GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1999

HOUSE BILL 294
RATIFIED BILL

AN ACT TO AMEND THE LAW GOVERNING THE APPLICABILITY OF PREEXISTING CONDITION LIMITATIONS TO CERTAIN TYPES OF HEALTH INSURANCE POLICIES; TO PRESCRIBE STANDARDS FOR DISABILITY INCOME INSURANCE; TO CONFORM NORTH CAROLINA'S 1997 POSTMASTECTOMY RECONSTRUCTIVE SURGERY LAWS TO THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998; TO UPDATE THE LAW ON VIATICAL SETTLEMENTS; TO AUTHORIZE THE WRITING OF FAMILY LEAVE CREDIT INSURANCE; TO CLARIFY THAT LOCAL GOVERNMENT INSURANCE RISK POOLS ARE SUBJECT TO INSURANCE LAWS IN CHAPTER 58 ONLY WHEN SPECIFICALLY REFERRED TO IN THOSE LAWS; TO MAKE CONFORMING CHANGES IN THE STATE HEALTH PLAN REIMBURSEMENT FOR PASTORAL COUNSELORS; AND TO MAKE A TECHNICAL CHANGE CONCERNING THE CLAIMS ACKNOWLEDGMENT STATUTE.

The General Assembly of North Carolina enacts:

PART 1. PREEXISTING CONDITIONS FOR SPECIFIED DISEASE AND HOSPITAL INDEMNITY POLICIES.

Section 1. G.S. 58-51-15(h) reads as rewritten:

"(h) Preexisting Condition Exclusion Clarification. – Sub-subdivision (a)(2)b. of this section does not apply to:

(1) Policies issued to eligible individuals under G.S. 58-68-60.

(2) Excepted benefits as described in ~~G.S. 58-68-25(b).~~ G.S. 58-68-25(b)(1), (2), and (4)."

PART 2. DISABILITY INCOME INSURANCE.

Section 2. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-130. Standards for disability income insurance policies.**

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

(1) 'Disability income insurance policy' or 'policy' means a policy of accident and health insurance that provides payments when the insured is unable to work because of illness, disease, or injury.

(2) 'Policy' includes the certificates referred to in subsection (b) of this section.

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

(c) Disclosure Standards. – Every disability income insurance policy shall include provisions, where applicable, addressing:

(1) Terms of renewability.

(2) Initial and subsequent conditions of eligibility.

(3) Nonduplication of coverage.

(4) Preexisting conditions.

(5) Probationary periods.
(6) Elimination periods.
(7) Requirements for replacement.
(8) Recurrent conditions.
(9) Definitions of terms.

(d) Preexisting Conditions. – If an insurer does not seek a prospective insured's medical history in the application or enrollment process, the insurer shall not deny a claim for disabilities that commence more than 24 months after the effective date of the insured person's coverage on the grounds the disability is caused by a preexisting condition. A policy shall not define a preexisting condition more restrictively than 'a condition for which medical advice, diagnosis, care, or treatment was received or recommended within the 24-month period immediately preceding the effective date of coverage of the insured person.'

(e) Exceptions. – Nothing in this section prohibits an insurer from:
(1) Using an application or enrollment form designed to elicit the medical history of a prospective insured.
(2) Underwriting based on answers on the form according to the insurer's established standards.
(3) Contesting the answers in accordance with G.S. 58-51-15(a)(2)a.

(f) Required Provisions. – Each policy shall include:
(1) A description of the principal benefits and coverage provided in the policy.
(2) A statement of the exceptions, reductions, and limitations contained in the policy.
(3) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

(g) Other Applicable Provisions. – G.S. 58-51-95(f) applies to individual policies and G.S. 58-51-80(g) applies to group policies.

(h) Other Income Sources. – If a policy contains a provision that provides for integration of benefits with other income sources, it shall include a definition of what is considered other income sources and a complete description of how benefits will be reduced by other income sources, if at all. No disability income policy shall provide that the amount of any disability benefit paid to the insured shall be reduced by reason of any cost-of-living increase, designated as such under the federal Social Security Act, if the cost-of-living increase occurs during the period for which benefits are payable."

PART 3. RECONSTRUCTIVE SURGERY CONFORMING CHANGES.

