**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 1993**

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SENATE BILL 42

Short Title: Health Benefits/ Deductibles. (Public)

Sponsors: Senators Kincaid; and Carpenter.

Referred to: Insurance.

February 3, 1993

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE COORDINATION OF BENEFITS PAID UNDER ACCIDENT AND HEALTH INSURANCE POLICIES, AND TO ESTABLISH MINIMUM DEDUCTIBLES UNDER HEALTH AND ACCIDENT INSURANCE POLICIES.

The General Assembly of North Carolina enacts:

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

"(a) Required Provisions. – Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision in the substance of the following language:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

(2) A provision in the substance of the following language:

TIME LIMIT ON CERTAIN DEFENSES:

a. After two years from the date of issue or reinstatement of this policy no misstatements except fraudulent misstatements made

by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provisions may be used in its entirety only in major or catastrophe hospitalization policies and major medical policies each affording benefits of five thousand dollars ($5,000) or more for any one sickness or injury. Disability income policies affording benefits of one hundred dollars ($100.00) or more per month for not less than 12 months and franchise policies. Other policies to which this section applies must delete the words 'except fraudulent misstatements.'

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(b), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

1. Until at least age 50 or,
2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption 'INCONTESTABLE.'

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

b. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3) A provision in the substance of the following language:

GRACE PERIOD: A grace period of ..... (insert a number not less than '7' for weekly premium policies, '10' for monthly premium policies and '31' for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the record of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.)

(4) A provision in the substance of the following language:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

a. Until at least age 50 or,

b. In the case of a policy issued after age 44, for at least five years from its date of issue.)

(5) A provision in the substance of the following language:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary

to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.)

(6) A provision in the substance of the following language:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision in the substance of the following language:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision in the substance of the following language:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any period payment will be paid immediately upon receipt of due

written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision in the substance of the following language:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed one thousand dollars ($1,000)), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services, may at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.)

(10) A provision in the substance of the following language:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision in the substance of the following language:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements

of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision in the substance of the following language:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

(13) A provision in the substance of the following language:

COORDINATION OF BENEFITS: If there is valid coverage under another insurance plan providing benefits for the same loss, this insurer's liability for the loss shall be coordinated with the other plan's liability. The primary plan shall pay one hundred percent (100%) of the actual and medically necessary costs incurred except to the extent that such costs exceed coverage limits for the loss under the primary plan. As used in this subdivision, a 'primary plan' is the plan determined to be such under the order of benefits provisions of this subdivision, and whose benefits shall be determined before those of the other plan and without considering the other plan's benefits.

ORDER OF BENEFIT DETERMINATION: When there is more than one plan providing benefits for the same loss, the order of benefits is determined by using the first of the following provisions that apply:

a. Plans that pay on other than an expense incurred basis pay first.

b. Plans which cover the person as an employee, member, or subscriber pay before plans that cover the person as a dependent.

c. When there are two or more plans that cover the person as an employee, member, or subscriber, the plan that has covered the person longest is primary; the plan that has covered the person next longest is secondary; the plan that has covered the person next longest after secondary is terciary.

d. When the person is covered as a dependent under two or more plans, the plan that has covered the person longest is primary; the plan that has covered the person next longest is secondary; the plan that has covered the person next longest after secondary is terciary.

(14) A provision in the substance of the following language:

MINIMUM DEDUCTIBLES: Under this policy, there shall be a deductible in the amount of five hundred dollars ($500.00) per year for losses due to illness; a deductible in the amount of two hundred fifty

dollars ($250.00) per year for reimbursements for prescription drugs; and a deductible in the amount of fifty dollars ($50.00) per year for losses due to accidental injury."

Sec. 2. G.S. 58-51-80(b) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(2) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase 'groups of 50' must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.

(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any prior group plan. Credit must be given for that portion of the waiting period which was met under the prior plan.

