

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017**

**SESSION LAW 2018-120
HOUSE BILL 382**

AN ACT TO INCORPORATE NAIC MODEL LANGUAGE INTO NORTH CAROLINA'S LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT; TO AMEND AND MAKE CLARIFYING CHANGES TO THE SURPLUS LINES ACT; TO AMEND CONSENT TO RATE AND CAPTIVE INSURANCE LAWS; AND TO AMEND AND MAKE TECHNICAL CHANGES TO OTHER INSURANCE LAWS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

PART I. AMEND THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT WITH NAIC MODEL LANGUAGE

SECTION 1.1.(a) G.S. 58-62-6 reads as rewritten:

"§ 58-62-6. Purpose.

(a) The purpose of this Article is to protect, subject to certain limitations, the persons specified in G.S. 58-62-21(a) against failure in the performance of contractual obligations, under ~~life and health insurance policies,~~ life, health, and annuity policies, plans, or contracts specified in G.S. 58-62-21(b), because of the delinquency of the member insurer that issued the ~~policies.~~ policies, plans, or contracts.

(b) To provide this protection, an association of member insurers is created to pay benefits and to continue coverages as limited herein, and members of the Association are subject to assessment to provide funds to carry out the purpose of this Article."

SECTION 1.1.(b) G.S. 58-62-16 reads as rewritten:

"§ 58-62-16. Definitions.

As used in this Article:

...

(2a) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the Board has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(2b) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

...

(3a) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the Association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the Association to member insurers.

(4) "Contractual obligation" means any obligation under a ~~policy~~ or ~~certificate~~ policy, contract, or certificate under a group ~~policy,~~ policy, or contract, or part thereof, for which coverage is provided under G.S. 58-62-21.



- (5) ~~"Covered"~~"Covered contract" or "covered policy" means any ~~policy within the scope of this Article~~policy, contract, or portion of a policy or contract for which coverage is provided under G.S. 58-62-21.
- (6) "Delinquent insurer" means an impaired insurer or an insolvent insurer; and "delinquency" means an insurer impairment or insolvency.
- (6a) "Extra-contractual claims" shall include claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.
- (6b) "Health benefit plan" means any hospital or medical expense policy or certificate or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include any of the following:
- a. Accident only insurance.
 - b. Credit insurance.
 - c. Dental only insurance.
 - d. Vision only insurance.
 - e. Medicare Supplement insurance.
 - f. Benefits for long-term care, home health care, community-based care, or any combination thereof.
 - g. Disability insurance.
 - h. Coverage for on-site medical clinics.
 - i. Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.
- (7) "Health insurance" includes hospital or medical service corporation contracts, health maintenance organization subscriber contracts and certificates, accident and health insurance, accident insurance, and disability insurance.
- ...
- (11) "Member insurer" means any ~~insurer~~insurer, health maintenance organization that is governed by Article 67 of this Chapter, and any hospital or medical service corporation that is governed by Article 65 of this Chapter and that is licensed or that holds a license to transact in this State any kind of insurance or health maintenance organization business for which coverage is provided under G.S. 58-62-21; and includes any insurer or health maintenance organization whose license in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include ~~an entity governed by Article 67 of this Chapter;~~ a fraternal order or fraternal benefit society; mandatory State pooling plan; mutual assessment company or any entity that operates on an assessment basis; insurance exchange; or any entity similar to any of the foregoing.
- ...
- (12a) "Owner" of a policy or contract and "policyholder," "policy owner," and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

- (13) "Person" includes an individual, corporation, limited liability company, partnership, association, ~~or aggregation of individuals~~, governmental body or entity, or voluntary organization.

...

- (14a) "Plan sponsor" means any of the following:

- a. The employer in the case of a benefit plan established or maintained by a single employer.
- b. The employee organization in the case of a benefit plan established or maintained by an employee organization.
- c. In a case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

- (15) ~~"Policy" includes a master group contract and subscriber contract under Article 65 of this Chapter, a contract of insurance and an annuity contract.~~

- (16) "Premiums" means amounts or considerations received in any calendar year on covered policies or contracts less returned premiums, considerations, and deposits returned thereon, deposits, and less dividends and experience credits thereon credits. "Premiums" does not include any amounts or considerations received for any ~~policies or for the parts of any policies~~ policies, contracts, or portions of policies or contracts for which coverage is not provided under G.S. 58-62-21(b); except that assessable premium shall not be reduced on account of G.S. 58-62-21(c)(3) relating to interest limitations and G.S. 58-62-21(d)(2) relating to limitations with respect to any one individual, any one participant, and any one ~~policy or contract holder~~ owner. Premiums shall not include premiums in excess of five million dollars (\$5,000,000) on an unallocated annuity contract not issued under a governmental retirement benefit plan or its trustee established under Section 401, 403(b), or 457 of the United States Internal Revenue Code of 1954, or with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars (\$5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

- (16a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

- a. The state in which the primary executive and administrative headquarters of the entity is located.
- b. The state in which the principal office of the chief executive officer of the entity is located.
- c. The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings.
- d. The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings.

- e. The state from which the management of the overall operations of the entity is directed.
- f. In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in G.S. 58-62-16(14a)c. shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(16b) "Receivership court" means the court in the delinquent insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

(17) "Resident" means any person who resides in this State when a member insurer is determined to be a delinquent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. "Resident" also means a U.S. citizen residing outside of the United States who owns a covered policy that was purchased from a member insurer while that person resided in this State. Citizens of the United States that are either (i) residents of foreign countries or (ii) residents of United States possessions, territories, or protectorates that do not have an association similar to the Association created by this Article shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

...
 (17b) "State" means any state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(17c) "Subaccount" means any of the subaccounts created under G.S. 58-62-26.

(17d) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

...."

SECTION 1.1.(c) G.S. 58-62-21 reads as rewritten:

"§ 58-62-21. Coverage and limitations.

(a) This Article provides coverage for the policies and contracts specified in subsection (b) of this ~~section~~:section to all of the following:

- (1) To persons other than persons specified in subdivisions (2a), (3) and (4) of this subsection who, regardless of where they ~~reside (except~~reside, ~~except~~ for nonresident certificate holders ~~or enrollees under group policies);~~policies or contracts, are the beneficiaries, assignees, or payees-payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subdivision (2) of this subsection;subsection.
- (2) To persons other than persons specified in subdivisions (2a), (3) and (4) of this subsection who are owners of or certificate holders or enrollees under the ~~policies, or in the case of unallocated annuity contracts to the persons who are~~

~~the contract holders, policies or contracts, and who are residents of this State, or who are not residents of this State, but only under all of the following conditions: (i) the insurers member insurer that issued the policies are or contracts is domiciled in this State; (ii) the insurers never held a license in the states in which the persons reside; (iii) the states in which the persons reside have associations similar to the association created by this Article; and (iv)~~(iii) the persons are not eligible for coverage by the associations; an association in any other state due to the fact that the insurer or the health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(2a) To persons who are the owners of unallocated annuity contracts, provided that the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this State, and persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents of this State, unless coverage is excluded pursuant to subsection (a1) or (a2) of this section.

(3) To persons who are payees (or payees, or beneficiaries of payees if the payees are deceased) deceased, under structured settlement annuities annuities, except as provided in subsections (a1) and (a2) of this section, if the payees are residents of this State, regardless of where the contract owners of the structured settlement annuities reside; and reside.

(4) To persons who are payees (or payees, or beneficiaries of payees if the payees are deceased) deceased, under structured settlement annuities annuities, except as provided in subsections (a1) and (a2) of this section, if the payees are not residents of this State, but only if all of the following conditions are met:

a. The contract owners of the structured settlement annuities are residents of this State or, if not residents of this State, (i) the insurers that issued the structured settlement annuities are domiciled in this State and (ii) the state in which the contract owners reside has an association similar to the Association created by this Article; and Article.

b. Neither the payees (or payees, or beneficiaries of payees if the payees are deceased) deceased, nor the contract owners of the structured settlement annuities are eligible for coverage by an association of the state in which the payees or contract owners reside.

(a1) This Article shall not provide coverage to any of the following:

(1) A person who is a payee or beneficiary of a contract owner resident of this State, if the payee or beneficiary is afforded any coverage by the association of another state.

(2) A person covered under subdivision (2a) of subsection (a) of this section, if any coverage is provided by the association of another state to the person.

(3) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(a2) This Article is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Article is provided coverage under the laws of any other state, the person shall not be provided coverage under this Article. In determining the application of the provisions of subsection (a) of this section in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee,

beneficiary, or assignee, this Article shall be construed in conjunction with other state laws to result in coverage by only one association.

(b) This Article provides coverage to the persons specified in subsection (a) of this section for policies or contracts of direct, nongroup life, health, annuity, life insurance, health insurance, or annuities, and supplemental policies, contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Article. Annuity contracts and certificates under group annuity contracts ~~include~~ include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, annuities, annuities issued in connection with government lotteries, and any immediate or deferred annuity contracts.

(c) ~~This~~ Except as provided for in subsection (c1) of this section, this Article does not provide coverage for ~~for any of the following:~~

- (1) Any part of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policyholder; policy or contract owner.
- (2) Any policy or contract of reinsurance, unless assumption certificates have been ~~issued;~~ issued pursuant to the reinsurance policy or contract.
- (3) Any part of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by the use of an index or other external reference stated in the policy or contract and employed in calculating returns or changes in value:
 - a. Averaged over the period of four years before the date on which the Association becomes obligated with respect to the policy, member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier, exceeds a the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for a lesser period if the policy or contract was issued less than four years before the Association became obligated; member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier; and
 - b. On and after the date on which the Association becomes obligated with respect to the policy, member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available; available.
- (4) Any portion of a policy or contract issued to a plan or program of an employer, association, or similar entity other person to provide life, health, or annuity benefits to its employees or members employees, members, or others to the extent that the plan or program is self-funded or uninsured, including including, but not limited to, benefits payable by an employer, association, or similar other entity under; under any of the following:
 - a. A multiple employer welfare arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended; 29 U.S.C. § 1002(40).
 - b. A minimum premium group insurance plan; plan.
 - c. A stop-loss group insurance plan; or plan.
 - d. An administrative services only contract; contract.
- (5) Any part of a policy or contract to the extent that it provides dividends or experience-rating credits, voting rights, or provides that any fees or

- allowances be paid to any person, including the ~~policyholder, policy or contract owner,~~ policy; policy or contract.
- (6) Any policy or contract issued in this State by a member insurer at a time when it was not licensed to issue the policy or contract in this ~~State;~~ State.
- (7) Any unallocated annuity contract issued ~~to an employee,~~ to, or in connection with, a benefit plan protected under the federal Pension Benefit Guaranty Corporation; and Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan.
- (8) Any part of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.
- (8a) Any part of a policy or contract to the extent that the assessments required by G.S. 58-62-41 with respect to the policy or contract are preempted by federal or state law.
- (8b) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including, without limitation:
- a. Claims based on marketing materials.
 - b. Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements.
 - c. Misrepresentations of or regarding policy or contract benefits.
 - d. Extra-contractual claims.
 - e. A claim for penalties or consequential or incidental damages.
- (8c) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.
- (9) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States ~~Code (commonly~~ Code, commonly known as Medicare Parts C & D); Subchapter XIX, Chapter 7 of Title 42 of the United States Code, commonly referred to as Medicaid, or any regulations issued pursuant thereto.
- (10) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this ~~Act,~~ Article, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture.

