GENERAL ASSEMBLY OF NORTH CAROLINA
1995 SESSION

CHAPTER 517
SENATE BILL 345

AN ACT TO MAKE SUBSTANTIVE CHANGES TO THE INSURANCE LAWS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-2-131(f) reads as rewritten:

"(f) Instead of examining any foreign or alien insurer licensed in this State, the Commissioner may accept an examination report on that insurer prepared by the insurer's domiciliary insurance ~~regulator until January 1, 1994. Thereafter, reports may only be accepted if~~ regulator. In making a determination to accept the domiciliary insurance regulator's report, the Commissioner may consider whether (i) the insurance regulator was at the time of the examination accredited under NAIC Financial Regulation Standards and Accreditation Program, or (ii) the examination is performed under the supervision of an NAIC-accredited insurance regulator or with the participation of one or more examiners who are employed by the regulator and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by the regulator."

Sec. 2. Article 2 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-2-171. Qualifications of actuaries.**

The Commissioner may adopt rules setting forth requisite qualifications of consulting actuaries for the sole purpose of qualifying them to certify financial statements filed and rate filings made by entities under this Chapter as to the actuarial validity of those filings. The qualifications shall be commensurate with the degree of complexity of the actuarial principles applicable to the various statements filed or rate filings made. Nothing in this section affects the scope of practice or the professional qualifications of actuaries."

Sec. 3. G.S. 58-3-90 reads as rewritten:

"**§ 58-3-90. ~~Revocation~~ Revocation, suspension, or restriction of license of foreign company; publication of notice.**

(a) If the ~~Commissioner is of the opinion,~~ Commissioner, upon examination or other evidence, makes a written finding of fact that a foreign insurance company is in an unsound financial condition; or, if a life insurance company, that its actual funds, exclusive of its capital, are less than its liabilities; or that the company has failed to comply with the statutes, rules, or orders applicable to it; or if the company, its officers, employees, agents, or other representatives refuse to submit to examination or to perform any legal obligation in relation to an examination, ~~he~~ the Commissioner shall

revoke or suspend all licenses and authority to do business granted to the company or its agents, and shall give written notification of the revocation or suspension to all of the company's agents in this ~~State; and no new business may thereafter be done by the company or its agents in this State until the company's license and authority to do business is restored by the Commissioner.~~ State. Until the Commissioner restores the company's license and authority to do business in this State, neither the company nor its agents shall do any new business in this State.

(b) The Commissioner may, after considering the standards under G.S. 58-30-60(b), restrict a foreign insurer's license by prohibiting or limiting the kind or amount of insurance written by that insurer in this State. The Commissioner shall remove any restriction under this subsection once the Commissioner determines that the operations of the insurer are no longer hazardous to the public or to the insurer's policyholders or creditors."

Sec. 3.1. G.S. 58-3-170 reads as rewritten:

"**§ 58-3-170. Requirements for maternity coverage.**

(a) Every entity providing a health benefit plan that provides maternity coverage in this State shall provide benefits for the necessary care and treatment related to maternity that are no less favorable than benefits for physical illness generally.

(b) A health benefit plan that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by caesarean section.

~~(b)~~(c) As used in 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 plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Sec. 4. G.S. 58-7-30 reads as rewritten:

"**§ 58-7-30. Insolvency of ceding insurer; ~~exceptions.~~ exceptions; written reinsurance agreements.**

(a) No credit shall be allowed, as an admitted asset or as a deduction from liability, to any ceding insurer for reinsurance, unless the reinsurance is payable by the assuming insurer, on the basis of claims allowed against the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer, directly to the ceding insurer or to its domiciliary receiver except (1) where the contract specifically provides for another payee of the reinsurance in the event of the insolvency of the ceding insurer or (2) where the assuming insurer, with the consent of the direct insured or insureds, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution of the obligations of the ceding insurer to the payees.

(b) No credit shall be allowed, as an admitted asset or as a deduction from liability, to any ceding insurer for reinsurance, unless the reinsurance is documented by a policy, certificate, treaty, or other form of agreement that is properly executed by an authorized officer of the assuming insurer. If the reinsurance is ceded through an

underwriting manager or agent, the manager or agent shall provide to the domestic ceding insurer evidence of the manager or agent's authority to assume reinsurance for and on behalf of the assuming insurer. The evidence shall consist of either an acceptable letter of authority executed by an authorized officer of the assuming insurer or a copy of the actual agency agreement between the underwriting manager or agent and the assuming insurer; and the evidence shall be specific as to the classes of business within the authority and as to the term of the authority. If there is any conflict between this subsection and Article 9 of this Chapter, the provisions of Article 9 govern."

Sec. 5. G. S. 58-12-30 reads as rewritten:

"**§ 58-12-30. Hearings.**

Upon (i) notification to an insurer by the Commissioner of an adjusted risk-based capital report; or (ii) notification to an insurer by the Commissioner that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, and the notification constitutes a regulatory action level event with respect to the insurer; or (iii) notification to any insurer by the Commissioner that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its risk-based capital plan or revised risk-based capital plan; or (iv) notification to an insurer by the Commissioner of a ~~Corrective Order~~ corrective order with respect to the insurer, the insurer has a right to a confidential hearing, at which the insurer may challenge any determination or action by the Commissioner. The insurer shall notify the Commissioner of its request for a hearing within five days after the notification by the Commissioner under this section. Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the ~~hearing, which~~ hearing; the date shall be no less than 10 days nor more than 30 days after the date of the insurer's request."

Sec. 6. G.S. 58-16-5(3) is repealed.

Sec. 7. Article 16 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-16-6. Conditions of continued licensure.**

In order for a foreign insurance company to continue to be licensed, it shall report any changes in the documents filed under G.S. 58-16-5(1) or G.S. 58-16-5(5), maintain the amounts of capital and surplus specified in G.S. 58-16-5(2), and remain in substantial compliance with the statutes listed in G.S. 58-16-5(6) and G.S. 58-16-5(7)."

Sec. 8. G.S. 58-16-30 reads as rewritten:

"**§ 58-16-30. Service of legal process upon Commissioner.**

As an alternative to service of legal process under ~~the provisions of Rule 4 of the Rules of Civil Procedure,~~ G.S. 1A-1, Rule 4, the service of such process upon any insurance company or any foreign or alien entity licensed or admitted and authorized to do business in this State under the provisions of ~~Articles 1 through 64 of~~ this Chapter may be made by the sheriff or any other person delivering and leaving a copy of ~~such~~ the process in the office of the Commissioner with a deputy or any other person duly appointed by the Commissioner for ~~such purpose~~ that purpose; or acceptance of service of ~~such~~ the process may be made by the Commissioner or ~~such~~ a duly appointed ~~deputy.~~

deputy or person. Service may also be made by mailing a copy of the summons and of the complaint, registered or certified mail, return receipt requested, addressed to the Commissioner. As a condition precedent to a valid service of process under this section, the party obtaining such service shall pay to the Commissioner at the time of service or acceptance of service the sum of ten dollars ($10.00), which ~~such~~ the party shall recover as part of the taxable costs if ~~he~~ the party prevails in ~~his~~ the action."

