

NORTH CAROLINA GENERAL ASSEMBLY
1981 SESSION

CHAPTER 706
HOUSE BILL 983

AN ACT TO REQUIRE CONTINUATION AND CONVERSION PRIVILEGES IN GROUP
HEALTH INSURANCE POLICIES AND PLANS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 58 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 26C.

"Group Health Insurance Continuation and Conversion Privileges.

"Part 1. Continuation.

"§ 58-254.40. Definitions. — As used in this Article, the following terms have the meanings specified:

- (1) 'Group policy' means a group accident and health insurance policy issued by an insurance company and a group contract issued by a health service corporation or health maintenance organization or similar corporation or organization.
- (2) 'Individual policy' or 'converted policy' means an individual health insurance policy issued by an insurance company or an individual health services contract issued by a health service corporation or health maintenance organization or similar corporation or organization.
- (3) 'Insurance' and 'insured' refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided by reason of a disability extension.
- (4) 'Insurer' means the entity issuing a group policy or an individual or converted policy.
- (5) 'Medicare' means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.
- (6) 'Premium' includes any premium or other consideration payable for coverage under a group or individual policy.
- (7) 'Reasonable and customary' means the most frequently used level of charge made for the supplies or for a specific service in the geographic sub-area in which such supplies or services are received, of like kind or by physicians, or other practitioners, with similar qualifications.

"§ 58-254.41. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership. — A group policy delivered or issued for delivery in this State which insures employees or members, other than the members and their dependents, if they have elected to include them, whose eligibility under the group policy does not extend to any employee(s) the insured may have for hospital, surgical or major medical insurance on an expense incurred or service basis under Chapters 57, 57B, and 58 of the General Statutes, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose insurance for these types of coverage under the group policy would otherwise terminate because of termination of active employment or membership, or

termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans already in force, or hereafter placed into effect, that provide continuation benefits equal to or better than those required in this Part.

"§ 58-254.42. Eligibility. — Continuation shall only be available to an employee or member who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately prior to the date of termination.

"§ 58-254.43. Exception. — Continuation shall not be available for any person who is or could be covered by any other arrangement of hospital, surgical, or medical coverage for individuals in a group, whether insured or uninsured, within 31 days immediately following the date of termination; or whose insurance terminated because he failed to pay any required contribution for the insurance.

"§ 58-254.44. Benefits not included. — Continuation is not required to include dental, vision care, or prescription drug benefits, or any other benefits provided under the group policy in addition to its hospital, surgical, or major medical benefits.

"§ 58-254.45. Notification to employee. — In addition to the notification requirement set forth in G.S. 58-254.48, notification may be included on insurance identification cards or may be given by the employer, orally or in writing as a part of the exit process from the employment.

"§ 58-254.46. Payment of premiums. — An employee or member electing continuation must pay to the group policyholder or his employer, in advance, the amount of contribution required by the policyholder or employer, but not more than the full group rate for the insurance applicable under the group policy on the due date of each payment. The employee or member may not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member must make a written election of continuation, on a form furnished by the group policyholder, and pay the first contribution, in advance, to the policyholder or employer on or before the date on which employee's or member's insurance would otherwise terminate.

"§ 58-254.47. Termination of continuation. — Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

- (1) The date three months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership;
- (2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;
- (3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;
- (4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-254.49 if the date of termination precedes that on which his actual continuation of insurance under that policy would have terminated.

"§ 58-254.48. Notification. — A notification of the continuation privilege shall be included in each individual certification of coverage.

"Part 2. Conversion.

"§ 58-254.49. Right to obtain individual policy upon termination of group hospital, surgical or major medical coverage. — A group policy delivered or issued for delivery in this State that insures employees or members for hospital, surgical, or medical insurance on an expense incurred or service basis under General Statutes Chapters 57, 57B, and 58, other than for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy has been terminated shall be entitled to have a converted policy issued to him by the insurer under whose group policy he was last insured, without evidence of insurability, subject to the terms and conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans already in force, or hereafter placed into effect, that provide conversion benefits equal to or better than those required in this Part.

"§ 58-254.50. Restrictions. — A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred because:

- (1) Of termination of employment or membership and either he was not entitled to continuation of group coverage under Part 1 of this Article or failed to elect such continuation;
- (2) He failed to make timely payment of any required contribution for the cost of continuation of insurance;
- (3) He had not been continuously covered under the group policy or for similar benefits under any other group policy that it replaced during the period of three consecutive months immediately prior to termination of active employment ending with such termination;
- (4) The group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of date of termination; or
- (5) He failed to continue his insurance for the entire maximum period of three consecutive months following termination of active employment as provided for in Part 1 of this Article.