(11) Structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(c1) The exclusion for coverage referenced in subdivision (3) of subsection (c) of this section shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

(d) The benefits for which the Association is liable do not, in any event, exceed the lesser of:

(1) The contractual obligations for which the member insurer is liable or would have been liable if it were not a delinquent ~~insurer; or insurer.~~

(2) With respect to any one ~~individual, life,~~ regardless of the number of ~~policies, policies or contracts,~~ three hundred thousand dollars (\$300,000) for all benefits, including cash ~~values; or values.~~

(2a) With respect to health insurance benefits for any one ~~individual, life,~~ regardless of the number of policies:

a. Three hundred thousand dollars (\$300,000) for coverages not defined as ~~basic hospital, medical, and surgical insurance or major medical insurance as defined in this Chapter and regulations adopted pursuant to this Chapter, including disability insurance and long-term care insurance; or~~ health benefit plans.

b. Five hundred thousand dollars (\$500,000) for ~~basic hospital, medical, and surgical insurance or major medical insurance as defined in this Chapter and regulations adopted pursuant to this Chapter;~~ health benefit plans.

...

(6) However, in no event shall the Association be obligated to cover more than (i) an aggregate of three hundred thousand dollars (\$300,000) in benefits with respect to any one ~~individual—life~~ under subdivisions (2) and (3) and sub-subdivision (2a)a. except with respect to benefits for ~~basic hospital, medical, and surgical and major medical insurance~~ health benefit plans under sub-subdivision (2a)b. of this subsection, in which case the aggregate liability of the Association shall not exceed five hundred thousand dollars (\$500,000) with respect to any one ~~individual, life.~~

(7) The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this Article may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

(8) For the purposes of this Article, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(e) Repealed by Session Laws 2010-11, s. 2, effective June 23, 2010, and applicable to claims submitted to the North Carolina Life and Health Insurance Guaranty Association on or after August 7, 2009."

SECTION 1.1.(d) G.S. 58-62-26 reads as rewritten:

"§ 58-62-26. Creation of the Association.

(a) There is created a nonprofit legal entity to be known as the North Carolina Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance or a health maintenance organization business in this State. The Association shall perform its functions under the Plan established and approved under G.S. 58-62-46 and shall exercise its powers through the Board established under G.S. 58-62-31. For purposes of administration and assessment, the Association shall maintain two accounts:

(1) The life insurance and annuity account, which includes the following subaccounts:

- a. Life insurance ~~account;~~ account.
- b. Annuity ~~account;~~ account, which shall include annuity contracts owned by a governmental retirement plan or its trustee established under Section 401, 403(b), or 457 of the United States Internal Revenue Code 1954, but shall otherwise exclude unallocated annuities.
- c. Unallocated annuity account, which shall exclude contracts owned by a governmental retirement benefit plan or its trustee established under Section 401, 403(b), or 457 of the United States Internal Revenue Code 1954.

(2) The health ~~insurance~~-account.

(b) The Association is under the immediate supervision of the Commissioner and is subject to the applicable provisions of this ~~Chapter.~~ Article. Meetings or records of the Association may be opened to the public upon majority vote of the Board."

SECTION 1.1.(e) G.S. 58-62-31 reads as rewritten:

"§ 58-62-31. Board of directors.

(a) The Board shall consist of not less than ~~five-seven~~ nor more than ~~nine-11~~ member insurers serving terms as established in the Plan. The members of the Board shall be selected by member insurers, subject to the Commissioner's approval. Vacancies on the Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members, subject to the Commissioner's approval. In addition, two persons who must be public representatives shall be appointed by the Commissioner to the Board. A public representative may not be an officer, director, or employee of an insurance company or health maintenance organization or any person engaged in insurance or health maintenance organization business. To select the initial Board, and initially organize the Association, the Board's predecessor shall notify all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the Board is not selected within 60 days after notice of the organizational meeting, the Commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the Board, the Commissioner shall ~~consider, among other things, whether~~ ensure that all member insurers are fairly ~~represented.~~ represented between member insurers that write primarily life insurance and annuity contracts and member insurers that write primarily health benefit plans.

(c) Members of the Board may be reimbursed from the assets of the Association for expenses they incur as members of the Board, but they shall not otherwise be compensated by the Association for their services."

SECTION 1.1.(f) G.S. 58-62-36 reads as rewritten:

"§ 58-62-36. Powers and duties of the Association.

(a) If a member insurer is an impaired ~~domestic~~-insurer, the Association ~~may, may, in its discretion, and~~ may, in its discretion, and subject to any conditions imposed by the Association and approved by the Commissioner that do not impair the contractual obligations of the impaired ~~insurer and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired~~ insurer:

- (1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired ~~insurer;~~insurer.
- (2) Provide such monies, pledges, loans, notes, guarantees, or other means as are proper to carry out subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this ~~subsection;~~ subsection.
- ~~(3) Lend money to the impaired insurer.~~
- (b), (c) Repealed by Session Laws 2013-136, s. 2, effective July 1, 2013.
- (d) If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:
 - (1) Guarantee, ~~assume~~-assume, reissue, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent ~~insurer;~~ insurer, or
 - (2) ~~Assure~~assure payment of the contractual obligations of the insolvent ~~insurer;~~ insurer, and
 - (3) ~~Provide~~provide such monies, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge ~~those duties;~~ the Association's duties.
 - (4) ~~With respect only to life and health insurance policies, provide benefits and coverages in accordance with subsection (e) of this section.~~
 - (5) Provide benefits and coverages in accordance with the following provisions:
 - a. With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:
 - 1. With respect to group policies and contracts, not later than the earlier of the next renewal date under the policies or contracts or 45 days, but in no event less than 30 days after the date on which the Association becomes obligated with respect to the policies and contracts.
 - 2. With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than 30 days from the date on which the Association becomes obligated with respect to the policies or contracts.
 - b. Make diligent efforts to provide all known insureds, enrollees, or, in the case of nongroup policies and contracts, annuitants, or group policy or contract owners with respect to group policies and contracts 30 days' notice of the termination of the benefits provided.
 - c. With respect to nongroup policies and contracts covered by the Association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured, enrollee, or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of sub-subdivision d. of this subdivision, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had

no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.

- d. In providing the substitute coverage required under sub-subdivision c. of this subdivision, the Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the Commissioner. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract. The Association may reinsure any alternative or reissued policy or contract.
- e. Alternative policies or contracts adopted by the Association are subject to the Commissioner's approval. The Association may adopt alternative policies or contracts of various types for future issuance without regard to any particular delinquency. Alternative policies or contracts shall contain at least the minimum statutory provisions required in this State and provide benefits that are not unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates, which it shall adopt. The premium shall reflect the amount of insurance or coverage to be provided and the age and class of risk of each insured or enrollee but shall not reflect any changes in the health of the insured or enrollee after the original policy or contract was last underwritten. Any alternative policy or contract issued by the Association shall provide coverage of a type similar to that of the policy or contract issued by the delinquent insurer, as determined by the Association.
- f. If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the Association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to the prior approval of the Commissioner.
- g. The Association's obligations with respect to coverage under any policy or contract of the delinquent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the Association.
- h. When proceeding under subdivision (5) of this subsection with respect to any policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with G.S. 58-62-21(c)(3).

(d1) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections (a) and (d) of this section, the Association ~~may, subject to approval of the receivership court,~~ may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with all of the following provisions:

- (1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate, (ii) payment of dividends with minimum guarantees, or (iii) a different method for calculating interest or changes in ~~value;~~value.
 - (2) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or ~~contract;~~and contract.
 - (3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material ~~terms;~~terms.
- (e) ~~When proceeding under subdivision (b)(2) or (d)(4) of this section, the Association shall, with respect to only life and health insurance policies:~~
- (1) ~~Assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies of the insolvent insurer, for claims incurred:~~
 - a. ~~With respect to group policies, not later than the earlier of the next renewal date under the policies or 45 days, but in no event less than 30 days after the date on which the Association becomes obligated with respect to the policies;~~
 - b. ~~With respect to individual policies, not later than the earlier of the next renewal date (if any) under the policies or one year, but in no event less than 30 days from the date on which the Association becomes obligated with respect to the policies;~~
 - (2) ~~Make diligent efforts to provide all known insureds or group policyholders with respect to group policies 30 days' notice of the termination of the benefits provided; and~~
 - (3) ~~With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subsection (f) of this section, if the insured had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.~~
- (f) ~~In providing the substitute coverage required under subdivision (e)(3) of this section, the Association may offer either to reissue the terminated coverage or to issue an alternative policy. An alternative or reissued policy shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy. The Association may reinsure any alternative or reissued policy.~~
- (g) ~~Alternative life or health insurance policies adopted by the Association are subject to the Commissioner's approval. The Association may adopt alternative policies of various types for future issuance without regard to any particular delinquency. Alternative policies shall contain at least the minimum statutory provisions required in this State and provide benefits that are not unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates, which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but it shall not reflect any changes in the health of the insured after the original policy was last underwritten. Any alternative policy issued by the Association shall provide coverage of a type similar to that of the policy issued by the delinquent insurer, as determined by the Association.~~

(h) ~~If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated life or health insurance policy, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to the approval of the Commissioner or by a court of competent jurisdiction.~~

(i) ~~The Association's obligations with respect to coverage under any life or health insurance policy of the delinquent insurer or under any reissued or alternative policy cease on the date the coverage or policy is replaced by another similar policy by the policyholder, the insured, or the Association.~~

(j) ~~When proceeding under subdivision (b)(2) of this section or under subsection (e) of this section with respect to any policy carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with G.S. 58-62-21(e)(3).~~

(k) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued ~~policy policy, contract,~~ or substitute coverage terminates the Association's obligations under the ~~policy policy, contract,~~ or coverage under this Article with respect to the ~~policy policy, contract,~~ or coverage, except with respect to any claims incurred or any net cash surrender value that may be due under this Article.

