GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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HOUSE BILL DRH30071-MH-24B*

Short Title:	Insurance Technical Changes.-AB	(Public)
Sponsors:	Representatives Setzer, Bumgardner, and Corbin (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND CLARIFYING CHANGES TO THE INSURANCE LAWS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

PART I. CAPTIVE INSURANCE CHANGES

SECTION 1. G.S. 58-10-395 reads as rewritten:

"**§ 58-10-395. Plan of operation change.**

(a) Any material change in a captive insurance company's plan of operation ~~plan of operation~~ that was filed with the Commissioner at the time of initial application and any subsequent amendment of the plan requires prior approval from the Commissioner.

(b) Any change in any other information filed with the application must be filed with the Commissioner within 60 days but does not require prior approval.

(c) G.S. 58-10-345(f) shall apply to all information filed pursuant to this section."

SECTION 2. G.S. 58-10-415(c) reads as rewritten:

"(c) ~~Captive insurance companies with less than one million two hundred thousand dollars ($1,200,000) in written premium may make a written request for exemption from the annual audit requirement.~~ Upon written request by any captive insurance company, the Commissioner may grant an exemption from compliance with any and all provisions of this section if the Commissioner finds, upon review of the request, that compliance with this section would constitute a financial or organizational hardship upon the insurer. Such request must be made at least 90 days prior to the captive insurance company's fiscal year-end or as otherwise required by the Commissioner. Requests will be considered on a case-by-case basis and may be subject to the Commissioner receiving an annual audit of the captive insurance company's parent in lieu of the annual audit of the captive insurance company."

SECTION 3. G.S. 58-10-430 reads as rewritten:

"**§ 58-10-430. ~~Audits.~~Audits and Financial Analyses.**

(a) Whenever the Commissioner determines it to be prudent, the Commissioner shall audit a captive insurance company's affairs to ascertain its financial condition, its ability to fulfill its obligations, and whether it has complied with this Part. The expenses and charges of the audit shall be paid by the captive insurance company.

(a1) Whenever the Commissioner determines it to be prudent, the Commissioner shall conduct a financial analysis of information submitted to or obtained by the Commissioner pursuant to this Part. Except as otherwise provided in this Part, the captive insurance company is not required to pay the expense and charges of the financial analysis.

(b) G.S. 58-2-160 shall apply to audits and financial analyses conducted under this section.

(c) All audit reports, preliminary audit reports or results, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an audit or financial analysis made under this section are confidential, are not subject to subpoena, and may not be made public by the Commissioner or an employee or agent of the Commissioner. Nothing in this subsection shall prevent the Commissioner from using such information in furtherance of the Commissioner's regulatory authority under this Chapter. The Commissioner shall have the discretion to grant access to such information to public officials having jurisdiction over the regulation of insurance in any other state or country or to law enforcement officers of this State or any other state or agency of the federal government at any time only if the officials receiving the information agree in writing to maintain the confidentiality of the information in a manner consistent with this subsection.

(d) Risk retention groups are not subject to this section and shall instead be audited in accordance with the Examination Law, G.S. 58-2-131 through G.S 58-2-134."

SECTION 4.(a) G.S. 58-10-340 is amended by adding a new subsection to read:

"(16a) Governing board. – The board of directors or officials possessing similar authority."

SECTION 4.(b) G.S. 58-10-345(b) reads as rewritten:

"(b) No captive insurance company shall transact any insurance business in this State unless:

…

(2) Its ~~board of directors or committee of managers or, in the case of a reciprocal insurer, its subscribers' advisory committee~~ governing board holds at least one meeting each year in this State. A captive insurance company will be exempt from this board meeting requirement if the captive insurance company utilizes the services of at least two of the following North Carolina-based service providers:

a. Legal.
b. Accounting.
c. Actuarial.
d. Investment advisor.
e. Captive manager.
f. Other service providers acceptable to the Commissioner.

…."

SECTION 4.(c) G.S. 58-10-380(e) reads as rewritten:

"(e) ~~In the case of a captive insurance company formed as a corporation, at~~ At least one of the members of the ~~board of directors~~ governing board shall be a resident of this State. ~~In the case of a captive insurance company formed as a reciprocal insurer, at least one of the members of the subscribers' advisory committee shall be a resident of this State. In the case of a captive insurance company formed as a limited liability company, at least one of the managers shall be a resident of this State.~~"

SECTION 4.(d) G.S. 58-10-380(i) reads as rewritten:

"(i) The ~~articles of incorporation or bylaws~~ organizational documents of a captive insurance company ~~formed as a corporation~~ may authorize a quorum of its ~~board of directors~~ governing board to consist of no fewer than one-third of the fixed or prescribed number of ~~directors.~~board members."

SECTION 4.(e) G.S. 58-10-385 reads as rewritten:

"**§ 58-10-385. ~~Directors.~~Governing board members, officers, and employees.**

(a) Every captive insurance company shall report to the Commissioner within 30 days after any change in its executive officers or ~~directors,~~ governing board members, including in its

report a biographical affidavit for each new officer or ~~director.~~ governing board member. 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.