(4) Policies shall contain a provision requiring coordination of benefits, as follows: If there is valid coverage under another insurance plan providing benefits for the same loss, this insurer's liability for the loss

shall be coordinated with the other plan's liability. The primary plan shall pay one hundred percent (100%) of the actual and medically necessary costs incurred except to the extent that such costs exceed coverage limits for the loss under the primary plan. As used in this subdivision, a 'primary plan' is the plan determined to be such under the order of benefits provisions of this subdivision, and whose benefits shall be determined before those of the other plan and without considering the other plan's benefits.

ORDER OF BENEFIT DETERMINATION: When there is more than one plan providing benefits for the same loss, the order of benefits is determined by using the first of the following provisions that apply:

a. Plans that pay on other than an expense incurred basis pay first.

b. Plans which cover the person as an employee, member, or subscriber pay before plans that cover the person as a dependent.

c. When there are two or more plans that cover the person as an employee, member, or subscriber, the plan that has covered the person longest is primary; the plan that has covered the person next longest is secondary; the plan that has covered the person next longest after secondary is terciary.

d. When the person is covered as a dependent under two or more plans, the plan that has covered the person longest is primary; the plan that has covered the person next longest is secondary; the plan that has covered the person next longest after secondary is terciary.

(5) Policies shall contain a provision requiring mandatory deductibles, in the substance of the following language:

MINIMUM DEDUCTIBLES: Under this policy, there shall be a deductible in the amount of five hundred dollars ($500.00) per year for losses due to illness; a deductible in the amount of two hundred fifty dollars ($250.00) per year for reimbursements for prescription drugs; and a deductible in the amount of fifty dollars ($50.00) per year for losses due to accidental injury."

Sec. 3. G.S. 58-65-60(c) reads as rewritten:

"(c) Every contract entered into by any such corporation with any subscriber thereof shall be in writing and a certificate stating the terms and conditions thereof shall be furnished to the subscriber to be kept by him. No such certificate form, other than to group subscribers of groups of 10 or more certificate holders or those issued pursuant to a master group contract covering 10 or more certificate holders shall be made, issued or delivered in this State unless it contains the following provisions, provided, however, groups between five and 10 certificate holders complying with and maintaining eligibility status under regulations approved by the Commissioner of Insurance for group enrollment may be cancelled if such participation falls below the minimum

participation of five certificate holders; or if the group takes other group hospital, medical or surgical coverage:

(1) A statement of the amount payable to the corporation by the subscriber and the times at which and manner in which such amount is to be paid; this provision may be inserted in the application rather than in the certificate. Application need not be attached to certificate.

(2) A statement of the nature of the benefits to be furnished and the period during which they will be furnished.

(3) A statement of the terms and conditions, if any, upon which the contract may be cancelled or otherwise terminated at the option of either party. Said statement shall be in the following language:

a. 'Renewability': Any contract subject to the provisions hereof is renewable at the option of the subscriber unless sufficient notice in writing of nonrenewal is mailed to the subscriber by the corporation addressed to the last address recorded with the corporation.

b. 'Sufficient notice' shall be as follows:

1. During the first year of any such contract, or during the first year following any lapse and reinstatement, or reenrollment, a period of 30 days.

2. During the second and subsequent years of continuous coverage, a number of full calendar months most nearly equivalent to one fourth the number of months of continuous coverage from the first anniversary of the date of issue or reinstatement or reenrollment, whichever date is more recent, to the date of mailing of such notice.

3. No period of required notice shall exceed two years, and no renewal hereunder shall renew any such contract for any period beyond the required period of notice except by written agreement of the subscriber and corporation.

Any such contract may be modified, terminated or cancelled by the corporation at any time at its option, upon:

a. Nonpayment of fees or dues as required, or

b. Failure or refusal to comply with rate or benefit changes approved by the State Insurance Department after public hearing as outlined in G.S. 58-65-45.

c. Failure or refusal after 30 days' written notice to subscriber to transfer into hospital and medical and/or dental service plan serving the area to which he has changed residence and is eligible for or to which corporation is required to transfer by interplan agreement of transfer.

d. The provisions of these amendments to subsection (c) and (c)(3) shall apply only to such contracts as are first issued on and after January 1, 1956.

(4) A statement that the contract includes the endorsement thereon and attached papers, if any, and together with the applications contains the entire contract.