(l) Premiums due for coverage after an entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the ~~Association; and the Association. If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding such premium collected by the Association. The Association is liable for unearned premiums owed to policyowners due to policy or contract owners~~ arising after the entry of the order.

(m) The protection provided by this Article does not apply where any similar guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of a delinquent foreign or alien member insurer.

(n) In carrying out its duties under ~~subsections (b) through~~ subsection (d) of this section, the Association may, subject to approval by ~~the court; a court in this State;~~

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the Association finds that the amounts that can be assessed under this Article are less than the amounts needed to assure full and prompt performance of the Association's duties under this Article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy or contract liens to be in the public ~~interest; interest.~~

(2) Impose temporary moratoria or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with ~~policies, policies or contracts,~~ in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the delinquent insurer, the Association may defer the payment of cash values, policy loans, or other rights by the Association for the period of the moratorium or moratorium charge imposed by the court, except for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(o) If the Association fails to act within a reasonable period of time as provided in ~~subdivision (b)(2) of this section and subsections~~ subsection (d) and (e) of this section, the Commissioner has the powers and duties of the Association under this Article with respect to delinquent insurers.

(p) The Association may render assistance and advice to the Commissioner, upon the Commissioner's request concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any delinquent insurer.

(q) The Association has standing to appear or intervene before any court or agency in this State with jurisdiction over a delinquent insurer for which the Association is or may become obligated under this ~~Article~~ Article or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. This standing extends to all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the delinquent insurer and the determination of the policies or contracts and contractual obligations. The Association also has the right to appear or intervene before a court or agency in another state with jurisdiction over a delinquent insurer for which the Association is or may become obligated or with jurisdiction over ~~a third party~~ any person or property against whom the Association may have rights through subrogation ~~of the insurer's policyholders~~ or otherwise.

(r) Any person receiving benefits under this Article is considered to have ~~been~~ assigned the rights under, and any causes of action against any person for losses arising under, resulting, from or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits received because of this Article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The Association may require an assignment to it of such rights and cause of action by any enrollee, payee, policyowner, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Article upon the person. The subrogation rights of the Association under this subsection have the same priority against the delinquent insurer's assets as that possessed by the person entitled to receive benefits under this Article. In addition to other provisions of this subsection, the Association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the delinquent insurer or ~~holder~~ owner, beneficiary, enrollee, or payee of a policy or contract with respect to the ~~policy~~ policy or contracts, including in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this Article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130. If the provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts or portion thereof covered by the Association. If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights as described in this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts or portion thereof covered by the Association.

(s) ~~The~~ In addition to the rights and powers elsewhere in this Article, the Association may do all of the following:

- (1) Enter into contracts that are necessary or proper to carry out the provisions and purposes of this ~~Article~~ Article.
- (2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under G.S. 58-62-41 and to settle claims or potential claims against ~~it~~ it.
- (3) Borrow money to effect the purposes of this Article; any notes or other evidence of indebtedness of the Association not in default shall be legal

investments for domestic member insurers and may be carried as admitted ~~assets;~~assets.

- (4) Employ or retain persons that are necessary to handle the financial transactions of the Association, and to perform other functions that become necessary or proper under this ~~Article;~~Article.
- (5) Take legal action that may be necessary to avoid or recover payment of improper ~~claims;~~claims.
- (6) Exercise, for the purposes of this Article and to the extent approved by the Commissioner, the powers of a domestic life ~~or~~ insurer, health insurer, or health maintenance organization, but in no case may the Association issue ~~insurance~~ policies or ~~annuity~~ contracts other than those issued to perform its obligations under this Article.
- (7) Organize itself as a corporation or in other legal form permitted by the laws of this State.
- (8) Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this Article with respect to the person, and the person shall promptly comply with the request.
- (9) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this Article.
- (10) Take other necessary or appropriate action to discharge its duties and obligations under this Article or to exercise its powers under this Article.

(t) The Association may join an organization of one or more other state associations of similar purposes, in order to further the purposes of this Article and administer the powers and duties of the Association.

(u) Reinsurance Contracts. –

- (1) At any time within 180 days of the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or in part, by the Association in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the Association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.
- (2) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the Association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings (i) copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed and (ii) notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.
- (3) The following shall apply to reinsurance contracts so assumed by the Association:
 - a. The Association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the

date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation in each case which relate to policies, contracts, or annuities covered, in whole or in part, by the Association. The Association may charge policies, contracts, or annuities covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these charges to the liquidator.

b. The Association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, provided that, upon receipt of any such amounts, the Association shall be obliged to pay to the beneficiary under the policy, contracts, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

1. The amount received by the Association.
2. The excess of the amount received by the Association over the amount equal to the benefits paid by the Association on account of the policy, contracts, or annuity less the retention of the insurer applicable to the loss or event.

c. Within 30 days following the Association's election (the "election date"), the Association and each reinsurer under contracts assumed by the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the Association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the Association pursuant to subdivision (2) of this subsection, the receiver shall remit the same to the Association as promptly as practicable.

d. If the Association or receiver, on the Association's behalf, within 60 days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium insofar as the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or in part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

- (4) During the period from the date of the order of liquidation until the election date or, if the election date does not occur, until 180 days after the date of the order of liquidation, neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under this subsection, whether for periods prior to or after the date of the order of liquidation; and the reinsurer, the receiver, and the Association shall, to the extent practicable, provide each other data and records reasonably requested; provided that once the Association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by this subsection.
- (5) If the Association does not elect to assume a reinsurance contract by the election date pursuant to this subsection, the Association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.
- (6) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the Association, in the case of contracts assumed under this subsection, subject to the following:
- a. Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred.
- b. The obligations described in this subsection shall no longer apply with respect to matters arising after the effective date of the transfer.
- c. Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days prior to the effective date of the transfer.
- (7) The provisions of this subsection shall supersede the provisions of any state law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.
- (8) Except as otherwise provided in this subsection, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this subsection shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this subsection shall give a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this subsection shall limit or affect the Association's rights as a creditor of the estate against the assets of the estate. Nothing in this subsection shall apply to reinsurance agreements covering property or casualty risks.

(v) The Board shall have discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of this Article in an economical and efficient manner.

(w) Where the Association has arranged or offered to provide the benefits of this Article to a covered person under a plan or arrangement that fulfills the Association's obligations under this Article, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

(x) Venue in a suit against the Association arising under this Article shall be in the Superior Court of Wake County. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this Article."

SECTION 1.1.(g) G.S. 58-62-41 reads as rewritten:

"§ 58-62-41. Assessments.

(a) ~~To provide~~For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the Board shall assess the member insurers, separately for each account, at such time and for such amounts as the Board finds necessary. Assessments are due not less than 30 days after prior written notice to the member insurers and shall accrue interest at the rate of one percent (1%) per month, or any part thereof, after the due date.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be ~~made~~authorized and called for the purpose of meeting administrative and legal costs and other ~~expenses and examinations conducted under the authority of G.S. 58-62-56(e).~~expenses. Class A assessments may be ~~made~~authorized and called whether or not ~~they are~~ related to a particular delinquent insurer.

(2) Class B assessments shall be ~~made~~authorized and called to the extent necessary to carry out the powers and duties of the Association under G.S. 58-62-36 with regard to a delinquent insurer.

(c) The amount of any Class A assessment shall be determined by the Board and may or may not be prorated. If prorated, the Board may provide that it be credited against future Class B assessments. ~~If not prorated, the assessment shall not exceed five hundred dollars (\$500.00) per member insurer in any one calendar year.~~ The amount of any Class B ~~assessment~~assessment, ~~except for assessments relating to long-term care insurance,~~ shall be allocated for assessment purposes ~~among~~between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula, which may be based on the premiums or reserves of the delinquent insurer or any other standard considered by the Board in its sole discretion to be fair and reasonable under the circumstances.

(c1) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the Plan and approved by the Commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

(d) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this State by each assessed member insurer or policies and contracts covered by each account and subaccount for the three most recent calendar years for which information is available preceding the year in which the member insurer became delinquent, ~~as the case may be, delinquent~~ bears to the premiums received on business in this State for those calendar years by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the Association with respect to a delinquent insurer shall not be ~~made~~authorized or called until necessary to implement the purposes of this Article. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

(f) The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the Board's opinion, payment of the assessment would endanger the member insurer's ability to fulfill its contractual obligations. If an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for

assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the Association.

(g) The total of all assessments authorized by the Association upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent (2%) of the life insurance and annuity account and for the health account shall not in any one calendar year exceed two percent (2%) of the member insurer's average annual premiums received in this State on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became a delinquent insurer. If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this subsection. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in either account an amount sufficient to carry out the Association's responsibilities, the necessary additional funds shall be assessed as soon thereafter as permitted by this Article.

(h) The Board may provide in the Plan a method of allocating funds among claims, whether relating to one or more delinquent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(i) If a one percent (1%) the maximum assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the Association's responsibilities, then under subsection (d) of this section, the Board shall assess all access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (g) of this section.

(j) The Board may, by an equitable method as established in the Plan, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses. ~~losses claims.~~

(k) It is proper for any member insurer, in determining its premium rates and ~~policy owner policy or contract owner~~ dividends as to any kind of insurance or health maintenance organization business within the scope of this Article, to consider the amount reasonably necessary to meet its assessment obligations under this Article.

(l) The Association shall issue to each member insurer paying an assessment under this Article, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

(m) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest. Within 60 days following the payment of an assessment under protest by a member insurer, the Association shall notify the member insurer in writing of its determination with respect to the protest unless the Association notifies the member insurer that additional time is required to resolve the issues raised by the protest. Within 30 days after a final decision has been made, the Association shall

notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the Commissioner. In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the Association may refer protests to the Commissioner for a final decision, with or without a recommendation from the Association. If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the Association.

(n) The Association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request."

