GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S **1**

SENATE BILL 736*

Short Title:	Revise Life and Health Insurance Laws.-AB	(Public)
Sponsors:	Senator Dalton.	
Referred to:	Commerce, Small Business and Entrepreneurship.	

March 14, 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) Nothing in this Part shall be construed to create or imply a private cause of action for a violation of this Part.

(c) 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 the execution of a 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:

(1) The consumer's financial status.

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

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

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

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

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

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

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

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

(1) The insurer annually obtains a certification from a third-party senior manager who has responsibility for the delegated functions that the manager has a reasonable basis to represent, and does represent, that the third party is performing the required functions. No person may

provide a certification under this subdivision unless (i) the person is a senior manager with responsibility for the delegated functions; and (ii) the person has a reasonable basis for making the certification.

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

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

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

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

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

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

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

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

(a) The Commissioner may order:

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

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

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

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

"**§ 58-60-180. Record keeping.**

(a) Insurers, general agents, independent agencies, and insurance producers shall maintain or be able to make available to the Commissioner records of the information

collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for five years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

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

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

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

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

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

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

PART II. PORTABILITY IN ACCIDENT AND HEALTH AND LIFE INSURANCE.

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

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

TIME LIMIT ON CERTAIN DEFENSES:

…

b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy ____ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." ~~Except for the excepted benefits described in G.S. 58-68-25(b), credit~~ Credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with ~~G.S. 58-68-30.~~ G.S. 58-51-17. The excepted benefits described in G.S. 58-68-25(b) are not subject to this requirement for giving credit."

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

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

(a) Rules Relating to Crediting Previous Coverage. –

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

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

b. Group or individual health insurance coverage.

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

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

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

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

g. A State health benefits risk pool.

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

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

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

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

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

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

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

b. Waiting period not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision and subdivision (b)(3) of this subsection, any period that an individual is in a waiting period, as defined in G.S. 58-68-30(b)(4)c., for any coverage under an individual health insurance plan shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.

c. For an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group

health plan coverage and the first day of the second COBRA election period shall not be considered when determining whether a significant break in coverage has occurred.

(3) Method of crediting coverage. – An individual health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.

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

(5) Determination of creditable coverage. –

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

b. No time limit on presenting evidence of creditable coverage. – An individual health insurer shall not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(b) Exceptions. –

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (3) of this subsection, an individual health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (3) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day

period during all of which the individual was not covered under any creditable coverage.

(c) Certifications and Disclosure of Coverage. –

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

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

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

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

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

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

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

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

a. In general. – A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health insurance plan, if, after the period and before the

enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

b. Waiting period not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision and subdivision (d)(4) of this subsection, any period that an individual is in a waiting period for any coverage under a group health insurance plan or is in an affiliation period shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.

c. Time spent on short term limited duration health insurance not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision, any period that an individual is enrolled on a short term limited duration health insurance policy shall not be taken into account in determining the continuous period under sub-subdivision. a. of this subdivision so long as the period of time spent on the short term limited duration health insurance policy or policies does not exceed 12 months.

d. For an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period shall not be considered when determining whether a significant break in coverage has occurred.

(3) Method of crediting coverage. –

a. Standard method. – Except as otherwise provided under sub-subdivision b. of this subdivision for the purposes of applying subdivision (a)(3) of this subsection, a group health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.

b. Election of alternative method. – A group health insurer may elect to apply subdivision (a)(3) of this subsection based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations rather than as provided under sub-subdivision a. of this subdivision. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election a group health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

c. Health insurer notice. – In the case of an election under sub-subdivision b. of this subdivision with respect to health insurance coverage in the small or large group market, the health insurer: (i) shall prominently state in any disclosure

statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made the election, and (ii) shall include in the statements a description of the effect of the election.

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

(5) Determination of creditable coverage. –

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

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

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

"(f) Special Enrollment Periods. –

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

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

b. The employee stated in writing at the time that coverage under the group health plan or health insurance coverage was the reason for declining enrollment, but only if the health insurer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

c. With respect to the employee's or dependent's coverage described in sub-subdivision a. of this subsection: (i) the

coverage was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) the coverage was not under that provision and either the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; (iii) employer contributions toward the coverage were terminated; (iv) in the case of coverage offered through an arrangement that does not provide benefits to individuals who no longer reside, live, or work in a service area, there has been loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (v) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vi) a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or (vii) the health insurer terminated coverage under G.S. 58-68-45(c)(2).