(5) A statement that if the subscriber defaults in making any payment, under the contract, the subsequent acceptance of a payment by the corporation at its home office shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance.

(6) A provision requiring coordination of benefits, as follows: If there is valid coverage under another insurance plan providing benefits for the same loss, this insurer's liability for the loss shall be coordinated with the other plan's liability. The primary plan shall pay one hundred percent (100%) of the actual and medically necessary costs incurred except to the extent that such costs exceed coverage limits for the loss under the primary plan. As used in this subdivision, a 'primary plan' is the plan determined to be such under the order of benefits provisions of this subdivision and whose benefits shall be determined before those of the other plan and without considering the other plan's benefits.

ORDER OF BENEFIT DETERMINATION: When there is more than one plan providing benefits for the same loss, the order of benefits is determined by using the first of the following provisions that apply:

a. Plans that pay on other than an expense incurred basis pay first.

b. Plans which cover the person as an employee, member, or subscriber pay before plans that cover the person as a dependent.

c. When there are two or more plans that cover the person as an employee, member, or subscriber, the plan that has covered the person longest is primary; the plan that has covered the person next longest is secondary; the plan that has covered the person next longest after secondary is terciary.

d. When the person is covered as a dependent under two or more plans, the plan that has covered the person longest is primary; the plan that has covered the person next longest is secondary; the plan that has covered the person next longest after secondary is terciary.

(7) A provision requiring mandatory deductibles, in the substance of the following language:

MINIMUM DEDUCTIBLES: Under this policy, there shall be a deductible in the amount of five hundred dollars ($500.00) per year for losses due to illness; a deductible in the amount of two hundred fifty dollars ($250.00) per year for reimbursements for prescription drugs; and a deductible in the amount of fifty dollars ($50.00) per year for losses due to accidental injury."

Sec. 4. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-67-87. Coordination of benefits required.**

Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1994, that is subject to this Article, shall contain a written provision regarding the coordination of benefits when there is other valid coverage providing benefits for the same loss. Coordination of benefits provisions applicable to health maintenance organizations shall be those adopted as rules by the Commissioner of Insurance.

"**§ 58-67-88. Minimum deductibles required.**

Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1994, that is subject to this Article, shall provide for the following minimum deductibles: five hundred dollars ($500.00) per year for losses due to illness; two hundred fifty dollars ($250.00) per year for reimbursements for prescription drugs; and fifty dollars ($50.00) per year for losses due to accidental injury."

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

"**§ 58-36-1. North Carolina Rate Bureau created.**

There is hereby created a Bureau to be known as the 'North Carolina Rate Bureau,' with the following objects and functions:

(1) To assume the functions formerly performed by the North Carolina Fire Insurance Rating Bureau, the North Carolina Automobile Rate Administrative Office, and the Compensation Rating and Inspection Bureau of North Carolina, with regard to the promulgation of rates, for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof and valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; for theft of and physical damage to private passenger (nonfleet) motor vehicles as the same are defined under Article 40 of this Chapter; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and for workers' compensation and employers' liability insurance written in connection therewith except for insurance excluded from the Bureau's jurisdiction in G.S. 58-36-1(3).

(2) The Bureau shall provide reasonable means to be approved by the Commissioner whereby any person affected by a rate made by it may be heard in person or by his authorized representative before the governing committee or other proper executive of the Bureau.

(3) The Bureau shall have the duty and responsibility of promulgating and proposing rates for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof or valuable interest therein and other insurance

coverages written in connection with the sale of such property insurance; for insurance against theft of or physical damage to private passenger (nonfleet) motor vehicles; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and for workers' compensation and employers' liability insurance written in connection therewith. The provisions of this subdivision shall not apply to motor vehicles operated under certificates of authority from the Utilities Commission, the Interstate Commerce Commission, or their successor agencies, where insurance or other proof of financial responsibility is required by law or by regulations specifically applicable to such certificated vehicles. The Bureau shall have no jurisdiction over excess workers' compensation insurance for employers qualifying as self-insurers as provided in G.S. 97-93; nor shall the Bureau's jurisdiction include farm buildings, farm dwellings and their appurtenant structures, farm personal property or other coverages written in connection with farm real or personal property; travel or camper trailers designed to be pulled by private passenger motor vehicles, unless insured under policies covering nonfleet private passenger motor vehicles; residential real and personal property insured in multiple line insurance policies covering business activities as the primary insurable interest; and marine, general liability, burglary and theft, glass, and animal collision insurance, except when such coverages are written as an integral part of a multiple line insurance policy for which there is an indivisible premium.