SECTION 1.1.(h) G.S. 58-62-46(d) reads as rewritten:

"(d) The Plan shall, in addition to other requirements specified in this Article, ~~establish:~~establish all of the following:

- (1) Procedures for handling the assets of the Association;~~Association.~~
- (2) The amount and method of reimbursing members of the Board under G.S. 58-62-31;~~G.S. 58-62-31.~~
- (3) Regular places and times for meetings, including telephone conference calls, of the Board;~~Board.~~
- (4) Procedures for records to be kept of all financial transactions of the Association, its agents, and the Board;~~Board.~~
- (5) ~~The procedures~~ Procedures whereby selections for the Board will be made and submitted to the ~~Commissioner;~~ Commissioner.
- (6) Any additional procedures for assessments under G.S. 58-62-41;~~G.S. 58-62-41.~~
- (7) Additional provisions necessary or proper for the execution of the powers and duties of the Association.
- (8) Procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes a delinquent insurer.
- (9) Policies and procedures for the Board to address conflicts of interests."

SECTION 1.1.(i) G.S. 58-62-51 reads as rewritten:

"§ 58-62-51. Duties and powers of the Commissioner.

(a) In addition to other duties and powers specified in this Article, the Commissioner ~~shall:~~shall do all of the following:

- (1) Upon request of the Board, provide the Association with a statement of the premiums in this State and any other appropriate states for each member insurer;~~insurer.~~
- (2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the impaired insurer to comply promptly with the demand does not excuse the Association from the performance of its powers and duties under this Article;~~and Article.~~
- (3) ~~In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator as provided in Article 30 of this Chapter.~~

(b) The Commissioner may suspend or revoke, after notice and hearing, the license to transact ~~insurance~~business in this State of any member insurer that fails to pay an assessment when due or fails to comply with the Plan. As an alternative the Commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall

not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars (\$100.00) per month.

(c) Any action of the Board or the Association may be appealed to the Commissioner by any member insurer if the appeal is taken within 60 days of its receipt of notice of the final action being appealed. If a member ~~company~~insurer is appealing an assessment, the amount assessed shall be paid to the Association and available to meet Association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member ~~company~~insurer. No later than 20 days before each hearing, the appellant shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellee a written statement of the appellant's case and any evidence the appellant intends to offer at the hearing. No later than five days before the hearing, the appellee shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellant a written statement of the appellee's case and any evidence the appellee intends to offer at the hearing. Each hearing shall be recorded and transcribed. The cost of the recording and transcribing shall be borne equally by the appellant and appellee; however, upon any final adjudication the prevailing party shall be reimbursed for that party's share of the costs by the other party. Each party shall, on a date determined by the Commissioner or the Commissioner's designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or the Commissioner's designated hearing officer and serve on the other party, a proposed order. The Commissioner or the Commissioner's designated hearing officer shall then issue an order. Any final action or order of the Commissioner or the Commissioner's designated hearing officer is subject to judicial review under G.S. 58-2-75.

(d) The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify all interested persons of the effect of this Article."

SECTION 1.1.(j) G.S. 58-62-56 reads as rewritten:

"§ 58-62-56. Prevention of delinquencies.

(a) To aid in the detection and prevention of member insurer delinquencies, it is the Commissioner's duty to:

(1) Notify insurance regulators of all the other states, territories of the United States, and the District of Columbia within 30 days when revoking or suspending the license of a member insurer, or making any formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from this State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of ~~policyholders~~policy owners, contract owners, certificate holders or creditors. ~~That notice shall be sent electronically through the NAIC headquarters and mailed to all insurance regulators within 30 days following the action taken or the date on which the action occurs.~~

...

(3) Report to the Board when the Commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the member insurer may be delinquent.

...

(b) The Commissioner may seek the advice and recommendations of the Board concerning any matter affecting the Commissioner's duties and responsibilities regarding the financial condition of member insurers and ~~other entities~~insurers or health maintenance organizations seeking admission to transact ~~insurance~~ business in this State.

(c) The Board may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any ~~company~~insurer or health

maintenance organization seeking to do an ~~insurance~~ business in this State. The reports and recommendations are not public records.

...
(e) ~~The Board may, upon majority vote, request that the Commissioner order an examination of any member insurer that the Board in good faith believes may be delinquent. Within 30 days of the receipt of the request, the Commissioner shall begin the examination. The examination may be conducted as an NAIC examination or may be conducted by persons the Commissioner designates. The examination report shall be treated as are other examination reports. In no event shall the examination report be released to the Board before its release to the public; but this does not preclude the Commissioner from complying with subsection (a) of this section. The Commissioner shall notify the Board when the examination is completed. The request for an examination shall be kept on file by the Commissioner, but shall not be open to public inspection before the release of the examination report to the public.~~

(f) The Board may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of member insurer delinquencies, insolvencies.

(g) ~~The Board shall, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims, prepare a report to the Commissioner containing any information that it has in its possession bearing on the history and causes of the insolvency. The Board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and the Board may adopt by reference any report prepared by such other associations."~~

SECTION 1.1.(k) G.S. 58-62-61 reads as rewritten:

"§ 58-62-61. Miscellaneous provisions.

(a) Nothing in this Article reduces the liability for unpaid assessments of the insureds or enrollees of a delinquent insurer operating under ~~an insurance~~ plan with assessment liability.

(b) Records shall be kept of all negotiations and meetings in which the Association or its representatives are involved and in which the activities of the Association in carrying out its powers and duties under G.S. 58-62-36 are discussed. Records of those negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the delinquent insurer, upon the termination of the delinquency of the member insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the Association to render a report of its activities under G.S. 58-62-66.

(c) For the purpose of carrying out its obligations under this Article, the Association is a creditor of the delinquent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee under G.S. 58-62-36(r). Assets of the delinquent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the delinquent insurer as required by this Article. Assets attributable to covered ~~policies, policies or contracts,~~ as used in this subsection, are that proportion of the assets that the reserves that should have been established for the policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the delinquent insurer.

(d) Before the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders, contract owners, certificate holders, enrollees, and policyowners ~~policy owners~~ of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In making such a determination, consideration shall be given to the welfare of the ~~policyholders~~ policy owners, certificate holders, and enrollees of the continuing or successor member insurer.

(e) No distribution to stockholders, if any, of a delinquent insurer shall be made until and unless the Association has fully recovered the total amount of its valid claims with interest

thereon for funds expended in carrying out its powers and duties under G.S. 58-62-36 with respect to the member insurer.

(f) If an order for liquidation or rehabilitation of ~~an~~ a member insurer domiciled in this State has been entered, the receiver appointed under the order has a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections (g) through (i) of this section.

(g) No such distribution is recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the member insurer's ability to fulfill its contractual obligations.

(h) Any person who was an affiliate that controlled the member insurer when the distributions were paid is liable up to the amount of distributions it received. Any person who was an affiliate that controlled the member insurer when the distributions were declared is liable up to the amount of distributions it would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

...."

SECTION 1.1.(l) G.S. 58-62-66 reads as rewritten:

"§ 58-62-66. Examination of the Association; annual report.

The Association is subject to examination and regulation by the Commissioner. The Board shall submit to the Commissioner each year, not later than 120 days after the Association's fiscal year, a financial report in a form approved by the Commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the Association shall provide the member insurer with a copy of the report."

SECTION 1.1.(m) G.S. 58-62-81 reads as rewritten:

"§ 58-62-81. Stay of proceedings; reopening default judgments.

All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed ~~60~~180 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict or finding based on default, the Association may apply to have the judgment set aside by the same court that made the judgment and may defend against such suit on the merits."

SECTION 1.1.(n) G.S. 58-62-86 reads as rewritten:

"§ 58-62-86. Prohibited advertisement of Article in insurance sales; notice to policyholders.

(a) No ~~person~~person, including a member insurer, agent, or affiliate of a member insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any oral or written advertisement, announcement, or statement that uses the existence of the Association or this Article for the purpose of sale or solicitation of or inducement to purchase any kind of insurance or other coverage covered by this Article. However, this subsection does not apply to the Association or any other person who does not sell or solicit ~~insurance~~insurance or coverage by a health maintenance organization.

(b) Within 180 days after the effective date of this Article, the Association shall prepare a summary document that describes the general purposes and current limitations of this Article and that complies with subsection (c) of this section. This summary document shall be submitted to the Commissioner for the Commissioner's approval. Sixty days after receiving approval, no member insurer may deliver a policy ~~described in G.S. 58-62-21(b)~~or contract to any ~~person~~a

policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to ~~that person~~ the policy owner, contract owner, certificate holder, or enrollee before or at the time of delivery of the ~~policy, policy or contract~~, unless subsection (d) of this section applies. The summary document shall also be available upon request by a ~~policyholder~~ policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, contents, or interpretation of this summary document does not mean that either the policy or the contract or the ~~policyholder~~ policy owner, contract owner, certificate holder, or enrollee would be covered in the event of the ~~delinquency~~ impairment or insolvency of a member insurer. The summary document shall be revised by the Association as amendments to this Article require. Failure to receive this summary document does not give ~~any person~~ the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this Article.

(c) The summary document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall prescribe the form and content of the disclaimer. The disclaimer ~~shall~~ shall do all of the following:

- (1) State the name and addresses of the Association and ~~Department~~ Department.
- (2) Prominently warn the ~~policyholder~~ policy owner, contract owner, certificate holder, or enrollee that the Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this ~~State~~ State.
- (2a) State the types of policies or contracts for which guaranty funds will provide coverage.
- (3) State that the member insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sale or solicitation of or inducement to purchase any kind of ~~insurance~~ insurance or health maintenance organization coverage.
- (4) Emphasize that the ~~applicant or policyholder~~ applicant, policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the Association when selecting an ~~insurer~~ insurer or health maintenance organization.
- (4a) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this Article.
- (5) Provide other information as directed by the ~~Commissioner~~ Commissioner, including, but not limited to, sources for information about the financial condition of member insurers provided that the information is not proprietary and is subject to disclosure under public records law.

(d) No ~~insurer~~ insurer, health maintenance organization, or agent may deliver a policy or contract described in G.S. 58-62-21(b) and excluded under G.S. 58-62-21(c) from coverage under this Article unless the ~~insurer~~ insurer, health maintenance organization, or agent, before or at the time of delivery, gives the ~~policyholder~~ policy or contract owner, certificate holder, or enrollee a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the Association. The Commissioner shall prescribe the form and content of the notice."

SECTION 1.1.(o) G.S. 58-62-95 reads as rewritten:

"§ 58-62-95. Use of deposits made by impaired or insolvent insurer.