Section 3.1. G.S. 58-51-62 reads as rewritten:

"**§ 58-51-62. Coverage for reconstructive breast surgery ~~resulting from~~ following mastectomy.**

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under ~~G.S. 58-50-60~~ G.S. 58-50-56 ~~that is issued, renewed, or amended on or after January 1, 1998, and~~ that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery ~~resulting from~~ following a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry ~~when~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) " Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) " Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter."

Section 3.2. G.S. 58-65-96 reads as rewritten:

"**§ 58-65-96. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56 ~~that is issued, renewed, or amended on or after January 1, 1998,~~ that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery ~~resulting from~~ following a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry ~~when~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) " Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) " Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;
(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;
(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or
(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the certificate, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter."

Section 3.3. G.S. 58-67-79 reads as rewritten:

"**§ 58-67-79. Coverage for reconstructive breast surgery following mastectomy.**

(a) Every health care plan written by a health maintenance organization ~~and in force, issued, renewed, or amended on or after January 1, 1998,~~ that is subject to this Article and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery ~~resulting from~~ following a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry ~~when~~ if reconstructive surgery on a diseased breast is ~~performed.~~ performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:
(1) " Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.
(2) " Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:
(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;
(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;
(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;
(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or
(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every individual person insured under the plan upon enrollment and annually thereafter."

PART 4. VIATICAL SETTLEMENTS.

Section 4. G.S. 58-58-42 reads as rewritten:

"**§ 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.~~

(1a) 'Financing entity' means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, reinsurer, or any person that may be a party to a viatical settlement contract and that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a licensed viatical settlement provider to act as a participant in a financing transaction.

(1b) 'Financing transaction' means a transaction in which a viatical settlement provider or a financing entity obtains financing for viatical settlement contracts, viaticated policies or interests therein including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering either registered or exempt from registration under federal and State securities law, or any direct purchase of interests in a policy or certificate, if the financing transaction complies with federal and State securities law.

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

(2a) 'Viatical settlement broker' means a person that on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers. 'Viatical settlement broker' does not include an attorney, accountant, or financial planner who is retained to represent the viator and whose compensation is paid directly by or at the direction of the viator.

~~(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 viatical settlement provider and a viator that establishes the terms under which the viatical settlement 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 all or a portion of the policy to the viatical settlement provider. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

(4a) 'Viatical settlement provider' means a person who enters into a viatical settlement contract with a viator. 'Viatical settlement provider' also means a person that obtains financing from a financing entity for the purchase, acquisition, transfer, or other assignment of one or more viatical settlement contracts, viaticated policies, or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates, or otherwise disposes of one or more viatical settlement contracts, viaticated policies, or interests therein. '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.

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.

d. A financing entity (i) whose sole activity related to the transaction is providing funds to effect the viatical settlement provider and (ii) that has a written agreement with a licensed viatical settlement provider to act as a participant in a financing transaction.

(4b) 'Viatical settlement representative' means a person who is an authorized agent of a viatical settlement provider or viatical settlement broker, as applicable, who acts in any manner in the solicitation of a viatical settlement. A viatical settlement representative is deemed to represent only the viatical settlement provider or viatical settlement broker. Viatical settlement representative does not include:

a. An attorney, accountant, or financial planner or any person exercising a power of attorney granted by a viator.

b. Any person who is retained to represent a viator and whose compensation is paid by or at the direction of the viator, regardless of whether the viatical settlement is consummated.

(4c) 'Viaticated policy' means a policy that has been acquired by a viatical settlement provider under a viatical settlement contract.

(5) " Viator" means the owner or holder of a policy insuring the life of an individual who has ~~a catastrophic or life-threatening~~ an illness or condition that is catastrophic, life-threatening, or chronic, and who enters into or seeks to enter into a viatical settlement contract.

(a1) Fiduciary Duty. – Regardless of the manner in which a viatical settlement broker is compensated, a viatical settlement broker represents only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

(b) Registration. – No person may act as a ~~provider~~ viatical settlement provider, viatical settlement representative, or viatical settlement broker, 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,~~ stockholders directly or indirectly holding ten percent (10%) or more of the voting securities of the viatical settlement provider, partners, officers, and employees. The Commissioner may refuse registration of any partnership, corporation, or other business entity if not satisfied that any

stockholder directly or indirectly holding ten percent (10%) or more of the voting securities of the viatical settlement provider, 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 viatical settlement 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 viatical settlement provider if the Commissioner finds that:

(1) There was any misrepresentation in the application for registration;
(2) The viatical settlement 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 viatical settlement provider;
(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to policy owners;
(4) The viatical settlement provider has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or
(5) The viatical settlement provider has violated a provision of this section.