(b) No ~~director,~~ governing board member, officer, or employee of a captive insurance company shall, except on behalf of the captive insurance company, accept or be the beneficiary of, any fee, brokerage, gift, or other compensation because of any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the captive insurance company unless otherwise approved in advance by the Commissioner, but such person may receive reasonable compensation for necessary services rendered to the captive insurance company in his or her usual private, professional, or business capacity.

(c) Any profit or gain received by or on behalf of any person in violation of this section shall inure to and be recoverable by the captive insurance company."

SECTION 4.(f) G.S. 58-10-390 reads as rewritten:

"**§ 58-10-390. Conflict of interest.**

(a) Each captive insurance company licensed in this State is required to adopt a conflict of interest statement for officers, ~~directors,~~ governing board members, and key employees. Such statement shall disclose that the individual has no outside commitments, personal or otherwise, that would divert him or her from his or her duty to further the interests of the captive insurance company he or she represents, but this shall not preclude such person from being a director or officer in more than one insurance company.

(b) Each officer, ~~directors,~~ governing board member, and key employee shall file such disclosure with ~~the board of directors or other governing body~~ governing board of the captive insurance company annually."

SECTION 4.(g) G.S. 58-10-420(b) reads as rewritten:

"(b) A captive insurance company shall require its independent certified public accountant to immediately notify in writing an officer and all members of the ~~board of directors or other governing body~~ governing board of the captive insurance company of any determination by the independent certified public accountant that the captive insurance company has materially misstated its financial condition in its report to the Commissioner as required in G.S. 58-10-405. A captive insurance company receiving a notification pursuant to this subsection shall forward a copy of the notification to the Commissioner within five business days after receipt of the notification and shall provide the independent certified public accountant with proof that the notification was forwarded to the Commissioner. If the independent certified public accountant fails to receive the proof within the five-day period required by this subsection, the independent certified public accountant shall within the next five business days submit a copy of the notification to the Commissioner."

SECTION 4.(h) G.S. 58-10-510(d) reads as rewritten:

"(d) A protected cell captive insurance company shall establish administrative and accounting procedures necessary to properly identify (i) the one or more protected cells of the protected cell captive insurance company and (ii) the assets and liabilities attributable to each protected cell. The ~~directors~~ governing board of a protected cell captive insurance company shall keep protected cell assets and liabilities:

(1) Separate and separately identifiable from the assets and liabilities of the protected cell captive insurance company's general account.

(2) Attributable to one protected cell separate and separately identifiable from protected cell assets and protected cell liabilities attributable to other protected cells.

If this subsection is violated, then the remedy of tracing is applicable to protected cell assets when commingled with protected cell assets of other protected cells or the assets of the protected cell captive insurance company's general account. The remedy of tracing shall not be construed as an exclusive remedy."

SECTION 4.(i) G.S. 58-10-512(c) reads as rewritten:

"(c) An incorporated protected cell may be organized and operated in any form of business organization authorized by the Commissioner. Unless otherwise permitted by the organizational documents of a protected cell captive insurance company, each incorporated protected cell of the protected cell captive insurance company must have the same ~~directors,~~ governing board members, secretary, and registered office as the protected cell captive insurance company."

SECTION 4.(j) G.S. 58-10-565(b) reads as rewritten:

"(b) To transact business in this State, an SPFC shall:

…

(3) Hold at least one management meeting each year in this State. For the purposes of this section, management is defined as the ~~board of directors, managing board,~~ governing board or other individual or individuals vested with overall responsibility for the management of the affairs of the SPFC, including the election and appointment of officers or other of those agents to act on behalf of the SPFC.

…."

SECTION 4.(k) G.S. 58-10-565(c) reads as rewritten:

"(c) A complete SPFC application shall include the following:

…

(4) Biographical affidavits in NAIC format of all of the prospective SPFC's officers and ~~directors,~~ governing board members, providing the officers' and ~~directors'~~ governing board members' legal names, any names under which they have or are conducting their affairs, and any other biographical information as the Commissioner may request.

…."

SECTION 5.(a) G.S. 105-228.4A(a) reads as rewritten:

"(a) Tax Levied. – A tax is levied in this section on a captive insurance company doing business in this State. In the case of a branch captive insurance company, the tax levied in this section applies only to the branch business of the company. Two or more captive insurance companies under common ownership and ~~control~~ control, other than a protected cell captive insurance company or a special purpose captive insurance company with a cell or series structure, are taxed under this section as a single captive insurance company. The tax levied in this section does not apply to a foreign captive insurance company."

SECTION 5.(b) G.S. 105-228.4A(f) reads as rewritten:

"(f) Total Tax Liability. – The aggregate amount of tax payable under this section by a protected cell captive insurance company with more than 10 cells or a special purpose captive insurance company with a cell or series structure with 10 or more cells or series may not be less than ten thousand dollars ($10,000) and may not exceed the lesser of (i) one hundred thousand dollars ($100,000) plus five thousand dollars ($5,000) multiplied by the number of cells or series over 10 and (ii) two hundred thousand dollars ($200,000). The aggregate amount of tax payable under this section for any other captive insurance company may not be less than five thousand dollars ($5,000) and may not exceed one hundred thousand dollars ($100,000).

