GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1995

H **1**

HOUSE BILL 289

Short Title: Insurance Reform/HPC. (Public)

Sponsors: Representatives Dickson, Blue, Wright; Alexander, Boyd-McIntyre, Earle, Hurley, Ives, Luebke, Rogers, Shaw, and Wainwright.

Referred to: Insurance.

February 23, 1995

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO CHAPTER 58 OF THE GENERAL STATUTES, INSURANCE, AND TO MAKE OTHER CHANGES REGARDING INSURANCE MATTERS, AS RECOMMENDED BY THE NORTH CAROLINA HEALTH PLANNING COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-130(a)(5) reads as rewritten:

"(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary ~~or~~ of an insurer, or controlled individual of an insurance holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. ~~No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act.~~"

Sec. 2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-185. Excess or stop loss coverage.**

Insurance against the risk of an economic loss assumed by a plan sponsor under a less than fully underwritten employee health benefit plan is subject to the following:

(1) The policy must be issued by a licensed insurer to the employer, trustee, other sponsor of the plan, or the plan itself for the purpose of insuring the purpose or plan but not for the purpose of insuring the employees, members, or participants;

(2) Payment by the insurer must be made to the employer, to the trustee or other sponsor of the plan, or to the plan itself, but not to the employees, members, participants, or health care providers;

(3) If the policy establishes an aggregate attaching point or retention, the point or retention may not be less than the greater of:

a. One hundred twenty percent (120%) of the expected claims against the health benefit plan; or

b. One hundred fifty thousand dollars ($150,000) for one plan year; and

(4) If the policy establishes an attaching point or retention applicable to each individual, the point or retention must not be less than twenty-five thousand dollars ($25,000)."

Sec. 3. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-173. Guaranteed health benefit plan; provisions.**

(a) As used in this section:

(1) 'Health benefit plan' means a plan covering a group of persons and in the form of: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by other federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident

b. Credit

c. Disability income

d. Long-term or nursing home care

e. Medicare supplement

f. Specified disease

g. Dental or vision

h. Coverage issued as a supplement to liability insurance

i. Workers' compensation

j. Medical payments under automobile or homeowners

k. Hospital income or indemnity

l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an entity subject to Articles 49, 65, or 67 of this Chapter.

(b) Effective January 1, 1996, notwithstanding any other provision of law, no insurer shall on account of the physical or mental condition or health of any person:

(1) Refuse to issue, deliver, or renew any health benefit plan.

(2) Have higher premium rate or charge for any health benefit plan.

(3) Reduce coverages or benefits or charge higher deductibles or copayments on any health benefit plan.

(4) Require evidence of individual insurability.

(c) An insurer shall not modify any health benefit plan with respect to any insured through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(d) Renewal of the health benefit plans shall be guaranteed by the insurer except:

(1) For nonpayment of the required premium by the policyholder or contract holder.

(2) For fraud or material misrepresentation by the policyholder or contract holder.

(3) When the insured ceases providing health benefit plans, provided notice of the decision to cease providing health benefit plans is given to the Commissioner and to the policyholder or contract holder six months before the renewal of the health benefit plan would have taken effect."

Sec. 4. G.S. 58-50-130(a)(1) and (2) read as rewritten:

"(1) Except in the case of a late enrollee, any preexisting-conditions provision may not limit or exclude coverage for a period beyond ~~12~~ six months following the insured's initial effective date of coverage and must define preexisting conditions as 'those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the ~~12-month~~ six-month period immediately preceding the effective date of the person's 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 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan. As used in this subdivision with respect to previous coverage, 'health benefit plan' is not limited to plans subject to this Act under G.S. 58-50-115."

Sec. 5. G.S. 58-51-80(b)(3) reads as rewritten:

"(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than ~~12~~ six

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~~ six-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~~ previous plan. Credit must be given for that portion of the waiting period which was met under the ~~prior~~ previous plan. As used in this subdivision, a 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more ~~persons:~~ persons and for groups under subdivision (1a) of this subsection and under G.S. 58-51-81: In determining whether a preexisting condition provision applies to an eligible ~~employee~~ employee, association member, student, 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 plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage."

