HOUSE BILL 1183

Short Title:	Health and Other Insurance Law Changes.-AB	(Public)
Sponsors:	Representatives Goforth, Wray (Primary Sponsors); and Lucas.	
Referred to:	Health, if favorable, Insurance.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS CHANGES IN THE LAWS GOVERNING HEALTH INSURANCE AND MANAGED CARE; TO CHANGE CERTAIN HEALTH INSURANCE LAWS TO COMPORT WITH RECENT CONGRESSIONAL ENACTMENTS; TO MAKE A TECHNICAL CORRECTION IN A CREDIT INSURANCE LAW; AND TO REPEAL THE EXPIRATION DATE OF THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-17(a)(1)a. and b. read as rewritten:

"**§ 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.~~group health plan as defined in G.S. 58-68-25(a)(4a.)

b. ~~Group or individual health insurance coverage.~~Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise."

SECTION 2. G.S. 58-68-25(a) is amended by adding the following new subdivisions to read:

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. – In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

…

(4a) 'Group health insurance coverage.' – Health insurance coverage offered in connection with a group health plan.

(4b) 'Group health plan.' – The meaning given the term under 45 C.F.R.§ 146.145(a).

(4c) 'Group market.' – The market for health insurance coverage offered in connection with a group health plan.

…."

SECTION 3. G.S. 58-58-25(a)(5) reads as rewritten:

"(5) "Health insurance coverage" or "coverage" or "health insurance plan" or "plan". – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical

care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage."

SECTION 4. G.S. 58-68-30(c)(1) 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.~~group health plan.

b. ~~Group or individual health insurance coverage.~~ Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.

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.~~ section."

SECTION 5. G.S. 58-68-60(b)(1) reads as rewritten:

"(b) Eligible Individual Defined. – In this Part, "eligible individual" means an individual:

(1) (i) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under ~~an ERISA~~ a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

…."

SECTION 6. G.S. 58-65-2 is amended by adding two new statutory references to read:

"**§ 58-65-2. Other laws applicable to service corporations.**

The following provisions of this Chapter are applicable to service corporations that are subject to this Article:

…

58-51-15(a)(2)b. Accident and health policy provisions.

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

SECTION 7. G.S. 58-67-171 is amended by adding two new statutory references to read:

"**§ 58-67-171. Other laws applicable to HMOs.**

The following provisions of this Chapter are applicable to HMOs that are subject to this Article:

…

58-51-15(a)(2)b. Accident and health policy provisions.

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

SECTION 8. G.S. 58-51-15 is amended by adding the following new subsection to read:

"(i) Applicability. – This section applies to all accident and health insurance policies delivered or issued for delivery in this State, including certificates issued under group policies that are delivered or issued for delivery in this State. This section also applies to certificates issued under a policy issued and delivered to a trust or association outside this State and covering persons residing in this State."

SECTION 9. G.S. 58-51-17 is amended by adding the following new subsection to read:

"(d) Applicability. – This section applies to all health benefit plans of individual health insurance coverage delivered or issued for delivery in this State, including certificates issued under group policies that are delivered or issued for delivery in this State. This section also applies to certificates issued under a policy issued and delivered to a trust or association outside this State and covering persons residing in this State."

SECTION 10. G.S. 58-51-17(b) reads as rewritten:

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

…

(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~~ an individual 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."

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

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

(a) In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement ~~Plans A, C, and J~~ Plan A available to persons eligible for Medicare by reason of disability before age ~~65.~~ 65 and also standardized Plan C or F if marketing either Plan to persons eligible for Medicare due to age. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within

a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision."

SECTION 12. G.S. 58-56-26(c) reads as rewritten:

"(c) In cases where a TPA administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the TPA. At least one semiannual review shall be an on-site audit of the operations of the TPA. On July 1, 2010, and annually thereafter, every insurer shall file with the Commissioner a certification of completion of the audits as required by this subsection and performed during the previous calendar year, in the format, content, and manner as specified by the Commissioner. The insurer shall maintain in its corporate records documentation of the audits conducted to support its certification of audits for a period of five years or, if a domestic insurer, until the completion of the next quinquennial examination."

SECTION 13. G.S. 58-56-26 is amended by adding the following new subsection to read:

"**§ 58-56-26. Responsibilities of the insurer.**

…

(d) The Commissioner may adopt rules necessary to implement, administer, and enforce the provisions of this section."