(4) Agreements may be made between or among members with respect to equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. The members may agree between or among themselves on the use of reasonable rate modifications for such insurance, agreements, and rate modifications to be subject to the approval of the Commissioner.

(5) 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. 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.

(6) The Bureau shall maintain and furnish to the Commissioner on an annual basis the statistics on earnings derived by member companies from the investment of unearned premium, loss, and loss expense reserves on nonfleet private passenger motor vehicle insurance policies written in this State. Whenever the Bureau proposes rates under this Article, it shall prepare a separate exhibit for the experience years in question showing the combined earnings realized from the investment of such reserves on policies written in this State. The amount of earnings may in an equitable manner be included in the ratemaking formula to arrive at a fair and equitable rate. The Commissioner may require further information as to such earnings and may require calculations of the Bureau bearing on such earnings.

(7) Member companies shall furnish, upon request of any person carrying nonfleet private passenger motor vehicle insurance in the State upon whose risk a rate has been promulgated, information as to rating, including the method of calculation.

(8) The Bureau shall ensure that motor vehicle insurance policies written in this State and providing coverage for automobile medical payments contain written provisions requiring coordination of benefits when there is other valid coverage providing benefits for the same loss. Coordination of benefits provisions required under this subdivision, including order of benefits determinations, shall be governed by rules

adopted by the Commissioner of Insurance governing coordination of benefits for motor vehicle insurance policies."

Sec. 6. G.S. 58-37-25 is amended by adding the following new subsection to read:

"( d) All motor vehicle insurance policies regulated under this Article and providing coverage for automobile medical payments shall contain written provisions requiring coordination of benefits when there is other valid coverage providing benefits for the same loss. Coordination of benefits provisions required under this subsection, including order of benefits determinations, shall be governed by rules adopted by the Commissioner of Insurance for coordination of benefits under motor vehicle insurance policies."

Sec. 7. G.S. 58-36-35(b) reads as rewritten:

"(b) The Facility shall reinsure for each coverage available therein to the standard percentage of one hundred percent (100%) or lesser equitable percentage established in the plan of operation as follows:

(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

a. Bodily injury liability: twenty-five thousand dollars ($25,000) each person, fifty thousand dollars ($50,000) each accident;

b. Property damage liability: fifteen thousand dollars ($15,000) each person;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall not be available for motorcycles; medical payments covering the insured party on an expense incurred basis shall be subject to a fifty dollar ($50.00) deductible;

d. Uninsured motorist: twenty-five thousand dollars ($25,000) each person; fifty thousand dollars ($50,000) each accident for bodily injury; fifteen thousand dollars ($15,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission.

(2) Additional ceding privileges for motor vehicle insurance shall be provided by the Board of Governors if there is a substantial public demand for a coverage or coverage limit of any component of motor vehicle insurance up to the following:

Bodily injury liability: one hundred thousand dollars ($100,000) each person, three hundred thousand dollars ($300,000) each accident;

Property damage liability: fifty thousand dollars ($50,000) each accident;

Medical payments: two thousand dollars ($2,000) each person;

Underinsured motorist: one hundred thousand dollars ($100,000) each person and three hundred thousand dollars ($300,000) each accident for bodily injury liability;

Uninsured motorist: one hundred thousand dollars ($100,000) each person and each accident for bodily injury and fifteen thousand dollars ($15,000) for property damage (one hundred dollars ($100.00) deductible).

(3) Whenever the additional ceding privileges are provided as in G.S. 58-37-35(b)(2) for any component of motor vehicle insurance, the same additional ceding privileges shall be available to 'all other' types of risks subject to the rating jurisdiction of the North Carolina Rate Bureau."