Notwithstanding any other provision of this Chapter pertaining to the use of deposits made by insurance or health maintenance organization companies for the protection of ~~policyholders~~ policy or contract owners, certificate holders, or enrollees, the Association shall receive, upon its request, from the Commissioner and may expend, any deposit or deposits made, whether or not made pursuant to statute, by ~~an~~ a member insurer determined to be impaired or insolvent under this Article to the extent those deposits are needed by the Association to pay contractual obligations of that impaired or insolvent insurer owed under covered policies as

required by this Article, and to the extent those deposits are needed to pay all expenses of the Association relating to the impaired or insolvent insurer: Provided that the Commissioner may retain and use an amount of the deposit up to ten thousand dollars (\$10,000) to defray administrative costs to be incurred by the Commissioner in carrying out his powers and duties with respect to the impaired or insolvent insurer, notwithstanding G.S. 58-5-70. The Association shall account to the Commissioner and the impaired or insolvent insurer for all deposits received from the Commissioner under this section. After the deposits of the impaired or insolvent insurer received by the Association under this section have been expended by the Association for the purposes set out in this section, the member insurers shall be assessed as provided by this Article to pay any remaining liabilities of the Association arising under this Article."

SECTION 1.2.(a) G.S. 58-67-145 reads as rewritten:

"§ 58-67-145. Rehabilitation, liquidation, or conservation of health maintenance organization.

Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies, except that the provisions of ~~Articles~~Article 48 and 62 of this Chapter shall not apply to health maintenance organizations. The Commissioner may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon one or more grounds set out in Article 30 of this Chapter or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State."

SECTION 1.2.(b) G.S. 58-67-171 reads as rewritten:

"§ 58-67-171. Other laws applicable to HMOs.

The following provisions of this Chapter are applicable to HMOs that are subject to this ~~Article:~~Article are as follows:

G.S. 58-2-125.	Authority over all insurance companies; no exemptions from license.
G.S. 58-2-150.	Oath required for compliance with law.
G.S. 58-2-155.	Investigation of charges.
G.S. 58-2-160.	Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
G.S. 58-2-162.	Embezzlement by insurance agents, brokers, or administrators.
G.S. 58-2-185.	Record of business kept by companies and agents; Commissioner may inspect.
G.S. 58-2-190.	Commissioner may require special reports.
G.S. 58-2-195.	Commissioner may require records, reports, etc., for agencies, agents, and others.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-50.	Companies must do business in own name; emblems, insignias, etc.
G.S. 58-3-100(c),(e).	Insurance company licensing provisions.
G.S. 58-3-115.	Twisting with respect to insurance policies; penalties.
G.S. 58-7-46.	Notification to Commissioner for president or chief executive officer changes.
G.S. 58-7-73.	Dissolution of insurers.
Part 7 of Article 10.	Annual Financial Reporting.
G.S. 58-50-35	Notice of nonpayment of premium required before forfeiture.
G.S. 58-51-15(a)(2)b.	Accident and health policy provisions.

G.S. 58-51-17	Portability for accident and health insurance.
G.S. 58-51-25.	Policy coverage to continue as to mentally retarded or physically handicapped children.
G.S. 58-51-35.	Insurers and others to afford coverage to mentally retarded and physically handicapped children.
G.S. 58-51-45.	Policies to be issued to any person possessing the sickle-cell trait or hemoglobin C trait.
<u>G.S. 58-62</u>	<u>Life and Health Insurance Guaranty Association."</u>

SECTION 1.3. Sections 1.1 and 1.2 of this act are effective when this act becomes law. The provisions of Sections 1.1 and 1.2 of this act shall not apply to any member insurer that is insolvent or unable to fulfill its contractual obligations on the effective date of this act.

PART II. AMEND SURPLUS LINES ACT AND MAKE CLARIFYING CHANGES

SECTION 2.1.(a) G.S. 58-21-2 reads as rewritten:

"§ 58-21-2. Relationship to other insurance laws.

~~Unless~~Except as provided in G.S. 58-21-21(c) and (g), unless surplus lines insurance, surplus lines licensees, nonadmitted domestic surplus lines insurers, or nonadmitted insurers are specifically referenced in a particular section of this Chapter, no sections contained in Articles of this Chapter other than this Article apply to surplus lines insurance, surplus lines licensees, nonadmitted domestic surplus lines insurers, or nonadmitted insurers."

SECTION 2.1.(b) G.S. 58-21-5 reads as rewritten:

"§ 58-21-5. Purposes; necessity for regulation.

This Article shall be liberally construed and applied to promote its underlying purposes, which ~~include~~include all of the following:

- (1) Protecting persons in this State seeking ~~insurance;~~insurance.
- (2) Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted domestic surplus lines insurers, nonadmitted insurers and exported from this State pursuant to this ~~Article;~~Article.
- (3) Establishing a system of regulation that will permit orderly access to surplus lines insurance in this State and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this ~~State;~~ and State.
- (4) Protecting revenues of this State."

SECTION 2.1.(c) G.S. 58-21-10 reads as rewritten:

"§ 58-21-10. Definitions.

As used in this Article:

- (1) "Admitted insurer" means an insurer licensed to engage in the business of insurance in this State.
- ...
- (3) "Eligible surplus lines insurer" means an alien insurer as defined in ~~G.S. 58-21-17~~G.S. 58-21-17, a nonadmitted domestic surplus lines insurer, or a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20.
- (4) "Export" means to place surplus lines insurance with a nonadmitted domestic surplus lines insurer or a nonadmitted insurer.
- (4a) "Nonadmitted domestic surplus lines insurer" means an insurer that is domiciled in and authorized pursuant to G.S. 58-21-21 to transact surplus lines insurance in this State.
- (5) "Nonadmitted insurer" means an insurer not licensed to do an insurance business in this State. "Nonadmitted insurer" includes insurance exchanges

authorized under the laws of various states. "Nonadmitted insurer" does not include a risk retention group, as defined in G.S. 58-22-10(10).

...

- (8) "Surplus lines insurance" means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted domestic surplus lines insurer or a nonadmitted insurer eligible to accept such insurance, including salary protection insurance. The term does not include reinsurance, commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities.
- (9) "Surplus lines licensee" means a person licensed under G.S. 58-21-65 to place insurance on risks resident, located, or to be performed in this State with a nonadmitted domestic surplus lines insurer or with nonadmitted insurers eligible to accept such insurance.
- (10) "Wet marine and transportation insurance" ~~means:~~means any of the following:
- a. Insurance upon vessels, crafts, hulls and of interests therein or with relation ~~thereto;~~thereto.
 - b. Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity ~~insurance;~~insurance.
 - c. Insurance of freights and disbursements pertaining to a subject of insurance coming within this ~~subsection;~~and subsection.
 - d. Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters including transportation by land, water, or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, transshipment, or reshipment incident thereto."

SECTION 2.1.(d) G.S. 58-21-16(a)(2) reads as rewritten:

"(2) The exempt commercial purchaser has subsequently requested in writing the licensee to procure or place such insurance from a nonadmitted domestic surplus lines insurer or a nonadmitted insurer."

SECTION 2.1.(e) G.S. 58-21-20 reads as rewritten:

"§ 58-21-20. Eligible surplus lines insurer required.

...

(a1) A surplus lines licensee shall not place coverage with a nonadmitted domestic surplus lines insurer unless, at the time of placement, the surplus lines licensee has verified that the insurer is a nonadmitted domestic surplus lines insurer as defined in G.S. 58-21-10."

SECTION 2.1.(f) Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read as follows:

"§ 58-21-21. Nonadmitted domestic surplus lines insurer.

(a) Notwithstanding any other law, a domestic insurer possessing minimum capital and surplus of at least fifteen million dollars (\$15,000,000), pursuant to a resolution by its board of directors and on the written approval of the Commissioner, may be designated as a nonadmitted domestic surplus lines insurer.

(b) A nonadmitted domestic surplus lines insurer shall only write surplus lines insurance in this State procured pursuant to the requirements of this Article. A nonadmitted domestic surplus lines insurer may write surplus lines insurance in any other jurisdiction in which the

insurer is eligible to write surplus lines insurance if the nonadmitted domestic surplus lines insurer complies with any requirements of that jurisdiction.

(c) Insurance written by a nonadmitted domestic surplus lines insurer is subject to the premium receipts tax required by G.S. 58-21-85.

(d) For the purposes of the federal Nonadmitted and Reinsurance Act of 2010 (15 U.S.C. § 8206), a domestic nonadmitted surplus lines insurer shall be considered a nonadmitted insurer as the term is defined in the Act with respect to risks insured in this State.

(e) Surplus lines insurance policies issued in this State by a nonadmitted domestic surplus lines insurer are not subject to the protection of or other provisions of Article 48 or 62 of this Chapter.

(f) Surplus lines insurance policies issued in this State by a nonadmitted domestic surplus lines insurer are not subject to and are exempt from all statutory requirements relating to insurance rating and rating plans, policy forms, policy cancellation, and nonrenewal in the same manner and to the same extent as a surplus lines insurer domiciled in another state.

(g) All financial and solvency requirements imposed upon domestic admitted insurers including the following, shall apply to nonadmitted domestic surplus lines insurers unless nonadmitted domestic surplus lines insurers are otherwise specifically exempted:

<u>G.S. 58-1-5.</u>	<u>Definitions.</u>
<u>G.S. 58-2-125.</u>	<u>Authority over all insurance companies; no exemptions from license.</u>
<u>G.S. 58-2-131.</u>	<u>Examinations to be made; authority, scope, scheduling, and conduct of examinations.</u>
<u>G.S. 58-2-132.</u>	<u>Examination Reports.</u>
<u>G.S. 58-2-133.</u>	<u>Conflict of interest; cost of examinations; immunity from liability.</u>
<u>G.S. 58-2-134.</u>	<u>Cost of certain examinations.</u>
<u>G.S. 58-2-150.</u>	<u>Oath required for compliance with law.</u>
<u>G.S. 58-2-155.</u>	<u>Investigation of charges.</u>
<u>G.S. 58-2-160.</u>	<u>Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.</u>
<u>G.S. 58-2-162.</u>	<u>Embezzlement by insurance agents, brokers, or administrators.</u>
<u>G.S. 58-2-165.</u>	<u>Annual, semiannual, monthly, or quarterly statements to be filed with Commissioner.</u>
<u>G.S. 58-2-185.</u>	<u>Record of business kept by companies and agents; Commissioner may inspect.</u>
<u>G.S. 58-2-190.</u>	<u>Commissioner may require special reports.</u>
<u>G.S. 58-2-195.</u>	<u>Commissioner may require records, reports, etc., for agencies, agents, and others.</u>
<u>G.S. 58-2-200.</u>	<u>Books and papers required to be exhibited.</u>
<u>G.S. 58-7-21.</u>	<u>Credit allowed a domestic ceding insurer.</u>
<u>G.S. 58-7-26.</u>	<u>Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of G.S. 58-7-121.</u>
<u>G.S. 58-7-30.</u>	<u>Insolvent ceding insurer.</u>
<u>G.S. 58-7-31.</u>	<u>Life and health reinsurance agreements.</u>
<u>G.S. 58-7-46.</u>	<u>Notification to Commissioner for president or chief executive officer changes.</u>
<u>G.S. 58-7-73.</u>	<u>Dissolution of insurers.</u>
<u>G.S. 58-7-160.</u>	<u>Investments unlawfully acquired.</u>