Sec. 6. G.S. 58-51-80(h) reads as rewritten:

"(h) Nothing contained in this section ~~shall be deemed applicable~~ applies to any contract issued by any corporation defined in ~~Articles~~ Article 65 ~~and 66~~ of this Chapter. Subdivision (b)(3) of this section applies to MEWAs, as defined in G.S. 58-49-30(a)."

Sec. 7. G.S. 58-65-60(e)(2) reads as rewritten:

"(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than ~~12~~ six 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~~ six-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~~ previous plan. Credit must be given for that portion of the waiting period which was met under the ~~prior~~ previous plan. As used in this subdivision, a 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more persons: In determining whether a

preexisting condition 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 plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage."

Sec. 8. G.S. 58-67-85(c) reads as rewritten:

"(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than ~~12~~ six 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~~ six-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~~ previous plan. Credit must be given for that portion of the waiting period which was met under the ~~prior~~ previous plan. As used in this subdivision, a 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. ~~For employer groups of 50 or more persons:~~ In determining whether a preexisting condition 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 plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage."

Sec. 9. G.S. 58-51-15(a)(2)b. reads as rewritten:

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.~~ This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than one year after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the one-year 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 previous plan. Credit must be given for that portion of the waiting period that was met under the previous plan. As used in

this policy, the term 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an insured person, all health benefit plans must credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage."

Sec. 10. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-174. Subrogation by health insurers allowed.**

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by other federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Credit
b. Disability income
c. Coverage issued as a supplement to liability insurance
d. Workers' compensation
e. Medical payments under automobile or homeowners
f. Hospital income or indemnity
g. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an entity subject to Articles 49, 65, or 67 of this Chapter and Part 3 of Chapter 135 of the General Statutes governing the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

(b) Any health benefit plan may include a provision that, to the extent of the amount of benefits paid under a health benefit plan, an insurer shall be subrogated to all rights of recovery of the beneficiary of such benefits against any person for personal injuries for the treatment of which the benefits were paid. Once the insurer is so subrogated, the insurer may enforce, in its own name or in the name of the beneficiary, the legal liability of any person.

(c) Each insurer that writes health benefit plans shall periodically make and provide to the Commissioner an accounting of its subrogation activities under this section.

(d) The respective rights and interests of the beneficiary and insurer, if any, with respect to a common law cause of action against the person or persons responsible for the personal injuries for the treatment of which the benefits were paid (hereinafter referred to as 'third party'), and the damages recovered, shall be as set forth in this subsection:

(1) The beneficiary, or his personal representative if the beneficiary is dead, has the exclusive right to proceed to enforce the liability of the third party by appropriate proceedings if the proceedings are instituted not later than 12 months after the date of injury or death, whichever is later. During the 12-month period, and at any time thereafter if summons is issued against the third party during the 12-month period, the beneficiary or his personal representative has the right to settle with the third party and to give a valid and complete release of all claims to the third party by reason of the injury or death, subject to the provisions of subdivision (6) of this subsection.

(2) If settlement is not made and summons is not issued within the 12-month period, and if the insurer has made payment or acknowledged liability for the benefits giving rise to the subrogation rights authorized in this section, then either the beneficiary or the insured has the right to proceed to enforce the liability of the third party by appropriate proceedings; provided that, before exercising the right to enforce liability, the insurer must send written notice by certified mail, return receipt requested, to the beneficiary notifying the beneficiary of the insurer's intent to enforce its subrogation rights under this section, which notice must be given at least 60 days before the insurer's filing suit or making settlement. Either party has the right to settle with the third party and to give a valid and complete release of all claims to the third party by reason for the injury or death, subject to the provisions of subdivision (6) of this subsection; provided, that 60 days before the expiration of the period fixed by the applicable statute of limitations, if neither the beneficiary nor the insured has settled with or instituted proceedings against a third party, all the rights shall revert to the beneficiary or his personal representative.