Sec. 9. G.S. 58-19-5(2) reads as rewritten:

"(2) 'Control', including the terms 'controlling', 'controlled by', and 'under common control with', means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or ~~otherwise, unless the power is the result of an official position with or corporate office held by the person.~~ otherwise. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by G.S. 58-19-25(j) that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect."

Sec. 10. G.S. 58-19-5(5) reads as rewritten:

"(5) 'Person' means an individual, corporation, partnership, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing acting in concert. ~~'Person' does not include any joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property.~~"

Sec. 11. G.S. 58-19-15(a) reads as rewritten:

"(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer, if, after the consummation thereof, ~~such~~ the person would, directly or indirectly (or by conversion or by exercise of any right to acquire), be in control of ~~such~~ the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless ~~such~~ the offer, request, invitation, agreement, or acquisition is conditioned upon the approval of the Commissioner ~~pursuant to~~ under this section. No such merger or other acquisition of control ~~shall be~~ is effective until a statement containing the information required by this section has been filed with the Commissioner and all other provisions of this section have been complied with and the merger or acquisition of control has

been approved by the Commissioner ~~pursuant to~~ under this section. The statement containing the information required by this section shall also be filed with the domestic insurer ~~at the time~~ when it is filed with the Commissioner.

(a1) For the purposes of this section a 'domestic insurer' includes any person controlling a domestic insurer. Further, for the purposes of this section, 'person' does not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person that controls an insurance company."

Sec. 12. G.S. 58-19-15 is further amended by adding two new subsections to read:

"(a2) Any acquisition of control of a domestic insurer must be completed not later than 90 days after the date of the Commissioner's order approving the acquisition under this section, unless the Commissioner grants an extension in writing on a showing of good cause for the delay. Any increase in a company's capital and surplus required under this Article as a result of the change of control of a domestic insurer must be completed not later than 90 days after the date of the Commissioner's order approving the change of control and before the company writes any new insurance business.

(a3) If the deadlines for completion in subsection (a2) of this section are not met, the person seeking to acquire control of the domestic insurer must resubmit the statement required by subsection (b) of this section, and the Commissioner may reconsider approval of acquisition of control under this section."

Sec. 13. G.S. 58-30-180(b)(1) reads as rewritten:

"(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in G.S. 58-30-220(1) and ~~(2); (4);~~".

Sec. 14. G.S. 58-30-220 reads as rewritten:

"**§ 58-30-220. Priority of distribution.**

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds shall be retained for payment before the members of the next class receive any payment. No subcategories shall be established within the categories in a class. The order of distribution of claims shall be:

(1) ~~Claims for cost of~~ The receiver's expenses for the administration and conservation of assets of the insurer.

(2) ~~Compensation actually owing to employees other than officers of the insurer for services rendered within three months prior to the commencement of a delinquency proceeding against the insurer under this Article, but not exceeding one thousand dollars ($1,000) for each employee. In the discretion of the Commissioner, this compensation may be paid as soon as practicable after the proceeding has been commenced. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of those employees.~~

~~(3)~~ Claims or portions of claims for benefits under policies and for losses incurred, including claims of third parties under liability policies; claims for unearned premiums; claims for funds or consideration held under funding agreements, as defined in G.S. 58-7-16; claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values; and claims of domestic and foreign guaranty ~~associations;~~ associations, including claims for the reasonable administrative expenses of domestic and foreign guaranty associations; but excluding claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements, claims of other insurers for subrogation, and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages.

(3) Claims of the federal or any state or local government or taxing authority, including claims for taxes.

(4) ~~Claims for unearned premiums.~~ Compensation actually owing to employees other than officers of the insurer for services rendered within three months before the commencement of a delinquency proceeding against the insurer under this Article, but not exceeding one thousand dollars ($1,000) for each employee. In the discretion of the Commissioner, this compensation may be paid as soon as practicable after the proceeding has been commenced. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of those employees.

(5) Claims of general creditors, including claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements; claims of other insurers for subrogation; and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages."

Sec. 15. Article 31 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-31-52. State motor vehicle safety program.**

(a) Findings, Policy, and Purpose. – Motor vehicle accidents exact a terrible toll of human tragedy and suffering as well as national resources within the United States. The same is true, on a smaller scale, within North Carolina State government. Every year State employees or members of the general public are killed or injured, and a significant portion of the State's financial resources is expended as a direct result of accidents involving State-owned vehicles. Accordingly, it is North Carolina policy that the State-owned motor vehicle fleet and vehicles used on behalf of the State be operated and maintained in such a manner as to minimize deaths, injuries, and costs. The purpose of this section is to direct the Commissioner of Insurance to develop a program to provide policy, requirements, procedures, technical information, and standards for administering a State vehicle safety program which will apply to all State personnel involved in the administration and operation of vehicles on behalf of the State.

(b) The Commissioner shall develop and adopt a State motor vehicle safety program to assure that State-owned motor vehicles are operated and maintained in a safe manner.

(c) In developing the program, the Commissioner shall include the following:

(1) Basic criteria concerning qualifications, screening, and education of drivers.

(2) Required and prohibited driving practices.

(3) Safety maintenance requirements.

(4) Accident reporting and review procedures.

(d) The requirements and procedures established under the program apply to all agencies and persons operating vehicles on behalf of the State, unless specifically exempted by the Commissioner. Agencies may adopt more stringent requirements and procedures than those adopted by the Commissioner under this section. The administration of the program in each agency is the responsibility of each agency head or that person's designee.

(e) The provisions of Chapter 150B of the General Statutes do not apply to the program developed and adopted under this section."

Sec. 16. G.S. 58-33-25(e) reads as rewritten:

"(e) A limited representative may receive qualification for one or more licenses without examination for the following kinds of insurance:

(1), (2) Repealed by Session Laws 1989, c. 485, s. 19.

(3) Credit Life, Accident and ~~Health~~ Health.

(4) Credit, as specified in ~~G.S. 58-7-15(17)~~ G.S. 58-7-15(17).

(5) Travel Accident and ~~Baggage~~ Baggage.

(6) Motor ~~Club~~ Club.

(7) Dental ~~Services~~ Services.

(8) Credit Property Insurance and Single Interest Automobile Physical Damage Insurance when either is made in connection with a ~~loan~~ loan.

