GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2007

SESSION LAW 2008-124
HOUSE BILL 738

AN ACT TO REQUIRE UNINSURED AND UNDERINSURED MOTORIST COVERAGE; MAKE TECHNICAL CHANGES TO INSURANCE FINANCIAL PROVISIONS; AMEND THE UNAUTHORIZED INSURER LAWS; MAKE TECHNICAL CHANGES TO THE RATE EVASION LAW TO CLARIFY THAT IT APPLIES ONLY TO PRIVATE PASSENGER VEHICLES AND TO ADD A TERMINATION RESTRICTION CONSISTENT WITH G.S. 58-37-50 TO CLARIFY THAT THE RATE EVASION LAW APPLIES TO CEDED AND UNCEDED POLICIES; REVISE MANAGED CARE AND HMO RECORD RETENTION LAWS; MAKE CHANGES TO THE HEALTH INSURANCE RISK POOL LAWS; STRENGTHEN PROFESSIONAL EMPLOYER ORGANIZATION PROTECTIONS; MAKE CHANGES TO THE LAW GOVERNING THE CODE OFFICIALS QUALIFICATION BOARD; PROHIBIT FREE INSURANCE; AND TO MAKE OTHER MISCELLANEOUS CHANGES.

The General Assembly of North Carolina enacts:

PART I. UNINSURED AND UNDERINSURED MOTORIST COVERAGE.

SECTION 1.1. G.S. 20-279.21(b)(3) and (b)(4) read as rewritten:

"(b) Such owner's policy of liability insurance:

…

(3) No policy of bodily injury liability insurance, covering liability arising out of the ownership, maintenance, or use of any motor vehicle, shall be delivered or issued for delivery in this State with respect to any motor vehicle registered or principally garaged in this State unless coverage is provided therein or supplemental thereto, under provisions filed with and approved by the Commissioner of Insurance, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of bodily injury, sickness or disease, including death, resulting therefrom, ~~in an amount not to be less than the financial responsibility amounts for bodily injury liability as set forth in G.S. 20-279.5 nor greater than one million dollars ($1,000,000), as selected by the policy owner.~~ with limits equal to the highest limits of bodily injury liability coverage for any one vehicle insured under the policy. The named insured may purchase uninsured motorist bodily injury coverage with greater limits, subject to the limitation that in no event shall uninsured motorist bodily injury coverage limits exceed one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident. The insurer shall notify the named insured of his or her right to purchase uninsured motorist bodily injury coverage with greater limits, when the policy is issued and renewed, as provided in subsection (m) of this section. The provisions shall include coverage for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of injury to or destruction of the property of such insured, with a limit in

the aggregate for all insureds in any one accident ~~of up~~ equal to the highest limits of property damage liability coverage for any one vehicle insured in the owner's policy of liability insurance, and subject, for each insured, to an exclusion of the first one hundred dollars ($100.00) of such damages. The provision shall further provide that a written statement by the liability insurer, whose name appears on the certification of financial responsibility made by the owner of any vehicle involved in an accident with the insured, that the other motor vehicle was not covered by insurance at the time of the accident with the insured shall operate as a prima facie presumption that the operator of the other motor vehicle was uninsured at the time of the accident with the insured for the purposes of recovery under this provision of the insured's liability insurance policy. ~~The coverage required under this subdivision is not applicable where any insured named in the policy rejects the coverage. An insured named in the policy may select different coverage limits as provided in this subdivision. If the named insured in the policy does not reject uninsured motorist coverage and does not select different coverage limits, the amount of uninsured motorist coverage shall be equal to the highest limit of bodily injury and property damage liability coverage for any one vehicle in the policy. Once the option to reject the uninsured motorist coverage or to select different coverage limits is offered by the insurer, the insurer is not required to offer the option in any renewal, reinstatement, substitute, amended, altered, modified, transfer, or replacement policy unless the named insured makes a written request to exercise a different option. The selection or rejection of uninsured motorist coverage or the failure to select or reject by a named insured is valid and binding on all insureds and vehicles under the policy. Rejection of or selection of different coverage limits for uninsured motorist coverage for policies under the jurisdiction of the North Carolina Rate Bureau shall be made in writing by a named insured on a form promulgated by the Bureau and approved by the Commissioner of Insurance.~~

If a person who is legally entitled to recover damages from the owner or operator of an uninsured motor vehicle is an insured under the uninsured motorist coverage of a policy that insures more than one motor vehicle, that person shall not be permitted to combine the uninsured motorist limit applicable to any one motor vehicle with the uninsured motorist limit applicable to any other motor vehicle to determine the total amount of uninsured motorist coverage available to that person. If a person who is legally entitled to recover damages from the owner or operator of an uninsured motor vehicle is an insured under the uninsured motorist coverage of more than one policy, that person may combine the highest applicable uninsured motorist limit available under each policy to determine the total amount of uninsured motorist coverage available to that person. The previous sentence shall apply only to insurance on nonfleet private passenger motor vehicles as described in G.S. 58-40-10(1) and (2).

In addition to the above requirements relating to uninsured motorist insurance, every policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of any motor vehicle, which policy is delivered or issued for delivery in this State, shall be subject to the following provisions which need not be contained therein.

a. A provision that the insurer shall be bound by a final judgment taken by the insured against an uninsured motorist if the insurer has been served with copy of summons, complaint or other process in the action against the uninsured motorist by registered or certified mail, return receipt requested, or in any manner provided by law; provided however, that the determination of whether a motorist is uninsured may be decided only by an action against the insurer alone. The insurer, upon being served as herein provided, shall be a party to the action between the insured and the uninsured motorist though not named in the caption of the pleadings and may defend the suit in the name of the uninsured motorist or in its own name. The insurer, upon being served with copy of summons, complaint or other pleading, shall have the time allowed by statute in which to answer, demur or otherwise plead (whether the pleading is verified or not) to the summons, complaint or other process served upon it. The consent of the insurer shall not be required for the initiation of suit by the insured against the uninsured motorist: Provided, however, no action shall be initiated by the insured until 60 days following the posting of notice to the insurer at the address shown on the policy or after personal delivery of the notice to the insurer or its agent setting forth the belief of the insured that the prospective defendant or defendants are uninsured motorists. No default judgment shall be entered when the insurer has timely filed an answer or other pleading as required by law. The failure to post notice to the insurer 60 days in advance of the initiation of suit shall not be grounds for dismissal of the action, but shall automatically extend the time for the filing of an answer or other pleadings to 60 days after the time of service of the summons, complaint, or other process on the insurer.

