

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2007

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HOUSE BILL 731*
Committee Substitute Favorable 5/2/07
Senate Commerce, Small Business and Entrepreneurship Committee Substitute
Adopted 7/11/07

Short Title: Revise Life and Health Insurance Laws.-AB

(Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO PROTECT CONSUMERS PURCHASING ANNUITY PRODUCTS;
ADDRESS PORTABILITY IN ACCIDENT AND HEALTH AND LIFE
INSURANCE; MAKE MINOR CHANGES IN THE LAWS ON MANAGED
CARE EXTERNAL REVIEWS; CLARIFY DEFINITIONS IN LONG-TERM
CARE INSURANCE; ADDRESS SMALL EMPLOYER CARRIER PLAN
ELECTIONS; DEFINE "CRITICAL PERIOD CONVERSION RATIO" FOR
CREDIT INSURANCE; MAKE MISCELLANEOUS AMENDMENTS TO
OTHER PROVISIONS RELATED TO LIFE AND HEALTH INSURANCE; AND
MAKE TECHNICAL CORRECTIONS IN INSURANCE CODE REFERENCES
TO THE TEACHERS' AND STATE EMPLOYEES' MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

PART I. SUITABILITY IN ANNUITY TRANSACTIONS.

SECTION 1.1. Article 60 of Chapter 58 of the General Statutes is amended
by adding a new Part to read:

"Part 4. Suitability in Annuity Transactions.

"§ 58-60-150. Title and reference.

This Part may be cited as the "Suitability in Annuity Transactions Act".

"§ 58-60-155. Purpose; scope.

(a) The purpose of this Part is to set forth standards and procedures for recommendations to consumers that result in a transaction involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed.

(b) This Part shall apply to any recommendation to purchase or exchange an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase or exchange recommended.

"§ 58-60-160. Exemptions.

Unless otherwise specifically included, this Part does not apply to recommendations involving any of the following:

- (1) Direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to this Part.
- (2) Contracts used to fund any of the following:
 - a. An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA).
 - b. A plan described by section 401(a), 401(k), 403(b), 408(k), or 408(p) of the Internal Revenue Code if established or maintained by an employer.
 - c. A government or church plan defined in section 414 of the Internal Revenue Code, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or 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. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process.
 - f. Formal prepaid funeral contracts.

"§ 58-60-165. Definitions.

As used in this Part:

- (1) "Annuity" means a fixed annuity or variable annuity that is individually solicited, whether the product is classified as an individual or group annuity.
- (2) "Insurance producer" has the same meaning as in G.S. 58-33-10(7).
- (3) "Recommendation" means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase or exchange of an annuity in accordance with that advice.

"§ 58-60-170. Duties of insurers and insurance producers.

(a) In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's financial situation and needs.

(b) Before recommending the purchase or exchange of an annuity resulting from a recommendation, the insurance producer, or the insurer where no producer is involved, shall make reasonable efforts to obtain information about the particular consumer's circumstances, including, but not limited to, all of the following:

- 1 (1) The consumer's financial status.
- 2 (2) The consumer's tax status.
- 3 (3) The consumer's investment objectives.
- 4 (4) Any other information used or considered to be reasonable by the
5 insurance producer, or the insurer where no producer is involved, in
6 making recommendations to the consumer.

7 (c) Except as provided under subdivision (1) of this subsection, neither an
8 insurance producer, nor an insurer where no producer is involved, shall have any
9 obligation to a consumer under subsection (a) of this section related to any
10 recommendation if a consumer does any of the following:

- 11 (1) Refuses to provide relevant information requested by the insurer or
12 insurance producer. An insurer or insurance producer's
13 recommendation subject to this subdivision shall be reasonable under
14 all the circumstances actually known to the insurer or insurance
15 producer at the time of the recommendation.
- 16 (2) Decides to enter into an insurance transaction that is not based on a
17 recommendation of the insurer or insurance producer.
- 18 (3) Fails to provide complete or accurate information requested by the
19 insurer or insurance producer.

20 (d) An insurer either shall assure that a system to supervise recommendations
21 that is reasonably designed to achieve compliance with this Part is established and
22 maintained by complying with subsections (e), (f), and (g) of this section, or shall
23 establish and maintain such a system, including:

- 24 (1) Maintaining written procedures.
- 25 (2) Conducting periodic reviews of its records that are reasonably
26 designed to assist in detecting and preventing violations of this Part.

27 (e) A general agent and independent agency either shall adopt a system
28 established by an insurer to supervise recommendations of its insurance producers that
29 is reasonably designed to achieve compliance with this Part, or shall establish and
30 maintain such a system, including:

- 31 (1) Maintaining written procedures.
- 32 (2) Conducting periodic reviews of records that are reasonably designed to
33 assist in detecting and preventing violations of this Part.

34 (f) An insurer may contract with a third party, including a general agent or
35 independent agency, to establish and maintain a system of supervision as required by
36 subsection (d) of this section with respect to insurance producers under contract with, or
37 employed by, the third party. An insurer shall make reasonable inquiry to assure that the
38 third-party contracting under this subsection is performing the functions required under
39 subsection (d) of this section and shall take any action that is reasonable under the
40 circumstances to enforce the contractual obligation to perform the functions. An insurer
41 may comply with its obligation to make reasonable inquiry by doing all of the
42 following:

- 43 (1) The insurer annually obtains a certification from a third-party senior
44 manager who has responsibility for the delegated functions that the

1 manager has a reasonable basis to represent, and does represent, that
2 the third party is performing the required functions. No person may
3 provide a certification under this subdivision unless (i) the person is a
4 senior manager with responsibility for the delegated functions; and (ii)
5 the person has a reasonable basis for making the certification.

6 (2) The insurer, based on reasonable selection criteria, periodically selects
7 third parties contracting under this subsection for a review to
8 determine whether the third parties are performing the required
9 functions. The insurer shall perform those procedures to conduct the
10 review that are reasonable under the circumstances.