(9) Bail bonds executed or countersigned by surety bondsmen under Article 71 of this ~~Chapter~~ Chapter.

(10) Credit unemployment.

(11) Vehicle service agreements and mechanical breakdown insurance.

(12) Prearrangement insurance, as defined in G.S. 58-60-35(a)(2), when offered or sold by a preneed sales licensee licensed under Article 13D of Chapter 90 of the General Statutes."

Sec. 17. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-132. Qualifications of instructors.**

(a) The Commissioner may adopt rules to establish requisite qualifications for and issuance, renewal, summary suspension, and termination of provider, presenter, and instructor authority for prelicensing and continuing insurance education courses. During any suspension, the instructor shall not engage in any instruction of prelicensing or continuing insurance education courses prior to an administrative review. No person

shall provide, present, or instruct any course unless that person has been qualified and possesses a certificate of authority from the Commissioner.

(b) The Commissioner may summarily suspend or terminate the authority of an instructor, course provider, or presenter if the course presentation:

(1) Is determined to be inaccurate; or

(2) Receives an evaluation of poor from any Department monitor and a majority of attendees responding to Department questionnaires about the presentation."

Sec. 18. G.S. 58-36-1(5) reads as rewritten:

"(5) a. It is the duty of every insurer that writes workers' compensation insurance in this State and is a member of the Bureau, as defined in this section and G.S. 58-36-5 to insure and accept any workers' compensation insurance risk that has been certified to be 'difficult to place' by any fire and casualty insurance agent who is licensed in this State. When any such risk is called to the attention of the Bureau by receipt of an application with an estimated or deposit premium payment and it appears that the risk is in good faith entitled to such coverage, the Bureau will bind coverage for 30 days and will designate a member who must issue a standard workers' compensation policy of insurance that contains the usual and customary provisions found in those policies. Multiple coordinated policies, as defined by the Bureau and approved by the Commissioner, may be used for the issuance of coverage under this subdivision for risks involved in employee leasing agreements. Coverage will be bound at 12:01 A.M. on the first day following the postmark time and date on the envelope in which the application is mailed including the estimated annual or deposit premium, or the expiration of existing coverage, whichever is later. If there should be no postmark, coverage will be effective 12:01 A.M. on the date of receipt by the Bureau unless a later date is requested. Those applications hand delivered to the Bureau will be effective as of 12:01 A.M. of the date following receipt by the Bureau unless a later date is requested. ~~The designated carrier may request of the Bureau certification of the State Department of Labor that the insured is complying with the laws, rules, and regulations of that Department. The certification must be finished within 30 days by the State Department of Labor unless extension of time is granted by agreement between the Bureau and the State Department of Labor.~~ The Bureau will make and adopt such rules as are necessary to carry this section into effect, subject to final approval of the Commissioner. As a prerequisite to the transaction of workers' compensation insurance in this State,

every member of the Bureau that writes such insurance must file with the Bureau written authority permitting the Bureau to act in its behalf, as provided in this section, and an agreement to accept risks that are assigned to the member by the Bureau, as provided in this section.

b. ~~Upon notice of cancellation or the decision to decline to write or renew a policy of workers' compensation insurance for an employer, the carrier or its agents shall supply the employer with a form, supplied by the Bureau, by which the employer may request the Bureau to list the employer and pertinent information about it among a compendium of such information on~~ The Bureau shall maintain a compendium of employers refused voluntary coverage, which shall be made available by the Bureau to all ~~insurers~~ insurers, licensed agents, and self-insureds' administrators doing business in this State. It shall be stored and indexed to allow access to information by industry, primary classifications of employees, geography, experience modification, and in any other manner the Bureau determines is commercially useful to facilitate voluntary coverage of listed employers. The Bureau shall be immune from civil liability for erroneous information released by the Bureau pursuant to this section, provided that the Bureau acted in good faith and without malicious or willful intent to harm in releasing the erroneous information."

Sec. 19. G.S. 58-36-25 reads as rewritten:

"**§ 58-36-25. Appeal of Commissioner's order.**

(a) Any order or decision of the Commissioner shall be subject to judicial review as provided in Article 2 of this Chapter.

(b) Whenever a Bureau rate is held to be unfairly discriminatory or excessive and no longer effective by order of the Commissioner issued under G.S. 58-36-20, the members of the Bureau, in accordance with rules and regulations established and adopted by the governing committee, shall have the option to continue to use such rate for the interim period pending judicial review of such order, provided each such member shall place in escrow account the purportedly unfairly discriminatory or excessive portion of the premium collected during such interim period. Upon a final determination by the Court, or upon a consent agreement or consent order between the Bureau and the Commissioner, the Commissioner shall order the escrowed funds to be distributed ~~appropriately,~~ appropriately. ~~except that individual refunds that are five dollars ($5.00) or less shall not be required.~~ If refunds are to be made to policyholders, the Commissioner shall order that the members of the Bureau refund the difference between the total premium per policy using the rate levels finally determined and the total premium per policy collected during the interim period pending judicial review, except that refund amounts that are five dollars ($5.00) or less per policy shall not be required. The court may also require that purportedly excess premiums resulting from

an adjustment of premiums ordered pursuant to G.S. 58-36-20(b) be placed in such escrow account pending judicial review. If refunds made to policyholders are ordered under this subsection, the amounts refunded shall bear interest at the rate determined under this subsection. ~~That rate shall be the average of the prime rates of the four largest banking institutions domiciled in this State, plus three percent (3%), as of the effective date of the filing, to be computed by the Commissioner.~~ That rate, to be computed by the Bureau, shall be the average of the prime rates on the effective date of the filing and each anniversary of that date occurring prior to the date of the Commissioner's order requiring refunds, with the prime rate on each of the dates being the average of the prime rates of the four largest banking institutions domiciled in this State as of that date, plus three percent (3%)."

Sec. 20. G.S. 58-36-30(b) reads as rewritten:

"(b) A rate in excess of that promulgated by the Bureau may be charged on any specific risk provided such higher rate is charged with the approval of the Commissioner and with the knowledge and written consent of the insured. This subsection may be used to provide motor vehicle liability coverage limits above those required under Article 9A of Chapter 20 of the General Statutes and above those cedable to the Facility under Article 37 of this Chapter to persons whose personal excess liability insurance policies require that they maintain specific higher liability coverage limits. All data filed with the Commissioner under this subsection are proprietary and confidential and are not public records under G.S. 132-1 or G.S. 58-2-100."

Sec. 21. G.S. 58-36-30(c) reads as rewritten:

"(c) Any deviation with respect to workers' compensation and employers' liability insurance written in connection therewith as filed under subsection (a) of this section shall apply uniformly to all classifications. Any approved rate under subsection (b) of this section with respect to workers' compensation and employers' liability insurance written in connection therewith shall be furnished to the Bureau."