b. Where the insured, under the uninsured motorist coverage, claims that he has sustained bodily injury as the result of collision between motor vehicles and asserts that the identity of the operator or owner of a vehicle (other than a vehicle in which the insured is a passenger) cannot be ascertained, the insured may institute an action directly against the insurer: Provided, in that event, the insured, or someone in his behalf, shall report the accident within 24 hours or as soon thereafter as may be practicable, to a police officer, peace officer, other judicial officer, or to the Commissioner of Motor Vehicles. The insured shall also within a reasonable time give notice to the insurer of his injury, the extent thereof, and shall set forth in the notice the time, date and place of the injury. Thereafter, on forms to be mailed by the insurer within 15 days following receipt of the notice of the accident to the insurer, the insured shall furnish to insurer any further reasonable information concerning the accident and the injury that the insurer requests. If the forms are not furnished within 15 days, the insured is deemed to have complied with the requirements for furnishing information to the insurer. Suit may not be instituted against the insurer in less than 60 days from the posting of the first notice of the injury or accident to the insurer at the address shown on the policy or after personal delivery of the notice to the insurer or its agent. The failure to post notice to the insurer 60 days before the

initiation of the suit shall not be grounds for dismissal of the action, but shall automatically extend the time for filing of an answer or other pleadings to 60 days after the time of service of the summons, complaint, or other process on the insurer.

Provided under this section the term "uninsured motor vehicle" shall include, but not be limited to, an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability within the limits specified therein because of insolvency.

An insurer's insolvency protection shall be applicable only to accidents occurring during a policy period in which its insured's uninsured motorist coverage is in effect where the liability insurer of the tort-feasor becomes insolvent within three years after such an accident. Nothing herein shall be construed to prevent any insurer from affording insolvency protection under terms and conditions more favorable to the insured than is provided herein.

In the event of payment to any person under the coverage required by this section and subject to the terms and conditions of coverage, the insurer making payment shall, to the extent thereof, be entitled to the proceeds of any settlement for judgment resulting from the exercise of any limits of recovery of that person against any person or organization legally responsible for the bodily injury for which the payment is made, including the proceeds recoverable from the assets of the insolvent insurer.

For the purpose of this section, an "uninsured motor vehicle" shall be a motor vehicle as to which there is no bodily injury liability insurance and property damage liability insurance in at least the amounts specified in subsection (c) of G.S. 20-279.5, or there is that insurance but the insurance company writing the insurance denies coverage thereunder, or has become bankrupt, or there is no bond or deposit of money or securities as provided in G.S. 20-279.24 or 20-279.25 in lieu of the bodily injury and property damage liability insurance, or the owner of the motor vehicle has not qualified as a self-insurer under the provisions of G.S. 20-279.33, or a vehicle that is not subject to the provisions of the Motor Vehicle Safety and Financial Responsibility Act; but the term "uninsured motor vehicle" shall not include:

a. A motor vehicle owned by the named insured;
b. A motor vehicle that is owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or any similar law;
c. A motor vehicle that is owned by the United States of America, Canada, a state, or any agency of any of the foregoing (excluding, however, political subdivisions thereof);
d. A land motor vehicle or trailer, if operated on rails or crawler-treads or while located for use as a residence or premises and not as a vehicle; or
e. A farm-type tractor or equipment designed for use principally off public roads, except while actually upon public roads.

For purposes of this section "persons insured" means the named insured and, while resident of the same household, the spouse of any named insured and relatives of either, while in a motor vehicle or otherwise, and any person who uses with the consent, expressed or implied, of the named insured, the motor vehicle to which the policy applies and a guest in the motor vehicle to which the policy applies or

the personal representative of any of the above or any other person or persons in lawful possession of the motor vehicle.

Notwithstanding the provisions of this subsection, no policy of motor vehicle liability insurance applicable solely to commercial motor vehicles as defined in G.S. 20-4.01(3d) or applicable solely to fleet vehicles shall be required to provide uninsured motorist coverage. Any motor vehicle liability policy that insures both commercial motor vehicles as defined in G.S. 20-4.01(3d) and noncommercial motor vehicles shall provide uninsured motorist coverage in accordance with the provisions of this subsection in amounts equal to the highest limits of bodily injury and property damage liability coverage for any one noncommercial motor vehicle insured under the policy, subject to the right of the insured to purchase higher uninsured motorist bodily injury liability coverage limits as set forth in this subsection. For the purpose of the immediately preceding sentence, noncommercial motor vehicle shall mean any motor vehicle that is not a commercial motor vehicle as defined in G.S. 20-4.01(3d), but that is otherwise subject to the requirements of this subsection.

(4) Shall, in addition to the coverages set forth in subdivisions (2) and (3) of this subsection, provide underinsured motorist coverage, to be used only with a policy that is written at limits that exceed those prescribed by subdivision (2) of this ~~section and that afford uninsured motorist coverage as provided by subdivision (3) of this subsection, in an amount not to be less than the financial responsibility amounts for bodily injury liability as set forth in G.S. 20-279.5 nor greater than one million dollars ($1,000,000) as selected by the policy owner.~~ section, with limits equal to the highest limits of bodily injury liability coverage for any one vehicle insured under the policy. The named insured may purchase underinsured motorist coverage with greater limits, subject to the limitation that in no event shall the underinsured motorist coverage limits exceed one million dollars ($1,000,000) per person and one million dollars ($1,000.000) per accident. The insurer shall notify the named insured of his or her right to purchase underinsured motorist coverage with greater limits, when the policy is issued and renewed, as provided in subsection (m) of this section. An "uninsured motor vehicle," as described in subdivision (3) of this subsection, includes an "underinsured highway vehicle," which means a highway vehicle with respect to the ownership, maintenance, or use of which, the sum of the limits of liability under all bodily injury liability bonds and insurance policies applicable at the time of the accident is less than the applicable limits of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner's policy. For purposes of an underinsured motorist claim asserted by a person injured in an accident where more than one person is injured, a highway vehicle will also be an "underinsured highway vehicle" if the total amount actually paid to that person under all bodily injury liability bonds and insurance policies applicable at the time of the accident is less than the applicable limits of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner's policy. Notwithstanding the immediately preceding sentence, a highway vehicle shall not be an "underinsured motor vehicle" for purposes of an underinsured motorist claim under an owner's policy insuring that vehicle ~~if~~ unless the owner's policy insuring that vehicle provides underinsured motorist coverage with limits that are ~~less than or equal to~~ greater than that policy's bodily

injury liability limits. For the purposes of this subdivision, the term "highway vehicle" means a land motor vehicle or trailer other than (i) a farm-type tractor or other vehicle designed for use principally off public roads and while not upon public roads, (ii) a vehicle operated on rails or crawler-treads, or (iii) a vehicle while located for use as a residence or premises. The provisions of subdivision (3) of this subsection shall apply to the coverage required by this subdivision. Underinsured motorist coverage is deemed to apply when, by reason of payment of judgment or settlement, all liability bonds or insurance policies providing coverage for bodily injury caused by the ownership, maintenance, or use of the underinsured highway vehicle have been exhausted. Exhaustion of that liability coverage for the purpose of any single liability claim presented for underinsured motorist coverage is deemed to occur when either (a) the limits of liability per claim have been paid upon the claim, or (b) by reason of multiple claims, the aggregate per occurrence limit of liability has been paid. Underinsured motorist coverage is deemed to apply to the first dollar of an underinsured motorist coverage claim beyond amounts paid to the claimant under the exhausted liability policy.