If a captive insurance company is a special purpose financial captive and if the special purpose financial captive is under common ownership and control with one or more other captive insurance companies, the following provisions apply to the consolidated group of companies that are taxed as a single captive insurance company pursuant to subsection (a) of this section:

(1) The amount of premium tax payable under this section is allocated to each member of the consolidated group in the same proportion that the premium allocable to the member bears to the total premium of all members.

(2) The aggregate amount of tax payable under this section by the consolidated group is equal to the greater of the following:

a. The sum of the premium tax allocated to the members.
b. Five thousand dollars ($5,000).

(3) If the total premium tax allocated to all members of a consolidated group that are special purpose financial captives exceeds one hundred thousand dollars ($100,000), then the total premium tax allocated to those members is one hundred thousand dollars ($100,000).

(4) If the total premium tax allocated to all members of the consolidated group that are not special purpose financial captives exceeds one hundred thousand dollars ($100,000), then the total premium tax allocated to those members is one hundred thousand dollars ($100,000)."

SECTION 5.(c) G.S. 105-228.4A is amended by adding a new subsection to read:

"(g) A captive insurance company formed and licensed under the laws of a jurisdiction other than North Carolina that (i) obtains the approval of the North Carolina Commissioner of Insurance to redomesticate to North Carolina pursuant to G.S. 58-10-380(g) to operate as a North Carolina-domiciled captive insurance company and (ii) redomesticates to North Carolina on or before December 31, 2020, is exempted from prorated premium taxes imposed by this section for the year in which the redomestication occurs and the premium taxes imposed by this section for the calendar year following the redomestication. This subsection expires for taxable years beginning on or after January 1, 2022."

SECTION 5.(d) Subsections (a) and (b) of this section are effective for premium taxes imposed for taxable years beginning on or after January 1, 2020. Subsection (c) of this section is effective for premium taxes imposed for taxable years beginning on or after January 1, 2019.

PART II. HOLDING COMPANY ACT TECHNICAL CHANGES

SECTION 6. G.S. 58-19-10(b) reads as rewritten:

"(b) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under this Chapter, a domestic insurer may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more affiliates or subsidiaries, amounts that do not exceed the lesser of ten percent (10%) of the insurer's admitted assets or fifty percent (50%) of the insurer's policyholders' surplus, provided that after those investments, the insurer's policyholders' surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, investments in domestic or foreign insurance affiliates or subsidiaries and health maintenance organizations shall be excluded, and there shall be included: (i) total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and (ii) all amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;

…

(3) With the approval of the Commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more affiliates or subsidiaries; provided that after such investment the insurer's policyholders' surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs."

PART III. SURPLUS LINES TECHNICAL CHANGES

SECTION 7.(a) G.S. 58-21-35(b) reads as rewritten:

"(b) The licensee shall complete and retain a copy of the report in paper or electronic form as required by the Commissioner. The report required by this section ~~and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records~~ is not a public record under G.S. 132-1 or G.S. 58-2-100."

SECTION 7.(b) G.S. 58-21-40(b)(3) is repealed.

SECTION 7.(c) 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;
(2) Brief description of the property insured and its location;
(3) Gross premium charged;
(4) Any return premium paid;
(5) Rate of premium charged upon the several items of property;
(6) Effective date of the contract, and the terms of the contract;
(7) Name and address of the insured;
(8) Name and address of the 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.~~application; and
(11) Copy of the compliance agreement.

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 five years following termination of the contract."

SECTION 7.(d) G.S. 58-21-80 is repealed.

SECTION 7.(e) G.S. 58-21-95 reads as rewritten:

"**§ 58-21-95. Suspension, revocation or nonrenewal of surplus lines licensee's license.**

The Commissioner may suspend, revoke, or refuse to renew the license of a surplus lines licensee after notice and hearing as provided under G.S. 58-2-70 upon any one or more of the following grounds:

(1) ~~Removal of the surplus lines licensee's office from this State;~~
(2) Removal of the surplus lines licensee's office accounts and records ~~from this State~~ during the period during which such accounts and records are required to be maintained under G.S. 58-21-75;
(3) Closing of the surplus lines licensee's office for a period of more than 30 business days, unless permission is granted by the Commissioner;
(4) Failure to make and file required reports;
(5) Failure to transmit the required tax on surplus lines premiums;
(6) ~~Failure to maintain the required bond;~~Failure to pay the stamping fee to the stamping office;
(7) Violation of any provision of this Article; or
(8) For any other cause for which an insurance license could be denied, revoked, suspended, or renewal refused under the Insurance Law."