11 An insurer that contracts with a third party, and that complies with the requirements
12 to supervise the third party pursuant to this subsection, shall have fulfilled its
13 responsibilities under subsection (d) of this section.

14 A general agent or independent agency contracting with an insurer shall promptly,
15 when requested by the insurer pursuant to this subsection, give a certification as
16 described in this subsection or give a clear statement that it is unable to meet the
17 certification criteria.

18 (g) An insurer, general agent, or independent agency is not required by
19 subsections (d) or (e) of this section to:

20 (1) Review, or provide for review of, all insurance producer solicited
21 transactions; or

22 (2) Include in its system of supervision an insurance producer's
23 recommendations to consumers of products other than the annuities
24 offered by the insurer, general agent, or independent agency.

25 (h) Compliance with the National Association of Securities Dealers Conduct
26 Rules pertaining to suitability shall satisfy the requirements under this section for the
27 recommendation of variable annuities. However, nothing in this subsection limits the
28 Commissioner's ability to enforce the provisions of this Part.

29 **"§ 58-60-175. Mitigation of responsibility.**

30 (a) The Commissioner may order:

31 (1) An insurer to take reasonably appropriate corrective action for any
32 consumer harmed by the insurer's, or by its insurance producer's,
33 violation of this Part.

34 (2) An insurance producer to take reasonably appropriate corrective action
35 for any consumer harmed by the insurance producer's violation of this
36 Part.

37 (3) A general agency or independent agency that employs or contracts
38 with an insurance producer to sell, or solicit the sale, of annuities to
39 consumers, to take reasonably appropriate corrective action for any
40 consumer harmed by the insurance producer's violation of this Part.

41 (b) Any applicable penalty under G.S. 58-2-70 for a violation of subsection (a) or
42 (b) of G.S. 58-60-170 may be reduced or eliminated if corrective action for the
43 consumer was taken promptly after a violation was discovered.

1 (c) A violation of this Part is an unfair method of competition and unfair and
2 deceptive act or practice in the business of insurance in violation of G.S. 58-63-10.

3 **"§ 58-60-180. Record keeping.**

4 (a) Insurers, general agents, independent agencies, and insurance producers shall
5 maintain or be able to make available to the Commissioner records of the information
6 collected from the consumer and other information used in making the
7 recommendations that were the basis for insurance transactions for five years after the
8 insurance transaction is completed by the insurer. An insurer is permitted, but shall not
9 be required, to maintain documentation on behalf of an insurance producer.

10 (b) Records required to be maintained by this Part may be maintained in paper,
11 photographic, microprocess, magnetic, mechanical, or electronic media or by any
12 process that accurately reproduces the actual document."

13 **SECTION 1.2.** Article 58 of Chapter 58 of the General Statutes is amended
14 by adding two new sections to read:

15 **"§ 58-58-146. Application for annuities required.**

16 Each individual annuity contract shall be issued only upon application of the
17 applicant. Any application or enrollment form is subject to G.S. 58-3-150, and if taken
18 by an agent, shall include the certificate of the agent that the agent has truly and
19 accurately recorded on the application or enrollment form the information provided by
20 the applicant. Every annuity contract subject to this section shall contain as part of the
21 contract the original or reproduction of the application required by this section.

22 **"§ 58-58-147. Surrender fees on death benefits.**

23 No authorized insurer shall deliver or issue for delivery in this State any deferred
24 annuity contract that contains a provision that reduces the death benefit of the contract
25 by a surrender fee when death occurs during the surrender period."

26
27 **PART II. PORTABILITY IN ACCIDENT AND HEALTH AND LIFE**
28 **INSURANCE.**

29 **SECTION 2.1.** G.S. 58-51-15(a)(2)b. reads as rewritten:

30 "(2) A provision in the substance of the following language:

31 **TIME LIMIT ON CERTAIN DEFENSES:**

32 ...

33 b. This policy contains a provision limiting coverage for
34 preexisting conditions. Preexisting conditions are covered under
35 this policy ____ (insert number of months or days, not to
36 exceed one year) after the effective date of coverage.
37 Preexisting conditions mean "those conditions for which
38 medical advice, diagnosis, care, or treatment was received or
39 recommended within the one-year period immediately
40 preceding the effective date of the person's coverage." ~~Except~~
41 ~~for the excepted benefits described in G.S. 58-68-25(b), credit~~
42 Credit for having satisfied some or all of the preexisting
43 condition waiting periods under previous health benefits
44 coverage shall be given in accordance with ~~G.S. 58-68-30.~~

1 G.S. 58-51-17. The excepted benefits described in
2 G.S. 58-68-25(b) are not subject to this requirement for giving
3 credit."

4 **SECTION 2.2.** Article 51 of Chapter 58 of the General Statutes is amended
5 by adding a new section to read:

6 **"§ 58-51-17. Portability for accident and health insurance.**

7 (a) Rules Relating to Crediting Previous Coverage. –

8 (1) Creditable coverage defined. – For the purposes of this section,
9 "creditable coverage" means, with respect to an individual, coverage of
10 the individual under any of the following:

11 a. A self-funded employer group health plan under the Employee
12 Retirement Income Security Act of 1974.

13 b. Group or individual health insurance coverage.

14 c. Part A or part B of title XVIII of the Social Security Act.

15 d. Title XIX of the Social Security Act, other than coverage
16 consisting solely of benefits under section 1928.

17 e. Chapter 55 of title 10, United States Code.

18 f. A medical care program of the Indian Health Service or of a
19 tribal organization.

20 g. A State health benefits risk pool.

21 h. A health plan offered under chapter 89 of title 5, United States
22 Code.

23 i. A public health plan (as defined in federal regulations).

24 j. A health benefit plan under section 5(e) of the Peace Corps Act
25 (22 U.S.C. § 2504(e)).

26 k. Title XXI of the Social Security Act (State Children's Health
27 Insurance Program).

