

## SUMMARY OF 2015 REGULAR SESSION LEGISLATION

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The following is a summary of legislation passed in the 2015 General Assembly Regular Session which has some impact upon Life & Health Insurance (including policy forms and rates), Health Care Provider Contracts, Viatical Settlement Provider Licensing, and/or Third Party Administrator (TPA) Licensing.

- ❖ Any amendments to previously approved insurance policy forms or provider contracts must be submitted to the Life & Health Division for review and prior approval, unless the Division has implemented an administrative process relating to a specific bill or issue. Refer to the “Implementation Notes” sections below for details.
- ❖ L&H will entertain riders/endorsements to accommodate the changes from the 2015 General Assembly session as appropriate. Refer to the summary for any exceptions or special notes.
- ❖ If amendments result in changes in rating, insurers should submit the revised rates in the same submission as the form revisions or in a separate filing submitted simultaneously. If submitted separately, the submissions should indicate this and then cross reference the other submission by referencing the SERFF Tracking Number. If rates are not changing and the new law is a new benefit, then insurers should provide a certification from an actuary indicating such.
- ❖ The lack of an approval from DOI does not discharge the insurer from its obligation to comply with the law as of the effective date.

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### 1. HB 97 (S.L. 2015-241) – Appropriations Bill

<http://www.ncga.state.nc.us/Sessions/2015/Bills/House/PDF/H97v9.pdf>

- Section 20.2(a) adopts new **G.S. §58-3-181. Synchronization of prescription refills.**
- Every health benefit plan (as defined by reference to G.S. 58-3-167 but note the legislation specifically- includes applicability to limited-scope dental and vision insurance plans in this definition) that provides coverage for prescription drugs shall provide for synchronization of medication under certain circumstances listed in the statute.
- When applicable, the health benefit plan shall apply prorated daily cost-sharing rate to any medication dispensed by a network pharmacy. Any dispensing fee shall not be prorated.
- Effective ~~01/01/16~~ **08/01/16<sup>1</sup>** and applies to insurance contracts issued, renewed, or amended on or after that date.
- **Implementation Notes:** NCDI will expect insurers to make amendments to impacted insurance policy forms to include a provision explaining how prescription drug synchronization occurs, what cost sharing is associated with synchronization, and to remove any provisions in previously approved insurance forms which may conflict with the new statute.

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<sup>1</sup> The effective date of Section 20.2 of HB 97 was changed to 08/01/16 in SB 119 (S.L. 2015-264) in Section 90.2. (<http://www.ncleg.net/Sessions/2015/Bills/Senate/PDF/S119v6.pdf>)

**2. HB 16 (S.L. 2015-92) – Repeal Outdated and Unnecessary Insurance Reporting Requirements**

<http://www.ncga.state.nc.us/Sessions/2015/Bills/House/PDF/H16v5.pdf>

- Repeals reporting under G.S. §§58-3-191(a) and (b1), 58-50-95, and 58-67-140(a)(7).
- Effective June 19, 2015.
- **Implementation Notes:** None.

**3. SB 665 (S.L. 2015-236) – Unclaimed Life Insurance Benefits**

<http://www.ncleg.net/Sessions/2015/Bills/Senate/PDF/S665v6.pdf>

- Adopts new **Part 7 - Unclaimed Life Insurance Benefits** in Article 58.
- Requires insurance companies authorized to transact life insurance business in North Carolina to determine, semi-annually, if that insurer's records of in-force policies, annuities, and account owners cross-match with any record in the United States Social Security Administration's death master file or a similar database, with some exceptions.
- Upon a match, the insurer would be required to engage in a good-faith effort to verify the death and locate any beneficiaries.
- The bill does not apply to various situations as outlined in (b) of newly adopted G.S. §58-58-390.
- G.S. § 58-58-390(b)(2) provides that the statute does not apply for any policy, annuity, or retained asset account issued or delivered prior to 10/1/15 for which the insurer submits to the Commissioner a sworn statement of compliance with G.S. §58-58-390(b)(2)a. through c. The statement should identify all of the policies, annuities, and/or retained asset accounts to which the attestation applies, include an attestation of compliance with a. through c. specifically and be signed by an officer or director of the insurer. The Division does NOT anticipate issuing a template for this certification.
- A pattern of failures to meet the requirements above may constitute an unfair claims settlement practice under Chapter 58 of the General Statutes.
- Effective 10/1/15.
- **Implementation Notes:** The attestation referred to in the fifth bullet shall be submitted to the Life & Health Division and insurers should use the process:

Submit the attestation in SERFF using the “Unclaimed Life Benefit Exemption Attestation” filing type.