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the date of the applicable event described in sub-subdivision c. of this subdivision.

(2) For dependent beneficiaries. –

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

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

b. Dependent special enrollment period. – A dependent special enrollment period under this sub-subdivision shall be a period of not less than 30 days and shall begin on the later of: (i) the

date dependent coverage is made available, or (ii) the date of the marriage, birth, or adoption or placement for adoption described in sub-subdivision a.(iii) of this subdivision.

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

(3) Treatment of special enrollees. –

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

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

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

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

A group health insurer shall provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the insurer for enrollment. If the insurer does not distribute these materials, the notice shall be provided by the earliest date following a request for enrollment that the insurer, acting in a reasonable and prompt fashion, can provide the notice.

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

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

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

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

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

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

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

A group health insurer shall disclose:

(1) Its determination of any preexisting condition exclusion period that applies to the individual, including the last day on which the preexisting condition exclusion applies.

(2) The basis for that determination, including the source and substance of any information on which the plan or insurer relied.

(3) An explanation of the individual's right to submit additional evidence of creditable coverage.

(4) A description of any applicable appeal procedures established by the group health insurer.

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

(1) A notice of the new determination, consistent with the requirements of subsection (i) of this section, is provided to the individual; and

(2) Until the notice of the new determination is provided, the group health insurer, for purposes of approving access to medical services (such as a presurgery authorization), acts in a manner consistent with the initial determination.

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

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

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

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

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

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

PART III. EXTERNAL REVIEW.

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

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

(1) Notify the insurer that made the noncertification, noncertification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the request or verbally convey all of the information included in the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one business day after the request was made.

…."

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

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

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

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

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

PART IV. LONG-TERM CARE INSURANCE.

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

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

a. Group and individual annuities and life insurance policies or riders that supplement or directly provide long-term care insurance.

b. A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

c. Qualified long-term care insurance contracts.

d. Group and individual policies whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations prepaid health plans, health maintenance organizations, or any similar organization. "Long-term care insurance" does not include any policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement

indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

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

PART V. SMALL EMPLOYER GROUP HEALTH INSURANCE.

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

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

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

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

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

PART VI. CREDIT INSURANCE.

SECTION 6.1. G.S. 58-57-5 is amended by adding a new subdivision after G.S. 58-57-5(4b) to read:

"(4c) "Critical period conversion ratio" means the ratio of the benefit value of the critical period divided by the benefit value of the full term."

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

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

PART VII. MISCELLANEOUS PROVISIONS.

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

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

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

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

(c) All conditions and stipulations forbidden by this section are ~~void.~~ void ab initio."

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

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

~~a. Accident.~~
~~b. Credit.~~
~~c. Disability income.~~
~~d. Long-term or nursing home care.~~
~~e. Medicare supplement.~~
~~f. Specified disease.~~
~~g. Dental or vision.~~
~~h. Coverage issued as a supplement to liability insurance.~~
~~i. Workers' compensation.~~
~~j. Medical payments under automobile or homeowners.~~
~~k. Hospital income or indemnity.~~
~~l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.~~
~~m. Short-term limited-duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.~~

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

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

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

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

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

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

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

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

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

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

a. A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

b. The issuer of a life insurance policy providing accelerated benefits under rules adopted by the Commissioner and under the contract;

c. An authorized or eligible insurer that provides stop-loss coverage to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;
d. A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;
e. A financing entity;
f. A special purpose entity;
g. A related provider trust;
h. A viatical settlement purchaser; or
i. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, and who purchases a viaticated policy from a viatical settlement provider."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART IX. EFFECT OF HEADINGS.

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

PART X. EFFECTIVE DATES.

SECTION 10. Part I of this act becomes effective January 1, 2008. Part IV of this act becomes effective October 1, 2007. The remainder of this act is effective when it becomes law.