PART IV. ALIGN STATE LAW WITH NAIC MODEL LAW REGARDING IMMUNITY FOR CONTRACTORS HIRED BY THE DEPARTMENT

SECTION 8.(a) G.S. 58-30-71(a) reads as rewritten:

"(a) ~~For the purposes of this section, the persons~~ Persons entitled to protection under this section are:

(1) All receivers responsible for the conduct of a delinquency proceeding under this Article, including present and former receivers; and

(2) ~~Their employees~~ All of the receiver's employees, meaning all present and former special deputies and assistant special deputies appointed by the Commissioner, staff assigned to the delinquency proceeding employed by the Attorney General's Office, and all persons whom the Commissioner, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding under this Article. ~~Attorneys, accountants, auditors, and other professional persons or firms, who are retained by the receiver as independent contractors and their employees are not employees of the receiver for purposes of this section.~~

(3) All of the receiver's contractors, meaning all persons who are retained by the receiver or the receiver's employees as independent contractors to assist in a delinquency proceeding under this Article, including attorneys, accountants, auditors, and other professional persons or firms and their employees."

SECTION 8.(b) G.S. 58-30-71(b) reads as rewritten:

"(b) The ~~receiver and his employees have~~ receiver, the receiver's employees, and the receiver's contractors shall have official immunity and are immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property or personal injury or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any employee arising out of or by reason of any of the following:

(1) ~~their~~ Their duties or ~~employment;~~employment.

(2) Any matters that have been subject to review by the Court after notice and opportunity to be heard, provided that the alleged act, error, or omission was not disapproved or disallowed by the Court.

~~provided that nothing~~ Provided, however, that nothing in this section holds the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors immune from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors or for any bodily injury caused by the operation of a motor vehicle."

SECTION 8.(c) G.S. 58-30-71(j) reads as rewritten:

"(j) Nothing in this section deprives the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors of any immunity, indemnity, benefits of law, rights, or any defense otherwise available."

PART V. CLARIFY CONSENT TO RATE

SECTION 9.(a) G.S. 58-36-30(b) reads as rewritten:

"(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. 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 also 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."

SECTION 9.(b) G.S. 58-36-30(b1) reads as rewritten:

"(b1) This subsection applies only to insurance against loss to residential 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. 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: IN ACCORDANCE WITH G.S. 58-36-30(b1), THE PREMIUM BASED UPON THE APPROVED RATES IN NORTH CAROLINA FOR RESIDENTIAL PROPERTY INSURANCE COVERAGE APPLIED FOR WOULD BE $____. OUR PREMIUM FOR THIS COVERAGE IS $____.

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. ~~for any subsequent increase above the.~~ The insurer shall retain consent 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."

SECTION 9.(c) G.S. 58-36-30(c) reads as rewritten:

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

SECTION 9.(d) G.S. 58-36-30(e) reads as rewritten:

"(e) Each insurer shall collect the following 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 (all forms, excluding HO4 and HO6) 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:

…."

SECTION 9.(e) The Commissioner may adopt temporary rules to implement this section.

PART VI. FAST ACT CONFIRMING CHANGE

SECTION 10.(a) G.S. 58-39-26(a) reads as rewritten:

"(a) Disclosure Required. – In addition to the notice requirements of G.S. 58-39-25, an insurance institution or agent shall provide, to all applicants and policyholders no later than (i)

before the initial disclosure of personal information under G.S. 58-39-75(11) or (ii) the time of the delivery of the insurance policy or certificate, a clear and conspicuous notice, in written or electronic form, of the insurance institution or agent's policies and practices with respect to:

(1) Disclosing nonpublic personal information to affiliates and nonaffiliated third parties, consistent with section 502 of Public Law 106-102, including the categories of information that may be disclosed.

(2) Disclosing nonpublic personal information of persons who have ceased to be customers of the financial institution.

(3) Protecting the nonpublic personal information of consumers.

These disclosures shall be made in accordance with the regulations prescribed under section ~~505~~ 504 of Public Law 106-102.

(b) Information to Be Included. – The disclosure required by subsection (a) of this section shall include:

(1) The policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the insurance institution or agent, consistent with section 502 of Public Law 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided under section 502(e) of Public Law 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(2) The categories of nonpublic personal information that are collected by the insurance institution or agent.

(3) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with section 501 of Public Law 106-102.

(4) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In the case of a policyholder, the notice required by this section shall be provided not less than annually during the continuation of the policy. As used in this subsection, "annually" means at least once in any period of 12 consecutive months during which the policy is in effect.

(d) Exception to Annual Notice Requirement. – An insurance institution or agent is not required to provide the privacy notice annually as required under subsection (c) of this section if all of the following apply:

(1) The insurance institution or agent provides nonpublic personal information only in accordance with the provisions of sections 502(b)(2) or 502(e) of Public Law 106-102 or regulations prescribed under section 504(b) of Public Law 106-102.

(2) The insurance institution or agent has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with this section.

If at any time subdivisions (1) or (2) of this section no longer apply to an insurance institution or agent, then the insurance institution or agent shall be required to provide the annual privacy notice required under subsection (c) of this section."