Sec. 22. G.S. 58-36-85(e) reads as rewritten:

"(e) Administrative Review. – When the Department receives a written request to review a termination, it must investigate and determine the reason for the termination. The Department shall ~~enter an order for~~ issue a letter requiring one of the following upon completing its review:

(1) Approval of the termination, if it finds the termination complies with the law.

(2) Renewal or reinstatement of the policy, if it finds the termination does not comply with the law.

(3) Renewal or reinstatement of the policy and payment by the insurer of the costs of the Department's review, not to exceed one thousand dollars ($1,000), if it finds the termination does not comply with the law and the insurer willfully violated this section.

The Department shall mail ~~a copy of the order~~ the letter to the insured and the insurer. An insured or an insurer who disagrees with the determination of the Department in the letter may file a petition for a contested case under Article 3A of

Chapter 150B of the General Statutes and the rules adopted by the Commissioner to implement that Article. The petition must be filed within 30 days after receiving the copy of the ~~order.~~ letter."

Sec. 23. G.S. 58-37-30(b) reads as rewritten:

"(b) It shall be the responsibility of the agent to write the coverage applied for at what he believes to be the appropriate rate level. If coverage is written at the Facility rate level and the company elects not to cede, the policy shall be rated at ~~the voluntary rate level.~~ a rate under Article 36 of this Chapter. Coverage written at ~~the voluntary rate level which~~ a rate under Article 36 of this Chapter that is not acceptable to the company must either be placed with another company or rated at the Facility rate level by the agent."

Sec. 24. G.S. 58-37-40(e) reads as rewritten:

"(e) Upon approval of the Commissioner of the plan so submitted or promulgation of a plan deemed approved by the Commissioner, all insurance companies licensed to write motor vehicle insurance in this State or any component thereof as a prerequisite to further engaging in writing ~~such~~ the insurance shall formally subscribe to and participate in the plan so approved.

The plan of operation shall provide for, among other matters, (i) the establishment of necessary ~~facilities,~~ facilities; (ii) the management of the ~~Facility,~~ Facility; (iii) the preliminary assessment of all members for initial expenses necessary to commence ~~operations,~~ operations; (iv) the assessment of members if necessary to defray losses and ~~expenses,~~ expenses; (v) the distribution of gains to defray losses incurred since ~~the effective date hereof and then to persons reinsured by the Facility, the recoupment of losses sustained by the Facility,~~ September 1, 1977; (vi) the distribution of gains by credit or reduction of recoupment or allocation surcharges to policies subject to recoupment or allocation surcharges pursuant to this Article (the Facility may apportion the distribution of gains among the coverages eligible for cession pursuant to this Article); (vii) the recoupment or allocation of losses sustained by the Facility since September 1, 1977, pursuant to this Article, which losses may be recouped by equitable pro rata assessment of member ~~companies,~~ companies; (viii) the standard amount (one hundred percent (100%) or any equitable lesser amount) of coverage afforded on eligible risks which a member company may cede to the ~~Facility,~~ Facility; and (ix) the procedure by which reinsurance shall be accepted by the ~~Facility; and~~ Facility. The plan shall further provide that:

(1) Members of the Board of Governors shall receive reimbursement from the Facility for their actual and necessary expenses incurred on Facility business, en route to perform Facility business, and while returning from Facility business plus a per diem allowance of twenty-five dollars ($25.00) a day which may be waived.

(2) In order to obtain a transfer of business to the Facility effective when the binder or policy or renewal thereof first becomes effective, the company must within 30 days of the binding or policy effective date notify the Facility of the identification of the insured, the coverage and limits afforded, classification data, and premium. The Facility shall

accept risks at other times on receipt of necessary information, but ~~such~~ acceptance shall not be retroactive. The Facility shall accept renewal business after the member on underwriting review elects to again cede the business."

Sec. 25. G.S. 58-40-10(2) reads as rewritten:

"(2) 'Nonfleet' motor vehicle means a motor vehicle not eligible for classification as a fleet vehicle for the reason that the motor vehicle ~~is~~ is:

a. ~~one~~ One of four or ~~less~~ fewer motor vehicles owned or hired under a long-term contract by ~~the~~ a policy named ~~insured.~~ insured; or

b. One of five or more private passenger motor vehicles owned or hired under a long-term contract:

1. By an individual who is a policy named insured;

2. Jointly by two or more individuals who are policy named insureds and are residents in the same household; or

3. Jointly by two or more individuals who are policy named insureds and are related by blood, marriage, or adoption."

Sec. 26. G.S. 58-42-55 reads as rewritten:

"**§ 58-42-55. Expiration.**

This Article shall expire on ~~July 1, 1995.~~ July 1, 1997."

Sec. 27. G.S. 58-44-10 is repealed.

Sec. 28. G.S. 58-45-35(b) reads as rewritten:

"(b) If the Association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance and shall offer additional extended coverage, optional perils endorsements, crime insurance, separate policies of windstorm and hail insurance, or their successor forms of coverage, for a term of one ~~year.~~ year or three years. Any policy issued under ~~the provisions of~~ this section shall be ~~renewed annually,~~ renewed, upon application, ~~so~~ as long as the property ~~meets the definition of "insurable property"set forth in G.S. 58-45-5(5).~~ is insurable property."

Sec. 29. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-149. Limit on cessions to the Reinsurance Pool.**

In addition to any individual or group previously reinsured in accordance with G.S. 58-50-150(g)(1), the Pool shall only reinsure a health benefit plan issued or delivered for original issue by a reinsuring carrier on or after October 1, 1995, if the health benefit plan provides coverage to a small employer with no more than 25 eligible employees, including self-employed individuals."

Sec. 30. G.S. 58-53-60 reads as rewritten:

"**§ 58-53-60. Premium.**

(a) The premium for the converted ~~policy~~ policy or group conversion trust certificate shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk to be covered under that policy and to the type and amount of insurance provided.

(b) All insurers licensed to do business in this State, who issue conversion ~~policies~~ policies or group conversion trust certificates under this Part, ~~shall~~ have the right to increase that element of the premium that applies to hospital room and board benefit increases provided for in G.S. 58-53-95(5) by an amount proportionate to the increase promulgated by the Commissioner. Such premium increases shall be filed with the Commissioner.