In any event, the limit of underinsured motorist coverage applicable to any claim is determined to be the difference between the amount paid to the claimant under the exhausted liability policy or policies and the limit of underinsured motorist coverage applicable to the motor vehicle involved in the accident. Furthermore, if a claimant is an insured under the underinsured motorist coverage on separate or additional policies, the limit of underinsured motorist coverage applicable to the claimant is the difference between the amount paid to the claimant under the exhausted liability policy or policies and the total limits of the claimant's underinsured motorist coverages as determined by combining the highest limit available under each policy; provided that this sentence shall apply only to insurance on nonfleet private passenger motor vehicles as described in G.S. 58-40-15(9) and (10). The underinsured motorist limits applicable to any one motor vehicle under a policy shall not be combined with or added to the limits applicable to any other motor vehicle under that policy.

An underinsured motorist insurer may at its option, upon a claim pursuant to underinsured motorist coverage, pay moneys without there having first been an exhaustion of the liability insurance policy covering the ownership, use, and maintenance of the underinsured highway vehicle. In the event of payment, the underinsured motorist insurer shall be either: (a) entitled to receive by assignment from the claimant any right or (b) subrogated to the claimant's right regarding any claim the claimant has or had against the owner, operator, or maintainer of the underinsured highway vehicle, provided that the amount of the insurer's right by subrogation or assignment shall not exceed payments made to the claimant by the insurer. No insurer shall exercise any right of subrogation or any right to approve settlement with the original owner, operator, or maintainer of the underinsured highway vehicle under a policy providing coverage against an underinsured motorist where the insurer has been provided with written notice before a settlement between its insured and the underinsured motorist and the insurer fails to advance a payment to the insured in an amount equal to the tentative settlement within 30 days following receipt of that notice. Further, the insurer shall have the right, at its election, to pursue its claim by assignment or subrogation

in the name of the claimant, and the insurer shall not be denominated as a party in its own name except upon its own election. Assignment or subrogation as provided in this subdivision shall not, absent contrary agreement, operate to defeat the claimant's right to pursue recovery against the owner, operator, or maintainer of the underinsured highway vehicle for damages beyond those paid by the underinsured motorist insurer. The claimant and the underinsured motorist insurer may join their claims in a single suit without requiring that the insurer be named as a party. Any claimant who intends to pursue recovery against the owner, operator, or maintainer of the underinsured highway vehicle for moneys beyond those paid by the underinsured motorist insurer shall before doing so give notice to the insurer and give the insurer, at its expense, the opportunity to participate in the prosecution of the claim. Upon the entry of judgment in a suit upon any such claim in which the underinsured motorist insurer and claimant are joined, payment upon the judgment, unless otherwise agreed to, shall be applied pro rata to the claimant's claim beyond payment by the insurer of the owner, operator or maintainer of the underinsured highway vehicle and the claim of the underinsured motorist insurer.

A party injured by the operation of an underinsured highway vehicle who institutes a suit for the recovery of moneys for those injuries and in such an amount that, if recovered, would support a claim under underinsured motorist coverage shall give notice of the initiation of the suit to the underinsured motorist insurer as well as to the insurer providing primary liability coverage upon the underinsured highway vehicle. Upon receipt of notice, the underinsured motorist insurer shall have the right to appear in defense of the claim without being named as a party therein, and without being named as a party may participate in the suit as fully as if it were a party. The underinsured motorist insurer may elect, but may not be compelled, to appear in the action in its own name and present therein a claim against other parties; provided that application is made to and approved by a presiding superior court judge, in any such suit, any insurer providing primary liability insurance on the underinsured highway vehicle may upon payment of all of its applicable limits of liability be released from further liability or obligation to participate in the defense of such proceeding. However, before approving any such application, the court shall be persuaded that the owner, operator, or maintainer of the underinsured highway vehicle against whom a claim has been made has been apprised of the nature of the proceeding and given his right to select counsel of his own choice to appear in the action on his separate behalf. If an underinsured motorist insurer, following the approval of the application, pays in settlement or partial or total satisfaction of judgment moneys to the claimant, the insurer shall be subrogated to or entitled to an assignment of the claimant's rights against the owner, operator, or maintainer of the underinsured highway vehicle and, provided that adequate notice of right of independent representation was given to the owner, operator, or maintainer, a finding of liability or the award of damages shall be res judicata between the underinsured motorist insurer and the owner, operator, or maintainer of underinsured highway vehicle.

As consideration for payment of policy limits by a liability insurer on behalf of the owner, operator, or maintainer of an underinsured motor vehicle, a party injured by an underinsured motor vehicle may execute a contractual covenant not to enforce against the owner,

operator, or maintainer of the vehicle any judgment that exceeds the policy limits. A covenant not to enforce judgment shall not preclude the injured party from pursuing available underinsured motorist benefits, unless the terms of the covenant expressly provide otherwise, and shall not preclude an insurer providing underinsured motorist coverage from pursuing any right of subrogation.

~~The coverage required under this subdivision shall not be applicable where any insured named in the policy rejects the coverage. An insured named in the policy may select different coverage limits as provided in this subdivision. If the named insured does not reject underinsured motorist coverage and does not select different coverage limits, the amount of underinsured motorist coverage shall be equal to the highest limit of bodily injury liability coverage for any one vehicle in the policy. Once the option to reject underinsured motorist coverage or to select different coverage limits is offered by the insurer, the insurer is not required to offer the option in any renewal, reinstatement, substitute, amended, altered, modified, transfer, or replacement policy unless a named insured makes a written request to exercise a different option. The selection or rejection of underinsured motorist coverage by a named insured or the failure to select or reject is valid and binding on all insureds and vehicles under the policy.~~

~~Rejection of or selection of different coverage limits for underinsured motorist coverage for policies under the jurisdiction of the North Carolina Rate Bureau shall be made in writing by the named insured on a form promulgated by the Bureau and approved by the Commissioner of Insurance.~~

Notwithstanding the provisions of this subsection, no policy of motor vehicle liability insurance applicable solely to commercial motor vehicles as defined in G.S. 20-4.01(3d) or applicable solely to fleet vehicles shall be required to provide underinsured motorist coverage. Any motor vehicle liability policy that insures both commercial motor vehicles as defined in G.S. 20-4.01(3d) and noncommercial motor vehicles shall provide underinsured motorist coverage in accordance with the provisions of this subsection in an amount equal to the highest limits of bodily injury liability coverage for any one noncommercial motor vehicle insured under the policy, subject to the right of the insured to purchase higher underinsured motorist bodily injury liability coverage limits as set forth in this subsection. For the purpose of the immediately preceding sentence, noncommercial motor vehicle shall mean any motor vehicle that is not a commercial motor vehicle as defined in G.S. 20-4.01(3d), but that is otherwise subject to the requirements of this subsection."