<u>G.S. 58-7-162.</u>	<u>Allowed or admitted assets.</u>
<u>G.S. 58-7-163.</u>	<u>Assets not allowed.</u>
<u>G.S. 58-7-165.</u>	<u>Eligible investments.</u>
<u>G.S. 58-7-167.</u>	<u>General qualifications.</u>
<u>G.S. 58-7-168.</u>	<u>Authorization of investment.</u>
<u>G.S. 58-7-170.</u>	<u>Diversification.</u>
<u>G.S. 58-7-172.</u>	<u>Cash and deposits.</u>
<u>G.S. 58-7-173.</u>	<u>Permitted insurer investments.</u>
<u>G.S. 58-7-179.</u>	<u>Mortgage loans.</u>
<u>G.S. 58-7-180.</u>	<u>Chattel mortgages.</u>
<u>G.S. 58-7-183.</u>	<u>Special consent investments.</u>
<u>G.S. 58-7-185.</u>	<u>Prohibited investments and investment underwriting.</u>
<u>G.S. 58-7-188.</u>	<u>Time limit for disposal of ineligible property and securities; effect of failure to dispose.</u>
<u>G.S. 58-7-190.</u>	<u>Valuation of securities and investments.</u>
<u>G.S. 58-7-193.</u>	<u>Valuation of property.</u>
<u>G.S. 58-7-197.</u>	<u>Replacing certain assets; reporting certain liabilities.</u>
<u>G.S. 58-7-200.</u>	<u>Investment transactions.</u>
<u>G.S. 58-7-205.</u>	<u>Derivative transactions.</u>
<u>Part 7 of Article 10.</u>	<u>Annual Financial Reporting.</u>
<u>Part 10 of Article 10.</u>	<u>Risk Management and Own Risk and Solvency Assessment.</u>
<u>Article 12.</u>	<u>Risk-Based Capital Requirements.</u>
<u>Article 13.</u>	<u>Asset Protection Act.</u>
<u>Article 19.</u>	<u>Insurance Holding Company System Regulatory Act.</u>
<u>Article 30.</u>	<u>Insurers Supervision, Rehabilitation, and Liquidation."</u>

SECTION 2.1.(g) G.S. 58-21-40 reads as rewritten:

"§ 58-21-40. Surplus lines regulatory support organization.

(a) ~~A surplus lines~~ The North Carolina Surplus Lines Association (NCSLA) shall serve as the regulatory support organization of surplus lines licensees shall be formed to and shall carry out the following functions:

- (1) Facilitate and encourage compliance by resident and nonresident surplus lines licensees with the laws of this State and the rules and regulations of the Commissioner relative to surplus lines insurance.
- (2) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market.
- (3) Receive and disseminate to surplus lines licensees information about surplus lines insurance, including, without limitation, new electronic filing procedures approved by the Commissioner, changes in the list of eligible surplus lines insurers, and modifications in coverages, procedures, and requirements as may be requested by the Commissioner.
- (4) Establish and operate a stamping office to process all surplus lines insurance and remit premium taxes for those coverages under G.S. 58-21-85 by means satisfactory to the Commissioner, and charge surplus lines licensees a fee for such processing.

(b) ~~The regulatory support organization~~ NCSLA shall file with the ~~Commissioner~~ Commissioner all of the following:

- (1) A copy of its constitution, articles of agreement or association, or certificate of ~~incorporation~~; incorporation.
- (2) A copy of its bylaws and rules governing its ~~activities~~; activities.
- (3) An annually updated list of ~~resident and nonresident surplus lines licensees~~; licensees.

- (4) The name and address of a resident of this State upon whom notices or orders of the Commissioner or processes issued at his direction may be ~~served; and served.~~
- (5) An agreement that the Commissioner may examine the ~~regulatory support organization~~ NCSLA in accordance with subsection (c) of this section.

(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of ~~each regulatory support organization; the NCSLA~~ in which case the provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-180, 58-2-185, 58-2-190, 58-2-195, and 58-2-200 shall apply. If the Commissioner finds the ~~regulatory support organization~~ NCSLA or any surplus lines licensee, ~~whether resident or nonresident,~~ licensee to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation.

(d) Each surplus lines licensee shall maintain active membership in a ~~regulatory support organization~~ the NCSLA as a condition of continued licensure under this Article."

SECTION 2.1.(h) G.S. 58-21-45(f) reads as rewritten:

"(f) Every evidence of insurance negotiated, placed, or procured under the provisions of this Article issued by the surplus lines licensee shall bear the name of the licensee and one of the following legend~~following legends,~~ whichever is applicable, in 12 point type and in contrasting color or in 12 point type and underlined and in bold print:

- (1) For nonadmitted insurers: "The insurance company with which this coverage has been placed is not licensed by the State of North Carolina and is not subject to its supervision. In the event of the insolvency of the insurance company, losses under this policy will not be paid by any State insurance guaranty or solvency fund."
- (2) For nonadmitted domestic surplus lines insurers: "The insurance company with which this coverage has been placed is domiciled and authorized by the State of North Carolina and is subject to its supervision. However, in the event of the insolvency of the insurance company, losses under this policy will not be paid by any State insurance guaranty or solvency fund."

SECTION 2.1.(i) G.S. 58-21-50 reads as rewritten:

"§ 58-21-50. Duty to notify insured.

No contract of insurance placed by a surplus lines licensee under this Article shall be binding upon the insured and no premium charged therefor shall be due and payable until the producing broker or surplus lines licensee notifies the insured in writing, a copy of which shall be maintained by the broker or licensee with the records of the contract and available for possible examination, that:

- (1) ~~The~~For surplus lines insurers that are not a nonadmitted domestic surplus lines insurer, the insurer with which the coverage has been placed is not licensed by this State and is not subject to its supervision; and~~supervision and in the event the insurer who issued this policy becomes insolvent, losses will not be paid by any State guaranty or solvency fund.~~
- (2) ~~In~~For nonadmitted domestic surplus lines insurers, in the event of the insolvency of the surplus lines ~~insurer;~~insurer with which the coverage has been placed, losses will not be paid by any State insurance guaranty or solvency fund.

Nothing in this section shall nullify any agreement by any insurer to provide insurance."

SECTION 2.1.(j) G.S. 58-21-65 reads as rewritten:

"§ 58-21-65. Licensing of surplus lines license.

"(a) For insureds whose home state is this State, no agent or broker licensed by the Commissioner shall directly procure any contract of surplus lines insurance with any

nonadmitted domestic surplus lines insurer or nonadmitted insurer, unless he possesses a current surplus lines insurance license issued by the Commissioner.

(b) The Commissioner shall issue a surplus lines license to any qualified holder of a current ~~property broker's or property and casualty agent's~~ license, but only when the ~~broker or agent has~~ has done all of the following:

- (1) Remitted the fifty dollars (\$50.00) annual fee to the ~~Commissioner;~~Commissioner.
- (2) Submitted a completed license application on a form supplied by the Commissioner, and the application has been approved by the ~~Commissioner;~~Commissioner.
- (3) Passed a qualifying examination approved by the Commissioner; except that all holders of a license prior to July 11, 1985 shall be deemed to have passed such an ~~examination; and~~examination.
- (4) Repealed by Session Laws 2004-199, s. 20(c), effective August 17, 2004.

...."

SECTION 2.1.(k) G.S. 58-21-75 reads as rewritten:

"§ 58-21-75. Records of surplus lines licensee.

Each surplus lines licensee shall keep in his or her office in this State a full and true record of each surplus lines insurance contract placed by or through the licensee, including a copy of the policy, certificate, cover note, or other evidence of insurance. The record shall include the following items:

- (1) Amount of the insurance and perils ~~insured;~~insured.
- (2) Brief description of the property insured and its ~~location;~~location.
- (3) Gross premium ~~charged;~~charged.
- (4) Any return premium ~~paid;~~paid.
- (5) Rate of premium charged upon the several items of ~~property;~~property.
- (6) Effective date of the contract, and the terms of the ~~contract;~~contract.
- (7) Name and address of the ~~insured;~~insured.
- (8) Name and address of the ~~insurer;~~insurer.
- (9) Amount of tax and other sums to be collected from the ~~insured; and~~insured.
- (10) Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the application.

The record of each contract shall be kept open at all reasonable times to examination by the Commissioner without notice for a period not less than ~~three~~ five years following termination of the contract."

SECTION 2.1.(l) G.S. 58-21-85(a) reads as rewritten:

"(a) Gross premiums charged, less any return premiums, for surplus lines insurance on insureds for whom North Carolina is the home state are subject to a premium receipts tax of five percent (5%), which shall be collected in a manner approved by the Commissioner, in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any portion of the premium unearned at termination of insurance having been credited by the State to the licensee shall be returned by the licensee directly to the ~~policyholder directly;~~policyholder. The surplus lines licensee is prohibited from absorbing such tax and from rebating for any reason, any part of such tax. To the extent that other states in which portions of the properties, risks, or exposures reside have failed to enter into a compact or reciprocal allocation procedure with this State, the premium tax collected shall be retained by this State."

SECTION 2.1.(m) G.S. 58-21-105(a) reads as rewritten:

"(a) Any surplus lines licensee who in this State represents or aids a nonadmitted domestic surplus lines insurer or a nonadmitted insurer in violation of this Article shall be guilty of a Class 1 misdemeanor."

PART III. AMEND CONSENT TO RATE LAWS

SECTION 3.1.(a) G.S. 58-36-30 reads as rewritten:

"§ 58-36-30. Deviations.

(a) Except as permitted by G.S. 58-36-100 for workers' compensation loss costs filings, no insurer and no officer, agent, or representative of an insurer shall knowingly issue or deliver or knowingly permit the issuance or delivery of any policy of insurance in this State that does not conform to the rates, rating plans, classifications, schedules, rules and standards made and filed by the Bureau. An insurer may deviate from the rates promulgated by the Bureau if the insurer has filed the proposed deviation with the Bureau and the Commissioner, if the proposed deviation is based on sound actuarial principles, and if the proposed deviation is approved by the Commissioner. Amendments to deviations are subject to the same requirements as initial filings. An insurer may terminate a deviation only if the deviation has been in effect for a period of six months before the effective date of the termination and the insurer notifies the Commissioner of the termination no later than 15 days before the effective date of the termination.

