HOUSE BILL 240

Short Title:	Insurance Technical/Clarifying Changes.-AB	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

March 7, 2013

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE CHOICES FOR HEALTH INSURANCE IN NORTH CAROLINA BY EXEMPTING HEALTH INSURANCE COMPANIES FROM OUTDATED RISK EXPOSURE REQUIREMENTS; TO REMOVE A BURDENSOME PHOTO IDENTIFICATION REQUIREMENT FOR NEW DOMESTIC COMPANIES; TO HELP MORTGAGE GUARANTY COMPANIES ADJUST THEIR CAPITAL AND SURPLUS REQUIREMENTS; TO REVISE CERTAIN RISK-BASED CAPITAL REQUIREMENTS IN ORDER TO MAINTAIN NORTH CAROLINA'S NAIC ACCREDITATION; TO CLARIFY CONSUMER CHOICE IN HOMEOWNER'S COVERAGE FOR WIND AND HAIL; TO CLARIFY THE CERTIFICATION REQUIREMENTS FOR AN ACTUARY WHO PRESENTS A SCHEDULE OF PREMIUM RATES; TO SHORTEN CERTAIN TIME PERIODS FOR AN EXTERNAL REVIEW BY THE COMMISSIONER OF CERTAIN INSURER DETERMINATIONS; TO EXPAND ACCESS OF COVERAGE TO BUSINESSES WHO NEED BLANKET ACCIDENT AND HEALTH COVERAGE; AND TO MAKE CERTAIN CONFORMING CHANGES RELATED TO THE RENAMING OF THE OFFICE OF MANAGED CARE PATIENT ASSISTANCE PROGRAM AS HEALTH INSURANCE SMART NC.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-105 reads as rewritten:

"**§ 58-3-105. Limitation of risk.**

Except as otherwise provided in Articles 1 through 64 of this Chapter, no insurer doing business in this State shall expose itself to any loss on any one risk in an amount exceeding ten percent (10%) of its surplus to policyholders. Any risk or portion of any risk which shall have been reinsured shall be deducted in determining the limitation of risk prescribed in this section. This section shall not apply to (i) life ~~insurance~~ insurance, (ii) accident and health insurance, (iii) ~~or to~~ the insurance of marine risks, or marine protection and indemnity risks, ~~or~~ (iv) workers' compensation or employer's liability risks, ~~or to~~ and (v) certificates of ~~title or~~title, guaranties of title or policies of title insurance. For the purpose of determining the limitation of risk under any provision of Articles 1 through 64 of this Chapter, "surplus to policyholders" shall

(1) Be deemed to include any voluntary reserves, or any part thereof, which are not required by or pursuant to law, and

(2) Be determined from the last sworn statement of such insurer on file with the Commissioner pursuant to law, or by the last report on examination filed by

the Commissioner, whichever is more recent at the time of assumption of such risk.

In applying the limitation of risk under any provision of Articles 1 through 64 of this Chapter to alien insurers, such provision shall be deemed to refer to the exposure to risk and to the surplus to policyholders of the United States branch of such alien insurer."

SECTION 2. G.S. 58-7-37(a) reads as rewritten:

"**§ 58-7-37. Background of incorporators and proposed management personnel.**

(a) Before a license is issued to a new domestic insurance company, each key person must furnish the Commissioner a complete set of the applicant's ~~fingerprints and a recent passport size full-face photograph of the applicant.~~fingerprints. The applicant's fingerprints shall be certified by an authorized law enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. An applicant shall pay the cost of the State and any national criminal history record check of the applicant."

SECTION 3.(a) G.S. 58-10-125(l) reads as rewritten:

"**§ 58-10-125. Policyholders position and capital and surplus requirements.**

…

(l) Any waiver shall be (i) for a specified period of time not to exceed two years and (ii) subject to any terms and conditions that the Commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by subsection (a) of this section. ~~Notwithstanding any other provision in this section, the Commissioner shall not grant a waiver that would extend beyond July 1, 2015.~~"

SECTION 3.(b) Section 2 of S.L. 2009-254, as rewritten by Section 2 of S.L. 2010-40, reads as rewritten:

"**SECTION 2.** This act becomes effective July 1, ~~2009, and expires July 1, 2015.~~2009."