SECTION 1.2. G.S. 20-279.21 is amended by adding the following new subsections to read:

"(m) Every insurer that sells motor vehicle liability policies subject to the requirements of subdivisions (b)(3) and (b)(4) of this section shall give reasonable notice to the named insured, when the policy is issued and renewed, that the named insured may purchase uninsured motorist bodily injury coverage and, if applicable, underinsured motorist coverage with limits up to one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident. An insurer shall be deemed to have given reasonable notice if it includes the following or substantially similar language on the policy's original and renewal declarations pages or in a separate notice accompanying the original and renewal declarations pages in at least 10 point type:

"NOTICE: YOU MAY PURCHASE UNINSURED MOTORIST BODILY INJURY COVERAGE AND, IF APPLICABLE, UNDERINSURED MOTORIST COVERAGE

WITH LIMITS UP TO ONE MILLION DOLLARS ($1,000,000) PER PERSON AND ONE MILLION DOLLARS ($1,000,000) PER ACCIDENT. THIS INSURANCE PROTECTS YOU AND YOUR FAMILY AGAINST INJURIES CAUSED BY THE NEGLIGENCE OF OTHER DRIVERS WHO MAY HAVE LIMITED OR ONLY MINIMUM COVERAGE OR EVEN NO LIABILITY INSURANCE. YOU SHOULD CONTACT YOUR INSURANCE COMPANY OR AGENT TO DISCUSS YOUR OPTIONS FOR OBTAINING THIS ADDITIONAL COVERAGE. YOU SHOULD ALSO READ YOUR ENTIRE POLICY TO UNDERSTAND WHAT IS COVERED UNDER UNINSURED AND UNDERINSURED MOTORIST COVERAGES."

(n) Nothing in this section shall be construed to provide greater amounts of uninsured or underinsured motorist coverage in a liability policy than the insured has purchased from the insurer under this section.

(o) An insurer that fails to comply with subsection (m) of this section is subject to a civil penalty under G.S. 58-2-70."

PART II. INSURANCE COMPANY FINANCIAL SOLVENCY PROVISIONS.

SECTION 2.1. G.S. 58-5-50 reads as rewritten:

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

In addition to other requirements ~~of Articles 1 through 64~~ of this Chapter, all foreign life insurance companies shall deposit securities, as specified in G.S. 58-5-20, ~~having~~ that have a market value of four hundred thousand dollars ($400,000) as a prerequisite of doing business in this State. All foreign life insurance companies shall deposit an additional two hundred thousand dollars ($200,000) where such companies cannot show three years of net ~~operational gains prior to admission.~~ income before being licensed in this State."

SECTION 2.2. The catch line of G.S. 58-10-145 reads as rewritten:

"**§ 58-10-145. ~~Mono-line~~ Monoline requirement for mortgage guaranty insurers.**"

SECTION 2.3. G.S. 58-7-15(17) reads as rewritten:

"(17) "Credit insurance," meaning indemnifying merchants or other persons extending credit against loss or damage resulting from the nonpayment of debts owed to them; and including the incidental power to acquire and dispose of debts so insured, and to collect any debts owed to the insurer or to any person so insured by the insurer; and also including insurance where the debt is secured by either (a) a junior lien on real estate or (b) ~~where the debt is secured by~~ a first lien on real estate as long as (i) the purpose of the debt being insured is not for the purchase of the real estate and the insurance is limited to twenty-five percent (25%) of the insurer's aggregate insured risk outstanding, before reinsurance ceded or assumed or (ii) the insurance is not included within the definition of mortgage guaranty insurance."

SECTION 2.4. G.S. 58-5-71 reads as rewritten:

"**§ 58-5-71. Liens of policyholders; subordination.**

Liens against the deposit of a foreign insurer under G.S. 58-5-70 shall be subordinated to the reasonable and necessary expenses of the Commissioner in liquidating the deposit and paying the special deposit claims. 'Special deposit claims' has the same meaning set forth in G.S. 58-30-10(19)."

SECTION 2.5. G.S. 58-5-55 reads as rewritten:

"**§ 58-5-55. Deposits of capital and surplus by domestic insurance companies.**

(a) In addition to other requirements of Articles 1 through 64 of this Chapter, all domestic stock insurance companies shall deposit their required statutory capital with the ~~Department.~~Commissioner. Such deposits shall be under the exclusive control of the ~~Department,~~ Commissioner for the protection of policyholders.

(b) In addition to other requirements of Articles 1 through 64 of this Chapter, all domestic mutual insurance companies shall deposit at least fifty percent (50%) of their minimum required surplus with the ~~Department,~~ Commissioner, with the amount of the

deposit to be determined by the Commissioner. Such deposits shall be under the exclusive control of the ~~Department,~~ Commissioner for the protection of policyholders.

(c) Deposits fulfilling the requirements of this section shall comprise:

(1) Interest-bearing bonds of the United States of America;

(2) Interest-bearing bonds of the State of North Carolina or of its cities or counties; or

(3) Certificates of deposit issued by any solvent bank domesticated in the State of North Carolina."

SECTION 2.6. G.S. 58-7-75 is amended by adding two new subdivisions to read:

"**§ 58-7-75. Amount of capital and/or surplus required; impairment of capital or surplus.**

…

(1a) Non-Stock Life Insurance Companies. – A nonstock corporation, not inclusive of a corporation organized pursuant to subdivision (6) of this section, may be organized in the manner prescribed in this Chapter and licensed to do the business of life insurance, only when it has a paid in initial surplus of at least one million five hundred thousand dollars ($1,500,000) and it may in addition do the kind of business specified in G.S. 58-7-15(2), without having additional surplus. Every such corporation shall at all times thereafter maintain a minimum surplus of at least seven hundred fifty thousand dollars ($750,000). Provided that, any such corporation may conduct the kind of insurance authorized for stock accident and health insurance companies, as set out in G.S. 58-7-15(3)a. and b., where its charter so permits, and only as long as it maintains a minimum surplus equal to the sum of the minimum surplus requirements of this subdivision and the minimum surplus requirements of subdivision (2a) of this section.