(b) This subsection applies only to insurance against loss to automobile physical damage and related expenses. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner and with the knowledge and written consent of the insured. ~~The insurer is not required to obtain the written consent of the insured on any renewal of or endorsement to the policy if the policy renewal or endorsement states that the rates are greater than those rates that are applicable in the State of North Carolina. The insurer shall retain the signed consent form and other policy information for each insured and make this information available to the Commissioner, upon request of the Commissioner. This subsection may be used to provide motor vehicle liability coverage limits above those required under Article 9A of Chapter 20 of the General Statutes and above those cedable to the Facility under Article 37 of this Chapter to persons whose personal excess liability insurance policies require that they maintain specific higher liability coverage limits. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100.~~ Commissioner. An insurer shall give notice to the insured that the rates used to calculate the premium for the policy are greater than those rates that are applicable in the State of North Carolina by including the following language in the policy on page one of the declarations page or on a separate page before the declarations page, in at least 14 point type or in a font size larger than the remainder of the document whichever is larger, bolded, and all capitalized:

NOTICE: THE PREMIUM THAT WE ARE CHARGING FOR AUTOMOBILE PHYSICAL DAMAGE AND RELATED EXPENSES THAT COVERS THE DAMAGE TO YOUR COVERED VEHICLE(S) EXCEEDS THE PREMIUM BASED UPON THE APPROVED RATES IN NORTH CAROLINA, IN ACCORDANCE WITH G.S. 58-36-30(b).

The disclosure statement noted above in this subsection shall be included on any renewal of or endorsement to the policy when the rates charged exceed the approved manual rate. The insurer shall retain consent to rate information for each insured and make this information available to the Commissioner, upon request of the Commissioner. This subsection may be used to provide motor vehicle liability coverage limits above those required under Article 9A of Chapter 20 of the General Statutes and above those that could be ceded to the North Carolina Reinsurance Facility under Article 37 of this Chapter to persons whose personal excess liability insurance policies require that they maintain specific higher liability coverage limits. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100.

(b1) This subsection applies only to insurance against loss to residential ~~real~~-property with not more than four housing units. A rate in excess of that promulgated by the Bureau may be

charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the ~~Commissioner and is charged with the knowledge and written consent of the insured-Commissioner.~~ An insurer shall give ~~reasonable~~ notice to the insured that the rates used to calculate the premium for the policy are greater than those rates that are applicable in the State of North Carolina by including the following language on the insured's written consent to rate form in at least 14 point type, bolded, and underlined: in the policy on page one of the declarations page or on a separate page before the declarations page, in at least 14 point type or in a font size larger than the remainder of the document whichever is larger, bolded, and all capitalized:

NOTICE: IN ACCORDANCE WITH G.S. 58-36-30(b1), THE PREMIUM USING NORTH CAROLINA RATE BUREAU'S APPROVED RATES FOR THE HOMEOWNER'S INSURANCE COVERAGE I APPLIED FOR IS \$ _____. THE PREMIUM FOR THIS COVERAGE IS \$ _____. THE TOTAL PERCENTAGE INCREASE ABOVE THE APPROVED RATES IS _____%. BASED UPON THE APPROVED RATES IN NORTH CAROLINA FOR RESIDENTIAL PROPERTY INSURANCE COVERAGE APPLIED FOR WOULD BE \$ _____. OUR PREMIUM FOR THIS COVERAGE IS \$ _____.

~~The insurer shall provide the rate information on the disclosure statement above, as applicable, to the insured. The disclosure statement noted above in this subsection shall be included on any renewal of or endorsement to the policy manual rate following the initial written consent of an insured. However, once an initial written consent to rate is received, the insurer is not required to obtain the written consent of the insured on any renewal of or endorsement to the policy. The insurer shall give at least 30 days' notice to the insured for all written consents to rate and notices required under this subsection on all policy renewals and endorsements. when the rates charged exceed the approved manual rate. The insurer shall retain the signed consent form and other policy to rate information for each insured and make this information available to the Commissioner, upon request of the Commissioner. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100.~~

(b2) Notwithstanding subsection (b1) of this section, the Commissioner shall collect annually from all insurers and publish on the Department's Web site no later than July 1 the following data aggregated across all insurers for each geographical rate-making territory:

- (1) The percentage of policies for which a consent to rate has been obtained.
- (2) The average difference between the approved premium and the consented premium.

The Commissioner shall designate the format and manner to collect the data to be published. Any nonaggregated data obtained by the Commissioner, including data identifying individual insurers or insureds, under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100. This subsection applies only to insurance against loss to residential real property with not more than four housing units.

(c) Any approved rate under subsection (b) of this section with respect to workers' compensation and employers' liability insurance written in connection therewith shall be furnished to the Bureau.

(d) Notwithstanding any other provision of law prohibiting insurance rate differentials based on age, with respect to nonfleet private passenger motor vehicle insurance under the jurisdiction of the Bureau, any member of the Bureau may apply for and use in this State, subject to the Commissioner's approval, a downward deviation in the rates for insureds who are 55 years of age or older. A member of the Bureau may condition a deviation under this subsection or a deviation under subsection (a) of this section on the successful completion of a motor vehicle accident prevention course that has been approved by the Commissioner of Motor Vehicles, as designated in the deviation.

(e) Each insurer shall collect consent to rate data for nonfleet private passenger motor vehicle physical damage and homeowners residential property (all forms excluding HO4 and HO6) with not more than four housing units and transmit the data electronically for each policy to the Commissioner on a semi-annual basis in a format prescribed and designated by the Commissioner:

- (1) NAIC Company Code.
- (2) Company Name.
- (3) Policy Number.
- (4) Amount of Coverage A Insurance (Homeowners).
- (5) Effective Date.
- (6) Expiration Date.
- (7) Zip Code.
- (8) Actual Homeowners Full Term Premium.
- (9) Actual Automobile Physical Damage Full Term Premium.
- (10) NC Rate Bureau Homeowners Full Term Premium.
- (11) NC Rate Bureau Automobile Physical Damage Full Term Premium excluding SDIP charges.
- (12) New Policy or Renewal Policy.
- (13) Such other information that may be required by any rule adopted by the Commissioner."

SECTION 3.1.(b) This section becomes effective January 1, 2019, and applies to policies issued, renewed, or amended on or after that date.

PART IV. AMEND AND MAKE TECHNICAL CHANGES TO VARIOUS INSURANCE LAWS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE

AMEND FEDERAL HOME LOAN BANK ADMITTED ASSET

SECTION 4.1. G.S. 58-7-163(9) reads as rewritten:

- "(9) Any asset that is encumbered in any manner unless the asset is authorized under G.S. 58-7-187 or ~~G.S. 58-7-162(13)~~. ~~For G.S. 58-7-162(13); provided that an asset that is used as collateral to secure access to advances from a federal home loan bank, as defined by G.S. 58-30-10(9a), the amount of the asset's par value that exceeds the par amount of any outstanding obligations to the federal home loan bank shall be considered an unencumbered admitted asset.~~ not be disallowed under the provisions of this section."

REVISE LOAN TO VALUE REQUIREMENTS FOR INSURER MORTGAGE INVESTMENTS

SECTION 4.2. G.S. 58-7-179(c) reads as rewritten:

"(c) No such mortgage loan or loans made or acquired by an insurer on any one property shall, at the time of investment by the insurer, exceed the larger of the following amounts, as applicable:

- (1) Ninety-five percent (95%) of the value of the real property or leasehold securing the real property in the case of a mortgage on a dwelling primarily intended for occupancy by not more than four families if they insure down to ~~seventy five percent (75%)~~ eighty percent (80%) with a licensed mortgage insurance company, or ~~seventy five percent (75%)~~ eighty percent (80%) of the value in the case of other real estate mortgages;
- (2) The amount of any insurance or guaranty of the loan by the United States or by an agency or instrumentality thereof; or

- (3) The percentage-of-value limit on the amount of the loan applicable under subdivision (1) of this subsection, plus the amount by which the excess of the loan over the percentage-of-value limit is insured or guaranteed by the United States or by any agency or instrumentality thereof."

AMEND NONRESIDENT AGENT LICENSING REQUIREMENT

SECTION 4.3. G.S. 58-33-30(h)(2) reads as rewritten:

"(2) Nonresident.

- a. An individual may qualify for a license under this Article as a nonresident if he holds a like license in another state or territory of the United States. An individual may qualify for a license as a nonresident motor vehicle damage appraiser or a nonresident adjuster if the applicant's state of residency does not offer such licenses and such applicant meets all other requirements for licensure of a resident. A license issued to a nonresident of this State shall grant the same rights and privileges afforded a resident licensee, except as provided in subsection (i) of this section.

- a1. If a nonresident licensee's license in his or her home state is no longer in good standing for any reason, the nonresident licensee's license issued by the Commissioner shall automatically lapse 30 days after the loss of the nonresident's home state license. Within 30 days following the lapse, the nonresident's lapsed license may be reinstated if (i) the nonresident licensee is otherwise entitled to licensure and (ii) he or she provides proof satisfactory to the Commissioner that his or her home state license has been reinstated or reissued. A lapsed nonresident license may also be reinstated upon proof satisfactory to the Commissioner that the nonresident has relocated to another jurisdiction, obtained a new home state license, and has filed a change of address notice with the Commissioner within 60 days after the issuance of the new home state license. If the lapsed nonresident license is not reinstated as provided herein, the nonresident must submit a new application for licensure to the Commissioner.

...."

INSURANCE PRODUCER NOTICE REQUIREMENT CONFORMING CHANGE

SECTION 4.4. G.S. 58-33-56(d) reads as rewritten:

"(d) Within 15 days after making the notification required by subsections (a), (b), and (c) of this section, the insurer shall ~~mail a copy of the notification to the producer at the producer's last known address.~~ notify the producer using a form prescribed by the Commissioner. If the producer is terminated for cause for any of the reasons listed in G.S. 58-33-46(a), the insurer shall provide a copy of the notification to the producer at the producer's last known address by certified mail, return receipt requested, postage prepaid, or by overnight delivery using a nationally recognized carrier."

AMEND PORTABLE ELECTRONICS INSURANCE NOTICE REQUIREMENTS

SECTION 4.5. G.S. 58-44A-10 is amended by adding a new subsection to read:

"(e) Notices and correspondence may be sent either by mail or by electronic means as set forth in this subsection. The consumer may provide an electronic mail address to the insurer or vendor of portable electronics which shall be considered to be the consumer's consent to receive notices and correspondence by electronic means so long as a disclosure to that effect is provided to the consumer within 30 days following the purchase of the portable electronics insurance."

