HOUSE BILL 220:
Insurance Technical Changes.

2019-2020 General Assembly

Committee:	Senate Commerce and Insurance. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 26, 2019
Introduced by:	Reps. Setzer, Bumgardner, Corbin	**Prepared by:**	Jeremy Ray Kristen L. Harris Committee Co-Counsel
Analysis of:	PCS to Second Edition H220-CSTU-22		

OVERVIEW: The Proposed Committee Substitute for House Bill 220 makes various changes to North Carolina's insurance laws, as recommended by the Department of Insurance (DOI), including:

- ***Incorporates model act language from the National Association of Insurance Commissioners (NAIC) regarding immunity for independent contractors hired by DOI to assist in delinquency proceedings.***
- ***Makes technical and clarifying changes to consent to rate laws.***
- ***Amends procedures for individuals to receive an expedited external review of noncertification decisions.***
- ***Amends bail bond laws.***
- ***Clarifies the rulemaking authority of the North Carolina Fire and Rescue Commission.***
- ***Makes various changes to the Prepaid Health Plan Licensing Act.***
- ***Makes Medicare Supplement changes.***
- ***Makes changes to Exclusive Provider Benefit Plans.***

[As introduced, this bill was identical to S211, as introduced by Sens. Edwards, Gunn, J. Alexander, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS:

PART I. HOLDING COMPANY ACT CHANGES

SECTION 1. Adds the term "affiliates" as it relates to affiliates of the domestic insurer, as an additional type of security that a domestic insurer may invest in, provided other existing safeguards are met. Domestic insurers are currently allowed to invest in certain types of securities of "subsidiaries" of the domestic insurer as they are defined under G.S. 58-19-10(a), consistent with the same conditions.

PART II. SURPLUS LINES CHANGES

SECTION 2.(a) Deletes language referencing a quarterly report requirement for surplus lines licencees repealed in subsection 2(d).

SECTION 2.(b) Repeals statute requiring The North Carolina Surplus Lines Association to provide the COI with an annually updated list of surplus lines licensees.

SECTION 2.(c) Adds a copy of the compliance agreement to the documents a surplus lines licensee must keep in relation to its contracts.

SECTION 2.(d) Repeals a quarterly reporting requirement for surplus lines licenees.

SECTION 2.(e) Replaces failure to maintain the required bond, with failure to pay the stamping fee to the stamping office, as a grounds for Commissioner to suspend, revoke, or refuse to renew the licensee of a surplus lines licensee.

PART III. ALIGN STATE LAW WITH NAIC MODEL LAW REGARDING IMMUNITY FOR CONTRACTORS HIRED BY THE DEPARTMENT

SECTIONS 3.(a), 3.(b), & 3.(c) Adds NAIC model language, and associated conforming changes, that extends immunity from suit and liability, to all independent contractors who are retained by the receiver or the receiver's employees, and who are hired to assist in a delinquency proceeding. This includes: attorneys, accountants, auditors, and other professional persons or firms and their employees retained by the receiver.

An independent contractor would receive immunity both personally, and in their official capacities, for certain claims arising from:

- Duties of employment
- Matters subject to review by the Court after notice and hearing that are not disapproved, or disallowed by the Court.

An independent contractor extended immunity through this section would still be held liable for damages caused by their intentional, or willful and wanton misconduct.

PART IV. CLARIFY CONSENT TO RATE

SECTIONS 4.(a) through 4.(e) Makes several clarifying and technical changes to the insurance deviations laws, otherwise known as consent to rate. This includes erroneous cross references to sections that conflict with one another.

PART V. FAST ACT CONFORMING CHANGE

SECTION 5. Makes a technical correction and conforms North Carolina law to current federal law (Gramm-Leach-Bliley Act) by providing an exception to the annual privacy notice requirement for insurance institutions or agents, if all of the following apply:

- The insurance institution or agency provides nonpublic personal information only in accordance with certain federal privacy regulations; and
- The insurance institution or agency has not changed its policies or practices with regard to disclosing nonpublic personal information that were disclosed in the most recent required disclosure sent to consumers.