(3) The person in whom the right to bring the proceeding or make settlement is vested shall, during the continuation thereof, also have the exclusive right to make settlement with the third party and release by the person having the right shall fully acquit and discharge the third party except as provided by the provisions of subdivision (6) of this subsection. A proceeding so instituted by the person having the right may be brought in the name of the beneficiary or his personal representative, and the insurer shall not be a necessary or proper party

thereto. During the time period that it has the right to proceed to enforce the liability of the third party, the insurer may bring the action in its own name but, in the event, shall notify the beneficiary of the action and allow the beneficiary to participate therein and assert any additional claims which the beneficiary has against the third party. If the beneficiary refuses to assert any claims, the insurer may only recover the subrogated amount, and the beneficiary's claims with respect to that amount against the third party shall thereafter be barred.

(4) The amount of benefits paid by the insurer on account of the injury or death shall not be admissible in evidence in any proceeding against the third party brought by the beneficiary. Any amount paid to the insurer by the third party for the insurer's subrogated claim for medical benefits, either through settlement or pursuant to a judgment, shall not be admissible in evidence in any proceeding against the third party brought by the beneficiary.

(5) If the insurer has filed a written admission of liability for benefits for which the insurer is subrogated pursuant to this section, or has made payments and obtained subrogation rights pursuant to this section, then any amount obtained by any person by settlement with, judgment against, or otherwise from the third party by reason of the injury or death shall be disbursed by order of the court for the following purposes and in the following order of priority:

a. First, to the payment of actual court costs taxed by judgment;

b. Second, to the payment of attorneys' fees. If the insurer and beneficiary are represented by separate counsel, each shall bear its own fees, regardless of by whom the action was initiated. Unless otherwise agreed to by the insurer or beneficiary:

1. The attorneys' fees are not to exceed one-third of the amount obtained or recovered of the third party; and

2. The attorneys' fees are to be paid by the beneficiary and the insurer in direct proportion to the amount each receives pursuant to this section, and the fees are to be deducted from the payments when distribution is made.

c. Third, to the beneficiary or his personal representative for amounts actually paid by the beneficiary to a hospital, physician, or other health care provider for the treatment of injuries caused by the third party.

d. Fourth, to the reimbursement of the insurer for all benefits paid for the treatment of injuries caused by the third party.

e. Fifth, to the payment of any amount remaining to the beneficiary or his personal representative.

(6) In any proceedings against or settlement with the third party, every party to the claim for damages shall have a lien to the extent of his

interest under subdivision (5) of this subsection, upon any payment made by the third party by reason of the injury or death, whether paid in settlement, in satisfaction of judgment, as consideration for covenant not to sue, or otherwise, and the lien may be enforced against any person receiving the funds. Neither the beneficiary nor his personal representative nor the insurer shall make any settlement with or accept any payment from the third party without the written consent of the other, and no release to or agreement with the third party shall be valid or enforceable for any purpose unless both insurer and beneficiary or his personal representative join therein; provided, this sentence shall not apply if the insurer is made whole for all benefits paid or to be paid by him under this section, less attorneys' fees as provided by sub-subdivisions (5)a. and b. of this subsection, and the release to or agreement with the third party is executed by the beneficiary.

(e) In no event shall the amount obtained by the insurer under this section exceed one-third of the net recovery made against a third party. As used in this subsection, 'net recovery' means the amount of money a beneficiary or personal representative is entitled to from a third party by virtue of a settlement or judgment, less attorneys' fees, and expenses incurred by the injured party in obtaining the settlement or judgment."

Sec. 11. G.S. 58-51-15(b) is amended by adding a new subdivision to read:

"(12) A provision in the substance of the following language: SUBROGATION: To the extent of the amount of benefits paid under this policy, the insurer shall be subrogated to all rights of recovery of the beneficiary of such benefits against any person for personal injuries for the treatment of which benefits were paid. Once the insurer is so subrogated, the insurer may enforce, in its own name or in the name of the beneficiary, the legal liability of any person."

Sec. 12. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-176. Prenatal and children's preventive health care.**

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by other federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident

b. Credit

c. Disability income

d. Long-term or nursing home care

e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an entity subject to Articles 49, 65, or 67 of this Chapter.

(3) 'Prenatal care services' include preventive, diagnostic, and therapeutic services which may include screening for potentially harmful conditions in the mother and fetus, and education and counseling as established in the reference compendium by the U.S. Preventive Services Task Force Report, Guide to Clinical Preventive Services.