28 "Creditable coverage" does not include coverage consisting solely of
29 coverage of excepted benefits as described in G.S. 58-68-25(b).
30 However, short-term limited-duration health insurance coverage shall
31 be considered creditable coverage for purposes of this section.

32 (2) Not counting periods before significant breaks in coverage. –

33 a. In general. – A period of creditable coverage shall not be
34 counted, with respect to enrollment of an individual under an
35 individual health insurance plan, if, after the period and before
36 the enrollment date, there was a 63-day period during all of
37 which the individual was not covered under any creditable
38 coverage.

39 b. Waiting period not treated as a break in coverage. – For the
40 purposes of sub-subdivision a. of this subdivision and
41 subdivision (b)(3) of this section, any period that an individual
42 is in a waiting period, as defined in G.S. 58-68-30(b)(4)c., for
43 any coverage under an individual health insurance plan shall not

- 1 be taken into account in determining the continuous period
2 under sub-subdivision a. of this subdivision.
- 3 c. For an individual who elects COBRA continuation coverage
4 during the second election period provided under the Trade Act
5 of 2002, the days between the date the individual lost group
6 health plan coverage and the first day of the second COBRA
7 election period shall not be considered when determining
8 whether a significant break in coverage has occurred.
- 9 (3) Method of crediting coverage. – An individual health insurer shall
10 count a period of creditable coverage without regard to the specific
11 benefits covered during the period.
- 12 (4) Establishment of period. – Periods of creditable coverage for an
13 individual shall be established through presentation of certifications
14 described in subsection (c) of this section or in another manner that is
15 specified in regulations.
- 16 (5) Determination of creditable coverage. –
- 17 a. Determination within reasonable time. – If an individual health
18 insurer receives creditable coverage information under
19 subsection (c) of this section, the insurer shall, within a
20 reasonable time following receipt of the information, make a
21 determination regarding the amount of the individual's
22 creditable coverage and the length of any exclusion that
23 remains. Whether this determination is made within a
24 reasonable time depends on the relevant facts and
25 circumstances. Relevant facts and circumstances include
26 whether a plan's application of a preexisting condition exclusion
27 would prevent an individual from having access to urgent
28 medical care.
- 29 b. No time limit on presenting evidence of creditable coverage. –
30 An individual health insurer shall not impose any limit on the
31 amount of time that an individual has to present a certificate or
32 other evidence of creditable coverage.
- 33 (b) Exceptions. –
- 34 (1) Exclusion not applicable to certain newborns. – Subject to subdivision
35 (3) of this subsection, an individual health insurer shall not impose any
36 preexisting condition exclusion in the case of an individual who, as of
37 the last day of the 30-day period beginning with the individual's date
38 of birth, is covered under creditable coverage.
- 39 (2) Exclusion not applicable to certain adopted children. – Subject to
40 subdivision (3) of this subsection, a group health insurer shall not
41 impose any preexisting condition exclusion in the case of a child who
42 is adopted or placed for adoption before attaining 18 years of age and
43 who, as of the last day of the 30-day period beginning on the date of
44 the adoption or placement for adoption, is covered under creditable

1 coverage. The previous sentence does not apply to coverage before the
 2 date of the adoption or placement for adoption.

3 (3) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection
 4 shall no longer apply to an individual after the end of the first 63-day
 5 period during all of which the individual was not covered under any
 6 creditable coverage.

7 (c) Certifications and Disclosure of Coverage. –

8 (1) In general. – An individual health insurer shall provide the certification
 9 described in this subdivision (i) at the time an individual ceases to be
 10 covered under the plan, and (ii) on the request on behalf of an
 11 individual made not later than 24 months after the date of cessation of
 12 the coverage described in clause (i) of this subdivision, whichever is
 13 later.

14 (2) Certification. – The certification described in this subdivision is a
 15 written certification of (i) the period of creditable coverage of the
 16 individual under the plan and (ii) any waiting period and affiliation
 17 period, if applicable, imposed with respect to the individual for any
 18 coverage under the plan."

19 **SECTION 2.3.** G.S. 58-68-30(c) reads as rewritten:

20 "(c) Rules Relating to Crediting Previous Coverage. –

21 (1) Creditable coverage defined. – For the purposes of this Article,
 22 "creditable coverage" means, with respect to an individual, coverage of
 23 the individual under any of the following:

- 24 a. A self-funded employer group health plan under the Employee
 25 Retirement Income Security Act of 1974.
- 26 b. Group or individual health insurance coverage.
- 27 c. Part A or part B of title XVIII of the Social Security Act.
- 28 d. Title XIX of the Social Security Act, other than coverage
 29 consisting solely of benefits under section 1928.
- 30 e. Chapter 55 of title 10, United States Code.
- 31 f. A medical care program of the Indian Health Service or of a
 32 tribal organization.
- 33 g. A State health benefits risk pool.
- 34 h. A health plan offered under chapter 89 of title 5, United States
 35 Code.
- 36 i. A public health plan (as defined in federal regulations).
- 37 j. A health benefit plan under section 5(e) of the Peace Corps Act
 38 (22 U.S.C. § 2504(e)).
- 39 k. Title XXI of the Social Security Act (State Children's Health
 40 Insurance Program).

41 "Creditable coverage" does not include coverage consisting solely of
 42 coverage of excepted benefits. However, short-term limited-duration
 43 health insurance coverage shall be considered creditable coverage for
 44 purposes of this section and G.S. 58-51-15(a)(2)b.