If at any time any of these requirements no longer apply to the insurance institution or agency, then the insurance institution or agency must provide the annual privacy notice required under this subsection.

PART VI. STREAMLINE EXPEDITED EXTERNAL REVIEW PROCESS

SECTIONS 6.(a), 6.(b), and 6.(c) Make changes to procedures for individuals to receive an expedited external review of noncertification decisions.

Part of this change would remove the requirement that medical advice from a medical consultant not affiliated with the organization be used in the determination of whether an expedited request should be

processed on an expedited basis. Instead, if the Commissioner determines that the request is eligible, a covered person's treating provider that is the subject of the external review would be allowed to certify the request on a form prescribed by the Commissioner.

Subsections (a) and (b) would become effective October 1, 2019, and apply to requests submitted on or after that date.

PART VII. BAIL BONDSMAN CHANGES

SECTION 7.(a) Adds a definition for premium to mean an amount of money paid in exchange for a bail bondsman's services in writing a bail bond.

SECTION 7.(b) Requires a bail bondsman to return a license to the Commissioner within 10 working days of a lapse (new status), suspension, or revocation of their license.

SECTION 7.(c) Requires bail bondsmen to include the court file or docket numbers for the principal's court obligation and the certificate seal number for each bond issued in the written reports filed with the Commissioner.

SECTION 7.(d) Amends language so information is provided to the principal automatically without the principal having to request it.

PART VIII. CLARIFY RULEMAKING AUTHORITY FOR STATE FIRE AND RESCUE

SECTION 8. Gives the State Fire and Rescue Commission with rule-making authority.

PART IX. PREPAID HEALTH PLAN LICENSING ACT CLARIFYING AND TECHNICAL CHANGES.

SECTIONS 9.(a), 9.(b), and **9.(f)** Makes technical and conforming changes to statutes relating to prepaid health plans.

SECTION 9.(c) Requires the Commissioner to notify the Department of Health and Human Services (DHHS) before conducting an examination of a prepaid health plan and provide the results of the examination.

SECTION 9.(d) Requires the Commissioner, to the greatest extent possible, to give notice to DHHS before seeking an application to rehabilitate or liquidate a prepaid health plan.

SECTION 9.(e) Requires the Commissioner to provide DHHS a copy of the written notice given to a prepaid health plan stating the grounds for denial, suspension, or revocation of a license.

PART X. CLARIFY WHEN APPLICATION SENT TO NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION

SECTION 10. Requires an application for a license as a self-insurer to be filed with the North Carolina Self-Insurance Security Association at the same time the application is filed with the Commissioner.

PART XI. MEDICARE SUPPLEMENT CHANGES

SECTION 11.(a) Requires insurers to make Medicare Supplement Plan A coverage available to disabled individuals before age 65. Insurers would also have to make Medicare Standardized Plan D and G coverage available to individuals age 65 or over. Section 11 would become effective January 1, 2020.

PART XII. EXCLUSIVE PROVIDER BENEFIT PLANS

SECTION 12.

Defines certain terms as they pertain to continuity of care decisions.

Provides a process for continued care for the insured under exclusive provider benefit plans if the insured is undergoing treatment for an *ongoing special condition* from a provider, and the contract between the provider and the insurer expires, or is terminated. An insured in this scenario would be allowed to elect continuation of treatment from the current provider.

Provides a transitional period to individuals who are *newly covered* under an exclusive provider benefit plan when the employer has changed benefit plans, and the insured is undergoing treatment for a special ongoing condition. Generally, a transitional period is determined by the treating physician, but is no longer than 90 days after notice is provided by the insurer following an expired or terminated contract, or the date of enrollment in a new plan.

Provides terms and conditions that an insurer may condition coverage of continued treatment.

Requires each insurer to provide a clear description of the insured's rights under this section in its evidence of coverage and summary plan description.

EFFECTIVE DATE: Except as otherwise provided, this act would become effective when it becomes law.

**Jason Moran-Bates, Legislative Analysis Division, substantially contributed to this summary.*