PART VII. STREAMLINE EXPEDITED EXTERNAL REVIEW PROCESS

SECTION 11.(a) G.S. 58-50-82(a) reads as rewritten:

"(a) Except as provided in subsection (g) of this section, a covered person may file a request for an expedited external review with the Commissioner at the time the covered person ~~receives:~~receives any of the following:

(1) A noncertification decision under G.S. 58-50-61(f) ~~if:~~if all of the following conditions apply:

a. The covered person has a medical condition where the time frame for completion of an expedited review of an appeal involving a noncertification set forth in G.S. 58-50-61(*l*) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum ~~function; and~~function.

b. The covered person has filed a request for an expedited appeal under G.S. 58-50-61(*l*).

(2) An appeal decision under G.S. 58-50-61(k) or ~~(l)~~G.S. 58-58-61(*l*) upholding a noncertification ~~if:~~if all of the following conditions apply:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum ~~function; and~~function.

b. The covered person has filed a request for an expedited second-level grievance review of a noncertification as set forth in ~~G.S. 58-50-61(i); or~~ G.S. 58-50-62(i).

(3) A second-level grievance review decision under ~~G.S. 58-60-62(h) or (i)~~ G.S. 58-50-62(h) or G.S. 58-50-62(i) upholding a ~~noncertification:~~noncertification if all of the following conditions apply:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum ~~function; or~~function.

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility."

SECTION 11.(b) G.S. 58-50-82(b) reads as rewritten:

"(b) Within two days after receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the noncertification, noncertification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one day after the request was made.

(2) Determine whether the request is eligible for external ~~review and, if it is eligible, determine whether it is eligible for expedited review.~~review.

(3) If the request is eligible for external review and the covered person's treating provider requesting the service that is the subject of the external review has

certified the request on a form prescribed by the Commissioner, then one of the following shall apply:

a. For a request made pursuant to subdivision (a)(1) of this ~~section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether~~ section, the request ~~should~~ shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-61(l) would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall ~~then~~ inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be ~~informed by the Commissioner that the covered person must exhaust, at a minimum, the insurer's internal appeal process under G.S. 58-50-61(l) before making another request for an external review with the Commissioner.~~notified.

b. For a request made pursuant to subdivision (a)(2) of this ~~section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether~~ section, the request ~~should~~ shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-62 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall ~~then~~ inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be ~~informed by the Commissioner that the covered person must exhaust the insurer's internal grievance process under G.S. 58-50-62 before making another request for an external review with the Commissioner.~~notified.

c. For a request made pursuant to sub-subdivision (a)(3)a. of this ~~section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall~~

~~determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether~~section, the request ~~should~~ shall be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall ~~then~~ inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

d. For a request made pursuant to sub subdivision (a)(3)b. of this section, ~~that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision.~~the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision."

SECTION 11.(c) G.S. 58-50-89 reads as rewritten:

"**§ 58-50-89. Hold harmless for ~~Commissioner, medical professionals,~~Commissioner and independent review organizations.**

~~Neither the~~ The Commissioner, ~~a medical professional rendering advice to the Commissioner under G.S. 58-50-82(b)(2),~~ an independent review organization, ~~nor shall~~ or a clinical peer reviewer working on behalf of an independent review organization shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence."

SECTION 11.(d) Subsections (a) and (b) of this section are effective October 1, 2019, and apply to requests for expedited review submitted on or after that date.

PART VIII. EXCLUSIVE PROVIDER BENEFIT PLANS

SECTION 12.(a) G.S. 58-50-56(i) reads as rewritten:

"(i) ~~A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan.~~ In accordance with rules adopted by the Commissioner and subject to G.S. 58-3-190 and G.S. 58-3-200(d), the preferred provider benefit plan may limit coverage for health care services obtained from a nonparticipating provider. The Commissioner shall adopt rules on product limitations, including payment differentials for services rendered by nonparticipating providers. These rules shall be similar in substance to rules governing HMO point-of-service products."

SECTION 12.(b) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-56.1. Continuity of Care.**

(a) Definitions. – The following definitions shall apply in this section:

(1) Exclusive provider benefit plan. – A preferred provider benefit plan in which enrollees must receive covered services from health care providers who are under contract with the insurer and under which there is no coverage for care

received from a health care provider who is not under contract with the insurer, except for emergency services as required by G.S. 58-3-190 and medically necessary covered services as required by G.S. 58-3-200(d).

(2) Insurer. – As defined in G.S. 58-50-56.

(3) Ongoing special condition. – One of the following conditions:

a. An acute illness that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

b. A chronic illness, disease, or condition that is life-threatening, degenerative, or disabling, and that requires medical care or treatment over a prolonged period of time.

c. Pregnancy from the start of the second trimester.

d. A terminal illness for which an individual has a medical prognosis of a life expectancy of six months or less.

(4) Terminated or termination. – The expiration or nonrenewal of a contract. This term does not include an ending of the contract by an insurer for failure to meet applicable quality standards or for fraud.

