

Article 55.

Long-Term Care Insurance.

Part 1. General Provisions.

§ 58-55-1. Short title.

This Article may be cited as the "Long-Term Care Insurance Act". (1987, c. 331.)

§ 58-55-5. Dual options.

(a) No policy that conditions the eligibility of benefits on prior hospitalization may be delivered or issued for delivery in this State unless the insurer or other entity offering that policy also offers a policy that does not condition eligibility of benefits on such a requirement.

(b) Policies that were delivered, issued for delivery, or renewed on and after October 1, 1989, that did not condition the eligibility of benefits on prior hospitalizations shall be amended, upon the insured's written request, to condition eligibility of benefits on prior hospitalization, provided that the insured receives the appropriate reduction in premium. (1991, c. 644, s. 24.)

§ 58-55-10. Purposes.

The purposes of this Article are to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage. (1987, c. 331.)

§ 58-55-15. Scope.

This Article applies to long-term care insurance policies in this State. This Article does not supersede the obligations of any person subject to its provisions to comply with other applicable laws and rules if those laws and rules do not conflict with this Article. The laws and rules established to govern Medicare supplement insurance policies shall not apply to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance is not subject to this Article. (1987, c. 331; 1991, c. 720, s. 84.)

§ 58-55-20. Definitions.

As used in this Article:

- (1) "Applicant" means:
 - a. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and
 - b. In the case of a group long-term care insurance policy, the proposed certificate holder.
- (2) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.
- (3) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this State and issued to:
 - a. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or both, for employees or former employees or both, or

- for members or former members or both, of the employers or labor organizations; or
- b. Any professional, trade, or occupational association for its members or former or retired members, or all, if such association:
 - (i) Comprises individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and
 - (ii) Has been maintained in good faith for purposes other than obtaining insurance; or
 - c. An association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering such policy within this State, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. Ninety days after such filing the association or associations will be deemed to have satisfied such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.
 - d. A group other than as described in subdivisions (3)a., (3)b., and (3)c. of this section, subject to a finding by the Commissioner that:
 - (i) The issuance of the group policy is not contrary to the best interest of the public;
 - (ii) The issuance of the group policy would result in economies of acquisition or administration; and
 - (iii) The benefits are reasonable in relation to the premiums charged.
- (4) "Long-term care insurance" means any policy or certificate advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. "Long-term care insurance" includes:
- a. Group and individual annuities and life insurance policies or riders that supplement or directly provide long-term care insurance.
 - b. A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.
 - c. Qualified long-term care insurance contracts.

- d. Group and individual policies whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization. "Long-term care insurance" does not include any policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to life insurance, "long-term care insurance" does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

- (5) "Policy" means any policy, contract, certificate, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital or medical service corporation, prepaid health plan, health maintenance organization, or any similar organization. (1987, c. 331, s. 1; c. 864, s. 68; 2007-298, s. 4; 2007-484, s. 43.5.)

§ 58-55-25. Limits of group long-term care insurance.

No group long-term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in G.S. 58-55-20(3)d, unless the Commissioner or the insurance regulator of the other state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this State has made a determination that such requirements have been met. (1987, c. 331; 1991, c. 720, s. 44.)

§ 58-55-30. Disclosure and performance standards for long-term care insurance.

(a) The Commissioner may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

(b) No long-term care insurance policy may:

- (1) Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or
- (2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

- (3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- (c) Pre-existing condition:
 - (1) No long-term care insurance policy, other than that issued to a group defined in G.S. 58-55-20(3)a, shall use a definition of "pre-existing condition" that is more restrictive than the following: "pre-existing condition" means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.
 - (2) No long-term care insurance policy, other than that issued to a group defined in G.S. 58-55-20(3)a, shall exclude coverage for a loss or confinement that is the result of a pre-existing condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.
- (d) Except as provided in G.S. 58-55-5, no long-term care insurance policy may be delivered or issued for delivery in this State if it:
 - (1) Conditions eligibility for any benefits on a prior hospitalization requirement; or
 - (2) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.
- (d1) Except as provided in G.S. 58-55-5, any long-term care insurance policy containing any limitations or conditions for eligibility other than those prohibited by law shall describe in a separate paragraph of the policy, to be entitled "Limitations or Conditions on Eligibility for Benefits", the limitations or conditions, including any required number of days of confinement.
- (d2) A long-term care insurance policy that contains a benefit advertised, marketed, or offered as home health care or a home care benefit may not condition receipt of benefits on a prior institutionalization requirement.
- (d3) A long-term care insurance policy that conditions eligibility for noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days for which benefits are paid.
- (e) The Commissioner may adopt rules establishing loss ratio standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the rules.
- (f) An individual long-term care insurance policyholder has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that unless the policyholder has received benefits under the policy, the policyholder has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.
- (g) A person insured under a long-term care insurance policy issued pursuant to a direct response has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that unless the insured person has received benefits under the policy, the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(h) An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request; but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

- (1) A description of the principal benefits and coverage provided in the policy;
- (2) A statement of the principal exclusions, reductions, and limitations contained in the policy;
- (3) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and
- (4) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

(i) A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this State, shall include:

- (1) A description of the principal benefits and coverage provided in the policy;
- (2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and
- (3) A statement that the group master policy determines governing contractual provisions.