…

(2a) Non-Stock Accident and Health Insurance Companies.

a. A non-stock corporation, not inclusive of a corporation organized pursuant to subdivision (6) of this section, may be organized in the manner prescribed in this Chapter and licensed to do only the kind of insurance specified in G.S. 58-7-15(3)a. when it has a paid in initial surplus of at least one million dollars ($1,000,000). Every such corporation shall at all times thereafter maintain a minimum surplus of at least five hundred thousand dollars ($500,000).

b. Any non-stock corporation organized under the provisions of sub-subdivision a. of this subdivision may, by the provisions of its original charter or any amendment thereto, acquire the power to do the kind of business specified in G.S. 58-7-15(3)b., if it has a paid-in initial surplus of at least one million five hundred thousand dollars ($1,500,000). Every such corporation shall at all times maintain a minimum surplus of at least seven hundred fifty thousand dollars ($750,000)."

PART III. UNAUTHORIZED INSURER AMENDMENTS.

SECTION 3.1. The catch line for G.S. 58-28-5 reads as rewritten:

"**§ 58-28-5. Transacting business without ~~certificate of authority~~ a license prohibited; exceptions.**"

SECTION 3.2. G.S. 58-28-5(a) reads as rewritten:

"(a) Except as otherwise provided in this section, it is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this State as set forth in ~~G.S. 58-28-10,~~ G.S. 58-28-13 without a license issued by the Commissioner. This section does not apply to the following acts or transactions:

(1) The procuring of a policy of insurance upon a risk within this State where the applicant is unable to procure coverage in the open market with admitted companies and is otherwise in compliance with Article 21 of this Chapter.
(2) Contracts of reinsurance; but not including assumption reinsurance transactions, whereby the reinsuring company succeeds to all of the liabilities of and supplants the ceding company on the insurance contracts that are the subject of the transaction, unless prior approval has been obtained from the Commissioner.
(3) Transactions in this State involving a policy lawfully solicited, written and delivered outside of this State covering only subjects of insurance not resident, located or expressly to be performed in this State at the time of issuance, and which transactions are subsequent to the issuance of such policy.
(4) Transactions in this State involving group life insurance, group annuities, or group, blanket, or franchise accident and health insurance where the master policy for the insurance was lawfully issued and delivered in a state in which the company was authorized to transact business.
(5) Transactions in this State involving all policies of insurance issued before July 1, 1967.
(6) The procuring of contracts of insurance issued to a nuclear insured. As used in this subdivision, "nuclear insured" means a public utility procuring insurance against radioactive contamination and other risks of direct physical loss at a nuclear electric generating plant.
(7) Insurance independently procured, as specified in subsection (b) of this section.
(8) Insurance on vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine insurance policies, as distinguished from inland marine insurance policies.
(9) Transactions in this State involving commercial aircraft insurance, meaning insurance against (i) loss of or damage resulting from any cause to commercial aircraft and its equipment, (ii) legal liability of the insured for loss or damage to another person's property resulting from the ownership, maintenance, or use of commercial aircraft, and (iii) loss, damage, or expense incident to a liability claim.
(10) An activity in this State by or on the sole behalf of a captive insurer that insures solely the risks of the company's parent and affiliated companies."

SECTION 3.3. G.S. 58-28-40(a) reads as rewritten:

"(a) Any act of entering into a contract of insurance as an insurer or transacting insurance business in this State, as set forth in ~~G.S. 58-28-10~~ G.S. 58-28-12 by an unauthorized, foreign or alien company, shall be equivalent to and shall constitute an appointment by such company of the Secretary of State to be its true and lawful attorney upon whom may be served all lawful process in any action or proceeding against it arising out of a violation of G.S. 58-28-5, and any of said acts shall be a signification of its agreement that any such process against it, which is so served, shall be of the same legal force and validity as if in fact served upon the company."

SECTION 3.4. Article 28 of Chapter 58 of the General Statutes is amended by adding three new sections to read:

"**§ 58-28-12. Transacting insurance business in this State.**

Definitions. – As used in this section, G.S. 58-28-13, and G.S. 58-28-14:

(1) "Admitted insurer" means an insurer that is licensed to write insurance in this State.

(2) "Kind of insurance" means one of the types of insurance specified in G.S. 58-7-15.

(3) "Nonadmitted insurer" means an insurer that is not licensed to write insurance in this State.

(4) "Transacting insurance business" or "transact insurance business" means:

a. The making of or proposing to make, as an insurer, an insurance contract.

b. The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety.

c. The solicitation, taking, or receiving of an application for insurance.

d. The receiving or collection of any premium, commission, membership fees, assessments, dues, or other consideration for a contract of insurance or any part of the contract of insurance.

e. The issuance or delivery in this State of a contract of insurance to a resident of this State or to a person authorized to do business in this State.

f. The solicitation, negotiation, procurement, effectuation, or renewal of a contract of insurance.

g. The dissemination of information as to coverage or rates; forwarding of an application; delivery of a contract of insurance; inspection of a risk; the fixing of rates; the investigation or adjustment of a claim or loss; the transaction of matters after effectuation of a contract of insurance and arising out of the contract; or any other manner of representing or assisting a person or insurer in transacting insurance business with respect to properties, risks, or exposures located or to be performed in this State.

h. The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of this Chapter.

i. The offering of insurance or the transacting of insurance business.

j. The offering of an agreement or contract which purports to alter, amend, or void coverage of an insurance contract.

k. The transaction of any matters before or after the execution of contracts of insurance in contemplation of or arising out of the execution.

l. The maintaining of any agency or office in this State where any acts in furtherance of an insurance business are transacted, including the execution of contracts of insurance with citizens of this State or any other state.

m. The maintaining of files or records of contracts of insurance in this State.

"**§ 58-28-13. Placement of insurance business.**

(a) An insurer shall not transact insurance business in this State unless it is an admitted insurer, is exempted by this Article, or is otherwise exempted by this Chapter.

(b) A person shall not transact insurance business or in this State directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, a nonadmitted insurer in the solicitation, negotiation, procurement, or effectuation of insurance, or renewals of insurance; forwarding of applications; delivery of policies or contracts; inspection of risks; fixing of rates; investigation or adjustment of claims or

losses; collection or forwarding of premiums; or in any other manner represent or assist the insurer in transacting insurance business.

(c) A person who represents or aids a nonadmitted insurer in violation of this section is subject to penalties or restitution, or both, as set forth in this section.

(d) This section does not prohibit employees, officers, directors, or partners of a commercial insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of the employer, provided that the person's compensation is not based on buying insurance.

(e) The venue of an act committed by mail or any other medium is at the point where the matter transmitted by mail or other medium is delivered or issued for delivery or takes effect.

(f) The remedies prescribed in this section are not exclusive. Penalties may also be assessed under Article 63 of this Chapter or G.S. 58-2-161, or both.