(c) All premium rates and adjustments to premium rates for converted ~~policies~~ policies or group conversion trust certificates shall be reasonable and must be filed with and approved by the Commissioner prior to use. A premium rate shall be deemed to be reasonable if ~~it can be demonstrated by~~ the insurer demonstrates that the premium charged is expected to produce an incurred loss ratio to earned premiums of not less than sixty percent (60%) for all ~~individual~~ policies or group conversion trust certificates providing similar benefits offered and issued by the insurer. If an insurer experiences an incurred loss ratio of greater than eighty percent (80%) for all such policies, it shall be deemed reasonable for that insurer to increase premium rates to a level that will produce a prospective incurred loss ratio of no greater than eighty percent (80%), and the insurer shall file such new rates with the Commissioner not more often than once a year."

Sec. 31. (a) Article 58 of Chapter 58 of the General Statutes is further amended by adding the following new sections to read:

"**§ 58-58-22. Individual policy standard provisions.**

No policy of individual life insurance shall be delivered in this State unless it contains in substance the following provisions, or provisions that in the Commissioner's opinion are more favorable to the person insured:

(1) Grace period. – A provision that the insured is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force. The policy may provide that if a claim arises under the policy during the grace period, the amount of any premium due or overdue may be deducted from any amount payable under the policy in settlement.

(2) Incontestability. – A provision that the validity of the policy shall not be contested, except for nonpayment of premium, once it has been in force for two years after its date of issue; and that no statement made by any person insured under the policy about that person's insurability shall be used during the person's lifetime to contest the validity of the policy after the insurance has been in force for two years.

(3) Misstatement of age or gender. – A provision specifying an equitable adjustment of premiums or benefits, or both, to be made if the age or

gender of the person insured has been misstated; the provision to contain a clear statement of the method of adjustment to be used.

(4) Suicide. – A provision that may not limit payment of benefits for a period more than two years after the date of issue of the policy because of suicide and that provides for at least the return of premiums paid on the policy if there is suicide during the two-year period.

(5) Reinstatement. – A provision that, unless the policy has been surrendered for its cash surrender value, or its cash surrender value has been exhausted, the policy will be reinstated at any time within five years after the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all overdue premiums, and the payment of reinstatement of any other indebtedness to the insurer upon the policy, all with interest at the rate specified.

"**§ 58-58-23. Standard provisions for annuity and pure endowment contracts.**

No annuity or pure endowment contract, except a reversionary or survivorship annuity and except a group annuity contract, shall be delivered or issued for delivery in this State unless it contains in substance the following provisions or provisions that in the opinion of the Commissioner are more favorable to the holders of the contracts:

(1) Grace period. – A provision for a grace period of not less than 31 days within which any stipulated payment to the insurer falling due after the first payment may be made. During the grace period, the contract shall continue in full force. If a claim arises under the contract because of death before the expiration of the grace period and before the overdue payment to the insurer is made, the amount of the payments, with interest on any overdue payments, may be deducted from any amount payable under the contract.

(2) Incontestability. – If any statements are required as a condition of issue, there shall be a provision that the contract shall be incontestable during the lifetime of the person or of each of the persons as to whom the statements are required after it has been in force for a period of two years after its date of issue, except for nonpayment of stipulated payments to the insurer.

(3) Misstatements of age or gender. – A provision that if the age or gender of any person upon whose life the contract is made has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have been according to the correct age or gender; and if the insurer makes an overpayment because of the misstatement, that amount with interest at the rate specified in the contract may be charged against any current or subsequent payment by the insurer under the contract.

(4) Reinstatement. – A provision that the contract may be reinstated at any time within one year after a default in making stipulated payments to the insurer, unless the cash surrender value has been paid; but all

overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest at a rate specified in the contract. When applicable, the insurer may also require evidence of insurability satisfactory to the insurer."

(b) Article 58 of Chapter 58 of the General Statutes is further amended by adding a new section to read:

"**§ 58-58-42. Viatical settlements.**

(a) Definitions. – As used in this section:

(1) 'Broker' means a person who, for consideration and on behalf of another, offers or advertises the availability of viatical settlements, introduces viators to providers, or offers or attempts to negotiate viatical settlement contracts between a viator and one or more providers; it does not mean an attorney, accountant, or financial planner retained to represent a viator and whose compensation is not paid by a provider.

(2) 'Policy' means an individual life insurance policy or a certificate under a group life insurance policy.

(3) 'Provider' means a person who enters into a viatical settlement contract with a viator. 'Provider' does not mean:

a. A licensed lending institution that takes an assignment of a policy as collateral for a loan.

b. The issuer of a policy providing accelerated benefits under 11 NCAC 12.1200.

c. A natural person who enters into no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.

(4) 'Viatical settlement contract' or 'contract' means a written agreement entered into between a provider and a viator that establishes the terms under which the provider will pay consideration that is less than the expected death benefit of the viator's policy in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the policy to the provider.

(5) 'Viator' means the owner or holder of a policy who has a catastrophic or life-threatening illness or condition and who enters into a viatical settlement contract.

(b) Registration. – No person may act as a provider or enter into or solicit a contract without first registering with the Commissioner. The applicant shall register on a form prescribed by the Commissioner. The Commissioner may require the applicant to disclose fully the identity of all stockholders, partners, officers, and employees. The Commissioner may refuse registration of any partnership, corporation, or other business entity if not satisfied that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct meets the standards of this section. Registration of a partnership, corporation, or other business entity authorizes all members, officers, and designated employees to act as providers under the registration;

all of those persons must be named in the application and any supplements to the application. Before any registration is complete, the Commissioner shall investigate each applicant and may register the applicant if the Commissioner finds that the applicant:

(1) Has provided a detailed plan of operation.

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for.

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied.

(4) If a corporation, is incorporated under the laws of this State or is a foreign corporation authorized to transact business in this State.

No registration is complete for any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the Commissioner or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(c) Enforcement. – The Commissioner may issue a cease and desist order upon any provider if the Commissioner finds that:

(1) There was any misrepresentation in the application for registration;

(2) The provider has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a provider;

(3) The provider demonstrates a pattern of unreasonable payments to policy owners;

(4) The provider has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or

(5) The provider has violated a provision of this section.

(d) Approval of Contracts. – No provider may use any viatical settlement contract in this State unless it has been filed with and approved by the Commissioner. Any contract form filed with the Commissioner is deemed to be approved if it has not been disapproved within 90 days after the filing. The Commissioner shall disapprove a contract form if, in the Commissioner's opinion, any provision of the contract is unreasonable, contrary to the public interest, or otherwise misleading or unfair to the policy owner.

(e) Reporting Requirements. – Each provider shall file with the Commissioner on or before March 1 of each year a statement containing the information required by the rules adopted by the Commissioner.