(j) No policy or certificate may be advertised, marketed, or offered as long-term care or nursing home insurance unless it complies with the provisions of this Article.

(k) The Commissioner shall adopt rules to establish minimum standards for marketing practices and compensation arrangements for long-term care insurance. (1987, c. 331; 1989, c. 207, ss. 1-4; 1989 (Reg. Sess., 1990), c. 941, s. 9; 1991, c. 720, ss. 45, 86; 1993, c. 504, s. 39, c. 553, s. 20.)

§ 58-55-31. Additional requirements.

(a) No policy shall be used in this State unless it provides for an offer of nonforfeiture, which shall not be less than an offer of reduced paid-up insurance benefits, extended term insurance benefits, or a shortened benefit period. No policy shall pay a cash surrender value unless the dividends or refunds are applied as a reduction of future premiums or an increase in future benefits.

(b) The Commissioner shall adopt rules to provide for annual reports by insurers of the number of claims denied, number of rescissions, and the percentage of sales involving the replacement of policies.

(c) No policy shall be used in this State unless the insurer has developed a financial or personal asset suitability test to determine whether or not issuing long-term care insurance to an applicant is appropriate. For purposes of this section:

- (1) All insurers except those issuing life insurance that accelerates the death benefit for long-term care shall use the financial or suitability form and format standards as developed and adopted by the NAIC. A personal long-term care worksheet and disclosure notice of issues an applicant should know before buying long-term care insurance shall be completed and provided before an application is taken.

- (2) Each applicant that does not meet the recommended financial or personal asset suitability test criteria shall receive a letter of notification and shall be given an option to waive the results of the financial suitability test and proceed with the purchase of the policy.

(d) The Commissioner shall adopt standards to handle consumer complaints about noncompliance with State requirements. (1997-259, s. 15.)

§ 58-55-35. Facilities, services, and conditions defined.

(a) Whenever long-term care insurance provides coverage for the facilities, services, or physical or mental conditions listed below, unless otherwise defined in the policy and certificate, and approved by the Commissioner, the facilities, services, or conditions have the following definitions:

- (1) Adult care home. – As defined in G.S. 131D-2.1(3).
- (1a) Adult day care program. – As defined in G.S. 131D-6(b).
- (2) Chore services. – Include the performance of tasks incidental to activities of daily living that do not require the services of a trained homemaker or other specialist. The services are provided to enable individuals to remain in their own homes and may include such services as: assistance in meeting basic care needs such as meal preparation; shopping for food and other necessities; running necessary errands; providing transportation to essential service facilities; care and cleaning of the house, grounds, clothing, and linens.
- (3) Combination home. – As defined in G.S. 131E-101(1a).
- (4) Repealed by Session Laws 1995, c. 535, s. 3.
- (5) Family care home. – As defined in G.S. 131D-2.1(9).
- (6) Renumbered.
- (7) Repealed by Session Laws 1995, c. 535, s. 3.
- (8) Home care services. – As defined in G.S. 131E-136(3).
- (9) Homemaker services. – Supportive services provided by qualified para-professionals who are trained, equipped, assigned, and supervised by professionals within the agency to help maintain, strengthen, and safeguard the care of the elderly in their own homes. These standards must, at a minimum, meet standards established by the North Carolina Division of Social Services and may include: providing assistance in management of household budgets; planning nutritious meals; purchasing and preparing foods; housekeeping duties; consumer education; and basic personal and health care.
- (10) Hospice. – As defined in G.S. 131E-176(13a).
- (11) Intermediate care facility for individuals with intellectual disabilities. – As defined in G.S. 131E-176(14a).
- (12) Nursing home. – As defined in G.S. 131E-101(6).
- (13) Respite care, institutional. – Provision of temporary support to the primary caregiver of the aged individual or individual with a disability by taking over the tasks of that person for a limited period of time. The insured receives care for the respite period in an institutional setting, such as a nursing home, family care home, rest home, or other appropriate setting.
- (14) Respite care, non-institutional. – Provision of temporary support to the primary caregiver of the aged individual or individual with a disability by taking over

the tasks of that person for a limited period of time in the home of the insured or other appropriate community location.