(g) If the Commissioner finds a violation of this section, the Commissioner may order the payment of a monetary penalty after considering the factors in G.S. 58-28-14; or petition the Superior Court of Wake County for an order directing payment of restitution as provided in subsection (i) of this section; or both. The monetary penalty shall not exceed five thousand dollars ($5,000) for the first offense and shall not exceed ten thousand dollars ($10,000) for each succeeding offense. Each day during which a violation occurs constitutes a separate violation. The clear proceeds of the penalty shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. Payment of the civil penalty under this section shall be in addition to payment of any other penalty for a violation of the criminal laws of this State.

(h) Upon petition of the Commissioner, the Superior Court of Wake County may order the person who committed a violation specified in this section to make restitution in an amount that would make whole any person harmed by the violation. The petition may be made at any time and also in any appeal of any order issued by the Commissioner.

(i) Restitution to the Department for extraordinary administrative expenses incurred in the investigation and hearing of the violation may also be ordered by the court in such amount that would reimburse the Department for the expenses.

(j) Nothing in this section prevents the Commissioner from negotiating a mutually acceptable agreement with any person as to any civil penalty or restitution.

(k) The Attorney General of the State of North Carolina at the request of and upon information from the Commissioner shall initiate a civil action in behalf of the Commissioner in any county of the State in which a violation under this section occurs to recover the penalty provided. Service of process upon the nonadmitted insurer shall be made under G.S. 58-28-40.

"**§ 58-28-14. Monetary penalty; factors to be considered.**

In determining the amount of the penalty under G.S. 58-28-13, the Commissioner shall consider:

(1) The amount of money that inured to the benefit of the violator as a result of the violation,

(2) Whether the violation was committed willfully.

(3) The prior record of the violator in complying or failing to comply with laws, rules, or orders applicable to the violator.

(4) The failure of the violator to provide timely and complete responses to the Department's inquiries about the violator's insurance activities in North Carolina.

(5) The extent and degree to which the violator marketed its insurance product in this State.

(6) The extent to which the violator's marketing materials, including fax solicitations, Internet Web sites, circulars, or other forms of advertisement or solicitations through any medium, were deceptive or misleading to residents of this State.

(7) The number of residents of this State who enrolled in the violator's insurance plan.

(8) The number of policies and amount of insurance coverage issued by the violator to residents of this State.

(9) The failure of the violator to promptly refund premiums and other consideration paid by residents of this State for insurance coverage issued by the violator upon requests by the residents of this State or the Department.

(10) The extent and degree of harm to residents of this State. In assessing the extent and degree of harm, the Commissioner shall consider, among other things, the amount of premiums and other consideration paid by residents of this State for coverage issued by the violator, the failure of the violator to pay claims made by residents of this State, and number and dollar amount of claims made by residents of this State that the violator has failed to pay.

(11) Whether the violator has a prior record of violating this Article or the unauthorized insurance laws of any other state. "Prior record" includes final administrative orders issued by the Commissioner or insurance regulator of any other state; federal or state criminal convictions, including pleas of guilty or nolo contendere; civil judgments; and written settlement agreements of state administrative proceedings, state or federal criminal proceedings, or civil lawsuits against the violator or any entity of which the violator was either a principal or owner."

SECTION 3.5. G.S. 58-28-10 is repealed.

PART IV. RATE EVASION TECHNICAL AMENDMENTS.

SECTION 4.1. G.S. 20-52(a)(4) reads as rewritten:

"(4) A statement that the owner is an eligible risk for insurance coverage as defined in ~~G.S. 58-37-1.~~G.S. 58-37-1(4a)."

SECTION 4.2. G.S. 58-36-85(b) reads as rewritten:

"(b) Termination Restrictions. – An insurer shall not terminate a policy for a reason that is not specified in ~~G.S. 58-37-50(1) through (5) or G.S. 58-36-65(g).~~ G.S. 58-2-164(g), 58-36-65(g), or 58-37-50. A termination of a policy is not effective unless the insurer either has notified a named insured of the termination by sending a written termination notice by first class mail to the insured's last known address or is not required by this subsection to send a written termination notice. Proof of mailing of a written termination notice is proof that the notice was sent.

An insurer is not required to send a written termination notice if any of the following applies:

(1) The insurer has manifested its willingness to renew the policy by issuing or offering to issue a renewal policy, a certificate, or other evidence of renewal.

(2) The insurer has manifested its willingness to renew the policy by any means not described in subdivision (1) of this subsection, including mailing a premium notice or expiration notice by first class mail to the named insured and the failure of the insured to pay the required premium on or before the premium due date.

(3) A named insured has given written notification to the insurer or its agent that the named insured wants the policy to be terminated."

PART V. MANAGED CARE RECORD RETENTION AMENDMENTS AND HMO TECHNICAL AMENDMENT.

SECTION 5.1. G.S. 58-50-61(n) reads as rewritten:

"(n) Maintenance of Records. – Every insurer and URO shall maintain records of each review performed and each appeal received or reviewed, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these

records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. These records shall be retained by the insurer and URO for a period of ~~three~~ five years ~~or~~ or, for domestic companies, until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later."

SECTION 5.2. G.S. 58-50-62(d) reads as rewritten:

"(d) Maintenance of Records. – Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for ~~three~~ five years ~~or~~ or, for domestic companies, until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later."

SECTION 5.3. G.S. 58-67-50(e) reads as rewritten:

"(e) Effective January 1, 1989, every health maintenance organization shall provide at least minimum cost and utilization information for group contracts of 100 or more subscribers on an annual basis when requested by the group. Such information shall be compiled in accordance with the Data Collection Form developed by the Standardized HMO Date Form Task Force as endorsed by the Washington Business Group on Health and the Group Health Association of America on November 19, 1986, and any subsequent amendments. In addition, beginning with data for the calendar year 1998, every HMO, for group contracts of 1,000 or more members, shall provide cost, use of service, prevention, outcomes, and other group-specific data as collected in accordance with the latest edition of the ~~Health Plan Employer Data and Information Set (HEDIS)~~ Healthcare Effectiveness Data and Information Set guidelines, as published by the National Committee for Quality Assurance. Beginning with data for the calendar year 1998, every HMO shall file with the Commissioner and make available to all employer groups, not later than July 1 of the following calendar year, a report of health benefit plan-wide experience on its costs, use of services, and other aspects of performance, in the ~~HEDIS~~ Healthcare Effectiveness and Information Set format."

PART VI. HEALTH INSURANCE RISK POOL AMENDMENTS.

SECTION 6.1. G.S. 58-50-180(c) reads as rewritten:

"(c) The initial appointments by the Governor and the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall serve a term of three years. The initial appointments by the Commissioner under sub-subdivisions a., b., and d. of subdivision (b)(3) of this section shall be for a term of two years. The initial appointments by the Commissioner under sub-subdivisions c., e., f., and g. of subdivision (b)(3) of this section shall be for a term of one year. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms.

A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the appointing authority for cause.

The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the Commission shall constitute a quorum.