"§ 58-254.51. Time limit. — In order to be eligible for conversion, written application and the first premium payment for the converted policy must be made to the insurer not later than 31 days after the date of termination of insurance provided under Part 1 of this Article. The effective date of the converted policy shall be the day following the later of:

- (1) The termination of insurance under the group policy when it is not replaced by one providing similar coverage within 31 days of the termination date of the immediately prior group plan; or
- (2) The termination of the three months of continued coverage under the group policy or policies.

"§ 58-254.52. Premium. — (a) The premium for the converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk to be covered under that policy and to the type and amount of insurance provided.

(b) All insurers licensed to do business in this State, who issue conversion policies under this Part, shall have the right to increase that element of the premium that applies to hospital room and board benefit increases provided for in G.S. 58-254.59(5) by an amount proportionate to the increase promulgated by the Commissioner. Such premium increases shall be filed with the Commissioner.

(c) All premium rates and adjustments to premium rates for converted policies shall be reasonable and must be filed with the Commissioner prior to use. A premium rate shall be deemed to be reasonable if it can be demonstrated by the insurer that the premium charged is expected to produce an incurred loss ratio to earned premiums of not less than sixty percent

(60%) for all individual policies providing similar benefits offered and issued by the insurer. If an insurer experiences an incurred loss ratio of greater than eighty percent (80%) for all such policies, it shall be deemed reasonable for that insurer to increase premium rates to a level that will produce a prospective incurred loss ratio of no greater than eighty percent (80%), and the insurer shall file such new rates with the Commissioner: Provided, however, that such action may be taken by the insurer at intervals not more frequently than two years, the first of which shall be no earlier than January 1, 1984.

"§ 58-254.53. Coverage. — The converted policy shall cover the employee or member and his eligible dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any such eligible dependent.

"§ 58-254.54. Exclusions. — The insurer shall not be required to issue a converted policy covering any person if such person is or can be covered by Medicare. Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

- (1)
 - a. Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by any other plan or program;
 - b. Such person is or could be covered for similar benefits, whether or not covered for such benefits, under any arrangement of coverage for individuals in a group, whether insured or uninsured; or
 - c. Similar benefits are provided for or available to such person, whether or not covered for such benefits, by reason of any State or federal law; and
- (2) The benefits under sources of the kind referred to in subdivision (1)a. of this section for such person, or benefits provided or available under sources of the kind referred to in subdivisions (1)b. and (1)c. of this section for such person, together with the converted policy's benefits would result in overinsurance according to the insurer's standards for overinsurance.

"§ 58-254.55. Information. — A converted policy may provide that the insurer may at any time request information of the insured policyholder with respect to any person covered thereunder as to whether he is covered for the similar benefits described in G.S. 58-254.54(1)a. or is or could be covered for the similar benefits described in G.S. 58-254.54(1)b. and G.S. 58-254.54(1)c. The converted policy may provide that as of any premium due date the insurer may refuse to renew the policy or the coverage of any insured person for the following reasons only:

- (1) Either those similar benefits for which such person is or could be covered, together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance, or the policyholder of the converted policy fails to provide the requested information;
- (2) Fraud or material misrepresentation in applying for any benefits under the converted policy; or
- (3) Eligibility of any insured person for coverage under Medicare, or under any other State or federal law providing benefits substantially similar to those provided by the converted policy.

"§ 58-254.56. Excess benefits. — An insurer shall not be required to issue a converted policy providing benefits in excess of the equivalent value of hospital, surgical, or major medical insurance under the group policy from which conversion is made.

"§ 58-254.57. Preexisting conditions. — The converted policy shall not exclude, as a preexisting condition, any condition covered by the group policy. However, the converted policy may provide for a reduction of its hospital, surgical or medical benefits by the amount of

any such benefits payable under the group polity after the individual's insurance terminates thereunder. The converted policy may also provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

"§ 58-254.58. Basic coverage plans. — (a) Subject to the provisions of this Article, if the group insurance policy from which conversion is made insures the employee or member for basic hospital and surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any of the following plans:

(1) Plan A:

- (i) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the major metropolitan area of this State, for a maximum duration of 70 days;
- (ii) Miscellaneous hospital expense benefits up to a maximum amount of 10 times the hospital room and board daily expense benefits; and
- (iii) Surgical expense benefits according to a surgical procedures schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars (\$800.00).

(2) Plan B:

Identical to Plan A, except that (i) the maximum hospital room and board daily expense benefit is seventy-five percent (75%) of the corresponding Plan A maximum and (ii) the surgical schedule maximum is six hundred dollars (\$600.00).

(3) Plan C:

Identical to Plan A, except that (i) the maximum hospital room and board daily expense benefit is fifty percent (50%) of the corresponding Plan A maximum and (ii) the surgical schedule maximum is four hundred dollars (\$400.00).

(b) The maximum dollar amount for the maximum hospital room and board daily expense benefit of Plan A shall be determined by the Commissioner and may be redetermined by him from time to time as to converted policies issued subsequent to such redetermination. Such redetermination shall not be made more often than once in three years. The Plan A maximum, and the corresponding maximums in Plans B and C, shall be rounded to the nearest multiple ten dollars (\$10.00), provided that rounding may be to the next higher or lower multiple often dollars (\$10.00) if otherwise exactly midway between.