(d) Approval of Contracts. – No viatical settlement 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 viatical settlement 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.

(e1) Identity of Viator. – Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement representative, viatical settlement broker, insurance company, insurance company agent, insurance broker, information bureau, rating agency or company, or any other person with actual knowledge of viator's identity, shall not disclose that identity to any other person unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator has provided prior written consent to the disclosure.
(2) Is provided in response to an investigation by the Commissioner or any other governmental officer or agency.

(3) Is a term of or condition to the transfer of a viaticated policy by one viatical settlement provider to another viatical settlement provider.

(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~~ viatical settlement provider, representative, or broker, or applicant for registration. The Commissioner may order any ~~provider~~ viatical settlement provider, representative, or broker, or applicant to produce records, books, files, or other information that is necessary to ascertain whether or not the ~~provider~~ viatical settlement provider, representative, or broker, or applicant is acting or has acted in violation of this section or otherwise contrary to the public interest. The ~~provider~~ viatical settlement provider, representative, or broker, 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 viatical settlement provider shall maintain records of all transactions of contracts and make the records available to the Commissioner for inspection during reasonable business hours. A viatical settlement provider shall maintain records of each viatical settlement until five years after the death of the insured.

(g) Disclosure. – A viatical settlement 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~~ viator 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.

(7) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator and that assistance should be sought from a financial adviser.

(g1) Disclosure Before Contract Execution. – A viatical settlement provider shall disclose the following information to the viator before the date the viatical settlement contract is signed by all parties:

(1) The affiliation, if any, between the viatical settlement provider and the issuer of an insurance policy to be viaticated.

(2) If a policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured, the viator shall be informed of the possible loss of coverage on the other lives and be advised to consult with his or her insurance producer or the company issuing the policy for advice on the proposed viatication.

(3) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy. The viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and

dismemberment benefits under the policy, and the viatical settlement provider's interest in those benefits.

(h) General Rules. – A viatical settlement 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 viatical settlement 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 viatical settlement 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.~~ State or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The account shall be managed by a trustee or escrow agent independent of the parties to the contract. 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 viatical settlement 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) Repealed by Session Laws 1998-211, s. 32.

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

PART 5. FAMILY LEAVE CREDIT INSURANCE.

Section 5.1. Article 57 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-57-115. Family leave credit insurance standards; policy provisions.**

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

(1) 'Foster child' means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

(2) 'Immediate family member' means a spouse, child (natural, adopted, or foster), or parent of the insured person.

(3) 'Placement in the foster home' means physically residing with the insured person appointed as the guardian or custodian of a foster child or children as long as the insured person has assumed the legal

obligation for total or partial support of the foster child or children with the intent that the foster child or children reside with the insured person on more than a temporary or short-term basis.

(b) Coverage. – Insurers may provide coverage for loss of income because of a voluntary, employer-approved leave of absence granted upon the occurrence of any of the qualifying events in subsection (d) of this section. The insured person shall not be required to meet any federal requirements in order to qualify for benefits provided by this coverage. Benefits shall be paid to the creditor to reduce the insured person's indebtedness.

(c) Eligibility. – Coverage may be provided or offered to any debtor who has not yet reached his or her 71st birthday and has been working for wages for at least 30 hours per week for the past five consecutive weeks.

(d) Qualifying Events. – Benefits shall be paid only for the following qualifying events:

(1) An accident involving sickness of, or incapacitation of, an immediate family member that requires the insured person to attend to the family member's needs.
(2) Birth of a child or children of the insured person.
(3) Adoption of a child or children of the insured person.
(4) Placement in the foster home of a foster child or children.
(5) The insured person's principal residence is in a federally declared disaster area.
(6) The insured person is called to active military duty.
(7) The insured person is called to petit or grand jury duty.

(e) Exclusions. – Coverage shall not contain any exclusions except:

(1) Retirement of the insured person from employment.
(2) Voluntary resignation of the insured person from employment.
(3) Seasonal unemployment of the insured person.
(4) Involuntary unemployment of the insured person.
(5) Disability of the insured person.
(6) Employment termination because of willful or criminal misconduct of the insured person.