(b) Termination of a Provider. – If (i) a contract between an insurer and a health care provider offering an exclusive provider benefit plan is terminated by the provider or by the insurer, or benefits or coverage provided by the insurer are terminated because of a change in the terms of provider participation in an insurer's exclusive provider benefit plan and (ii) an insured is undergoing treatment from the provider for an ongoing special condition on the date of termination, then the following shall apply:

(1) Upon termination of the contract by the insurer or upon receipt by the insurer of written notification of termination by the provider, the insurer shall notify the insured on a timely basis of the termination and of the insured's right to elect continuation of coverage of treatment by the provider. This subdivision shall apply only if the insured has a claim with the insurer for services provided by the terminated provider or the insured is otherwise known by the insurer to be a patient of the terminated provider.

(2) Subject to subsection (h) of this section, the insurer shall permit an insured to elect to continue to be covered with respect to the treatment by the terminated provider for the ongoing special condition during a transitional period, as provided under this section.

(c) Newly Covered Insured. – Each exclusive provider benefit plan offered by an insurer shall provide transition coverage to individuals who (i) are newly covered under an exclusive provider benefit plan because the individual's employer has changed benefit plans and (ii) are undergoing treatment from a provider for an ongoing special condition. On the date of enrollment, an insurer shall notify the newly covered insured of the right to elect continuation of coverage of treatment by a provider that is not contracted with the exclusive provider benefit plan and, subject to subsection (h) of this section, the insurer shall permit the newly covered insured to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period, as provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in this section, the length of a transitional period provided under this subsection shall be determined by the treating health care provider, so long as it does not exceed 90 days after the date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subsection (c) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual, or if the individual was on an established waiting list for surgery, organ transplantation, or other inpatient care, before the date of the notice required under subdivision (b)(1) of this section or the date of

enrollment described in subsection (c) of this section, then the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through post discharge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an individual has entered the second trimester of pregnancy on or before the date of the notice required under subdivision (b)(1) of this section or the date of enrollment in a new plan described in section (c) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the plan, then the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an individual was determined to be terminally ill at the time of a provider's termination of participation under subsection (b) of this section or at the time of enrollment in the plan under subsection (c) of this section, and the provider was treating the terminal illness before the date of the termination or enrollment in the plan, then the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An insurer may condition coverage of continued treatment by a provider under subsection (b) or subsection (c) of this section upon the following terms and conditions:

(1) When care is provided pursuant to subsection (b) of this section, the provider agrees to accept reimbursement from the insurer and, with respect to cost-sharing, from the insured involved at the rates applicable before the start of the transitional period as payment in full.

(2) When care is provided pursuant to subsection (c) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area, plus the applicable copayment from the newly covered insured, as reimbursement in full from the insurer and the insured for all covered services.

(3) The provider agrees to comply with the quality assurance programs of the insurer responsible for payment under this subsection and to provide to the insurer necessary medical information related to the care provided. The insurer's quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the insured.

(4) The provider agrees to adhere to the insurer's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan approved by the insurer, and member hold harmless provisions.

(5) The receipt of notification from the insured within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subsection (c) of this section, that the insured elects to continue receiving treatment by the provider.

(6) The provider agrees to discontinue providing services at the end of the transition period and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.

(i) Construction. – Nothing in this section shall do any of the following:

(1) Require the coverage of benefits that would not have been covered if the provider involved remained a participating provider or, in the case of a newly

covered insured, require the coverage of benefits not provided under the policy in which the newly covered insured is enrolled.

(2) Require an insurer to offer a transitional period when the insurer terminates a provider's contract for reasons relating to quality of care or fraud. Refusal by an insurer to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

(3) Prohibit an insurer from extending any transitional period beyond that specified in this section.

(4) Prohibit an insurer from terminating the continuing services of a provider when the insurer has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. A termination for these reasons shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each insurer shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

SECTION 12.(c) The Department of Insurance may adopt temporary rules to implement this section.

SECTION 12.(d) Subsections (a) and (b) of this section apply to insurance contracts issued, renewed, or amended on or after the effective date of this act.

PART IX. BAIL BONDSMAN TECHNICAL CHANGES

SECTION 13.(a) G.S. 58-71-1 is amended by adding a new subdivision to read:

"(6a) Premium. – An amount of money paid in exchange for a bail bondsman's services in writing a bail bond."

SECTION 13.(b) G.S. 58-71-45 reads as rewritten:

"**§ 58-71-45. Terms of licenses.**

A license issued to a bail bondsman or to a runner authorizes the licensee to act in that capacity until the license is lapsed, suspended or revoked. ~~Upon the suspension or revocation of a license, the~~ The licensee shall return the license to the ~~Commissioner.~~Commissioner within 10 working days of the lapse, suspension, or revocation of the license. A license of a bail bondsman and a license of a runner shall be renewed in accordance with G.S. 58-71-75. After notifying the Commissioner in writing, a professional bondsman who employs a runner may cancel the runner's authority to act for the professional bondsman."