- 1 (2) Not counting periods before significant breaks in coverage. –
2 a. In general. – A period of creditable coverage shall not be
3 counted, with respect to enrollment of an individual under a
4 group health insurance plan, if, after the period and before the
5 enrollment date, there was a 63-day period during all of which
6 the individual was not covered under any creditable coverage.
7 b. Waiting period not treated as a break in coverage. – For the
8 purposes of sub-subdivision a. of this subdivision and
9 subdivision (d)(4) of this subsection, any period that an
10 individual is in a waiting period for any coverage under a group
11 health insurance plan or is in an affiliation period shall not be
12 taken into account in determining the continuous period under
13 sub-subdivision a. of this subdivision.
14 c. Time spent on short term limited duration health insurance not
15 treated as a break in coverage. – For the purposes of
16 sub-subdivision a. of this subdivision, any period that an
17 individual is enrolled on a short term limited duration health
18 insurance policy shall not be taken into account in determining
19 the continuous period under sub-subdivision. a. of this
20 subdivision so long as the period of time spent on the short term
21 limited duration health insurance policy or policies does not
22 exceed 12 months.
23 d. For an individual who elects COBRA continuation coverage
24 during the second election period provided under the Trade Act
25 of 2002, the days between the date the individual lost group
26 health plan coverage and the first day of the second COBRA
27 election period shall not be considered when determining
28 whether a significant break in coverage has occurred.
- 29 (3) Method of crediting coverage. –
30 a. Standard method. – Except as otherwise provided under
31 sub-subdivision b. of this subdivision for the purposes of
32 applying subdivision (a)(3) of this subsection, a group health
33 insurer shall count a period of creditable coverage without
34 regard to the specific benefits covered during the period.
35 b. Election of alternative method. – A group health insurer may
36 elect to apply subdivision (a)(3) of this subsection based on
37 coverage of benefits within each of several classes or categories
38 of benefits specified in federal regulations rather than as
39 provided under sub-subdivision a. of this subdivision. This
40 election shall be made on a uniform basis for all participants
41 and beneficiaries. Under this election a group health insurer
42 shall count a period of creditable coverage with respect to any
43 class or category of benefits if any level of benefits is covered
44 within the class or category.

1 c. Health insurer notice. – In the case of an election under
 2 sub-subdivision b. of this subdivision with respect to health
 3 insurance coverage in the small or large group market, the
 4 health insurer: (i) shall prominently state in any disclosure
 5 statements concerning the coverage, and to each employer at
 6 the time of the offer or sale of the coverage, that the health
 7 insurer has made the election, and (ii) shall include in the
 8 statements a description of the effect of the election.

9 (4) Establishment of period. – Periods of creditable coverage for an
 10 individual shall be established through presentation of certifications
 11 described in subsection (e) of this section or in another manner that is
 12 specified in federal regulations.

13 (5) Determination of creditable coverage. –

14 a. Determination within reasonable time. – If a group health
 15 insurer receives creditable coverage information under
 16 subsection (e) of this section, the group health insurer shall,
 17 within a reasonable time following receipt of the information,
 18 make a determination regarding the amount of the individual's
 19 creditable coverage and the length of any exclusion that
 20 remains. Whether this determination is made within a
 21 reasonable time depends on the relevant facts and
 22 circumstances. Relevant facts and circumstances include
 23 whether a plan's application of a preexisting condition exclusion
 24 would prevent an individual from having access to urgent
 25 medical care.

26 b. No time limit on presenting evidence of creditable coverage. –
 27 A group health insurer shall not impose any limit on the amount
 28 of time that an individual has to present a certificate or other
 29 evidence of creditable coverage."

30 **SECTION 2.4.** G.S. 58-68-30(f) reads as rewritten:

31 "(f) Special Enrollment Periods. –

32 (1) Individuals losing other coverage. – A group health insurer shall
 33 permit an employee who is eligible, but not enrolled, for coverage
 34 under the terms of the plan (or a dependent of the employee if the
 35 dependent is eligible, but not enrolled, for coverage under the terms) to
 36 enroll for coverage under the terms of the plan if each of the following
 37 conditions is met:

38 a. The employee or dependent was covered under an ERISA
 39 group health plan or had health insurance coverage at the time
 40 coverage was previously offered to the employee or dependent.

41 b. The employee stated in writing at the time that coverage under
 42 the group health plan or health insurance coverage was the
 43 reason for declining enrollment, but only if the health insurer
 44 required the statement at the time and provided the employee

1 with notice of the requirement and the consequences of the
2 requirement at the time.

- 3 c. With respect to the employee's or dependent's coverage
4 described in sub-subdivision a. of this subsection: (i) the
5 coverage was under a COBRA continuation provision and the
6 coverage under the provision was exhausted; (ii) the coverage
7 was not under that provision and either the coverage was
8 terminated because of loss of eligibility for the coverage,
9 including legal separation, divorce, cessation of dependent
10 status (such as attaining the maximum age to be eligible as a
11 dependent child under the plan), death of an employee,
12 termination of employment, reduction in the number of hours of
13 employment, and any loss of eligibility for coverage after a
14 period that is measured by reference to any of the foregoing;
15 (iii) employer contributions toward the coverage were
16 terminated; (iv) in the case of coverage offered through an
17 arrangement that does not provide benefits to individuals who
18 no longer reside, live, or work in a service area, there has been
19 loss of coverage because an individual no longer resides, lives,
20 or works in the service area (whether or not within the choice of
21 the individual), and no other benefit package is available to the
22 individual; (v) an individual incurs a claim that would meet or
23 exceed a lifetime limit on all benefits; or (vi) a plan no longer
24 offers any benefits to the class of similarly situated individuals
25 that includes the individual; or (vii) the health insurer
26 terminated coverage under G.S. 58-68-45(c)(2).
27 d. Under the terms of the plan, the employee requests the
28 enrollment not later than 30 days after the date of the applicable
29 event described in sub-subdivision c. of this subdivision.

30 (2) For dependent beneficiaries. –

- 31 a. In general. – If: (i) a group health insurance plan makes
32 coverage available with respect to a dependent of an individual,
33 (ii) the individual is a participant under the plan (or has met any
34 waiting period applicable to becoming a participant under the
35 plan and is eligible to be enrolled under the plan but for a
36 failure to enroll during a previous enrollment period), and (iii) a
37 person becomes the dependent of the individual through
38 marriage, birth, or adoption or placement for adoption.