(f) Examination. – The Commissioner may, when the Commissioner deems it to be reasonably necessary to protect the public interest, examine the business and affairs of any provider or applicant for registration. The Commissioner may order any provider or applicant to produce records, books, files, or other information that is necessary to ascertain whether or not the provider or applicant is acting or has acted in violation of this section or otherwise contrary to the public interest. The provider or applicant shall

pay the expenses incurred in conducting an examination. Names and individual identification data for all viators are confidential and shall not be disclosed by the Commissioner. The provider shall maintain records of all transactions of contracts and make the records available to the Commissioner for inspection during reasonable business hours.

(g) Disclosure. – A provider shall disclose the following information to the viator no later than the date the contract is signed by all parties:

(1) Options other than the contract for a person with a catastrophic or life-threatening illness, including, but not limited to, accelerated benefits offered by the issuer of the policy.

(2) The fact that some or all of the contract consideration may be taxable, and that assistance should be sought from a personal tax advisor.

(3) The fact that the contract consideration could be subject to the claims of creditors.

(4) The fact that receipt of the contract consideration may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements; and that advice should be obtained from the appropriate government agencies.

(5) The viator's right to rescind a contract within 30 days after the date it is executed by all parties or within 15 days after the receipt of the contract consideration by the viator, whichever is less, as provided in subsection (h) of this section.

(6) The date by which the contract consideration will be available to the viator and the source of the consideration.

(h) General Rules. – A provider entering into a contract with a viator shall first obtain:

(1) A written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence.

(2) A witnessed document in which the viator (i) consents to the contract, (ii) acknowledges the catastrophic or life-threatening illness, (iii) represents that the viator has a full and complete understanding of the contract, (iv) represents that the viator has a full and complete understanding of the benefits of the policy, and (v) releases the medical records and acknowledges that the contract has been entered into freely and voluntarily.

All medical information solicited or obtained by any provider is subject to all State laws relating to confidentiality of medical information. All contracts entered into in this State shall contain an unconditional refund provision for at least 30 days after the date of the contract, or 15 days after the receipt of the viatical settlement proceeds, whichever is less.

(i) Contract Consideration. – Immediately upon receipt from the viator of documents to effect the transfer of the policy, the provider shall direct the contract consideration to an escrow or trust account managed by a trustee or escrow agent in a bank approved by the Commissioner, pending acknowledgment of the transfer by the

issuer of the policy. The trustee or escrow agent shall transfer the proceeds that are due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer. Failure to tender the contract consideration by the date disclosed to the viator renders the contract null and void.

(j) Authority to Adopt Standards. – The Commissioner may:

(1) Adopt rules to implement this section.

(2) Establish standards for evaluating reasonableness of payments under contracts. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy.

(3) Establish appropriate registration and other regulatory requirements for brokers.

(4) Require a bond.

(k) Unfair Trade Practices. – A violation of this section is considered an unfair trade practice under Article 63 of this Chapter."

Sec. 32. G.S. 58-60-35 reads as rewritten:

"**§ 58-60-35. Disclosure of prearrangement insurance policy provisions.**

(a) As used in this section:

(1) 'Prearrangement' means any contract, agreement, or mutual understanding, or any series or combination of contracts, agreements or mutual understandings, whether funded by trust deposits or prearrangement insurance policies, or any combination thereof, which has for a purpose the furnishing or performance of specific funeral services, or the furnishing or delivery of specific personal property, merchandise, or services of any nature in connection with the final disposition of a dead human body, to be furnished or delivered at a time determinable by the death of the person whose body is to be disposed of, but does not mean the furnishing of a cemetery lot, crypt, niche, mausoleum, grave marker or monument.

(2) 'Prearrangement insurance policy' means a life insurance policy, annuity contract, or other insurance contract, or any series of contracts or agreements in any form or manner, issued on a group or individual basis by an insurance company authorized by law to do business in this State, which, whether by assignment or otherwise, has for ~~a~~ its sole purpose the funding of a specific preneed funeral contract or a specific insurance-funded funeral or burial prearrangement, the insured being the person for whose service the funds were paid.

(b) The following information shall be adequately disclosed by the insurance agent or limited representative at the time an application is made, prior to accepting the applicant's initial premium, for a prearrangement insurance policy:

(1) The fact that a prearrangement insurance policy is involved or being used to fund a prearrangement;

(2) The nature of the relationship among the insurance agent or ~~agents,~~ limited representative, the provider of the funeral or cemetery merchandise or services, the administrator, and any other person;

(3) The relationship of the prearrangement insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

(4) The effect on the prearrangement of (i) any changes in the prearrangement insurance policy, including but not limited to, changes in the assignment, beneficiary designation, or use of the policy proceeds; (ii) any penalties to be incurred by the insured as a result of failure to make premium payments; and (iii) any penalties to be incurred or monies to be received as a result of cancellation or surrender of the prearrangement insurance policy;

(5) All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the policy proceeds and the amount actually needed to fund the prearrangement; and

(6) Any penalties or restrictions, including geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services, or the prearrangement guarantee."

Sec. 33. G.S. 58-81-1 is repealed.

Sec. 33.1. G.S. 20-109.1(a), as rewritten by Chapter 50 of the Session Laws of 1995, reads as rewritten:

"(a) Option to Keep Title. – When a vehicle is damaged to the extent that it becomes a salvage vehicle and the owner submits a claim for the damages to ~~the insurer of the vehicle,~~ an insurer, the insurer must determine whether the owner wants to keep the vehicle after payment of the claim. If the owner does not want to keep the vehicle after payment of the claim, the procedures in subsection (b) of this section apply. If the owner wants to keep the vehicle after payment of the claim, the procedures in subsection (c) of this section apply."

Sec. 34. G.S. 95-111.12(a) reads as rewritten:

"(a) No owner shall operate a device subject to the provisions of this Article, unless at the time, there is in existence a contract of insurance providing coverage of not less than one million dollars ($1,000,000) per occurrence against liability for injury to persons or property arising out of the operation or use of such device or there is in existence a contract of insurance providing coverage of not less than five hundred thousand dollars ($500,000) per occurrence against liability for injury to persons or property arising out of the operation or use of the amusement devices if the annual gross volume of the devices does not exceed two hundred seventy-five thousand dollars ($275,000); provided waterslides shall not be required to be insured as ~~herein~~ provided in this subsection for an amount in excess of one hundred thousand dollars ($100,000) per occurrence. The insurance contract to be provided must be by any insurer or surety that is acceptable to the North Carolina Insurance Commissioner and authorized to transact business in this State; provided, however, that insurance for waterslides may be

purchased under Article 21 of Chapter 58 of the General Statutes or under G.S. 58-28-5(b).