SECTION 13.(c) G.S. 58-71-165(a) reads as rewritten:

"(a) Each professional bail bondsman shall file with the Commissioner a written report in a form prescribed by the Commissioner regarding all bail bonds on which the bondsman is liable as of the first day of each month showing (i) each individual bonded, (ii) the date the bond was given, (iii) the principal sum of the bond, (iv) the ~~State or local official to whom given, and~~ court file or docket number for the principal's court obligation, (v) the fee charged for the bonding service in each ~~instance.~~instance, and (vi) the certificate seal number for each bond issued."

SECTION 13.(d) G.S. 58-71-167 reads as rewritten:

"(a) In any case where the agreement between principal and surety calls for some portion of the bond premium payments to be deferred or paid after the defendant has been released from custody, a written memorandum of agreement between the principal and surety shall be kept on file by the surety with a copy provided to the ~~principal, upon request.~~ principal. The memorandum shall contain the following information:

(1) The amount of the premium payment deferred or not yet paid at the time the defendant is released from jail.

(2) The method and schedule of payment to be made by the defendant to the bondsman, which shall include the dates of payment and amount to be paid on each date.

(3) That the principal ~~is, upon the principal's request,~~ is entitled to a copy of the memorandum.

(b) The memorandum must be signed by the defendant and the bondsman, or one of the bondsman's agents, and dated at the time the agreement is made. Any subsequent modifications of the memorandum must be in writing, signed, dated, and kept on file by the surety, with a copy provided to the ~~principal, upon request.~~principal."

PART X. CLARIFY RULEMAKING AUTHORITY FOR STATE FIRE AND RESCUE COMMISSION

SECTION 14. G.S. 58-78-5(a) is amended by adding a new subsection to read:

"(a) The Commission shall have the following powers and duties:

…

(17) To adopt, modify, or repeal any rules and regulations necessary for the purpose of carrying out the provisions of this Article."

PART XI. PREPAID HEALTH PLAN LICENSING ACT CLARIFYING AND TECHNICAL CHANGES

SECTION 15.(a) G.S. 58-93-20(c) reads as rewritten:

"(c) Any person that is already a licensed health organization in this State under this Chapter shall be recognized as a PHP under this Article and shall be issued a PHP license upon the licensed health organization's demonstration to the Commissioner of its compliance with this Article. A licensed health organization shall not be required to file a PHP application, pay a PHP application fee, or provide the notice required by subsection (d) of this section as a condition of receipt of a PHP license. Unless otherwise exempted, a licensed health organization shall be subject to the remaining requirements of this Article, including deposit, minimum capital and surplus, and working capital requirements."

SECTION 15.(b) G.S. 58-93-30 reads as rewritten:

"**§ 58-93-30. Fees.**

The Commissioner shall ~~establish~~ charge an application fee ~~not to exceed~~ of two thousand dollars ($2,000) for entities filing an application to be licensed as a PHP under this Article. The Commissioner shall ~~establish~~ charge an annual PHP license continuation fee ~~not to exceed~~ of five thousand dollars ($5,000). The PHP license shall continue in full force and effect subject to timely payment of the annual PHP license continuation fee in accordance with G.S. 58-6-7(c) and subject to any other provisions of this Chapter applicable to PHPs."

SECTION 15.(c) G.S. 58-93-60 reads as rewritten:

"**§ 58-93-60. Examinations.**

The Commissioner may make an examination of the affairs of any PHP as often as the Commissioner determines it to be necessary for the protection of the interests of the enrollees or the State but not less frequently than once every five years. The Commissioner shall notify DHHS prior to any examination of a PHP and shall provide DHHS with the results of an examination in accordance with G.S. 58-93-5(e). Examinations shall otherwise be conducted under G.S. 58-2-131 through G.S. 58-2-134."

SECTION 15.(d) G.S. 58-93-90 reads as rewritten:

"**§ 58-93-90. Rehabilitation or liquidation of PHP.**

(a) Any rehabilitation or liquidation of a PHP shall be deemed to be the rehabilitation or liquidation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to Article 30 of this Chapter. The Commissioner may apply for an order directing the rehabilitation or liquidation of a PHP upon one or more grounds set out in Article

30 of this Chapter or when it is the opinion of the Commissioner that the continued operation of the PHP would be hazardous either to the enrollees or to the State. Priority shall be given to DHHS's claims over all other claims in G.S. 58-30-220, except for claims in G.S. 58-30-220(1).

(b) To the greatest extent possible, the Commissioner shall provide notice to DHHS prior to seeking an application for an order to rehabilitate or liquidate a PHP under this section. If prior notice is not possible, the Commissioner shall provide the notice to DHHS as soon as possible after seeking the order."

SECTION 15.(e) G.S. 58-93-95(a) reads as rewritten:

"(a) When the Commissioner has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, notification shall be given to the PHP in ~~writing.~~ writing and a copy of the notice shall be provided to DHHS. This notice shall specifically state the grounds for denial, suspension, or revocation and shall set a date for a hearing on the matter at least 30 days after notice is given."

SECTION 15.(f) G.S. 58-93-120(16) reads as rewritten:

"(16) G.S. 58-7-26, 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.~~G.S. 58-7-21."