39 The plan shall provide for a dependent special enrollment period
40 described in sub-subdivision b. of this subdivision during which the
41 person (or, if not otherwise enrolled, the individual) may be enrolled
42 under the plan as a dependent of the individual, and in the case of the
43 birth or adoption of a child, the spouse of the individual may be

1 enrolled as a dependent of the individual if the spouse is otherwise
2 eligible for coverage.

3 b. Dependent special enrollment period. – A dependent special
4 enrollment period under this sub-subdivision shall be a period
5 of not less than 30 days and shall begin on the later of: (i) the
6 date dependent coverage is made available, or (ii) the date of
7 the marriage, birth, or adoption or placement for adoption
8 described in sub-subdivision a.(iii) of this subdivision.

9 c. No waiting period. – If an individual seeks to enroll a
10 dependent during the first 30 days of the dependent's special
11 enrollment period, the coverage of the dependent shall become
12 effective: (i) in the case of marriage, not later than the first day
13 of the first month beginning after the date the completed request
14 for enrollment is received; (ii) in the case of a dependent's birth,
15 as of the date of the birth; or (iii) in the case of a dependent's
16 adoption or placement for adoption, the date of the adoption or
17 placement for adoption.

18 (3) Treatment of special enrollees. –

19 a. If an individual requests enrollment while the individual is
20 entitled to special enrollment under this subsection, the
21 individual is a special enrollee, even if the request for
22 enrollment coincides with a late enrollment opportunity under
23 the plan. Therefore, the individual cannot be considered a late
24 enrollee.

25 b. Special enrollees shall be offered all of the benefit packages
26 available to similarly situated individuals who enroll when first
27 eligible. For this purpose, any difference in benefits or
28 cost-sharing requirements for different individuals constitutes a
29 different benefit package. In addition, a special enrollee cannot
30 be required to pay more for coverage than a similarly situated
31 individual who enrolls in the same coverage when first eligible.
32 The length of any preexisting condition exclusion that may be
33 applied to a special enrollee cannot exceed the length of any
34 preexisting condition exclusion that is applied to similarly
35 situated individuals who enroll when first eligible."

36 **SECTION 2.5.** G.S. 58-68-30 is amended by adding the following new
37 subsections to read:

38 "(h) General Notice of Preexisting Condition Exclusion. – A group health insurer
39 offering group health insurance coverage subject to a preexisting condition exclusion
40 shall provide a written general notice of preexisting condition exclusion to participants
41 under the plan; and shall not impose a preexisting condition exclusion with respect to a
42 participant or a dependent of the participant until the notice is provided.

43 A group health insurer shall provide the general notice of preexisting condition
44 exclusion as part of any written application materials distributed by the insurer for

1 enrollment. If the insurer does not distribute these materials, the notice shall be provided
2 by the earliest date following a request for enrollment that the insurer, acting in a
3 reasonable and prompt fashion, can provide the notice.

4 The general notice of preexisting condition exclusion shall notify participants of the
5 following:

6 (1) The existence and terms of any preexisting condition exclusion under
7 the plan. This description includes the length of the plan's look-back
8 period, which shall not exceed six months under subdivision (a)(1) of
9 this section; the maximum preexisting condition exclusion period
10 under the plan, which shall not exceed 12 months (18 months for late
11 enrollees) under subdivision (a)(2) of this section; and how the plan
12 will reduce the maximum preexisting condition exclusion period by
13 creditable coverage, as described in subsection (c) of this section.

14 (2) A description of the rights of individuals to demonstrate creditable
15 coverage, and any applicable waiting periods, through a certificate of
16 creditable coverage, as required by subsection (e) of this section, or
17 through other means as described in federal regulations. This shall
18 include a description of the right of the individual to request a
19 certificate from a prior insurer, if necessary, and a statement that the
20 current insurer will assist in obtaining a certificate from any prior plan
21 or insurer, if necessary.

22 (3) A person to contact, including an address or telephone number for
23 obtaining additional information or assistance about the preexisting
24 condition exclusion.

25 Nothing in this subsection affects a group health insurer's responsibility under this
26 section to fully disclose in the master group policy, the certificate or evidence of
27 coverage, and the member handbook the plan's preexisting condition limitation, the
28 rules relating to creditable coverage, including how an individual may provide proof of
29 creditable coverage, and the methods of counting and crediting coverage.

30 (i) Individual Notice of Period of Preexisting Condition Exclusion. – After an
31 individual has presented evidence of creditable coverage and the group health insurer
32 has made a determination of creditable coverage under subdivision (c)(5) of this section,
33 the group health insurer shall provide the individual a written notice of the length of
34 preexisting condition exclusion that remains after offsetting for prior creditable
35 coverage. In the notice, the insurer is not required to identify any medical conditions
36 specific to the individual that could be subject to the exclusion. A group health insurer is
37 not required to provide this notice if the plan does not impose any preexisting condition
38 exclusion on the individual or if the plan's preexisting condition exclusion is completely
39 offset by the individual's prior creditable coverage.

40 The individual notice must be provided by the earliest date following a
41 determination that the group health insurer, acting in a reasonable and prompt fashion,
42 can provide the notice.

43 A group health insurer shall disclose:

- 1 (1) Its determination of any preexisting condition exclusion period that
2 applies to the individual, including the last day on which the
3 preexisting condition exclusion applies.
- 4 (2) The basis for that determination, including the source and substance of
5 any information on which the plan or insurer relied.
- 6 (3) An explanation of the individual's right to submit additional evidence
7 of creditable coverage.
- 8 (4) A description of any applicable appeal procedures established by the
9 group health insurer.

10 (j) Determination Modification. – Nothing in this section prevents a plan or
11 insurer from modifying an initial determination of creditable coverage if it determines
12 that the individual did not have the claimed creditable coverage, provided that:

- 13 (1) A notice of the new determination, consistent with the requirements of
14 subsection (i) of this section, is provided to the individual; and
- 15 (2) Until the notice of the new determination is provided, the group health
16 insurer, for purposes of approving access to medical services (such as
17 a presurgery authorization), acts in a manner consistent with the initial
18 determination.