SECTION 14. G.S. 58-58-146 reads as rewritten:

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

(a) Each individual (non-group) annuity contract shall be issued only upon application of the ~~applicant.~~ annuitant or proposed owner. Any application ~~or enrollment form~~ form, whether paper or electronic, is subject to G.S. 58-3-150, and if taken by an agent, broker, or other producer, shall include the certificate of the ~~agent~~ agent, broker, or other producer that the ~~agent~~ agent, broker, or other producer has truly and accurately recorded on the application ~~or enrollment~~ form the information provided by the ~~applicant.~~annuitant or proposed owner. 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.

(b) The agent, broker, or other producer shall provide to the annuitant or proposed owner a copy of any application executed in applying for any individual annuity contract. The delivery may be electronic unless the annuitant, the proposed owner, or the insurer instructs the agent, broker, or other producer to deliver the copy in paper form. The agent, broker, or other producer shall obtain from the proposed owner an acknowledgement of receipt of the copy of the executed application."

SECTION 15. G.S. 58-58-147 reads as rewritten:

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

(a) ~~No authorized insurer shall deliver or issue for delivery in this State any~~ 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.~~period shall include a statement to that effect in prominent print on the cover page of the first specifications page.

(b) Any deferred annuity for which the death benefit in any year is less than the account value shall include a statement to that effect in prominent print on the coverage page or the first specifications page."

SECTION 16. Article 63 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-63-70. Senior-specific certifications and professional designations; rules.**

The Commissioner may adopt rules to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale, or purchase of, or advice made in connection with, a life insurance or annuity product. These rules shall be substantially similar to the NAIC Model Regulation on the Use of Senior-Specific Certifications and

Professional Designations in the Sale of Life Insurance and Annuities, as amended. The Commissioner may adopt, amend, or repeal provisions of these rules under G.S. 150B-21.1 in order to keep these rules current with the NAIC model rule."

SECTION 17. G.S. 58-3-225(h) reads as rewritten:

"(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments ~~may be made not more than~~ shall be made within the two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. ~~The period for which such recoveries may be made may not exceed~~ The recovery of underpayments or nonpayments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor."

SECTION 18. G.S. 58-51-25 reads as rewritten:

"**§ 58-51-25. Policy coverage to continue as to mentally retarded or physically handicapped ~~children.~~children; coverage of dependent students on medically necessary leave of absence.**

(a) An individual or group accident and health insurance policy, hospital service plan policy, or medical service plan ~~policy, delivered or issued for delivery in this State after July 1, 1969, which~~ policy that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract, shall also provide in substance that attainment of such limiting age shall not operate or terminate the coverage of such child while the child is and continues to be (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (ii) chiefly dependent upon the policyholder or subscriber for support and maintenance: Provided, proof of such incapacity and dependency is furnished to the insurer, hospital service plan corporation, or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation, but not more frequently than annually after the child's attainment of the limiting age.

(b) All health benefit plans, as defined in G.S. 58-3-167, that provide that coverage of a dependent child shall terminate upon a change in enrollment of the child in a postsecondary educational institution shall provide for the continued eligibility of the dependent child during a medically necessary leave of absence from the postsecondary educational institution in accordance with all applicable requirements of Public Law 110-381, known as 'Michelle's Law.'"

SECTION 19. G.S. 58-3-215 is amended by adding the following new subsection to read:

"(d) Notwithstanding any other provision of this section, a health benefit plan, as defined in G.S. 58-3-157, and insurers, as defined in G.S. 58-3-157, shall comply with all applicable

standards of Public Law 110-233 known as the 'Genetic Information Nondiscrimination Act of 2008' as amended by Public Law 110-343, and as further amended."

SECTION 20. G.S. 58-3-220 is amended by adding the following new subsections to read:

"(i) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and mental health benefits shall, with respect to the mental health benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(j) Subsection (i) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-255(a)(10)."

SECTION 21. G.S. 58-51-50 is amended by adding the following new subsections to read:

"(f) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(g) Subsection (f) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-255(a)(10)."

SECTION 22. G.S. 58-65-75 is amended by adding the following new subsections to read:

"(f) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(g) Subsection (f) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-255(a)(10)."

SECTION 23. G.S. 58-67-70 is amended by adding the following new subsections to read:

"(g) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(h) Subsection (g) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-255(a)(10)."