SECTION 4. G.S. 58-12-11(b)(3) reads as rewritten:

"**§ 58-12-11. Company action level event.**

…

(b) In the event of a company action level event, the insurer shall prepare and submit to the Commissioner a comprehensive financial plan that:

…

(3) Provides forecasts of the insurer's financial results in the current year and at least the four succeeding years (except for health organizations, which must provide forecasts in the current year and at least the two succeeding years), both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including forecasts of statutory balance sheets, operating income, net income, ~~capital, or surplus~~capital and surplus, and risk-based capital levels (the forecasts for both new and renewal business should include separate forecasts for each major line of business and separately identify each significant income, expense, and benefit component). ~~For a health organization, the forecasted financial results shall be for the current year and at least two succeeding years and shall include statutory balance sheets, operating income, net income, capital and surplus, and risk-based capital levels.~~"

SECTION 5. G.S. 58-12-35(a) reads as rewritten:

"**§ 58-12-35. Confidentiality and prohibition on announcements.**

(a) All risk-based capital reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and the risk-based capital plans, including the results or report of any examination or analysis of an insurer performed pursuant

hereto and any corrective order issued by the Commissioner pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer that are filed with the Commissioner constitute information that shall be kept confidential by the Commissioner. This information shall not be made public ~~or be~~and shall not be subject to subpoena, discovery, or admissible in evidence in any private civil action, other than by the Commissioner, and then only for the purpose of enforcement actions taken by the Commissioner under this Article or any other provision of this Chapter. In order to assist in the performance of the Commissioner's duties, the Commissioner may share and receive confidential and privileged risk-based capital information in a manner consistent with that information shared and received pursuant to G.S. 58-2-132(g) and (h). Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to this subsection."

SECTION 6. G.S. 58-30-60(b) reads as rewritten:

"**§ 58-30-60. Commissioner's summary orders and supervision proceedings.**

…

(b) The Commissioner may consider any or all of the following standards to determine whether the continued operation of any licensed insurer is hazardous to its policyholders, creditors, or the general public:

(1) Adverse findings reported in financial condition and market conduct examination ~~reports;~~reports, audit reports, and actuarial opinions, reports, or summaries;

(2) The NAIC Insurance Regulatory Information System and its ~~related~~ other financial analysis solvency tools and reports;

~~(3) The ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income that could lead to an impairment of capital and surplus;~~

(4) ~~Whether an insurer's asset portfolio, when viewed in light of current economic conditions, is not of sufficient value, liquidity, or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;~~Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items, including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts;

(5) The ability of an assuming reinsurer to perform and whether the ~~ceding~~ insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus, after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

(6) Whether an insurer's operating loss in the last 12-month period or any shorter period of time, ~~including~~ including, but not limited to, net capital gain or loss, changes in ~~nonadmitted~~ nonadmitted assets, and cash dividends paid to shareholders, is greater than fifty percent (50%) of the insurer's remaining policyholders' surplus in excess of the minimum required;

(6a) Whether the insurer's operating loss in the last 12-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining policyholders' surplus in excess of the minimum required;

(7) Whether a reinsurer, obligor, or any ~~affiliate, subsidiary, or reinsurer~~entity within the insurer's insurance holding company system is insolvent, threatened with insolvency, or delinquent in payment of its monetary or any other ~~obligation;~~obligation and which in the opinion of the Commissioner may affect the solvency of the insurer;

(8) Contingent liabilities, pledges, or guaranties that either individually or collectively involve a total amount that in the Commissioner's opinion may affect an insurer's solvency;

(9) Whether any controlling person of an insurer is delinquent in the transmitting to or payment of net premiums to the insurer;

(10) The age and collectibility of receivables;

(11) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, fails to possess ~~or~~ and demonstrate the competence, fitness, or reputation considered by the Commissioner to be necessary to serve the insurer in that position;

