability.**

(a) ~~In~~ For Persons Whose Eligibility for Medicare Occurred Before January 1, 2020. – In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plan A available to persons eligible for Medicare by reason of disability before age 65 and also standardized Plan C or F if marketing either Plan to persons eligible for Medicare before January 1, 2020, due to age. 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.

(a1) For Persons Whose Eligibility for Medicare Occurs on or After January 1, 2020. – In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plan A available to persons eligible for Medicare by reason of disability before age 65 and also standardized Plan D or G if marketing either Plan to persons eligible for Medicare on or after January 1, 2020, due to age. 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.

(b) Persons eligible for Medicare by reason of disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment have the guaranteed right to purchase Medicare Supplement Plans ~~A and C~~ A, D, or G from any insurer within 63 days after the date of termination or disenrollment.

(c) An insurer may develop premium rates specific to the disabled population. No insurer shall discriminate in the pricing of the Medicare supplement plans referred to in this section because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the plan is submitted during an open enrollment or is submitted within 63 days after the managed care plan is terminated. The rates and any applicable rating factors for the Medicare supplement plans referred to in this section shall be filed with and approved by the Commissioner."

SECTION 11.(b) This section becomes effective January 1, 2020.

PART XII. EXCLUSIVE PROVIDER BENEFIT PLANS

SECTION 12.(a) G.S. 58-50-56(i) reads as rewritten:

"(i) ~~A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan.~~ In accordance with rules adopted by the Commissioner and subject to G.S. 58-3-190 and G.S. 58-3-200(d), the preferred provider benefit plan may limit coverage for health care services obtained from a nonparticipating provider. The Commissioner shall adopt rules on product limitations, including payment differentials for services rendered by nonparticipating providers. These rules shall be similar in substance to rules governing HMO point-of-service products."

SECTION 12.(b) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-56.1. Continuity of care.**

(a) Definitions. – The following definitions shall apply in this section:

(1) Exclusive provider benefit plan. – A preferred provider benefit plan in which enrollees must receive covered services from health care providers who are under contract with the insurer and under which there is no coverage for care received from a health care provider who is not under contract with the insurer, except for emergency services as required by G.S. 58-3-190 and medically necessary covered services as required by G.S. 58-3-200(d).

(2) Insurer. – As defined in G.S. 58-50-56.

(3) Ongoing special condition. – One of the following conditions:
a. An acute illness that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
b. A chronic illness, disease, or condition that is life-threatening, degenerative, or disabling, and that requires medical care or treatment over a prolonged period of time.
c. Pregnancy from the start of the second trimester.
d. A terminal illness for which an individual has a medical prognosis of a life expectancy of six months or less.

(4) Terminated or termination. – The expiration or nonrenewal of a contract. This term does not include an ending of the contract by an insurer for failure to meet applicable quality standards or for fraud.

(b) Termination of a Provider. – If (i) a contract between an insurer and a health care provider offering an exclusive provider benefit plan is terminated by the provider or by the insurer, or benefits or coverage provided by the insurer are terminated because of a change in the terms of provider participation in an insurer's exclusive provider benefit plan and (ii) an insured is undergoing treatment from the provider for an ongoing special condition on the date of termination, then the following shall apply:

(1) Upon termination of the contract by the insurer or upon receipt by the insurer of written notification of termination by the provider, the insurer shall notify the insured on a timely basis of the termination and of the insured's right to elect continuation of coverage of treatment by the provider. This subdivision shall apply only if the insured has a claim with the insurer for services provided by the terminated provider or the insured is otherwise known by the insurer to be a patient of the terminated provider.

(2) Subject to subsection (h) of this section, the insurer shall permit an insured to elect to continue to be covered with respect to the treatment by the terminated provider for the ongoing special condition during a transitional period, as provided under this section.

(c) Newly Covered Insured. – Each exclusive provider benefit plan offered by an insurer shall provide transition coverage to individuals who (i) are newly covered under an exclusive provider benefit plan because the individual's employer has changed benefit plans and (ii) are undergoing treatment from a provider for an ongoing special condition. On the date of enrollment, an insurer shall notify the newly covered insured of the right to elect continuation of coverage of treatment by a provider that is not contracted with the exclusive provider benefit plan and, subject to subsection (h) of this section, the insurer shall permit the newly covered insured to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period, as provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in this section, the length of a transitional period provided under this subsection shall be determined by the treating health care provider, so long as it does not exceed 90 days after the date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subsection (c) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual, or if the individual was on an established waiting list for surgery, organ transplantation, or other inpatient care, before the date of the notice required under subdivision (b)(1) of this section or the date of enrollment described in subsection (c) of this section, then the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend through the date of discharge of the individual after completion of the surgery, transplantation,

or other inpatient care, and through post-discharge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an individual has entered the second trimester of pregnancy on or before the date of the notice required under subdivision (b)(1) of this section or the date of enrollment in a new plan described in subsection (c) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the plan, then the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

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

(h) Permissible Terms and Conditions. – An insurer may condition coverage of continued treatment by a provider under subsection (b) or (c) of this section upon the following terms and conditions:

(1) When care is provided pursuant to subsection (b) of this section, the provider agrees to accept reimbursement from the insurer and, with respect to cost-sharing, from the insured involved at the rates applicable before the start of the transitional period as payment in full.

(2) When care is provided pursuant to subsection (c) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area, plus the applicable copayment from the newly covered insured, as reimbursement in full from the insurer and the insured for all covered services.

(3) The provider agrees to comply with the quality assurance programs of the insurer responsible for payment under this subsection and to provide to the insurer necessary medical information related to the care provided. The insurer's quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the insured.

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

(5) The receipt of notification from the insured within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subsection (c) of this section, that the insured elects to continue receiving treatment by the provider.

(6) The provider agrees to discontinue providing services at the end of the transition period and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.

(i) Construction. – Nothing in this section shall do any of the following:

(1) Require the coverage of benefits that would not have been covered if the provider involved remained a participating provider or, in the case of a newly covered insured, require the coverage of benefits not provided under the policy in which the newly covered insured is enrolled.

(2) Require an insurer to offer a transitional period when the insurer terminates a provider's contract for reasons relating to quality of care or fraud. Refusal by

an insurer to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

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

(4) Prohibit an insurer from terminating the continuing services of a provider when the insurer has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. A termination for these reasons shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

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

SECTION 12.(c) The Department of Insurance may adopt temporary rules to implement this section.

SECTION 12.(d) Subsections (a) and (b) of this section apply to insurance contracts issued, renewed, or amended on or after the effective date of this act.

PART XIII. EFFECTIVE DATE

SECTION 13. Except as otherwise provided, this act is effective when it becomes law.