Use one of the following TOIs: A10 Annuities – Other, L08 Life – Other, or ML02 Multi-line – Other.

Attach the signed attestation on the Supporting Documentation Tab.

4. **HB 361 (S.L. 2015-281) – Principle-based Valuation in Life Insurance, External Review Technical Change, Revise Definition of Small Employer, and Other Technical Corrections**

<http://www.ncga.state.nc.us/Sessions/2015/Bills/House/PDF/H361v4.pdf>

- Part I amend G.S. §§58-58-50 and 58-58-55 to update the standard valuation laws to include principle-based valuation of reserves and makes some similar changes to the standard non-forfeiture law. These changes are not effective until the NAIC Valuation Manual operative date – which is defined in newly adopted **G.S. §58-58-51. NAIC valuation manual operative date.**
  - Provides for a principle-based reserving approach to valuing life insurance company reserves in NC and makes minor confirming changes to the Standard Non-forfeiture Law.
  - The PBR approach replaces the formulaic approach found currently in law and adopts a Valuation Manual which will be maintained by the NAIC.
  - These provisions do not become effective until the NAIC Valuation Manual implementation date which requires adoption of the PBR standard by 42 states representing 75% of the total U.S. premiums, and then will be implemented over three years and only for new business.
  - **Implementation Notes:** No impact at this time.
- Part II - Section 9- Makes a technical correction to the expedited external review law in G.S. §58-50-82(b)(1) which requires insurers in an expedited external review process to provide information to the Commissioner within one day as opposed to one "business" day after the request is made.
  - Changes from HB240 from 2013 Session (S.L. 2013-199) effective 1/1/16 Amends G.S. §58-50-82(b) to change the timeframe for processing an expedited external review request will be a total of three calendar days. Commissioner now has two days from receipt of a request for an expedited external review to have the process in (b) completed. Insurers shall submit to the external review organization as soon as possible but within the same day after receiving notice under G.S. §58-50-82(b)(2) all documents, etc. used in making its determination. External review organizations now have 3 days from receipt of a request for an expedited external review request to decide to uphold or reverse the non-certification, non-certification appeal decision, or second-level grievance review decision and notify all the appropriate parties of the decision.
  - These changes to expedited external review provisions from 2013 and 2015 were conveyed to insurers in an advisory memorandum issued by Health Insurance Smart NC on September 28, 2015.
  - Effective 1/1/16.
  - **Implementation Notes:** L&H will issue separate guidance to insurers permitting them to administratively make changes to previously approved insurance policy forms and existing contracts to accommodate these changes. Analysts should apply the new time frames to new and pending policy forms filings before approval.

- Part II - Section 10 amends G.S. §58-3-50 to specifically permit coverage within a policy to be issued by more than one insurance company so long as the policy clearly identifies the company responsible for each coverage.
  - Effective 10-22-15 (when the bill became law)
  - **Implementation Notes:** No change to current practices.
- Part IV - Section 12 amends the definition of small employer in G.S. §58-50-110(22b) applicable to non-transitional small group health plans to reference federal law rather than reference number of employees directly. Therefore NC's definition of small employer will get the applicable number of employees following the federal definition found in 42 U.S.C. 18024(b) (which is Section 1304 of the Public Health Service Act.)
  - This change was made in order that federal amendments under House Resolution 1624 (PACE Act - Public Law 114-60 - <https://www.congress.gov/114/bills/hr1624/BILLS-114hr1624enr.pdf> ) to keep the federal definition of small employer at 1 to 50 employees would be applicable in NC rather than NC's previously adopted definition which changed the number of employees to 1 to 100. Under the PACE Act a state may opt to have the definition of small group to include groups with 1 to 100 employees, but NC did not wish for our previously adopted standard to apply.
  - This means the definition of small employer in NC as of 1/1/16 will be employers with 1 to 50 employees and the count of employees shall be based upon full time equivalents.
  - This will eliminate the need for transitional offerings for employers with 51 to 100 who now will continue to be considered large employers and subject to large group rules.
  - Effective 1/1/16
  - **Implementation Notes:** L&H issued guidance to insurers on October 30, 2015 - <http://www.ncdoi.com/lh/Documents/Advisory%20Memorandum%20-%20October%2030,%202015%20-%20Definition%20of%20Small%20Employer%20and%20PACE%20Act.pdf> . Analysts should follow the guidance in handling previously approved forms and rates, and should enforce the revised definition on new and pending form filings before approval.