(12) Whether the management of an insurer has failed to respond to the Commissioner's inquiries about the condition of the insurer or has furnished false and misleading information in response to an inquiry by the Commissioner;

(12a) Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the Commissioner;

(13) Whether the management of an insurer has filed any false or misleading sworn financial statement, has released a false or misleading financial statement to a lending institution or to the general public, or has made a false or misleading entry or omitted an entry of material amount in the insurer's books;

(14) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;~~or~~

(15) Whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity ~~problems.~~problems;

(16) Whether management has established reserves that do not comply with minimum standards established by State insurance laws, regulations, statutory accounting standards, sound actuarial principles, and standards of practice;

(17) Whether management persistently engages in material under reserving that results in adverse development;

(18) Whether transactions among affiliates, subsidiaries, or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity, or diversity to assure the insurer's ability to meet its outstanding obligations as they mature; or

(19) Any other finding determined by the Commissioner to be hazardous to the insurer's policyholders, creditors, or general public.

To determine an insurer's financial condition under this Article, the Commissioner may: disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired, or otherwise subject to a delinquency proceeding; make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates of an insurer; refuse to recognize the stated value of accounts receivable if the insurer's ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or increase the insurer's liability in an

amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

If upon examination or at any other time the Commissioner has reasonable cause to believe that any domestic insurer is in such condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if the domestic insurer gives its consent, then the Commissioner shall upon the Commissioner's determination:

(1) ~~Notify~~ Issue an order notifying the insurer of that determination; and

(2) Furnish to the insurer a written list of the Commissioner's requirements to abate that ~~determination.~~determination that may include any of the following:

~~The written list may include requirements that the insurer: reduce~~

a. A reduction in the total amount of present and potential liability for policy benefits by ~~reinsurance;~~ reinsurance.

b. ~~reduce, suspend, or limit~~A reduction, suspension, or limitation of the volume of insurance being accepted or ~~renewed;~~renewed.

c. ~~reduce~~ A reduction in general insurance and commission expenses by specified ~~methods;~~methods.

d. An increase ~~its~~ in the insurer's capital and ~~surplus;~~surplus.

e. ~~suspend or limit its~~ A suspension or limitation in the insurer's declaration and payment of dividends to its stockholders or ~~policyholders;~~policyholders.

f. ~~file reports~~ The filing of reports in a form acceptable to the Commissioner concerning the market value of its ~~assets;~~assets.

g. ~~limit or withdraw~~A limitation or withdrawal from certain investments or ~~discontinue~~ the discontinuance of certain investment practices to the extent the Commissioner considers ~~to be necessary;~~necessary.

h. ~~document~~ Documentation of the adequacy of premium rates in relation to the risks ~~insured;~~insured.

i. ~~or file,~~The filing, in addition to regular annual financial statements, of interim financial reports on the form adopted by the NAIC or on such format prescribed by the ~~Commissioner.~~Commissioner.

j. The correction of corporate governance practice deficiencies.

k. The adoption and utilization of governance practices acceptable to the Commissioner.

l. The provision of a business plan to the Commissioner in order to continue to transact business in the State.

Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, the Commissioner may adjust rates for any non-life insurance product ~~include in the list of requirements any rate adjustments for any kinds of insurance~~ written by the insurer that the Commissioner considers necessary to improve the financial condition of the insurer."

SECTION 7. G.S. 58-31-45 reads as rewritten:

"**§ 58-31-45. Report required of Commissioner.**

The Commissioner must submit to the Governor a full report of his official action under this Article, with such recommendations as commend themselves to ~~him, and it shall be embodied in or attached to his biennial report to the General Assembly.~~the Commissioner."

SECTION 8. G.S. 58-36-42 reads as rewritten:

"**§ 58-36-42. Development of policy form or endorsement for residential property insurance that does not include coverage for perils of windstorm or hail.**

With respect to residential property insurance under its jurisdiction, the Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval ~~that~~ that, at the request of the insured, provides residential property insurance coverage in the coastal counties defined in G.S. 58-45-5(2b) without coverage for the perils of windstorm or hail. Insurers that sell such policies shall comply with the provisions of G.S. 58-44-60 and through such compliance shall be deemed to have given notice to all insured and persons claiming benefits under such policies that such policies do not include coverage for the perils of windstorm or hail."