The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under ~~G.S. 138-6~~ G.S. 138-5 when traveling to and from meetings of the ~~Board,~~ Board or for official business of the Pool, but shall not receive any ~~subsistence allowance or~~ per diem under ~~G.S. 138-5.~~subdivision (a)(1)of that section."

SECTION 6.2. G.S. 58-50-180(e)(1) reads as rewritten:

"(e) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Executive Director ~~in collaboration with~~ acting upon the approval or authorization of the Board, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions."

SECTION 6.3. G.S. 58-50-185(a) reads as rewritten:

"(a) The Executive Director, ~~in collaboration~~ with the approval or authorization of the Board, shall select through a competitive bidding process one or more insurers to administer the Pool. The Executive Director shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.
(2) Efficiency and timeliness of the claim processing procedures.
(3) Estimated total charges for administering the Pool.
(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.
(5) Financial condition and stability.
(6) Evidence of authority to provide third-party administrative services in North Carolina."

SECTION 6.4. G.S. 58-50-195(d) reads as rewritten:

"(d) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.
(2) On the date an individual requests coverage to end.
(3) Upon the death of the covered individual.
(4) On the date State law requires cancellation of the Pool policy.
(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.
(6) Because the individual has failed to make the payments required under this Part.
(7) Because the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage."

SECTION 6.5. G.S. 58-50-210 reads as rewritten:

"**§ 58-50-210. Preexisting conditions.**

(a) Except as otherwise provided by law, Pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible ~~individual.~~individual or an individual who is eligible for the Pool because of his or her eligibility for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986, pursuant to G.S. 58-50-195(a)(6).

~~(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated, provided that:~~

~~(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool~~

~~shall be effective from the date on which the prior coverage was terminated; and~~

~~(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.~~

(c) The period of any preexisting condition exclusion shall be reduced by the aggregate of the periods of creditable coverage, if any, applicable as of the enrollment date. Credit for having satisfied some or all of the preexisting condition waiting period under previous creditable coverage, as defined in G.S. 58-51-17(a)(1), shall be provided in accordance with G.S. 58-51-17."

PART VII. PEO AMENDMENTS.

SECTION 7.1. The catch line of G.S. 58-89A-50 reads as rewritten:

"**§ 58-89A-50. Surety bond; letter of ~~credit.~~credit; other deposits.**"

SECTION 7.2. G.S. 58-89A-50(a) reads as rewritten:

"(a) An applicant for licensure shall file with the Commissioner a surety bond for the benefit of the Commissioner in ~~the~~ an amount ~~of one hundred thousand dollars ($100,000) in favor of the State of North Carolina.~~equal to five percent (5%) of the applicant's prior year's total North Carolina wages, benefits, workers compensation premiums, and unemployment compensation contributions, but not greater than five hundred thousand dollars ($500,000), or such greater amount as the Commissioner may require."

SECTION 7.3. G.S. 58-89A-10 is repealed.

SECTION 7.4. G.S. 58-89A-105 reads as rewritten:

"**§ 58-89A-105. Employee benefit plans; required disclosure; other reports.**

(a) A licensee may sponsor and maintain employee benefit plans for the benefit of assigned employees. Any health insurance plan sponsored and maintained by a licensee shall only be fully insured by one of the following:

(1) A licensed insurance company that is authorized to write accident and health insurance, as defined in G.S. 58-7-15(3).

(2) A service corporation organized and licensed under Article 65 of this Chapter.

(3) A health maintenance organization organized and licensed under Article 67 of this Chapter.

~~(b) A client company may sponsor and maintain employee benefit plans for the benefit of assigned employees.~~

~~(c) If a licensee offers to its assigned employees any health benefit plan that is not fully insured by an authorized insurer, the plan shall:~~

~~(1) Utilize a third-party administrator licensed or registered to do business in this State;~~

~~(2) Hold all plan assets, including participant contributions, in a trust account; and~~

~~(3) Provide sound reserves for the plan as determined using generally accepted actuarial standards.~~

(d) ~~For purposes of this section, a "health benefit plan that is not fully insured by an authorized insurer" includes any arrangement except an arrangement under which an insurance company licensed to write insurance in this State has issued an insurance policy that covers all of the obligations of the health benefit plan.~~For the purposes of this section, a health insurance plan is fully insured only if all of the benefits provided under the plan are covered by an approved policy issued by one or more of the entities specified in subsection (a) of this section. A health insurance plan is not fully insured if the plan is any form of stop-loss insurance or any other form of reinsurance.

(e) Existing licensees shall comply with subsection (a) of this section by October 1, 2009. Before October 1, 2009, if an existing licensee sponsors and maintains any health insurance plan that is not fully insured by one or more of the entities specified in subsection (a) of this section, the licensee shall do all of the following:

(1) Use a third-party administrator licensed or registered under Article 56 of this Chapter.
(2) Hold all plan assets, including participant contributions, in a trust account.
(3) Provide sound reserves for the plan as determined by generally accepted actuarial standards."

PART VIII. CODE OFFICIALS QUALIFICATION BOARD AMENDMENTS.

SECTION 8.1. G.S. 143-151.13(a) reads as rewritten:

"(a) No person ~~may~~ shall engage in Code enforcement ~~pursuant to~~ under this Article unless ~~he~~ that person possesses one of the following types of certificates, currently valid, issued by the Board attesting to ~~his~~ that person's qualifications to ~~hold such position:~~ engage in Code enforcement: (i) a standard certificate; (ii) a limited certificate provided for in subsection ~~(c);~~(c) of this section; or (iii) a probationary certificate provided for in subsection ~~(d).~~(d) of this section. To obtain a standard certificate, a person must pass an examination, as prescribed by the ~~Board, which~~ Board or by a contracting party under G.S. 143-151.16(d), that is based on the North Carolina State Building Code and administrative procedures required ~~to enforce the Code.~~ for Code enforcement. The Board ~~shall~~ may issue a standard certificate of qualification to each person who successfully completes the ~~examination authorizing the person named therein~~ examination. The certificate authorizes that person to engage in Code enforcement and to practice as a qualified Code-enforcement official in North Carolina. The certificate of qualification shall bear the signatures of the chairman and secretary of the Board."