19 (k) Notice Form and Content. – Any notices required under this section shall be
20 in the form and content and be delivered as prescribed by, in accordance with, or as
21 specified in federal regulations, unless otherwise provided in this Chapter."

22 **SECTION 2.6.** Article 58 of Chapter 58 of the General Statutes is amended
23 by adding a new section to read:

24 **"§ 58-58-141. Portability of group life insurance.**

25 (a) Definition. – For purposes of this section, "portability" means the prerogative
26 to continue existing group life insurance coverage, or access alternate group life
27 insurance coverage, that may be provided by a group life insurance policy to an
28 individual insured after the individual's affiliation with the initial group terminates.

29 (b) Applicability. – This section applies to all certificates issued under group
30 policies that are used in this State. This section also applies to a certificate issued under
31 a policy issued and delivered to a trust or to an association outside of this State and
32 covering persons residing in this State.

33 (c) Prohibitions. – The use of health questions, underwriting, or eligibility
34 requirements that pertain to health status is prohibited when an individual insured elects
35 to access a portability option provided by a group life insurance policy."

36
37 **PART III. EXTERNAL REVIEW.**

38 **SECTION 3.1.** G.S. 58-50-82(b)(1) reads as rewritten:

39 (b) Within three business days of receiving a request for an expedited external
40 review, the Commissioner shall complete all of the following:

- 41 (1) Notify the insurer that made the noncertification, noncertification
42 appeal decision, or second-level grievance review decision which is
43 the subject of the request that the request has been received and
44 provide a copy of the request or verbally convey all of the information

1 included in the request. The Commissioner shall also request any
2 information from the insurer necessary to make the preliminary review
3 set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the
4 information not later than one business day after the request was made.

5"

6 **SECTION 3.2.** G.S. 58-50-82(c) reads as rewritten:

7 "(c) As soon as possible, but within the same business day of receiving notice
8 under subdivision (b)(2) of this section that the request has been assigned to a review
9 organization, the insurer or its designee utilization review organization shall provide or
10 transmit all documents and information considered in making the noncertification
11 appeal decision or the second-level grievance review decision to the assigned review
12 organization electronically or by telephone or facsimile or any other available
13 expeditious method. A copy of the same information shall be sent by the same means or
14 other expeditious means to the covered person or the covered person's representative
15 who made the request for expedited external review."

16 **SECTION 3.3.** G.S. 58-50-95 reads as rewritten:

17 **"§ 58-50-95. Report by Commissioner.**

18 The Commissioner shall report ~~semiannually~~— annually to the Joint Legislative
19 Health Care Oversight Committee regarding the nature and appropriateness of reviews
20 conducted under this Part. The report, which shall be provided to the public upon
21 request, should include the number of reviews, underlying issues in dispute, character of
22 the reviews, dollar amounts in question, whether the review was decided in favor of the
23 covered person or the health benefit plan, the cost of review, and any other information
24 relevant to the evaluation of the effectiveness of this Part."

25
26 **PART IV. LONG-TERM CARE INSURANCE.**

27 **SECTION 4.** G.S. 58-55-20(4) reads as rewritten:

28 "(4) "Long-term care insurance" means any policy or certificate advertised,
29 marketed, offered, or designed to provide coverage for not less than 12
30 consecutive months for each covered person on an expense incurred,
31 indemnity, prepaid, or other basis, for one or more necessary or
32 medically necessary diagnostic, preventive, therapeutic, rehabilitative,
33 maintenance, or personal care services, provided in a setting other than
34 an acute care unit of a hospital. "Long-term care insurance" ~~includes~~
35 group includes:

- 36 a. Group and individual annuities and life insurance policies or
37 riders that supplement or directly provide long-term care
38 insurance.
39 b. A policy or rider that provides for payment of benefits based
40 upon cognitive impairment or the loss of functional capacity.
41 c. Qualified long-term care insurance contracts.
42 d. Group and individual policies whether issued by insurers,
43 fraternal benefit societies, nonprofit health, hospital, and
44 medical service corporations prepaid health plans, health

1 maintenance organizations, or any similar organization.
2 "Long-term care insurance" does not include any policy that is
3 offered primarily to provide basic Medicare supplement
4 coverage, basic hospital expense coverage, basic
5 medical-surgical expense coverage, hospital confinement
6 indemnity coverage, major medical expense coverage, disability
7 income protection coverage, accident only coverage, specified
8 disease or specified accident coverage, or limited benefit health
9 coverage.

10 With regard to life insurance, "long-term care insurance" does not
11 include life insurance policies that accelerate the death benefit
12 specifically for one or more of the qualifying events of terminal
13 illness, medical conditions requiring extraordinary medical
14 intervention or permanent institutional confinement, and that provide
15 the option of a lump-sum payment for those benefits and where neither
16 the benefits nor the eligibility for the benefits is conditioned upon the
17 receipt of long-term care."
18

19 PART V. SMALL EMPLOYER GROUP HEALTH INSURANCE.

20 SECTION 5.1. G.S. 58-50-126(d) reads as rewritten:

21 "(d) Election. – The small employer carrier elections of the policies to be offered
22 under this section shall apply uniformly to all small employers in this State for that
23 small employer carrier. The election shall be effective for a period of not less than two
24 years. An election under this section shall be made in accordance with G.S. 58-50-127."

25 SECTION 5.2. Article 50 of Chapter 58 of the General Statutes is amended
26 by adding a new section to read:

27 "§ 58-50-127. Small employer carrier plan elections.