SECTION 9. G.S. 58-50-131(a) reads as rewritten:

"**§ 58-50-131. Premium rates for health benefit plans; approval authority; hearing.**

(a) No schedule of premium rates for coverage for a health benefit plan subject to this act, or any amendment to the schedule, shall be used in conjunction with any such health benefit plan until a copy of the schedule of premium rates or premium rate amendment has been filed with and approved by the Commissioner. Any schedule of premium rates or premium rate amendment filed under this section shall be established in accordance with G.S. 58-50-130(b). The schedule of premium rates shall not be excessive, unjustified, inadequate, or unfairly discriminatory and shall exhibit a reasonable relationship to the benefits provided by the contract of insurance. Each filing shall include a certification by ~~an individual who is a member in good standing with the Society of Actuaries.~~an actuary who is a member of the American Academy of Actuaries and qualified to provide such certifications as described in the U.S. Qualifications Standards promulgated by the American Academy of Actuaries pursuant to its Code of Professional Conduct."

SECTION 10. G.S. 58-50-82 reads as rewritten:

"**§ 58-50-82. Expedited external review.**

…

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

…

(c) As soon as possible, but within the same ~~business~~ day ~~of~~ after 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.

…

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than ~~four business~~three days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification, noncertification appeal decision, or second-level grievance review decision and notify the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner of the decision. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

…."

SECTION 11. G.S. 143-730 reads as rewritten:

"**§ 143-730. ~~Managed Care Patient Assistance Program.~~Health Insurance Smart NC.**

(a) The Office of Managed Care Patient Assistance Program ~~is established in the Department of Insurance.~~shall hereafter be known as the Health Insurance Smart NC.

(b) The ~~Managed Care Patient Assistance Program~~Health Insurance Smart NC shall provide information and assistance to individuals enrolled in ~~managed~~ health care plans. ~~The Managed Care Patient Assistance Program shall have expertise and experience in both health care and advocacy and will assume the specific duties and responsibilities set forth in subsection (c) of this section.~~

(c) ~~The duties and responsibilities of the Managed Care Patient Assistance Program are as follows:~~Health Insurance Smart NC shall have the responsibility and duty to:

(1) Develop and distribute educational and informational materials for consumers, explaining their rights and responsibilities as ~~managed~~ health care plan enrollees.

(2) Answer inquiries posed by ~~consumers and refer inquiries of a regulatory nature to staff within the Department of Insurance.~~consumers.

(3) Advise ~~managed~~ health care plan enrollees about the utilization review process.

(4) Assist enrollees with the grievance, appeal, and external review procedures established by Article 50 of Chapter 58 of the General Statutes.

(5) Publicize the ~~Office of the Managed Care Patient Assistance Program.~~Health Insurance Smart NC.

(6) Compile data on the activities of the Office and evaluate such data to make recommendations as to the needed activities of the Office.

~~(d) The Director of the Managed Care Patient Assistance Program shall annually report the activities of the Managed Care Patient Assistance Program, including the types of appeals, grievances, and complaints received and the outcome of these cases. The report shall be submitted to the General Assembly, upon its convening or reconvening, and shall make recommendations as to efforts that could be implemented to assist managed care consumers.~~

(e) All health information in the possession of the ~~Managed Care Patient Assistance Program~~Health Insurance Smart NC is confidential and is not a public record pursuant to G.S. 132-1 or any other applicable statute.

For purposes of this section, "health information" means any of the following:

(1) Information relating to the past, present, or future physical or mental health or condition of an individual.

(2) Information relating to the provision of health care to an individual.

(3) Information relating to the past, present, or future payment for the provision of health care to an individual.

(4) Information, in any form, that identifies or may be used to identify an individual, that is created by, provided by, or received from any of the following:

a. An individual or an individual's spouse, parent, legal guardian, or designated representative.

b. A health care provider, health plan, employer, health care clearinghouse, or an entity doing business with these entities."