(4) 'Well-child clinical preventive services' include health history, physical examinations, and developmental/risks assessments by physicians or other health practitioners acting within the scope of their license or certification, and specific age, gender, and risk factor-appropriate parental/patient counseling, immunizations, laboratory tests and other screening tests/measurements as established in the reference compendia by the U.S. Preventive Services Task Force Report, Guide to Clinical Preventive Services, and the National Coordinating Committee on Clinical Preventive Services, Preventive Services in the Clinical Setting: What Works and What It Costs.

(b) The same deductibles, coinsurance, and other limitations that apply to similar services covered under the health benefit plan apply to the coverages required by this section.

(c) Every insurer providing a health benefit plan in this State shall provide the coverages listed in this section.

(d) Coverage for 'prenatal care services' shall, at a minimum, be provided for all pregnant women, and shall include:

(1) An initial physical examination to include:
a. Blood pressure measurement,
b. Health history,
c. Counseling on nutrition, tobacco use, alcohol and other drug use, and motor vehicle safety belts,
d. Laboratory/diagnostic procedures including hemoglobin and hematocrit, ABO/Rh typing, Rh(D) antibody test, VDRL, Hepatitis B surface antigen (HBsAg), urinalysis for bacteriuria, gonorrhea culture;

(2) Follow-up physical examinations for nulliparous women, to include:
a. Discussion of the meaning of upcoming tests, blood pressure measurements, and urinalysis for bacteriuria for nulliparous women between 6-8, 8-10, 14-16, 24-28 weeks of gestation, and during the 32nd, 36th, 38th, and 40th weeks of gestation,
b. Maternal serum alpha-fetoprotein (MSAFP) between 14-16 weeks of pregnancy,
c. 50g oral glucose tolerance test between 24-28 weeks of gestation;
(3) Follow-up physical examinations for multiparous women, to include:
a. Discussion of the meaning of upcoming tests, blood pressure measurements, and urinalysis for bacteriuria for multiparous women between 6-8, 8-10, 14-16, 24-28 weeks of gestation, and during the 32nd, 36th, 39th, and 41st weeks of gestation.
b. Maternal serum alpha-fetoprotein (MSAFP) between 14-16 weeks of gestation.
c. 50g oral glucose tolerance test between 24-28 weeks of gestation.

(e) In consultation with the Department of Environment, Health, and Natural Resources, the Department shall adopt rules defining 'selective risk factors' necessitating hemoglobin electroporesis, rubella antibodies, chlamydia testing, counseling and testing for human immunodeficiency (HIV) in accordance with G.S. 130A-148(h), ultrasound cephalometry, and ultrasound examination.

(f) For women with selective risk factors, as defined pursuant to subsection (e) of this section, at a minimum the following additional interventions should be provided:
(1) During the initial visit, rubella antibodies screen, chlamydia testing and counseling and testing for human immunodeficiency (HIV),
(2) Between the 14-16 weeks of gestation, ultrasound cephalometry,
(3) Between the 24-28 weeks of gestation, Rh(D) antibody, gonorrhea culture, VDRL, Hepatitis B surface antigen (HBsAg), and counseling and testing for HIV, in accordance with G.S. 130A-148(h), between the 24-28 weeks of gestation, and
(4) During the 36th week of gestation, an ultrasound examination.

(g) The list of preventive services in this section is not exhaustive. It reflects those topics reviewed by the U.S. Preventive Services Task Force.

(h) Coverage for childhood immunizations shall at a minimum be provided as required by G.S. 130A-152.

(i) Coverage for well-child clinical preventive services shall, at a minimum, be provided as follows:
(1) For children ages birth to five years, nine office visits to include:
a. As appropriate by age, health history, a physical examination, developmental/risks assessments, parental counseling, and immunizations as required by G.S. 130A-152,

b. For children ages birth to 18 months, measurements for height and weight, and one hematocrit and one urinalysis during this period,

c. At least one serum lead measurement for all children between the ages of 6 and 24 months, and

d. An eye examination for amblyopia and strabismus for children between the ages of 3 and 4 years;

(2) For children ages 6 through 19 years, five office visits to include: as appropriate by age, immunizations as required under G.S. 130A-152, health history, physical examination, measurement of height, weight, and blood pressure, risks assessments, and parental/patient counseling.