Sec. 8. G.S. 58-50-130(a) reads as rewritten:

"(a) Health benefit plans covering small employers are subject to the following provisions:

(1) Except in the case of a late enrollee, any preexisting-conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months immediately before the effective date of coverage or as to a pregnancy existing on the effective date of coverage.

(2) In determining whether a preexisting-conditions provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous group health benefit plan if the previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:

a. For nonpayment of the required premiums by the policyholder or contract holder;

b. For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives;

c. For noncompliance with plan provisions that have been approved by the Commissioner;

d. When the number of enrollees covered under the plan is less than the number of insureds or percentage of enrollees required by participation requirements under the plan; or

e. When the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

f. When the small employer carrier stops writing new business in the small employer market, if:

1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and

2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.

A small employer carrier that stops writing new business in the small employer market in this State after January 1, 1992, shall be prohibited from writing new business in the small employer market in this State for a period of five years from the date of notice to the Commissioner. In the case of an HMO doing business in the small employer market in one service area of this State, the rules set forth in this subdivision shall apply to the HMO's operations in the service area, unless the provisions of G.S. 58-50-125(g) apply.

(4) Late enrollees may be excluded from coverage for the greater of 18 months or an 18-month preexisting-condition exclusion; however, if both a period of exclusion from coverage and a preexisting-condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months.

(5) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group.

(6) Health benefit plans covering small employers shall require the following deductibles: five hundred dollars ($500.00) per year for each loss due to illness; two hundred fifty dollars ($250.00) per year for reimbursement for prescription drugs; and fifty dollars ($50.00) per year for each loss due to accidental injury.

(7) Health benefit plans covering small employers shall require coordination of benefits when there is other valid coverage providing benefits for the same loss. Coordination of benefits provisions required under this subdivision, including order of benefits determinations, shall be governed by rules adopted by the Commissioner of Insurance."

Sec. 9. G.S. 58-53-95 reads as rewritten:

"**§ 58-53-95. Major medical plans.**

Subject to the provisions of this Article, if the group policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(1) A maximum benefit at least equal to either, at the option of the insurer,
   a. A maximum payment per covered person for all covered medical expenses incurred during that person's lifetime, equal to the lesser of the maximum benefit provided under the group policy or one hundred thousand dollars ($100,000); or
   b. A maximum payment for each unrelated injury or sickness, equal to the lesser of the maximum benefit provided under the group policy or one hundred thousand dollars ($100,000).

(2) Payment of benefits at the rate of eighty percent (80%) of covered medical expenses that are in excess of the deductible, until twenty percent (20%) of such expenses in a benefit period reaches one thousand dollars ($1,000), after which benefits will be paid at the rate of one hundred percent (100%) during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than fifty percent (50%).

(3) A deductible for each benefit period ~~which, at the option of the insurer,~~ which shall be ~~(i) the sum of the benefits deductible and one hundred dollars ($100.00),~~ (i) five hundred dollars ($500.00) for losses due to illness; two hundred fifty dollars ($250.00) for reimbursements for prescription drugs; and fifty dollars ($50.00) per year for losses due to accidental injury, or (ii) the corresponding deductible in the group ~~policy.~~ policy, whichever is higher. The term 'benefits deductible,' as used in this Part, means the value of any benefits provided on an expense incurred basis that are provided with respect to covered medical expenses by any other group or individual hospital, surgical, or medical insurance policy or medical practice or other prepayment plan, or any other plan, or program whether insured or uninsured, or by reason of any State or federal law and if, pursuant to G.S. 58-53-100, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by subdivision (1)a of this section, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is one hundred dollars ($100.00) or less, and not less than six months if the deductible exceeds one hundred dollars ($100.00).

(4) The benefit period shall be each calendar year when the maximum benefit is determined by subdivision (1)a of this section or 24 months when the maximum benefit is determined by subdivision (1)b of this section.

(5) The term 'covered medical expenses,' as used in this Part, shall include, in the case of hospital room and board charges, at a minimum the lesser of the dollar amount in G.S. 58-53-90(a)(1) and the average semiprivate room and board rate for the hospital in which the individual is confined, and at a minimum twice such amount for charges in an intensive care unit. Any surgical procedures schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a one thousand two hundred dollar ($1,200) maximum."