- (15) Skilled nursing facility. – An institution licensed under applicable State laws and primarily engaged in providing to inpatients, under the supervision of a doctor and a registered professional nurse, skilled nursing care and related services on a 24-hour basis, and rehabilitative services.
- (16) Supervised living facility for adults with developmental disabilities. – A residential facility, as defined in G.S. 122C-3(14), that has two to nine adult residents with developmental disabilities.

(b) Whenever long-term care insurance provides coverage for organic brain disorder syndrome, progressive dementing illness, or primary degenerative dementia, such phrases shall be interpreted to include Alzheimer's Disease. A clinical diagnosis of "organic brain disorder syndrome," "progressive dementing illness," or "primary degenerative dementia" must be accepted as evidence that such a condition exists in an insured if a pathological diagnosis cannot be made, the medical evidence substantially documents the diagnosis of the condition, and the insured received treatment for the condition.

(c) All long-term care insurance policies must be filed with and approved by the Commissioner before they can be used in this State and are subject to the provisions of Article 38 of this Chapter. (1987, c. 331, s. 1; 1989, c. 207, ss. 5, 6; 1991, c. 721, s. 85; 1995, c. 535, s. 3; 2001-209, s. 4; 2008-187, s. 38(a); 2009-462, s. 4(a); 2019-76, s. 13(a).)

§ 58-55-50. Rules for compliance with federal law and regulations.

The Commissioner may adopt temporary rules necessary to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies. (2001-334, s. 11.2.)

Part 2. Long-Term Care Partnership.

§ 58-55-55. Definitions.

The following definitions apply in this section:

- (1) Asset. – Resources and income.
- (2) Department. – The Department of Health and Human Services.
- (3) Division. – The Division of Health Benefits.
- (4) Estate recovery. – The placing of a statutory claim on the estate of a deceased Medicaid recipient, as provided by G.S. 108A-70.5.
- (5) Medicaid. – The federal medical assistance program established under Title XIX of the Social Security Act.
- (6) Qualified long-term care partnership policy or qualified policy. – A long-term care insurance policy approved for use in North Carolina and that meets all the requirements of the federal Deficit Reduction Act of 2005, P.L. 109-171.
- (7) Resource. – Cash or its equivalent and real or personal property that is available to an applicant or recipient.
- (8) Resource disregard. – The amount of resources of an applicant for long-term care Medicaid that is equal to the amount of benefits paid to the applicant under a qualified long-term care partnership policy.

- (9) Resource protection. – An amount equal to the resource disregard given to a Medicaid recipient during the long-term care Medicaid eligibility determination process. (2010-68, s. 4; 2019-81, s. 15(a).)

§ 58-55-60. Qualified long-term care partnership policy.

A qualified long-term care partnership policy is a long-term care insurance policy or a certificate issued under a group long-term care insurance policy that satisfies all of the following requirements:

- (1) The policy meets the requirements for a qualified long-term care insurance contract, as defined in section 7702B of the Internal Revenue Code of 1986 (26 U.S.C. § 7702B(b)).
- (2) The effective date of the coverage is on or after January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.
- (3) The policy covers an insured who was a resident of North Carolina or another reciprocal partnership state when coverage first became effective under the policy.
- (4) The policy meets the federal consumer protection requirements of section 1917(b) of the Social Security Act as amended by section 6021(a) of the Deficit Reduction Act of 2005, P.L. 109-171 of the Social Security Act (42 U.S.C. § 1396p(b)(5)(A)).
- (5) The policy is issued with and retains inflation protection coverage which meets the inflation standards based on the insured's then attained age as defined in sub-subdivisions a., b., and c. below:
 - a. Policies or certificates issued to an individual who is under 61 years old must provide compound annual inflation protection.
 - b. Policies or certificates issued to an individual who is 61 to 76 years old must provide some level of inflation protection. This may include simple interest or compound inflation protection.
 - c. For purchasers 76 years old or older, inflation protection may be offered but is not required.

Notwithstanding the above, purchasers of qualified long-term care insurance policies may adjust their inflation protection as they age. However, their policies shall continue to be qualified long-term care insurance policies as long as the inflation protection in the qualified policies continues to meet the minimum requirements for the insured's attained age.

- (6) The policy states that it is intended to be a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- (7) A qualified policy issued, executed, and delivered in North Carolina shall be accompanied by a Partnership Disclosure Notice explaining the benefits associated with a qualified policy and indicating that at the time issued, the policy is a qualified long-term care insurance partnership policy in North Carolina. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for Medicaid. Notices providing additional information may be used in conjunction with the Partnership Disclosure Notice described in

this section if filed and approved by the Commissioner. The Notice shall state the following in at least 12-point font:

"Partnership Policy Status: Your long-term care insurance policy is intended to qualify as a Partnership Policy under the North Carolina Long-Term Care Partnership Program as of your policy's effective date. For Medicaid applicants applying for help with the cost of long-term care, this means that an amount of your resources equal to the dollar amount of long-term care insurance benefits paid to you or on your behalf under this policy may be disregarded for purposes of determining your eligibility for long-term care Medicaid and from any subsequent recovery by the State from your estate for payment of Medicaid paid services. The amount that may be disregarded at eligibility will be equal to the amount of the long-term care partnership benefits paid out prior to the time you apply for long-term care Medicaid. As a result, you may qualify for coverage of the cost of your long-term care needs under Medicaid without first being required to substantially exhaust your personal resources. The amount that may be protected from recovery by the State from your estate will be equal to the amount disregarded for purposes of eligibility for long-term care Medicaid. If you are already a recipient of long-term care Medicaid, this policy will not allow a resource disregard or estate recovery resource protection. The purchase of a Partnership Policy does not automatically qualify you for Medicaid.

Please note that this policy may lose long-term care partnership program status if you move to a different state that does not recognize North Carolina's Long-Term Care Partnership Program or you modify this policy after issuance. This policy may also lose long-term care partnership program status due to changes in federal or state laws.

If you have questions regarding long-term care insurance and the North Carolina Long-Term Care Partnership Program, you may contact the Seniors' Health Insurance Information Program of the Department of Insurance at 1-855-408-1212."

In the case of a group insurance contract, this Partnership Disclosure Notice shall be provided to the insured upon the issuance of the certificate. The insurer shall include in that Notice that the amount of the insured's resources that may be disregarded at eligibility will be equal to the amount of qualified long-term care partnership policy benefits paid prior to the time the insured applied for long-term care Medicaid. The insurer shall also include in the notice a warning to the insured that the policy may lose long-term care partnership program status if the insured moves to another state that does not recognize North Carolina's Long-Term Care Partnership Program, or if the policy is modified after issuance.

- (8) When the insured's remaining lifetime maximum benefit is equal to 90 times the current daily benefit, or three times the current monthly benefit, the insurer shall notify the insured in writing advising the insured to go to the local department of

social services to apply for Medicaid if the insured had not already done so. (2010-68, s. 4; 2022-46, s. 8.)

§ 58-55-65. Compliance with federal regulations.

(a) The Commissioner may adopt rules to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies.

(b) The tax-qualified long-term care provisions required of the Health Insurance Portability and Accountability Act of 1996, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58 of the General Statutes.

(c) The long-term care partnership provisions required of the Deficit Reduction Act of 2005, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58 of the General Statutes. (2010-68, s. 4.)

§ 58-55-70. Disclosure notices.

(a) Prior to making a change requested by the policyholder to a qualified long-term care partnership policy that would result in the loss to the policy of qualified policy status, the insurer shall provide to the policyholder a written explanation within 30 calendar days of how this action would affect the insured and shall obtain the insured's signature indicating consent to the change.

(b) If a qualified long-term care partnership policy subsequently loses qualified policy status, the insurer shall explain in writing within 30 calendar days to the policyholders the reason for the loss of status.

(c) The disclosures required in this section shall be provided to any insured who exchanges a policy for a qualified long-term care partnership policy. (2010-68, s. 4.)

§ 58-55-75. Exchange of long-term care policies for long-term care partnership policies.

An insurer shall offer, on a onetime basis, in writing, to all existing policyholders that were issued a long-term care policy on or after February 8, 2006, the option to exchange their existing long-term care coverage for coverage that is intended to qualify under North Carolina's Long-Term Care Partnership Program. The insurer shall provide notification of this onetime offer within 180 days from the date on which the company begins to offer partnership coverage in the State. The mandatory offer of an exchange shall only apply to products issued by the insurer that are comparable to the type of policy form, such as group policies and individual policies, and on the policy series that the company has certified as partnership qualified. This exchange may be subject to underwriting and premium adjustment. A policy received in an exchange after the effective date of North Carolina's Long-Term Care Partnership Program is treated as newly issued and is eligible for qualified policy status. For purposes of applying the Medicaid rules relating to qualified long-term care partnership policies, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange. The effective date of the long-term care partnership policy shall be the date the policy was exchanged. (2010-68, s. 4.)

§ 58-55-80. Information sharing.

(a) In order to assist in the performance of the Commissioner's duties under the long-term care partnership program specified in the federal Deficit Reduction Act of 2005, the Commissioner may:

- (1) Share information, including identifying information, related to the long-term care partnership program with other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the program.
- (2) Receive information, including identifying information, related to the long-term care partnership program from other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the program, and shall maintain as confidential or privileged any identifying information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information. Information received under this subdivision of this subsection is not a "public record" as defined in G.S. 132-1.
- (3) Enter into agreements governing sharing and use of information consistent with this section.

(b) No waiver of an existing privilege or claim of confidentiality in the identifying information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (a) of this section.

(c) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, this State.

(d) As used in this section, "identifying information" has the same meaning as in G.S. 14-113.20(b). (2010-68, s. 4.)