28 A small employer carrier shall submit, in a format prescribed by the Commissioner,
29 an election pursuant to G.S. 58-50-125(d) pertaining to the offering of at least one basic
30 and standard health care plan or the alternative health care plans as provided in
31 G.S. 58-50-126. The election shall be effective for a period of not less than two years.
32 The election shall be submitted with policy forms when they are submitted for approval,
33 or if the policy forms have been previously approved, then no later than February 1 of
34 the year in which the small employer carrier wishes the election to begin. If a small
35 employer carrier does not make a new election, or if the new election is not approved if
36 applicable, the existing election at the end of the two-year election period shall continue
37 to apply for another two-year period."
38

39 PART VI. CREDIT INSURANCE.

40 SECTION 6.1. G.S. 58-57-5 is amended by adding a new subdivision after
41 G.S. 58-57-5(5b) to read:

42 "(5b) "Critical period conversion ratio" means the ratio of the benefit value
43 of the critical period divided by the benefit value of the full term."

1 **SECTION 6.2.** G.S. 58-57-35 is amended by adding a new subsection to
2 read:

3 "(d) Premium rates for benefits provided during a critical period shall be adjusted
4 by a critical period conversion ratio that reduces the rates giving recognition to the
5 shorter benefit period provided."

6
7 **PART VII. MISCELLANEOUS PROVISIONS.**

8 **SECTION 7.1.** G.S. 58-3-35 reads as rewritten:

9 **"§ 58-3-35. Stipulations as to jurisdiction and limitation of actions.**

10 (a) No insurer, self-insurer, service corporation, HMO, ~~or MEWA~~ MEWA,
11 continuing care provider, viatical settlement provider, or professional employer
12 organization licensed under this Chapter shall make any condition or stipulation in its
13 ~~insurance contracts or policies~~ concerning the court or jurisdiction in which any suit or
14 action on the contract may be brought.

15 (b) No insurer, self-insurer, service corporation, HMO, ~~or MEWA~~ MEWA,
16 continuing care provider, viatical settlement provider, or professional employer
17 organization licensed under this Chapter shall limit the time within which any suit or
18 action referred to in subsection (a) of this section may be commenced to less than the
19 period prescribed by law.

20 (c) All conditions and stipulations forbidden by this section are void."

21 **SECTION 7.2.** G.S. 58-3-167(a)(1) reads as rewritten:

22 "(1) "Health benefit plan" means an accident and health insurance policy or
23 certificate; a nonprofit hospital or medical service corporation
24 contract; a health maintenance organization subscriber contract; a plan
25 provided by a multiple employer welfare arrangement; or a plan
26 provided by another benefit arrangement, to the extent permitted by
27 the Employee Retirement Income Security Act of 1974, as amended,
28 or by any waiver of or other exception to that act provided under
29 federal law or regulation. "Health benefit plan" does not mean any
30 plan implemented or administered by the North Carolina or United
31 States Department of Health and Human Services, or any successor
32 agency, or its representatives. "Health benefit plan" does not mean any
33 ~~of the following kinds of insurance:~~

- 34 a. ~~Accident.~~
35 b. ~~Credit.~~
36 c. ~~Disability income.~~
37 d. ~~Long term or nursing home care.~~
38 e. ~~Medicare supplement.~~
39 f. ~~Specified disease.~~
40 g. ~~Dental or vision.~~
41 h. ~~Coverage issued as a supplement to liability insurance.~~
42 i. ~~Workers' compensation.~~
43 j. ~~Medical payments under automobile or homeowners.~~
44 k. ~~Hospital income or indemnity.~~

1 l. ~~Insurance under which benefits are payable with or without~~
2 ~~regard to fault and that is statutorily required to be contained in~~
3 ~~any liability policy or equivalent self insurance.~~

4 m. ~~Short-term limited duration health insurance policies as defined~~
5 ~~in Part 144 of Title 45 of the Code of Federal Regulations.~~

6 plan consisting of one or more of any combination of benefits described in
7 G.S. 58-68-25(b)."

8 **SECTION 7.3.** G.S. 58-10-35(c) reads as rewritten:

9 "(c) After no fewer than 24 months after the mailing of the initial notice of
10 transfer required under G.S. 58-10-30, if positive consent to, or rejection of, the transfer
11 and assumption has not been received or consent has not been deemed to have occurred
12 under subsection (b) of this section, the transferring insurer shall send to the
13 policyholder a second and final notice of transfer as specified in G.S. 58-10-30. If the
14 policyholder does not accept or reject the transfer during the one-month period
15 immediately after the date on which the transferring insurer mailed the second and final
16 notice of transfer, the policyholder's consent and novation of the contract will occur.
17 With respect to the home service business, or any other business not using premium
18 notices, the 24-month and one-month periods shall be measured from the date of
19 delivery of the notice of transfer under G.S. 58-10-30."

20 **SECTION 7.4.** G.S. 58-56-51(a) reads as rewritten:

21 "(a) No person shall act as, offer to act as, or hold himself or herself out as a TPA
22 in this State without a valid TPA license issued by the Commissioner. Licenses shall be
23 renewed annually. Failure to submit a complete renewal application shall result in the
24 expiration of the license of the TPA as a matter of law; provided, however, the
25 Commissioner may grant the TPA an extension of time for good cause."

26 **SECTION 7.5.** G.S. 58-56-51(f) reads as rewritten:

27 "(f) A person is not required to be licensed as a TPA in this State if the person
28 provides services exclusively to one or more bona fide employee benefit plans each of
29 which is established by an employer, an employee organization, or both, and for which
30 the insurance laws of this State are preempted pursuant to the Employee Retirement
31 Income Security Act of 1974. Persons who are not required to be licensed shall register
32 with the Commissioner annually, verifying their status as described in this subsection.
33 Failure to submit an annual verification shall result in the expiration of the registration
34 of the TPA as a matter of law; provided, however, the Commissioner may grant the
35 TPA an extension of time for good cause."

36 **SECTION 7.6.** G.S. 58-58-135(1)c. is repealed.