SECTION 12. G.S. 58-6-25(d)(4) reads as rewritten:

"**§ 58-6-25. Insurance regulatory charge.**

…

(4) Money appropriated for the office of ~~Managed Care Patient Assistance Program~~Health Insurance Smart NC ~~established~~ under G.S. 143-730 to pay the actual costs of administering the program."

SECTION 13. G.S. 58-50-61(h) reads as rewritten:

"**§ 58-50-61. Utilization review.**

…

(h) Notice of Noncertification. – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. An insurer shall also inform the covered person in writing about the availability of assistance from ~~the Managed Care Patient Assistance Program,~~Health Insurance Smart NC, including the telephone number and address of the Program."

SECTION 14. G.S. 58-50-61(k)(6) reads as rewritten:

"**§ 58-50-61. Utilization review.**

…

(6) Notice of the availability of assistance from ~~the Managed Care Patient Assistance Program,~~Health Insurance Smart NC, including the telephone number and address of the Program."

SECTION 15. G.S. 58-50-61(m) reads as rewritten:

"**§ 58-50-61. Utilization review.**

…

(m) Disclosure Requirements. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from ~~the Managed Care Patient Assistance Program,~~Health Insurance Smart NC, including the telephone number and address of the Program. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes."

SECTION 16. G.S. 58-50-62 reads as rewritten:

"**§ 58-50-62. Insurer grievance procedures.**

…

(c) Grievance Procedures. – Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office. ~~The description shall also inform the covered person about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.~~

…

(e) First-Level Grievance Review. – A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance.

…

(2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the

matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall contain:

…

f. Notice of the availability of assistance from ~~the Managed Care Patient Assistance Program,~~Health Insurance Smart NC, including the telephone number and address of the Program."

…

(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance.

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:

…

c. The availability of assistance from ~~the Managed Care Patient Assistance Program,~~Health Insurance Smart NC, including the telephone number and address of the Program.

…."

SECTION 17. G.S. 58-50-62(h)(9) reads as rewritten:

"**§ 58-50-62. Insurer grievance procedures.**

…

(9) Notice of the availability of assistance from ~~the Managed Care Patient Assistance Program,~~Health Insurance Smart NC, including the telephone number and address of the Program."

SECTION 18. G.S. 58-50-80(b)(3) reads as rewritten:

"**§ 58-50-80. Standard external review.**

…

(3) Notify in writing the covered person and the covered person's provider who performed or requested the service whether the request is complete and whether the request has been accepted for external review. If the request is complete and accepted for external review, the notice shall include a copy of the information that the insurer provided to the Commissioner pursuant to subdivision (b)(1) of this section, and inform the covered person that the covered person may submit to the assigned independent review organization in writing, within seven days after the receipt of the notice, additional information and supporting documentation relevant to the initial denial for the organization to consider when conducting the external review. If the covered person chooses to send additional information to the assigned independent review organization, then the covered person shall at the same time and by the same means, send a copy of that information to the insurer. The Commissioner shall also notify the covered person in writing of the availability of assistance from ~~the Managed Care Patient Assistance Program,~~Health Insurance Smart NC, including the telephone number and address of ~~the Program.~~Health Insurance Smart NC."

SECTION 19. G.S. 58-50-82(e) reads as rewritten:

"**§ 58-50-82. Expedited external review.**

…

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than ~~four~~ three business days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse

the noncertification, noncertification appeal decision, or second-level grievance review decision and notify the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner of the decision. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62."

SECTION 20. G.S. 58-51-75 reads as rewritten:

"**§ 58-51-75. Blanket accident and health insurance defined.**

(a) Any policy or contract of insurance against death or injury resulting from accident or from accidental means which insures a group of persons conforming to the requirements of one of the following subdivisions (1) to (7), inclusive, shall be deemed a blanket accident policy. Any policy or contract which insures a group of persons conforming to the requirements of one of the following subdivisions (3), (5), (6) or (7) against total or partial disability, excluding such disability from accident or from accidental means, shall be deemed a blanket health insurance policy. Any policy or contract of insurance which combines the coverage of blanket accident insurance and of blanket health insurance on such a group of persons shall be deemed a blanket accident and health insurance policy:

~~(1) Under a policy or contract issued to any railroad, steamship, motorbus or airplane carrier of passengers, which shall be deemed the policyholder, a group defined as all persons who may become such passengers may be insured against death or bodily injury either while, or as a result of, being such passengers.~~

(1) Under a policy or contract issued to any common carrier or to any operator, owner, or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group defined as all persons or all persons of a class who may become passengers on the common carrier or the means of transportation.