PART XII. CLARIFY WHEN APPLICATION SENT TO NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION

SECTION 16. G.S. 97-170(b) reads as rewritten:

"(b) An applicant for a license as a self-insurer shall file with the Commissioner the information required by subsection (d) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. No application is complete until the Commissioner has received all required information. A copy of the application ~~must~~ shall also be filed with the North Carolina Self-Insurance Security Association ~~at least 90 days before the proposed licensing date~~at the same time the application is filed with the Commissioner."

PART XIII. MODIFY CERTAIN CRIMINAL PENALTIES

SECTION 17.(a) G.S. 58-2-161(b) reads as rewritten:

"(b) ~~Any person~~ It shall be unlawful for any person who, with the intent to injure, defraud, or deceive an insurer or insurance ~~claimant:~~claimant, does any of the following:

(1) Presents or causes to be presented a written or oral statement, including computer-generated documents as part of, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or matter material to the ~~claim, or~~claim.

(2) ~~Assists, abets, solicits, or conspires with~~ Assists or abets another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning a fact or matter material to the ~~claim is guilty of~~ claim.

(c) Any person who violates subsection (b) of this section shall be penalized as follows:

(1) If the value of the claim for payment or other benefit sought is less than one thousand dollars ($1,000), it shall be a Class 1 misdemeanor.

(2) If the value of the claim for payment or other benefit sought is one thousand dollars ($1,000) or more, it shall be a Class H felony.

(3) If the value of the claim for payment or other benefit sought is fifty thousand dollars ($50,000) or more, it shall be a Class E felony.

(4) If the value of the claim for payment or other benefit sought is one hundred thousand dollars ($100,000) or more, it shall be a Class C felony.

In addition to any other penalties authorized by law, a violation of this section may be punishable by a fine of not more than ten thousand dollars ($10,000) for each violation.

(d) Each claim ~~shall~~ may be considered a separate count. Upon conviction, if the court imposes probation, the court may order the defendant to pay restitution as a condition of probation. In determination of the amount of restitution pursuant to G.S. 15A-1343(d), the reasonable costs and attorneys' fees incurred by the victim in the investigation of, and efforts to recover damages arising from, the claim, may be considered part of the damage caused by the defendant arising out of the offense.

(e) In a civil cause of action for recovery based upon a claim for which a defendant has been convicted under this section, the conviction may be entered into evidence against the defendant. The court may award the prevailing party compensatory damages, attorneys' fees, costs, and reasonable investigative costs. If the prevailing party can demonstrate that the defendant has engaged in a pattern of violations of this section, the court may award treble damages."

SECTION 17.(b) G.S. 58-2-164(b) reads as rewritten:

"**§ 58-2-164. Rate evasion fraud; prevention programs.**

…

(b) It shall be a ~~Class 3~~ Class 1 misdemeanor for any person who, with the intent to deceive an insurer, does any of the following:

(1) Presents or causes to be presented a written or oral statement in support of an application for issuance of or amendment to a policy of auto insurance, knowing that the application contains false or misleading information that states the applicant is an eligible risk when the applicant is not an eligible risk.

(2) ~~Assists, abets, solicits, or conspires with~~ Assists or abets another person to prepare or make any written or oral statement that is intended to be presented to an insurer in connection with or in support of an application for issuance of or amendment to a policy of auto insurance, if the person knows that the statement contains false or misleading information that states the applicant is an eligible risk when the applicant is not an eligible risk.

In addition to any other penalties authorized by law, a violation of this subsection may be punishable by a fine of not more than one thousand dollars ($1,000) for each violation.

(b1) If the violation of subsection (b) of this section is committed with respect to an application for insurance or amendment to a policy of auto insurance for more than one passenger vehicle, the person shall be guilty of a Class H felony.

~~(b1)~~(b2) It shall be a Class H felony for any applicant who, with the intent to deceive an insurer, knowingly violates G.S. 58-2-164(b) for the purpose of obtaining auto insurance covering one or more vehicles, the operation of which requires a Commercial Drivers License pursuant to G.S. 20-4.01(3c).

In addition to any other penalties authorized by law, a violation of this subsection may be punishable by a fine of not more than ten thousand dollars ($10,000) for each violation.

…."

SECTION 17.(c) G.S. 58-3-150 is amended by adding a new subsection to read:

"(h) It shall be unlawful for any person who, with the intent to injure, defraud, or deceive, prepares, issues, or requests a certificate of insurance that meets the criteria of subdivision (2) or (3) of subsection (f) of this section. The person violating this subsection shall be punished as follows:

(1) If the value of the certificate of insurance is less than five thousand dollars ($5,000), it shall be a Class 1 misdemeanor.

(2) If the value of the certificate of insurance is five thousand dollars ($5,000) or more, it shall be a Class I felony."

SECTION 17.(d) This section becomes effective December 1, 2019, and applies to offenses committed on or after that date.

PART XIV. EFFECTIVE DATE

SECTION 18. Except as otherwise provided, this act is effective when it becomes law.