SECTION 8.2. G.S. 143-151.16(d) reads as rewritten:

"(d) ~~The Board may establish and collect a fee to be paid by each applicant for examination in an amount not to exceed one hundred twenty-five dollars ($125.00). In addition, the Board may establish and collect a fee to be paid by each applicant applying for a review of the applicant's examination. The amount of the examination review fee shall not exceed fifty dollars ($50.00). Examination and examination review fees may be paid directly to approved testing services that maintain regional facilities for the purpose of administering the Board's examinations.~~ The Board may contract with persons for the development and administration of the examinations required by G.S. 143-151.13(a), for course development related to the examinations, for review of a particular applicant's examination**,** and for other related services. The person with whom the Board contracts may charge applicants a reasonable fee for the costs associated with the development and administration of the examinations, for course development related to the examinations, for review of the applicant's examinations, and for other related services. The fee shall be agreed to by the Board and the other contracting party. The amount of the fee under this subsection shall not exceed one hundred seventy-five dollars ($175.00). Contracts for the development and administration of the examinations, for course development related to the examinations, and for review of examinations shall not be subject to Article 3, 3C, or 8 of Chapter 143 of the General Statutes or to Article 3D of Chapter 147 of the General Statutes."

PART IX. PROHIBITION AGAINST FREE INSURANCE.

SECTION 9.1. Chapter 66 of the General Statutes is amended by adding a new Article to read:

"Article 44.
"Free Insurance.

"**§ 66-380. Definitions.**

As used in this Article:

(1) "Consumer goods" means goods that are used primarily for personal, family, or household purposes. For the purposes of this Article, consumer goods do not include automobiles or residences.
(2) "Free insurance" means any of the following:

a. Insurance for which no identifiable or additional charge is made to the purchaser or lessee of consumer goods or services directly or indirectly connected with the purchase of consumer goods.

b. Insurance for which an identifiable or additional charge is made in an amount less than the cost of such insurance as to the seller, lessor, or other person other than the insurer providing the insurance.

"**§ 66-381. Free insurance.**

No person shall advertise, offer, or provide free insurance for damage, loss, or theft as an inducement to the purchase, sale, or rental of consumer goods or services directly or indirectly connected with the purchase of consumer goods.

"**§ 66-382. Unfair trade practice.**

A violation of G.S. 66-381 constitutes an unfair trade practice under G.S. 75-1.1."

PART X. MISCELLANEOUS CHANGES.

SECTION 10.1. G.S. 58-3-191(a) reads as rewritten:

"(a) Each health benefit plan shall annually, on or before the first day of ~~March~~ May of each year, file in the office of the Commissioner the following information for the previous calendar year:

(1) The number of and reasons for grievances received from plan participants regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution, and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every health benefit plan shall file with the Commissioner, as part of its annual grievance report, a certificate of compliance stating that the carrier has established and follows, for each of its lines of business, grievance procedures that comply with G.S. 58-50-62.

(2) The number of participants and groups who terminated coverage under the plan for any reason. The report shall include the number of participants who terminated coverage because the group contract under which they were covered was terminated, the number of participants who terminated coverage for reasons other than the termination of the group under which they were enrolled, and the number of group contracts terminated.

(3) The number of provider contracts that were terminated and the reasons for termination. This information shall include the number of providers leaving the plan and the number of new providers. The report shall show voluntary and involuntary terminations separately.

(4) Data relating to the utilization, quality, availability, and accessibility of services. The report shall include the following:

a. Information on the health benefit plan's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the plan's methodology for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in plan membership will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the health benefit plan's provider network; and an evaluation of actual plan performance against performance targets.

b. The health benefit plan's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.

c. Information on the health benefit plan's program to determine the level of provider network accessibility necessary to serve its membership. This information shall include the health benefit plan's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.
2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the health benefit plan's methods and standards for determining whether in-network services are reasonably available and accessible to a covered person, for the purpose of determining whether a covered person should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the health benefit plan's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, plan performance, and network provider performance.

f. A summary of the health benefit plan's utilization review program activities for the previous calendar year. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of covered persons. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 58-50-61.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive

payments. This information shall be submitted on a form prescribed by the Commissioner.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing."

SECTION 10.2. G.S. 58-21-65(b) reads as rewritten:

"(b) The Commissioner shall issue a surplus lines license to any qualified holder of a current ~~fire and casualty~~ property broker's or agent's license, but only when the broker or agent has:

(1) Remitted the fifty dollars ($50.00) annual fee to the Commissioner;
(2) Submitted a completed license application on a form supplied by the Commissioner, and the application has been approved by the Commissioner;
(3) Passed a qualifying examination approved by the Commissioner; except that all holders of a license prior to July 11, 1985 shall be deemed to have passed such an examination; and
(4) Repealed by Session Laws 2004-199, s. 20(c), effective August 17, 2004."

SECTION 10.3. G.S. 75-104(b) reads as rewritten:

"(b) Notwithstanding subsection (a) of this section, a person may use an automatic dialing and recorded message player to make an unsolicited telephone call only under one or more of the following circumstances:

(1) All of the following are satisfied:
  a. The person making the call is any of the following:
    1. A tax-exempt charitable or civic organization.
    2. A political party or political candidate.
    3. A governmental official.
    4. An opinion polling organization, radio station, television station, cable television company, or broadcast rating service conducting a public opinion poll.
  b. No part of the call is used to make a telephone solicitation.
  c. The person making the call clearly identifies the person's name and contact information and the nature of the unsolicited telephone call.
(2) Prior to the playing of the recorded message, a live operator complies with G.S. 75-102(c), states the nature and length in minutes of the recorded message, and asks for and receives prior approval to play the recorded message from the person receiving the call.
(3) The unsolicited telephone call is in connection with an existing debt or contract for which payment or performance has not been completed at the time of the unsolicited telephone call.
(4) The unsolicited telephone call is placed by a person with whom the telephone subscriber has made an appointment, provided that the call is conveying information only about the appointment, or by a utility, telephone company, cable television company, satellite television company, or similar entity for the sole purpose of conveying information or news about network outages, repairs or service interruptions, and confirmation calls related to restoration of service.
(5) The person plays the recorded message in order to comply with section 16 C.F.R. Part 310.4(b)(4) of the Telemarketing Sales Rule.
(6) The unsolicited telephone call is placed by, or on behalf of, a health insurer as defined in G.S. 58-51-115(a)(2) from whom the telephone subscriber or other covered family member of the health insurer

receives health care coverage or the administration of such coverage, provided that the call is conveying information related to the telephone subscriber or family member's health care, preventive services, medication or other covered benefits."

PART XI. SEVERABILITY.

SECTION 11.1. If any section or provision of this act is declared unconstitutional, preempted, or otherwise invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional, preempted, or otherwise invalid.

PART XII. EFFECTIVE DATES.

SECTION 12.1. Part I of this act becomes effective January 1, 2009, and applies to policies issued or renewed on or after that date. Part III of this act is effective when it becomes law and applies to violations that occur on or after that date. Parts VI and VII of this act become effective October 1, 2008. Part IX of this act becomes effective October 1, 2008, and applies to violations that occur on or after that date. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 8th day of July, 2008.

s/ Beverly E. Perdue
President of the Senate

s/ Joe Hackney
Speaker of the House of Representatives

s/ Michael F. Easley
Governor

Approved 5:50 p.m. this 28th day of July, 2008