(2) Under a policy or contract issued to an employer, or the trustee of a fund established by the employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment, insuring such employee against death or bodily injury resulting while, or from, being exposed to such exceptional hazard.

(3) Under a policy or contract issued to a college, school or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder.

(4) Under a policy or contract issued in the name of any volunteer fire department, emergency medical service, rescue first aid, civil defense, or any other such volunteer organization, which shall be deemed the policyholder, covering ~~all of the~~any group of members or other participants defined by reference to specified hazards incident to any activities or operations sponsored or supervised by such policyholder.~~of such department.~~

(5) Under a policy or contract issued to and in the name of an incorporated or unincorporated association of persons having a common interest or calling, which association shall be deemed the policyholder, having not less than 25 members, and formed for purposes other than obtaining insurance, covering all of the members of such association.

(6) Under a policy or contract issued to the head of a ~~family,~~household, who shall be deemed the policyholder, whereunder the benefits thereof shall provide for the payment by the insurer of amounts for expenses incurred by the policyholder on account of hospitalization or medical or surgical aid for

~~himself,~~the policyholder, his or her spouse, his or her child or children, or other persons chiefly dependent on him or her for support and maintenance.

(7) Under a policy or contract issued to or in the name of any municipal or county recreation commission or ~~department~~ department, sports team, league, tournament, or sponsor thereof, which shall be deemed the ~~policyholder.~~policyholder, covering participants, members, coaches, counselors, employees, officials, or supervisors defined by reference to specified hazards incident to activities or operations sponsored or supervised by such policyholder or on the premises of such policyholder.

(8) Under a policy or contract issued to any incorporated or unincorporated religious, charitable, recreational, educational, athletic, or civic organization or branch thereof, which shall be deemed the policyholder, covering any group of members, participants, or volunteers defined by reference to specified hazards incident to activities or operations sponsored or supervised by such policyholder or on the premises of such policyholder.

(9) Under a policy or contract issued to any overnight, day, religious, equestrian, adventure, wilderness, athletic, or other camp, or the sponsor thereof, which shall be deemed the policyholder, covering any group of campers, participants, counselors, employees, volunteers, or supervisors defined by reference to specified hazards incident to activities or operations sponsored or supervised by such policyholder or on the premises of such policyholder.

(10) Under a policy or contract issued to any bank, credit union, or other financial institution, which shall be deemed the policyholder, to insure any group of account holders or members of the policyholder and as defined by reference in the policy or contract, in which premiums for such insurance are paid by the policyholder, as authorized by the account holder or member from account holder or member funds on deposit with the policyholder, collected from the account holders or members by way of account billing or member billing, or by the policyholder and account holders jointly.

(11) Any other risk or class of risks which, in the discretion of the Commissioner, may be properly eligible for blanket accident, health, or accident and health insurance. The discretion of the Commissioner may be exercised on an individual risk basis or class of risks, or both after the Commissioner has made the following findings:

a. The issuance of the blanket policy is not contrary to the best interest of the public.

b. The issuance of the blanket policy would result in economies of acquisition or administration.

c. The benefits are reasonable in relation to the premiums charged.

(b) All benefits under any blanket accident, blanket health or blanket accident and health insurance policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, or to a person or persons chiefly dependent upon the person insured for support and maintenance, except that if the person insured be a minor, such benefits may be made payable to his parent, guardian, or other person actually supporting ~~him, or to a person or persons chiefly dependent upon him for support and maintenance.~~the minor.

…."

SECTION 21. This act becomes effective July 1, 2013.