AMEND PREFERRED PROVIDER DEFINITION

SECTION 4.6.(a) G.S. 58-50-56(a)(2) reads as rewritten:

"(2) "Preferred provider" means a health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care ~~services on a fee for service basis services~~. A "preferred provider" is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives."

SECTION 4.6.(b) G.S. 58-50-56(e) is repealed.

SECTION 4.6.(c) G.S. 58-65-1(a) reads as rewritten:

"(a) Any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the 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, unless otherwise provided.

The term "hospital service plan" as used in this Article 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 or any 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 or the American Medical Association.

The term "medical service plan" as used in this Article includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical or any other professional services authorized or permitted to be furnished by a duly licensed physician or other provider listed in G.S. 58-50-30. 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.

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

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

The term "preferred provider" as used in this Article 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 or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article. ~~Except to the extent prohibited either by G.S. 58-65-140 or by rules adopted by the Commissioner not inconsistent with this Article, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.~~

The term "full service corporation" as used in this Article means any corporation organized under the provisions of this Article that offers a medical service plan or a hospital service plan.

The term "single service corporation" as used in this Article means any corporation organized under the provisions of this Article that offers only a dental service plan."

SECTION 4.6.(d) The Department may adopt temporary rules to implement the provisions of subsection (a) of this section.

AMEND CONTINUING EDUCATION FOR BAIL BONDSMEN AND RUNNERS

SECTION 4.7. G.S. 58-71-71(b) reads as rewritten:

"(b) Each year by June 30 every licensee shall complete at least three hours of continuing education as provided by an approved provider in subjects related to the duties and responsibilities of a runner or bail ~~bondsman before renewal of the license.~~ bondsman. This continuing education shall not include a written or oral examination. A person who receives his or her first license on or after January 1 of any year does not have to comply with this subsection until ~~the period between his first and second license renewals.~~ June 30 of the following year."

NORTH CAROLINA MANUFACTURED HOUSING BOARD TECHNICAL CHANGE

SECTION 4.8. G.S. 143-143.10(a) reads as rewritten:

"(a) There is created the North Carolina Manufactured Housing Board within the Department. The Board shall be composed of 11 members as follows:

- (1) The Commissioner of Insurance or the Commissioner's designee.
- (2) A manufactured home manufacturer.
- (3) A manufactured home dealer.
- (4) A representative of the banking and finance industry.
- (5) A representative of the insurance industry.
- (6) A manufactured home supplier.
- (7) A set-up contractor.
- (8) Two representatives of the general public.
- (9) A person who is employed with a HUD-approved housing counseling agency in the State.
- (10) An accountant.

The Commissioner or the Commissioner's designee shall chair the Board. The Governor shall appoint to the Board the manufactured home manufacturer and the manufactured home dealer. The General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121 shall appoint to the Board the representative of the banking and finance industry, the employee of a HUD-approved housing counseling agency, and the representative of the insurance industry. The General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121 shall appoint to the Board the manufactured home supplier, the accountant, and the set-up contractor. The Commissioner shall appoint two representatives of the general public. Except for the representatives from the general public and the persons appointed by the General Assembly, each member of the Board shall be appointed by the appropriate appointing authority from a list of nominees submitted to the appropriate appointing authority by the Board of Directors of the North Carolina ~~Manufactured Housing Institute.~~ Manufactured and Modular Homebuilders Association. At least three nominations shall be submitted for each position on the Board. The members of the Board shall be residents of the State.

The members of the Board shall serve for terms of three years. In the event of any vacancy of a position appointed by the Governor or Commissioner, the appropriate appointing authority shall appoint a replacement in the same manner as provided for the original appointment to serve the remainder of the unexpired term. Vacancies in appointments made by the General Assembly shall be filled in accordance with G.S. 120-122. In the event of any vacancy, the appropriate

appointing authority shall appoint a replacement to serve the remainder of the unexpired term. Such appointment shall be made in the same manner as provided for the original appointment. No member of the Board shall serve more than two consecutive, three-year terms.

The members of the Board designated in subdivisions (8), (9), and (10) of this subsection shall have no current or previous financial interest connected with the manufactured housing industry. No member of the Board shall participate in any proceeding before the Board involving that member's own business.

Each member of the Board, except the Commissioner and any other State employee, shall receive per diem and allowances as provided with respect to occupational licensing boards by G.S. 93B-5. Fees collected by the Board under this Article shall be credited to the Insurance Regulatory Fund created under G.S. 58-6-25."

AMEND AUTOMOBILE INSURANCE UNDERWRITING PROCEDURE

SECTION 4.9.(a) G.S. 58-36-65(e) reads as rewritten:

"(e) Records of convictions for moving traffic violations to be considered under this section shall be obtained at least annually from the Division of Motor Vehicles and applied by the Bureau's member companies in accordance with rules to be established by the Bureau. Prior to the sale of a new policy of motor vehicle insurance, records of convictions for moving traffic violations shall be obtained in accordance with rules established by the Bureau. Such rules shall permit a reasonable period for underwriting review following the binding of coverage in the event access to such records of convictions are unavailable at the time of sale or the applicant has provided incorrect or incomplete data necessary to access such records of convictions."

SECTION 4.9.(b) This section becomes effective January 1, 2019, and applies to policies issued, renewed, or amended on or after that date.

ADD ADDITIONAL PROOFS OF RESIDENCY TO RATE EVASION STATUTE

SECTION 4.10. G.S. 58-2-164(c2) reads as rewritten:

"(c2) To the extent relevant to a particular criterion for eligible risk status and for the purpose of obtaining other than nonfleet private passenger motor vehicle insurance, reliable proof of North Carolina residency or eligible risk status includes two or more of the following:

- (1) A utility bill in the name of the applicant showing a North Carolina address for the principal place of business of the applicant.
- (2) A receipt for real property taxes paid by the applicant to a North Carolina locality within the preceding 12-month period and showing the applicant's current North Carolina address.
- (3) A valid North Carolina vehicle registration issued to the applicant and showing the applicant's current North Carolina address.
- (4) A federal Income Tax Return filed by the applicant for the most recent prior filing period showing the applicant's name and current North Carolina address.
- (5) The valid North Carolina driver's license of an owner of an applicant that is a corporation or an LLC, provided that the person holds at least twenty (20%) percent ownership interest in the applicant corporation or LLC.
- (6) If the principal place of business of a corporation or LLC is the primary residence of the sole owner, any of the documents identified in subdivisions (1) through (5) of this subsection, whether in the name of the corporation or LLC or in the name of the sole owner. For purposes of this subsection, "sole owner" shall mean an individual or a husband and wife.

For purposes of subdivisions (5) and (6) of this subsection, on policies to be ceded to the North Carolina Reinsurance Facility, proof of ownership is established through the execution by the owner of the corporation or LLC, of a form promulgated by the North Carolina Reinsurance

Facility. The execution of this form shall constitute a written statement in support of an application for insurance or amendment to a policy of auto insurance under subsections (b) and (b1) of this section."

CLARIFY EXCEPTED BENEFITS REQUIREMENTS

SECTION 4.11. G.S. 58-68-25(b) reads as rewritten:

"(b) Excepted Benefits. – Excepted benefits are not subject to requirements under this Chapter regarding coverage of a specific person, provider, treatment, service, condition, or disease unless that coverage is expressly required by law. For the purposes of this Article, "excepted benefits" means benefits under one or more or any combination of the following:

- (1) Benefits not subject to requirements. –
 - a. Coverage only for accident or disability income insurance or any combination of these.
 - b. Coverage issued as a supplement to liability insurance.
 - c. Liability insurance, including general liability insurance and automobile liability insurance.
 - d. Workers' compensation or similar insurance.
 - e. Automobile medical payment insurance.
 - f. Credit-only insurance.
 - g. Coverage for on-site medical clinics.
 - h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
 - i. Short-term limited-duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

...."

PART V. AMEND CAPTIVE INSURANCE LAWS AND MAKE CLARIFYING CHANGES

SECTION 5.1.(a) G.S. 58-10-345(g) reads as rewritten:

"(g) The Commissioner is authorized to retain legal, financial, and audit services from outside the Department, the costs of which shall be reimbursed by the business entity. G.S. 58-2-160 shall apply to ~~audits, investigations, audits~~ and processing conducted under the authority of this section."

SECTION 5.1.(b) G.S. 58-10-355 reads as rewritten:

"§ 58-10-355. Organizational audit.

In addition to the processing of the application, an organizational ~~investigation~~ or audit may be performed before an applicant business entity is licensed. Such investigation or audit shall consist of a general ~~survey~~ review of the applicant business entity's corporate records, including charters, bylaws, and minute books; verification of capital and surplus; verification of principal place of business; determination of assets and liabilities; and a review of such other factors as the Commissioner deems necessary."

SECTION 5.1.(c) G.S. 58-10-385(a) reads as rewritten:

"(a) Every captive insurance company shall report to the Commissioner within 30 days after any change in its executive officers or directors, including in its report a biographical affidavit for each new officer or director. The change shall be deemed approved unless it is disapproved within 30 days from the completion of the Commissioner's review of the biographical affidavit."

PART VI. AMEND BAIL BOND FORFEITURE LAW

SECTION 6.1.(a) G.S. 15A-544.5(b)(7) reads as rewritten:

"(7) The defendant was incarcerated in a local, state, or federal detention center, jail, or prison located anywhere within the borders of the United States at the time of the failure to appear, or any time between the failure to appear and the final judgment date, and the district attorney for the county in which the charges are pending was notified of the defendant's incarceration while the defendant was still incarcerated and the defendant remains incarcerated for a period of 10 days following the district attorney's receipt of notice, as evidenced by a copy of the written notice served on the district attorney via hand delivery or certified mail and written documentation of date upon which the defendant was released from incarceration, if the defendant was released prior to the time the motion to set aside was filed."

SECTION 6.1.(b) This section becomes effective October 1, 2018, and applies to hearings held on or after that date.

SECTION 7. Except as otherwise provided, this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 14th day of June, 2018.

s/ Bill Rabon
Presiding Officer of the Senate

s/ Tim Moore
Speaker of the House of Representatives

VETO Roy Cooper
Governor

Became law notwithstanding the objections of the Governor at 5:41 p.m. this 28th day of June, 2018.

s/ Sarah Lang Holland
Senate Principal Clerk