## 5. SB 676 (S.L. 2015-271) – Autism Health Insurance Coverage

<http://www.ncga.state.nc.us/Sessions/2015/Bills/Senate/PDF/S676v4.pdf>

- Sections 1 and 3 through 5 amend G. S. §§58-3-220, 58-51-55, 58-67-75 and 58-65-90 as follows:
  - Refer to DSM-5 which replaced DSM-IV.
  - Exclude “autism spectrum disorder” code (299.00) from the definition of “mental illness” as found in various mental health parity and statutes relating to non-discrimination relating to mentally ill or chemically dependent individuals.
  - Effective 7/1/16
  - **Implementation Notes:** Insurers will be expected to submit new policy forms and/or amendments to accommodate these new definitions. Analysts should note the new definition to insurers during review of new and pending policy form filings that are intended to be used with health benefit plan contracts issued or renewed on or after 7/1/16. Analysts should also require submission of new rates or an actuarial certification that the definition change does not result in a need to change rates.
    - i. An insurer may continue to include autism spectrum disorder as part of the definition of “mental illness” or “mental health” as found in a contract of insurance, but would then have to continue to apply state and federal mental health parity provisions to related benefits. See impact upon new mandate in next bullet.
- Section 2 adopts new statute **G.S. §58-3-192. Coverage for Autism Spectrum Disorder.**
  - Applies to health benefit plans issued, renewed or amended on or after 7/1/16 of the following types:
    - i. ALL large group health benefit plans.
    - ii. Grandfathered individual and small group health benefit plans.
    - iii. Transitional non-grandfathered individual and small group health benefit plans.
  - Establishes standard definitions for use with the mandate.
  - Establishes in subsection (b) a new mandate that health benefit plans shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder, and establishes non-discrimination provisions.
  - Establishes in subsection (c) a new mandate for coverage for adaptive behavior treatment (ABT) as defined in sub-subsection (a)(1).
    - i. Permits the health benefit plan to limit coverage for ABT to \$40,000 per year with provisions that allow that amount to change annually with inflation.
    - ii. Permits the health benefit plan to limit coverage for ABT to individuals 18 years of age and younger.
  - Prohibits a health benefit plan from excluding the coverage under the statute because the health benefit plan deems the services under the statute as habilitative or educational in nature.
  - Establishes in subsection (e) that the coverage under the statute (screening, diagnosis, and treatment of autism spectrum disorder) can be subject to co-payment, deductible, and coinsurance provisions of health benefit plan that are not less favorable than those same standards applicable to substantially all medical services covered by the health benefit plan.

- Establishes in subsection (i) that, except as provided in subsection (c), the health benefit plan shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder in accordance with the standards in the federal MHPAEA and the regulations thereunder. DOI will use the standards in MHPAEA to confirm compliance with this state law and insurers should administer these benefit in accordance with the federal law.
- **Implementation Notes:** Insurers will be expected to submit new policy forms and/or amendments to accommodate for this new mandated benefit. Analysts should require the mandate to be included in new and pending policy form filings that are intended to be used with contracts issued or renewed on or after 7/1/16. Analysts should also require submission of new rates or an actuarial certification that the new benefit does not result in a need to change rates.
  - i. If an insurer decides to include autism spectrum disorder as part of the definition of “mental illness” or “mental health” as found in a contract of insurance, then they must comply with state and federal mental health parity provisions to related benefits. This means that the health benefit plan could not include the annual dollar limit on the ABT as found in newly adopted G.S. §58-3-192(c) unless such a limit was compliant with applicable state and federal mental health parity provisions.
  - ii. For plans of insurance subject to the new mandate and which are non-grandfathered large group health benefit plans, if the insurer wishes to use the annual dollar limit on ABT benefits, then the insurer must indicate that ABT is NOT part of “essential health benefits” in order to comply with the federal regulation prohibiting annual and lifetime dollar limits on any benefit that is part of EHB as found in 45 CFR §147.126.

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Questions about this summary should be directed to the Life & Health Inbox at [L&Hinbox@ncdoi.gov](mailto:L&Hinbox@ncdoi.gov) or (919) 807-6055.