37 **SECTION 7.7.** G.S. 58-58-205(12) reads as rewritten:

38 "(12) "Viatical settlement provider" or "provider" means a person, other than
39 a viator, that enters into or effectuates a viatical settlement ~~contract~~
40 contract on residents of this State or residents of another state from
41 offices within this State. Viatical settlement provider— "Viatical
42 settlement provider" or "provider" does not include:

- 1 a. A bank, savings bank, savings and loan association, credit
2 union, or other licensed lending institution that takes an
3 assignment of a life insurance policy as collateral for a loan;
4 b. The issuer of a life insurance policy providing accelerated
5 benefits under rules adopted by the Commissioner and under
6 the contract;
7 c. An authorized or eligible insurer that provides stop-loss
8 coverage to a viatical settlement provider, purchaser, financing
9 entity, special purpose entity, or related provider trust;
10 d. A natural person who enters into or effectuates no more than
11 one agreement in a calendar year for the transfer of life
12 insurance policies for any value less than the expected death
13 benefit;
14 e. A financing entity;
15 f. A special purpose entity;
16 g. A related provider trust;
17 h. A viatical settlement purchaser; or
18 i. An accredited investor or qualified institutional buyer as
19 defined respectively in Regulation D, Rule 501 or Rule 144A of
20 the Federal Securities Act of 1933, as amended, and who
21 purchases a viaticated policy from a viatical settlement
22 provider."
23

24 **PART VIII. TEACHERS' AND STATE EMPLOYEES' MAJOR MEDICAL**
25 **PLAN TECHNICAL CORRECTIONS.**

26 **SECTION 8.1.** G.S. 58-2-161(a)(1)m. reads as rewritten:

27 "m. The Teachers' and State Employees' Comprehensive Major
28 Medical Plan and any optional plans or programs operating
29 under Part 2 of Article 3 of Chapter 135 of the General
30 Statutes."

31 **SECTION 8.2.** G.S. 58-3-171(c) reads as rewritten:

32 "(c) For purposes of this section, "health benefit plans" means accident and health
33 insurance policies or certificates; nonprofit hospital or medical service corporation
34 contracts; health maintenance organization (HMO) subscriber contracts and other plans
35 provided by managed-care organizations; plans provided by a MEWA or plans provided
36 by other benefit arrangements, to the extent permitted by ERISA; the Teachers' and
37 State Employees' Comprehensive Major Medical ~~Plan~~; Plan and any optional plans or
38 programs operating under Part 2 of Article 3 of Chapter 135 of the General Statutes; and
39 medical payment coverages under homeowners and automobile insurance policies."

40 **SECTION 8.3.** G.S. 58-3-172(b) reads as rewritten:

41 "(b) For purposes of this section, "health benefit plans" means accident and health
42 insurance policies or certificates; nonprofit hospital or medical service corporation
43 contracts; health, hospital, or medical service corporation plan contracts; health
44 maintenance organization (HMO) subscriber contracts and other plans provided by

1 managed-care organizations; plans provided by a MEWA or plans provided by other
2 benefit arrangements, to the extent permitted by ERISA; and the Teachers' and State
3 Employees' Comprehensive Major Medical ~~Plan~~. Plan and any optional plans or
4 programs operating under Part 2 of Article 3 of Chapter 135 of the General Statutes."

5 **SECTION 8.4.** G.S. 58-3-175(a) reads as rewritten:

6 "(a) As used in this section, "health benefit plan" has the same meaning as in
7 G.S. 58-50-110(11) and includes the Teachers' and State Employees' Comprehensive
8 Major Medical ~~Plan~~. Plan and any optional plans or programs operating under Part 2 of
9 Article 3 of Chapter 135 of the General Statutes."

10 **SECTION 8.5.** G.S. 58-50-75(b) reads as rewritten:

11 "(b) This Part applies to all insurers that offer a health benefit plan and that
12 provide or perform utilization review pursuant to G.S. 58-50-61, the Teachers' and State
13 Employees' Comprehensive Major Medical Plan, any optional plans or programs
14 operating under Part 2 of Article 3 of Chapter 135 of the General Statutes, and the
15 Health Insurance Program for Children. With respect to second-level grievance review
16 decisions, this Part applies only to second-level grievance review decisions involving
17 noncertification decisions."

18 **SECTION 8.6.** G.S. 58-51-115(a) reads as rewritten:

19 "(a) As used in this section and in G.S. 58-51-120 and G.S. 58-51-125:

20 (1) "Health benefit plan" means any accident and health insurance policy
21 or certificate; a nonprofit hospital or medical service corporation
22 contract; a health maintenance organization subscriber contract; a plan
23 provided by a multiple employer welfare arrangement; the Teachers'
24 and State Employees' Comprehensive Major Medical Plan and any
25 optional plans or programs operating under Part 2 of Article 3 of
26 Chapter 135 of the General Statutes; or a plan provided by another
27 benefit arrangement. "Health benefit plan" does not mean a Medicare
28 supplement policy as defined in G.S. 58-54-1(5).

29 (2) "Health insurer" means any health insurance company subject to
30 Articles 1 through 63 of this Chapter, including a multiple employee
31 welfare arrangement, and any corporation subject to Articles 65 and 67
32 of this Chapter; a group health plan, as defined in section 607(1) of the
33 Employee Retirement Income Security Act of 1974; and the Teachers'
34 and State Employees' Comprehensive Major Medical Plan and any
35 optional plans or programs operating under Part 2 of Article 3 of
36 Chapter 135 of the General Statutes."

37 38 **PART IX. EFFECT OF HEADINGS.**

39 **SECTION 9.** The headings to the parts of this act are a convenience to the
40 reader and are for reference only. The headings do not expand, limit, or define the text
41 of this act.

42 43 **PART X. EFFECTIVE DATES.**

1 **SECTION 10.** Part I of this act becomes effective January 1, 2008, and
2 applies to violations occurring on or after that date. Sections 7.4 and 7.5 apply to
3 renewal applications submitted on or after October 1, 2007. Section 10 and Parts II, III,
4 V, and VIII are effective when the bill becomes law. The remainder of the act becomes
5 effective October 1, 2007, and applies to policies issued or renewed on or after that date.