(j) In consultation with the Department of Environment, Health, and Natural Resources, the Department shall adopt rules for defining high-risk conditions necessitating lead screening, hearing tests, and tuberculin skin tests, clinical testicular examinations, rubella antibody screen, VDRL, chlamydial testing, gonorrhea cultures, counseling and testing for HIV, and papanicolaou smears.

(k) For children identified as having high-risk conditions, well-child clinical preventive services shall be provided as follows:

(1) Tuberculin skin tests for children at high risk of contracting this communicable disease when recommended by a physician;

(2) Two serum lead measurements for children between birth and five years at high risk for lead exposure;

(3) One hearing test before a child reaches age three years and a second test between the ages of 13 and 19 years for those at risk for hearing loss;

(4) For children ages 13-19 years, as appropriate, testicular exam, rubella antibody screen, VDRL, chlamydial testing, gonorrhea culture, counseling and testing for HIV, tuberculin skin test, and for females who are sexually active, a papanicolaou smear as required under G.S. 58-67-76(e).

(l) The list of preventive services in this section is not exhaustive. It reflects those topics reviewed by the U.S. Preventive Services Task Force.

(m) Nothing in this section shall be construed, expressly or by implication, to limit the provision of additional prenatal care services or additional well-child clinical preventive services by clinicians after considering the patient's medical history and other individual circumstances.

(n) Nothing in this section shall be construed, expressly or by implication, to limit an insurer from providing coverage in addition to that required under this section for other prenatal care services or other well-child clinical preventive services, including office visits."

Sec. 13. G.S. 58-50-110(1b) reads as rewritten:

"(1b) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, ~~gender,~~

family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b)."

Sec. 14. G.S. 58-50-130(b) reads as rewritten:

"(b) For all small employer health benefit plans that are subject to this section and are issued on or after January 1, 1995, premium rates for health benefit plans subject to this section are subject to the following provisions:

(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employee's or dependent's age as determined in accordance with subdivision (6) of this subsection, ~~the gender of the eligible employee or dependent,~~ number of family members covered, or geographic area as determined under subdivision (7) of this subsection;

(2) Rating factors related to age, ~~gender,~~ number of family members covered, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review;

(3) Small employer carriers shall not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changed by twenty percent (20%) or more or benefits are changed;

(4) Carriers participating in an Alliance in accordance with the Health Care Purchasing Alliance Act may apply a different community rate to business written in that Alliance;

(5) In the case of health benefit plans issued before January 1, 1995, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may vary from the adjusted community rate, as determined by the small employer carrier and in accordance with subdivisions (1), (2), (3), and (4) of this subsection, for a period of two years after January 1, 1995, as follows:

a. On January 1, 1995, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system shall not vary from the adjusted community rate by more than twenty percent (20%), adjusted pro rata for any rating period of less than one year;

b. On January 1, 1996, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system shall not vary from the adjusted community rate by more than ten percent (10%), adjusted pro rata for any rating period of less than one year; and

c. On January 1, 1997, all small employer benefit plans that are subject to this section and are issued by small employer carriers before January 1, 1995, and that are renewed on or after January 1, 1997, renewal rates shall be based on the same adjusted community rating standard applied to new business.

(6) For the purposes of subsection (b) of this section, a small employer carrier shall not use age brackets of less than five years;

(7) For the purposes of subsection (b) of this section, a carrier shall not apply different geographic rating factors to the rates of small employers located within the same county; and

(8) The Department may adopt rules to administer this subsection and to assure that rating practices used by small employer carriers are consistent with the purposes of this subsection. Those rules shall include consideration of differences based on the following:

a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims costs;

b. Except as provided for in sub-subdivision a. of this subdivision, differences in premium rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates because of the demographics of groups assumed to select particular health benefit plans; and

c. Small employer carriers shall apply allowable rating factors consistently with respect to all small employers. Adjustments in rates for ~~age, gender,~~ age and geography shall not be applied individually. Any such adjustment shall be applied uniformly to the rate charged for all employee enrollees of the small employer."

Sec. 15. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-157. Standard and basic health care plan coverage of childhood immunizations, well-child clinical preventive services, and prenatal care services.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for childhood immunizations at least equal to the coverage required under G.S. 58-3-176.