In lieu of a contract for insurance or surety, a waterslide owner may alternately comply with this subsection by furnishing to the Commissioner satisfactory proof of financial ability to directly pay one hundred thousand dollars ($100,000) per occurrence in liability for injury to persons or property arising out of the operation or use of the waterslide. The Commissioner may require the deposit of a security, indemnity, bond, or irrevocable letter of credit to secure the payment of any liability incurred. The Commissioner may consult with the Commissioner of Insurance, the Commissioner of Banks, the Secretary of Commerce, or the State Treasurer in order to determine if any security, indemnity, bond, or irrevocable letter of credit filed under this subsection is acceptable proof of financial responsibility."

Sec. 35. G.S. 97-2(2) reads as rewritten:

"(2) Employee. – The term 'employee' means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his employer, and as relating to those so employed by the State, the term 'employee' shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term 'employee' shall include all officers and employees thereof, including such as are elected by the people. The term 'employee' shall include members of the North Carolina national guard, except when called into the service of the United States, and members of the North Carolina State guard, and members of these organizations shall be entitled to compensation for injuries arising out of and in the course of the performance of their duties at drill, in camp, or on special duty under orders of the Governor. The term 'employee' shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving on a fee basis or on a salary basis, or whether deputy sheriffs serving upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment, and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been

injured shall, when the employee is dead, include also his legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee as herein defined of a municipality, county, or of the State of North Carolina while engaged in the discharge of his official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of his employer.

Every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation specifically excluding such executive officer in such contract of insurance and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term employee shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-491(a) when performing duties in the course and scope of a State approved mission pursuant to Article 11 of Chapter 143B.

Employee shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

Any sole proprietor or partner of a business or any member of a limited liability company ~~whose employees are eligible for benefits~~

~~under this Article~~ may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article."

Sec. 36. G.S. 97-19 reads as rewritten:

"**§ 97-19. Liability of principal contractors; certificate that subcontractor has complied with law; right to recover compensation of those who would have been liable; order of liability.**

Any principal contractor, intermediate contractor, or subcontractor who shall sublet any contract for the performance of any work without requiring from such subcontractor or obtaining from the Industrial Commission a certificate, issued by a workers' compensation insurance carrier, or a certificate of compliance issued by the Department of Insurance to a self-insured subcontractor, stating that such subcontractor has complied with G.S. 97-93 hereof, shall be liable, irrespective of whether such subcontractor has regularly in service fewer than three employees in the same business within this State, to the same extent as such subcontractor would be if he were subject to the provisions of this Article for the payment of compensation and other benefits under this Article on account of the injury or death of any such subcontractor, any principal or partner of such subcontractor or any employee of such subcontractor due to an accident arising out of and in the course of the performance of the work covered by such subcontract. If the principal contractor, intermediate contractor or subcontractor shall obtain such certificate at the time of subletting such contract to subcontractor, he shall not thereafter be held liable to any such subcontractor, any principal or partner of such subcontractor, or any employee of such subcontractor for compensation or other benefits under this Article. ~~If the subcontractor has no employees and waives in writing his right to coverage under this section, the principal contractor, intermediate contractor, or subcontractor subletting the contract shall not thereafter be held liable for compensation or other benefits under this Article to said subcontractor. Subcontractors who have no employees are not required to comply with G.S. 97-93.~~

Any principal contractor, intermediate contractor, or subcontractor paying compensation or other benefits under this Article, under the foregoing provisions of this section, may recover the amount so paid from any person, persons, or corporation who independently of such provision, would have been liable for the payment thereof.

Every claim filed with the Industrial Commission under this section shall be instituted against all parties liable for payment, and said Commission, in its award, shall fix the order in which said parties shall be exhausted, beginning with the immediate employer.

The principal or owner may insure any or all of his contractors and their employees in a blanket policy, and when so insured such contractor's employees will be entitled to compensation benefits regardless of whether the relationship of employer and employee exists between the principal and the contractor."

Sec. 37. Reserved.

Sec. 38. Section 208(d) of Chapter 757 of the 1985 Session Laws, as amended by Section 1 of Chapter 480 of the 1991 Session Laws, is repealed.

Sec. 39. (a) Article 11 of Chapter 131E of the General Statutes (G.S. 131E-210 through G.S. 131E-213) is repealed.

(b) Chapter 131E of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 11A.

"Medical Care Data.

"**§ 131E-214. Title and purpose.**

(a) This Article is the Medical Care Data Act.

(b) The General Assembly finds that, as a result of rising medical care costs and the concern expressed by medical care providers, medical care consumers, third-party payors, and health care planners involved with planning for the provision of medical care, there is an urgent and continuing need to understand patterns and trends in the use and cost of medical care services in this State. The purposes of this Article are as follows:

(1) To ensure that there is an information base containing medical care data from throughout the State that can be used to improve the appropriate and efficient use of medical care services and maintain an acceptable quality of health care services in this State.

(2) To ensure that the necessary medical care data is available to university researchers, State public policymakers, and all other interested persons to improve the decision-making process regarding access, identified needs, patterns of medical care, charges, and use of appropriate medical care services.

(3) To ensure that a data processor receiving data under this Article protects patient confidentiality.

These purposes are to be accomplished by requiring that all hospitals and freestanding ambulatory surgical facilities submit information necessary for a review and comparison of charges, utilization patterns, and quality of medical services to a data processor that maintains a statewide database of medical care data and that makes medical care data available to interested persons, including medical care providers, third-party payors, medical care consumers, and health care planners.

"**§ 131E-214.1. Definitions.**

As used in this Article:

(1) 'Division' means the Division of Facility Services of the Department of Human Resources.

(2) 'Freestanding ambulatory surgical facility' means a facility licensed under Part D of Article 6 of this Chapter.

(3) 'Hospital' means a facility licensed under Article 5 of this Chapter or Article 2 of Chapter 122C of the General Statutes, but does not include the following:

a. A facility with all of its beds designated for medical type 'LTC' (long-term care).

b. A facility with the majority of its beds designated for medical type 'PSY-3' (mental retardation).

c. A facility operated by the North Carolina Department of Correction.

(4) 'Patient data' means data that includes a patient's age, sex, zip code, third-party coverage, principal and other diagnosis, date of admission, procedure and discharge date, principal and other procedures, total charges and components of the total charges, attending physician identification number, and hospital or freestanding ambulatory surgical facility identification number.

(5) 'Patient identifying information' means the name, address, social security number, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a health care provider if that number does not consist of or contain numbers, including social security or drivers license numbers, that could be used to identify a patient with reasonable accuracy and speed from sources external to the health care provider.

(6) 'Statewide data processor' means a data processor certified by the Division as capable of complying with the requirements of G.S. 131E-214.4. The Division may deny, suspend, or revoke a certificate, in accordance with Chapter 150B of the General Statutes, if the statewide data processor does not comply with or is not capable of complying with the requirements of G.S. 131E-214.4. The Division is authorized to promulgate rules concerning the receipt, consideration, and limitation of a certificate applied for or issued under this Article.