SECTION 24. G.S. 58-68-30(f) is amended by adding a new subdivision to read:

"(4) Special rules for application in case of Medicaid or State Children's Health Insurance Program (Title XXI of the Social Security Act). – 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 either of the following conditions is met:

a. Termination of Medicaid or State Children's Health Insurance Program. – The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State children's health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under such a plan is

terminated as a result of the loss of eligibility for such coverage and the employee requests coverage under the group health insurance coverage not later than 60 days after the termination of such coverage.

b. Eligibility for employment assistance under Medicaid or State Children's Health Insurance Program. – The employee or dependent becomes eligible for assistance, with respect to coverage under the group health insurance coverage, under such Medicaid plan or State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance."

SECTION 25. 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 State Health Plan for Teachers and State Employees, any optional plans or programs operating under Part 2 of ~~Article 3~~ Article 3A of Chapter 135 of the General Statutes, the North Carolina Health Insurance Risk Pool, 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 no certification decisions."

SECTION 26. G.S. 58-50-79(b) reads as rewritten:

"(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a no certification appeal decision under G.S. 58-50-61 and G.S. 58-50-62, and

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 60 days since the date the covered person ~~filed the grievance with the insurer.~~can demonstrate that a grievance was filed with the insurer."

SECTION 27. G.S. 58-50-80(a) reads as rewritten:

"(a) Within ~~60~~ 120 days after the date of receipt of a notice under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner."

SECTION 28. G.S. 58-50-80(c) reads as rewritten:

"(c) If the finding of the preliminary review under subdivision (b)(2) of this section is that the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within ~~90~~ 150 days after the date of the insurer's decision for which external review is requested."

SECTION 29. The introductory paragraph of G.S. 58-50-82(a) reads as rewritten:

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

SECTION 30. G.S. 58-80-82(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 no certification, no certification 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 31. G.S. 58-50-82(f) reads as rewritten:

"(f) If the notice provided under subsection (e) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner and include the information set forth in ~~G.S. 58-50-80(m).~~ G.S. 58-50-80(k).

Upon receipt of the notice of a decision under subsection (e) of this section that reverses the no certification, no certification appeal decision, or second-level grievance review decision, the insurer shall within one day reverse the no certification, noncertification appeal decision, or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification, noncertification appeal decision, or second-level grievance review decision."

SECTION 32. G.S. 58-50-85(c) reads as rewritten:

"(c) ~~The Commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.~~In order to be eligible for approval by the Commissioner, an independent review organization shall be accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications established under G.S. 58-50-87. The Commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation."

SECTION 33. G.S. 58-50-90(b) reads as rewritten:

"(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, ~~at least annually,~~ upon the Commissioner's request, a report in the format specified by the Commissioner."

SECTION 34. G.S. 58-50-94(b) reads as rewritten:

"(b) After the public opening, the Commissioner shall review the proposals, examining the ~~costs and~~ quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations and shall ensure that, for any given type of case involving highly specialized

services and treatments, at least one review organization is available and capable of reviewing the case."

SECTION 35. G.S. 58-57-100(a) reads as rewritten:

"(a) Single interest or dual interest physical damage insurance may be written on nonfleet private passenger motor vehicles, as defined in G.S. 58-40-10, that are used as collateral for loans made under Article 15 of Chapter 53 of the General Statutes. Automobile physical damage insurance as described in this section is a form of credit property insurance, as referred to in G.S. 53-189. It is subject to the following conditions:

(1) Such insurance may be written only on a motor vehicle ~~on which there is a valid inspection sticker.~~that is in compliance with the inspection requirements of Part 2 of Article 3A of Chapter 20 of the General Statutes.

(2) If a motor vehicle is already insured and the lender is named loss payee and that insurance continues in force, then no other physical damage insurance may be written.

(3) Notification must be given orally and in writing to the borrower that he has the option to provide his own insurance coverage at any point during the term of the loan.

(4) The creditor must have either a first or second lien on the motor vehicle to be insured.

(5) The amount of insurance coverage may not exceed the lesser of (i) the principal amount of the loan plus allowable charges, excluding interest, plus two scheduled installment payments or (ii) the actual fair market value of the collateral at the time the insurance is written.

(6) When a creditor accepts other collateral in addition to a motor vehicle as herein defined, the combined insurance on all collateral may not exceed the initial indebtedness of the loan."

SECTION 36. Section 3 of S.L. 2005-183 reads as rewritten:

"**SECTION 3.** This act becomes effective October 1, ~~2005, and expires October 1, 2009.~~ 2005."

SECTION 37. Sections 34 and 35 are effective when this act becomes law. The remainder of this act becomes effective October 1, 2009.