Sec. 10. G.S. 58-53-100 reads as rewritten:

"**§ 58-53-100. Alternative plans.**

At the option of the insurer, such plans of benefits set forth in G.S. 58-53-90 and 58-53-95 may be provided under one policy. Instead of providing the plans of benefits set forth in G.S. 58-53-90 and 58-53-95, the insurer may elect to provide a policy of comprehensive medical expense benefits without first dollar coverage. Said policy shall conform to the requirements of G.S. 58-53-95; provided, however, that an insurer electing to provide such a policy shall make available the following deductible options: ~~one hundred dollars ($100.00),~~ seven hundred fifty dollars ($750.00), ~~five hundred dollars ($500.00), and~~ one thousand dollars ~~($1,000).~~ ($1,000), and one thousand five hundred dollars ($1,500). Alternatively, such a policy may provide for deductible options equal to the greater of the benefits deductible and the amount specified in the preceding sentence."

Sec. 11. G.S. 135-39.5B reads as rewritten:

"**§ 135-39.5B. Prepaid plans.**

The Executive Administrator and Board of Trustees may, after consultation with the Committee on Employee Hospital and Medical Benefits, provide for optional prepaid hospital and medical benefits plans. ~~Benefits~~ Benefits, including deductibles required under G.S. 135-40.4, offered under such optional plans shall be comparable to those offered under the Plan. The amounts of State funds contributed for such optional plans shall not be more than the amounts contributed for each person eligible under G.S. 135-40.2 on a noncontributory Employee Only basis, with the person selecting an optional plan paying any excess, if necessary. The amount of State funds contributed to such optional plans shall also not exceed the amount of an optional plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees are authorized to assess and collect fees from participating optional plans provided by this section for administrative purposes and for risk management purposes. Such fees may be based upon the enrollees' risk factors and the number and types of contracts enrolled by each participating optional plan, and may be collected by the Plan in a manner prescribed by the Executive Administrator and Board of Trustees. In no instance shall benefits be paid under Part 3 of this Article for persons enrolled in an optional prepaid hospital and

medical benefit plan authorized under this section on and after the effective date of enrollment in the optional prepaid plan, except in cases of continuous hospital confinement approved by the Executive Administrator."

Sec. 12. G.S. 135-40.4 reads as rewritten:

"**§ 135-40.4. Benefits in general.**

In the event a covered person, as a result of accidental bodily injury, disease or pregnancy, incurs covered expenses, the Plan will pay benefits up to the amounts described in G.S. 135-40.5 through G.S. 135-40.9.

The Plan is divided into two parts. The first part includes certain benefits which are not subject to ~~a deductible or~~ coinsurance. The second part is a comprehensive plan and includes those benefits which are subject to ~~both a two hundred fifty dollar ($250.00) deductible for each covered individual to an aggregate maximum of seven hundred fifty dollars ($750.00) per family~~ both the deductibles required under this section and coinsurance of 80%/20%. The deductible required under this section for each covered individual is as follows: five hundred dollars ($500.00) for loss due to illness; two hundred fifty dollars ($250.00) for reimbursement for prescription drugs covered under the Plan; and fifty dollars ($50.00) for loss due to accidental injury. ~~There is a limit on out-of-pocket expenses under the second part.~~

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may begin the process of negotiating prospective rates of charges that are to be allowed under the Plan with preferred providers of institutional and professional medical care and services. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred provider contracts on a timely basis and shall make monthly reports to the President of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating such prospective rates for allowable charges."

Sec. 13. G.S. 135-40.5 reads as rewritten:

"**§ 135-40.5. Benefits not subject to ~~deductible or~~ coinsurance.**

(a) Repealed by Session Laws 1985,c. 192, s.5.

(a1) After deductibles required under G.S. 135-40.4 have been met, the benefits authorized under subsections (c) and (d) of this section are payable.

(b) Repealed by Session Laws 1991, c. 427, s. 20.