(f) Notice. – The insurer shall send a notice to the insured person at the insured person's home address to inform the insured person that benefits have been paid, including the dates and the amount of payment. The notice shall be sent to the insured person within 60 days after the last day of the benefit period.

(g) Minimum Amounts. – The minimum monthly benefit amount shall be level for the entire benefit period. The minimum monthly benefit amount shall equal or exceed the minimum monthly payment required by the creditor, plus the premium charge for the coverage attributable to the benefit period.

(h) Miscellaneous Provisions. – Any waiting period for benefits shall not exceed 30 days. The insured shall provide satisfactory evidence of employer approval of qualified leave. Lump-sum benefits may be paid. Refunds of unearned single premiums shall be equal to the pro rata unearned gross premium.

(i) Rates. – Premium rates shall be actuarially demonstrated to generate a sixty percent (60%) incurred loss ratio. Joint coverage rates shall be one and two-thirds (1 2/3) times the approved single rate. Rates shall be filed for approval before they can be used.

(j) Reports. – By March 31 of each year every insurer writing family leave coverage shall file a statistical report of the past calendar year's actuarial experience for that coverage. The report shall demonstrate the actual experience loss ratio for the calendar year and shall include the: number of insureds, total earned premium, total number of incurred claims, total incurred claims, total number of incurred claims for each qualifying event, average monthly benefit per claim for each qualifying event, and premium refunds."

Section 5.2. G.S. 58-57-1 reads as rewritten:

"**§ 58-57-1. Application of Article.**

All credit life insurance, all credit accident and health insurance, all credit property insurance, all credit insurance on credit card balances, all family leave credit insurance, and all credit unemployment insurance written in connection with direct loans, consumer credit installment sale contracts of whatever term permitted by G.S. 25A-33, leases, or other credit transactions shall be subject to the provisions of this Article, except credit insurance written in connection with direct loans of more than 15 years' duration. The provisions of this Article shall be controlling as to such insurance and no other provisions of Articles 1 through 64 of this Chapter shall be applicable unless otherwise specifically provided; nor shall such insurance be subject to the provisions of this Article where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor."

Section 5.3. G.S. 58-57-5 is amended by adding the following new subdivision to read:

"(6a) 'Family leave credit insurance' means insurance on a debtor in connection with a specified loan or other credit transaction to provide payment to a creditor of the debtor for the installment payments or other periodic payments becoming due when the debtor suffers a loss of income because of a voluntary, employer-approved leave of absence for qualifying events specified in G.S. 58-57-115(d)."

PART 6. LOCAL GOVERNMENT RISK POOL CLARIFICATION.

Section 6. Article 23 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-23-45. Relationship to other insurance laws.**

Unless local government risk pools are specifically referenced in a particular section of this Chapter, no provisions in this Chapter other than this Article apply to local government risk pools."

PART 7. CONFORMING CHANGES FOR STATE HEALTH PLAN REIMBURSEMENT FOR PASTORAL COUNSELORS.

Section 7. G.S. 135-40.7B(c1) reads as rewritten:

"(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:

a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the direct supervision of such physicians, psychologists, or psychiatrists;

f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors; and
j. Certified fee-based practicing pastoral ~~counselors until July 1, 1999.~~ counselors.

(2) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager are authorized to provide treatment for chemical dependency in outpatient practice settings:
a. Licensed physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
f. Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. ~~Licensed~~ Certified fee-based practicing pastoral ~~counselors until July 1, 1999;~~ counselors; and
k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:
1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency."

PART 8. TECHNICAL CHANGE/CLAIMS SETTLEMENT STATUTE.

Section 8. If ratified Senate Bill 766 (1999 Session) becomes law, then G.S. 58-65-125(c), as enacted by Section 3 of that act, is repealed.

PART 9. EFFECT OF HEADINGS.

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

PART 10. EFFECTIVE DATE.

Section 10. Sections 2, 4, 5.1, 5.2, and 5.3 of this act become effective October 1, 1999. Section 7 of this act is retroactively effective to June 30, 1999. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 12th day of July, 1999.

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Dennis A. Wicker
President of the Senate

_____

James B. Black
Speaker of the House of Representatives

_____

James B. Hunt, Jr.
Governor

Approved _____.m. this _____ day of _____ , 19