"§ 58-254.59. Major medical plans. — Subject to the provisions of this Article, if the group policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(1) A maximum benefit at least equal to either, at the option of the insurer,

- (i) A maximum payment per covered person for all covered medical expenses incurred during that person's lifetime, equal to the lesser of the maximum benefit provided under the group policy or one hundred thousand dollars (\$100,000); or
- (ii) A maximum payment for each unrelated injury or sickness, equal to the lesser of the maximum benefit provided under the group policy or one hundred thousand dollars (\$100,000).

(2) Payment of benefits at the rate of eighty percent (80%) of covered medical expenses that are in excess of the deductible, until twenty percent (20%) of such expenses in a benefit period reaches one thousand dollars (\$1,000), after which benefits will be paid at the rate of one hundred percent (100%) during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than fifty percent (50%).

(3) A deductible for each benefit period which, at the option of the insurer, shall be (i) the sum of the benefits deductible and one hundred dollars (\$100.00), or (ii) the corresponding deductible in the group policy. The term 'benefits deductible', as used in this Part, means the value of any benefits provided on an expense incurred basis that are provided with respect to covered medical expenses by any other group or individual hospital, surgical, or medical insurance policy or medical practice or other prepayment plan, or any other plan, or program whether insured or uninsured, or by reason of any State or federal law and if, pursuant to G.S. 58-254.60, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by subdivision (1)(i) of this section, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is one hundred dollars (\$100.00) or less, and not less than six months if the deductible exceeds one hundred dollars (\$100.00).

(4) The benefit period shall be each calendar year when the maximum benefit is determined by subdivision (1)(i) of this section or 24 months when the maximum benefit is determined by subdivision (1)(ii) of this section.

(5) The term 'covered medical expenses', as used in this Part, shall include, in the case of hospital room and board charges, at a minimum the lesser of the dollar amount in G.S. 58-254.58(a)(1) and the average semiprivate room and board rate for the hospital in which the individual is confined, and at a minimum twice such amount for charges in an intensive care unit. Any surgical procedures schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a one thousand two hundred dollar (\$1,200) maximum.

"§ 58-254.60. Alternative plans. — At the option of the insurer, such plans of benefits set forth in G.S. 58-254.58 and G.S. 58-254.59 may be provided under one policy. Instead of providing the plans of benefits set forth in G.S. 58-254.58 and G.S. 58-254.59, the insurer may elect to provide a policy of comprehensive medical expense benefits without first dollar coverage. Said policy shall conform to the requirements of G.S. 58-254.59; provided, however, that an insurer electing to provide such a policy shall make available the following deductible options: one hundred dollars (\$100.00), five hundred dollars (\$500.00), and one thousand dollars (\$1,000). Alternatively, such a policy may provide for deductible options equal to the greater of the benefits deductible and the amount specified in the preceding sentence.

"§ 58-254.61. Insurer option. — The insurer may, at its option, offer alternative plans for group health conversion in addition to those required by this Part. Furthermore, if any insurer customarily offers individual policies on a service basis, that insurer may, in lieu of converted policies on an expense incurred basis, make available converted policies on a service basis which, in the opinion of the Commissioner satisfy the intent of this Part.

"§ 58-254.62. Other conversion provisions. — (a) If coverage would in any event have been continued under the group policy on an employee following his retirement prior to the time he

is or could be covered by Medicare and provided he would have been eligible for continuation under the group policy as specified in G.S. 58-254.42, the employee or member may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had that insurance terminated at retirement.

(b) The converted policy may provide for reduction or termination of coverage of any person upon his eligibility for coverage under Medicare or under any other State or federal law providing for benefits similar to those provided by the converted policy.

(c) Subject to the conditions set forth in this subsection, the conversion privilege shall also be available (i) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and any eligible children whose coverage under the group policy terminates by reason of such death, or if the group policy provides for continuation of dependents' coverage following the employee's or member's death, at the end of such continuation, or (ii) to the spouse of the employee or member upon termination of coverage of the spouse because the spouse becomes ineligible, while the employee or member remains insured under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time, or (iii) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be an eligible family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(d) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy, notwithstanding the maximum period of group continuation specified in G.S. 58-254.47(1).

(e) A notification of the conversion privilege shall be included in each certificate of coverage.

(f) A converted policy which is delivered outside this State may be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction."

Sec. 2. This act shall apply only to group policies delivered, issued for delivery, or amended on or after the effective date of this act. The provisions of this act shall not apply to hospital, surgical or major medical plans offered by employers on a self-insured basis.

Sec. 3. This act shall become effective January 1, 1982.

In the General Assembly read three times and ratified, this the 26th day of June, 1981.