(c) Preadmission Testing. – The Plan will pay one hundred percent (100%) of reasonable and customary charges for diagnostic, laboratory and x-ray examinations performed on an outpatient basis.

(d) Second Surgical Opinions. – The Plan will pay one hundred percent (100%) of usual, reasonable and customary charges for one presurgical consultation by a second surgeon or other qualified physician as determined by the Claims Processor and Executive Administrator regarding the performance of nonemergency surgery. The Plan will also pay one hundred percent (100%) of the reasonable and customary charges for diagnostic, laboratory and x-ray examinations required by the second surgeon. Second surgical opinions for tonsillectomy and adenoidectomy procedures may be provided by Board-qualified pediatricians and family practitioners when qualified

surgeons are not available to provide second surgical opinions. Should the first two opinions differ as to the necessity of surgery, the Plan will pay one hundred percent (100%) of reasonable and customary charges for the consultation of the third surgeon.

As used in this section and the provisions of G.S. 135-40.8(b), second surgical opinions, and third surgical opinions when the first two opinions differ as to the necessity of surgery, shall be required for the following procedures otherwise covered by the Plan as the primary payer of health benefits: hysterectomy, revision of the nasal structure, coronary artery bypass surgery and surgery on the knee (except in procedures involving arthroscopic surgery when the diagnosis and the surgery can be performed in the same procedure and through the same incision). Second surgical opinions for coronary bypass surgery may be provided by doctors who are Board-qualified in internal medicine when qualified surgeons are not available to provide a second surgical opinion. The Claims Processor may waive the requirement for obtaining a second surgical opinion required by this subsection or required by G.S. 135-40.8(b) if the location and availability of surgeons qualified to provide second opinions creates an unjust hardship or if the medical condition of the patient would be adversely affected."

Sec. 14. The first paragraph preceding subdivision (1) of G.S. 135-40.6 reads as rewritten:

"The following benefits are subject to a deductible of ~~two hundred fifty dollars ($250.00)~~ five hundred dollars ($500.00) per covered individual for loss due to illness, two hundred fifty dollars ($250.00) per covered individual for reimbursement for prescription drugs covered under this section; and fifty dollars ($50.00) per covered individual for loss due to accidental injury ~~to an aggregate maximum of seven hundred fifty dollars ($750.00) per family per fiscal year~~ and are payable on the basis of eighty percent (80%) by the Plan and twenty percent (20%) by the covered ~~individual~~ individual: ~~up to a maximum of one thousand dollars ($1,000) out-of-pocket per fiscal year:~~"

Sec. 15. G.S. 135-40.8 reads as rewritten:

"**§ 135-40.8. Out-of-pocket expenditures.**

(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in G.S. 135-40.6. The covered individual is then responsible for the remaining twenty percent ~~(20%)~~ (20%). ~~until one thousand dollars ($1,000), in excess of the deductible, has been paid out-of-pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses.~~

(b) Where a covered individual fails to obtain a second surgical opinion as required under the Plan, or where a covered individual elects to have a surgery performed that conflicts with a majority opinion of the rendered consultations that the surgery requiring a second or third surgical opinion is not necessary, the covered individual shall be responsible for fifty percent (50%) of the eligible ~~expenses,~~ expenses. ~~provided, however, that no covered individual shall be required to pay, in addition to the expenses in subsection (a) above out-of-pocket in excess of five hundred dollars ($500.00) per fiscal year.~~

(c) Notwithstanding any other provision of this Article, on the first day of each confinement the Plan does not pay the first seventy-five dollars ($75.00) of the room

accommodation charge allowable under G.S. 135-40.6(1). Any readmission within 60 days after discharge for the same reason shall be considered the same confinement for the purpose of this subsection. The exclusion made under this subsection shall not count toward the ~~deductible~~ deductible. ~~nor toward the maximum amount of out-of-pocket costs.~~

(d) Where a network of qualified preferred providers of inpatient and outpatient hospital care is reasonably available for use by those individuals covered by the Plan, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year per covered individual in addition to the general coinsurance percentage ~~and maximum fiscal year amount~~ specified by G.S. 135-40.4 and G.S. 135-40.6."

Sec. 16. This act becomes effective January 1, 1994.