"**§ 131E-214.2. Data submission required.**

Except as prohibited by federal law or regulation, each hospital and freestanding ambulatory surgical facility shall submit patient data to a statewide data processor within 60 calendar days after the close of each calendar quarter for patients that were discharged or died during that quarter.

"**§ 131E-214.3. Patient data not public records.**

(a) The following are not public records under Chapter 132 of the General Statutes:

(1) Patient data furnished to and maintained by a statewide data processor pursuant to this Article.

(2) Compilations of patient data prepared for release or dissemination by a statewide data processor pursuant to this Article.

(3) Patient data furnished by a statewide data processor to the State.

(b) Compilations of data under subdivision (a)(3) of this section, prepared for release or dissemination by the State, are public records.

(c) The State shall not allow proprietary information, including patient data, that it receives from a statewide data processor to be used by a person for commercial purposes. The State shall require the person requesting this information to certify that it will not use the information for commercial purposes.

(d) A person is immune from liability for actions arising from the required submission of data under this Article.

"**§ 131E-214.4. Statewide data processor.**

(a) A statewide data processor shall perform the following duties:

(1) Make available annually to the Division, at no charge, a report that includes a comparison of the 35 most frequently reported charges of hospitals and freestanding ambulatory surgical facilities. The report is a public record and shall be made available to the public in accordance with Chapter 132 of the General Statutes. Publication or broadcast by the news media shall not constitute a resale or use of the data for commercial purposes.

(2) Receive patient data from hospitals and freestanding ambulatory surgical facilities throughout this State.

(3) Compile and maintain a uniform set of data from the patient data submitted.

(4) Analyze the patient data.

(5) Compile reports from the patient data and make the reports available upon request to interested persons at a reasonable charge determined by the data processor.

(6) Ensure that adequate measures are taken to provide system security for all data and information received from hospitals and freestanding ambulatory surgical facilities pursuant to this Article.

(7) Protect the confidentiality of patient records and comply with applicable laws and regulations concerning patient confidentiality, including the confidentiality of patient-identifying information. The data processor shall not disclose patient-identifying information unless (i) the information was originally submitted by the party requesting disclosure or (ii) the State Health Director requests specific individual records for the purpose of protecting and promoting the public health under Chapter 130A of the General Statutes, and the disclosure is not otherwise prohibited by federal law or regulation. Such records shall be made available to the State Health Director at a reasonable charge. Such records made available to the State Health Director are not public records; the State Health Director shall maintain their confidentiality and shall not make the records available notwithstanding G.S. 130A-374(a)(2).

(b) The Department of Human Resources may take adverse action against a hospital under G.S. 131E-78 or G.S. 122C-24 or against a freestanding ambulatory surgical center under G.S. 131E-148 for a violation of this Article."

(c) G.S. 58-68A-10(5)i. reads as rewritten:

"i. Jointly with the Commission and ~~the North Carolina Medical Database Commission,~~ a statewide data processor certified under Article 11A of Chapter 131E of the General Statutes, collect data from all community health plans and sponsor research into health outcomes and practice guidelines."

(d) G.S. 120-123(45) is repealed.

(e) This section does not require a person, corporation, or other entity not previously required to report data to the Medical Database Commission to report data under this section. This section does not require a person, corporation, or other entity to be a statewide data processor.

(f) G.S. 58-6-25(a), as amended by Section 3 of Chapter 360 of the 1995 Session Laws, reads as rewritten:

"(a) Charge Levied. – There is levied on each insurance company an annual charge ~~to defray the cost of regulating the insurance industry.~~ for the purposes stated in subsection (d) of this section. As used in this section, the term 'insurance company' means a company that pays the gross premiums tax levied in G.S. 105-228.5 and G.S. 105-228.8, except that the term does not include a hospital, medical, or dental service corporation regulated under Articles 65 and 66 of this Chapter. The term 'insurance company' does not include a company regulated under Article 67 of this Chapter. The charge levied in this section is in addition to all other fees and taxes. The charge shall be at a percentage rate of the company's premium tax liability for the taxable year. In determining an insurance company's premium tax liability for a taxable year, additional taxes imposed by G.S. 105-228.8 shall be disregarded.

(g) G.S. 58-6-25(d), as amended by Section 3 of Chapter 360 of the 1995 Session Laws, reads as rewritten:

"(d) Use of Proceeds. – The Insurance Regulatory Fund is created in the State treasury, under the control of the Office of State Budget and Management. The proceeds of the charge levied in this section and all fees collected under Articles 69 through 71 of this Chapter and under Articles 9 and 9C of Chapter 143 of the General Statutes shall be credited to the Fund. The Fund shall be placed in an interest-bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund may be spent only pursuant to appropriation by the General Assembly and in accordance with the line item budget enacted by the General Assembly. The Fund is subject to the provisions of the Executive Budget Act, except that no unexpended surplus of the Fund shall revert to the General Fund. All money credited to the Fund shall be used to reimburse the General Fund for money appropriated to State agencies to pay the expenses incurred in regulating the insurance ~~industry.~~ industry, in certifying statewide data processors under Article 11A of Chapter 131E of the General Statutes, and in purchasing reports of patient data from statewide data processors certified under that Article."

(h) Of the amount appropriated in Chapter 324 of the 1995 Session Laws to the Department of Insurance for the Medical Database Commission, the sum of one hundred fifty thousand dollars ($150,000) is transferred for fiscal year 1995-96 from the Department of Insurance to the Department of Human Resources, Division of Facility

Services, to be used to certify statewide data processors under Article 11A of Chapter 131E of the General Statutes and to purchase reports from statewide data processors certified under that Article. The remainder of the amount appropriated for the Medical Database Commission for that fiscal year that has neither been expended nor encumbered as of September 30, 1995, shall revert to the General Fund.

(i) The provisions of this section are severable. If the court declares a portion of this section unconstitutional or invalid, the remainder of the section is valid.

Sec. 40. Reserved.

Sec. 41. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Sec. 42. Sections 4, 7, 13, 14, 20, 23, 25, 27, 28, 29, 30, 31, and 36 and all of Section 39 except subsections (f) and (g) of that section become effective October 1, 1995. Section 33.1 is effective July 1, 1995. Section 3.1 becomes effective October 1, 1995, and applies to health benefit plans issued, renewed, or amended on or after that date. Section 26 is effective June 30, 1995. The remainder of this act is effective upon ratification. Section 34 expires December 31, 1997.

In the General Assembly read three times and ratified this the 29th day of July, 1995.

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Dennis A. Wicker
President of the Senate

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Harold J. Brubaker
Speaker of the House of Representatives