(b) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for well-child clinical preventive services at least equal to the coverage required under G.S. 58-3-176.

(c) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prenatal care services at least equal to the coverage required under G.S. 58-3-176."

Sec. 16. (a) **Standardized benefit plans required.** Effective January 1, 1997, all entities licensed to provide group and nongroup health insurance or health benefit plans, hereinafter "health insurer", in this State shall offer on a guarantee-to-issue and guaranteed renewability basis at least three different health benefit plan products standardized according to coverage and premium rating structure.

(b) **Committee to design and evaluate standardized plans.** The Commissioner of Insurance shall appoint a committee to design the three standardized health insurance products required under subsection (a) of this section. Membership on the Committee shall include, in relatively equal proportions, representatives of business, health insurers, health care providers, and consumers. The Committee shall periodically review the products offered and shall eliminate and replace those that have proven to be unmarketable. The review shall be conducted annually during the first three years of implementation and biannually thereafter.

(c) **Three types of standardized plans.** The purpose of standardized plan offerings is to enable consumers and payers to make like-comparisons of costs and benefits among different plans. To this end, the three types of standardized products required to be offered by each health insurer are as follows:

(1) The small group standard product, developed in accordance with G.S. 58-50-125.

(2) Two different plans which are substantially similar to those recommended by the Benefits Advisory Committee in its September 22, 1994 report to the North Carolina Health Planning Commission. The plans shall include coverage of preventive primary, acute and chronic care, and mental health and substance abuse services. Mental health and substance abuse services shall be subject to case management and the same cost-sharing requirements as other nonpreventive medical services but without dollar or day limits. Preventive services shall be covered as recommended by the U.S. Preventive Services Task Force, with a periodicity schedule listed in "Preventive Services in the Clinical Setting, What Works and What It Costs", U.S. Department of Health and Human Services, Public Health Service, May 1993, with no cost-sharing.

Sec. 17. (a) The Department of Insurance shall phase in the adoption of the adjusted community rating method for premium rates for health plans covering nongroup products. The phase-in period shall commence effective January 1, 1996, shall be adopted over a five year period, and shall become effective for all nongroup products on January 1, 2001. In conducting the phase-in, the Department shall analyze and consider the recommendations of the National Association of Insurance Commissioners "Nongroup Consumer Protection and Market Reform Act".

(b) Effective January 1, 2001, G.S. 58-51-1 reads as rewritten:

"**§ 58-51-1. Form, classification and rates to be approved by Commissioner.**

No policy of insurance against loss or damage from the sickness or the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with, and the forms approved by, the Commissioner. Premium rates shall be developed according to the adjusted community rating method defined in G.S. 58-50-110. If the Commissioner shall notify, in writing, the company or other insurer which has filed such form that it does not comply with the requirements of law, specifying the reasons for his opinion, it shall be unlawful thereafter for any such insurer to issue any policy in such form. The action of the Commissioner in this regard shall be subject to review by any court of competent jurisdiction; but nothing in this Article shall be construed to give jurisdiction to any court not already having jurisdiction."

Sec. 18. The Department of Insurance shall continue to review and strengthen regulatory language and guidelines to enhance existing benefit requirements and ensure consumer protection and education with respect to the purchase of long-term care insurance. In doing so, the Department shall consider:

(1) Rules for preexisting conditions;
(2) Forfeiture of coverage;
(3) Impact of inflation on policy benefits;
(4) Notification procedures regarding lapsed policies; and
(5) Other applicable protections.

Sec. 19. (a) Section 5 of Chapter 347 of the 1993 Session Laws reads as rewritten:

"Sec. 5. This act becomes effective October 1, 1993, and applies to all plans and policies with an inception, renewal, or anniversary date on or after October 1, 1993. ~~This act expires October 1, 1998.~~"

(b) G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, or psychologist, physician assistant, or advanced practice registered nurse.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint which is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under such policy shall be entitled to payment of or reimbursement for such services, whether such services be performed by a duly licensed physician, a duly

licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a physician assistant, or an advanced practice registered nurse, notwithstanding any provision contained in such policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability which is within the scope of practice of a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under such policy shall be entitled to payment of or reimbursement for such disability whether such disability be certified by a duly licensed physician, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a physician assistant, or an advanced practice registered nurse, notwithstanding any provisions contained in such policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of such services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of his practice as defined in G.S. 90-151 unless a comparable limitation is imposed on such medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a 'duly licensed psychologist' shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a 'duly certified clinical social worker' is a 'certified clinical social worker' as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse or a physician assistant only when:

(1) The service performed is within the nurse's or physician assistant's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse or physician assistant is a regular employee in an office of a licensed physician;

(4) The service is not performed by the registered nurse while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); ~~and~~

(4a) The service is not performed by the physician assistant while the physician assistant is employed by a hospital, intermediate care facility, or home care agency; and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an 'advanced practice registered nurse' means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) For purposes of this section, a 'physician assistant' means only a physician assistant authorized to perform the medical acts, tasks, or functions authorized under G.S. 90-18 and G.S. 90-18.1."

(c) G.S. 58-65-1 reads as rewritten:

"**§ 58-65-1. Regulation and definitions; application of other laws; profit and foreign corporations prohibited.**

(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term 'hospital service plan' as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term 'medical service plan' as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, an advanced practice registered nurse, a duly certified clinical social worker, a physician assistant, and a duly licensed physician, then the insured or

beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, an advanced practice registered nurse, a duly certified clinical social worker, a physician assistant, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term 'medical services plan' also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

(b) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse or a physician assistant only when:

(1) The service performed is within the nurse's or physician assistant's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse or physician assistant is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); ~~and~~

(4a) The service is not performed while the physician assistant is employed by a hospital, intermediate care facility, or home care agency; and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

(c) For purposes of this section, an 'advanced practice registered nurse' means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

For the purposes of this section, a 'duly certified clinical social worker' is a 'certified clinical social worker' as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

For the purposes of this section, a 'duly licensed psychologist' shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

For purposes of this section, a 'physician assistant' means only a physician assistant authorized to perform the medical acts, tasks, or functions authorized under G.S. 90-18 and G.S. 90-18.1.

The term 'dental service plan' as used in this Article and Article 66 of this Chapter includes contracting for the payment of fees toward, or furnishing of dental and/or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The insured or beneficiary of every 'medical service plan' and of every 'dental service plan,' as those terms are used in this Article and Article 66 of this Chapter, or of any policy of insurance issued thereunder, that includes services which are within the scope of practice of both a duly licensed physician and a duly licensed dentist shall have the right to choose the provider of such care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed physician or a duly licensed dentist notwithstanding any provision to the contrary contained in any such plan or policy.

The term 'hospital service corporation' as used in this Article and Article 66 of this Chapter is intended to mean any nonprofit corporation operating a hospital and/or medical and/or dental service plan, as herein defined. Any corporation heretofore or hereafter organized and coming within the provisions of this Article and Article 66 of this Chapter, the certificate of incorporation of which authorizes the operation of either a hospital or medical and/or dental service plan, or any or all of them, may, with the approval of the Commissioner of Insurance, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical and/or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians and/or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical and/or dental service plan, or any or all of them.

The term 'preferred provider' as used in this Article and Article 66 of this Chapter with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article and Article 66 of this Chapter or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article and Article 66 of this Chapter. Except to the extent prohibited either by G.S. 58-65-140 or by regulations promulgated by the Department of Insurance not inconsistent with this Article and Article 66 of this Chapter, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.

(d) No foreign or alien hospital or medical and/or dental service corporation as herein defined shall be authorized to do business in this State."

Sec. 20. (a) The Department of Insurance in consultation with the Department of Environment, Health, and Natural Resources and the Department of Human Resources shall divide the State into health insurance regions for purposes of ensuring availability and continuity of health care insurance coverage and managed care. Regional boundaries should reflect to the fullest extent possible the SMSA, (Standard Metropolitan Statistical Area) county or existing public health service groupings, health-use patterns, and accessibility to a full array of appropriate health care services throughout the region. In

developing the regions, the Department shall take into account that effective July 1, 1996, insurance carriers and health plan providers that offer their services in a region, must offer the services to the entire region, subject to time limited exceptions granted by the Commissioner of Insurance.

(b) The Commissioner of Insurance shall adopt rules to implement this section. The rules shall include provisions for the Commissioner to grant time limited exceptions for plans that, for good cause shown, have been unable to develop their provider network in the entire region. The time limit shall be established to give the carrier or health plan the ability to bring in or develop its own resources in the affected communities.

Sec. 21. Effective July 1, 1996, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-177. Services available throughout region.**

(a) Definition. As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by other federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Health insurance region' means a geographic area of the State identified by the Department of Insurance as a health insurance region for purposes of making health care coverage and services available to all communities within the region.

(3) 'Insurer' includes an entity subject to Articles 49, 65, or 67 of this Chapter.

(b) Every insurer providing a health benefit plan in one or more health insurance regions in this State shall provide its services and products to the entire region for every

region served by the insurer. For good cause shown, an insurer may request an exception to this requirement for a limited period of time. The Commissioner shall review and act on the request for exception as provided in rules adopted by the Commissioner."

Sec. 22. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-178. Essential community provider contracts.**

(a) Purpose. The purpose of this section is to provide certain rural and urban primary care providers who serve medically underserved areas the opportunity to participate in managed care networks, to form local provider networks, and to contract in the more competitive managed care environment.

(b) Definitions. As used in this section:

(1) 'Eligible primary health care provider' means a health care provider who:

a. Meets the same credentialing and performance standards that the insurer or plan requires of other health care providers with whom the insurer or plan contracts for services, and

b. Is willing to accept the plan's reimbursement, utilization, and quality assurance arrangements, and

c. Serves significant percentages of Medicaid, Medicare, at-risk, or indigent patients in medically underserved areas, in accordance with rules adopted by the Commissioner.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by other federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(3) 'Insurer' includes an entity subject to Articles 49, 65, or 67 of this Chapter.

(4) 'Primary care' means health care provided under the health care practices of general pediatrics general internal medicine, family medicine, or obstetrics-gynecology.

(c) Limited term contracts required. Every insurer providing a health benefit plan in this State shall contract with an eligible health care provider in the insurer's or health benefit plan's service area for at least three consecutive years to provide services and receive reimbursement under the plan.

(d) The Commissioner shall adopt rules to implement this section."

Sec. 23. G.S. 58-3-171(a) reads as rewritten:

"(a) All claims submitted by health care providers to health benefit plans shall be submitted on a uniform form or format that shall be developed by the Department and approved by the ~~Commissioner.~~ Commissioner and shall conform to standards adopted by the American National Standards Institute pertaining to transmission, data element requirements, and security measures for protecting patient confidentiality. Additional information beyond that contained on the uniform form or format may be collected subject to rules adopted by the Commissioner. This section applies to the submission of claims in writing and by electronic means."

Sec. 24. G.S. 58-3-25(c) reads as rewritten:

"(c) ~~No insurer shall refuse to insure or refuse to continue to insure an individual; limit the amount, extent, or kind of coverage available to an individual; or charge and individual a different rate for the same coverage, because of the race, color, or national or ethnic origin of that individual.~~ Except as otherwise permitted by law, no insurer shall do any of the following to an individual based solely on the individual's race, color, age, gender, national origin, language, religion, socio-economic status, health status, real or perceived disability, or anticipated need for services:

(1) Refuse to insure or refuse to continue to insure the person; or

(2) Refuse to provide service under or refuse to enroll in any benefits plan; or

(3) Limit or reduce the amount, extent, or kind of benefits, service, or coverage.

This subsection supplements the provisions of G.S. 58-3-120, 58-33-80, 58-58-35, and 58-63-15(7). As used in this subsection, the term 'insurer' includes an entity subject to Articles 48, 65, or 67 of this Chapter and Part 3 of Chapter 135 of the General Statutes governing the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan."

Sec. 25. Effective January 1, 1997, the Department of Insurance shall monitor the compliance of health insurance plans under its regulatory authority to determine the extent of compliance with standards and measures adopted by the North Carolina Quality Improvement Commission. In monitoring compliance, the Department shall adopt rules to ensure that each health plan and randomly selected contracting providers are subject to

on-site review at least once every three years and more often, if necessary, to ensure compliance.

Sec. 26. This act is effective upon ratification. Sections 19 and 22 of this act apply to all plans and policies with an inception, renewal, or anniversary date on or after October 1, 1995.