§ 58-68-30. Increased portability through limitation on preexisting condition exclusions.

(a) Limitation on Preexisting Condition Exclusion Period; Crediting for Periods of Previous Coverage. – Subject to subsection (d) of this section, a group health insurer may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.

(2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.

(3) The period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions. – For the purposes of this Part:

(1) Enrollment date. – With respect to an individual covered under a group health insurance plan, the date of enrollment of the individual in the coverage or, if earlier, the first day of the waiting period for the enrollment. An individual's enrollment date does not change if the individual receiving benefits under a group health insurance plan changes benefit packages or if the plan changes health insurers.

(2) Late enrollee. – With respect to coverage under a group health insurance plan, a participant or beneficiary who enrolls under the plan other than during:

a. The first period in which the individual is eligible to enroll under the plan, or

b. A special enrollment period under subsection (f) of this section.

(3) Preexisting condition exclusion. –

a. In general. – "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

b. Treatment of genetic information. – Genetic information shall not be treated as a condition described in subdivision (a)(1) of this subsection in the absence of a diagnosis of the condition related to the information.

(4) Waiting period. –

a. With respect to a group health insurance plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

b. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period.

c. If an individual seeks individual health insurance coverage, a waiting period begins on the date the individual submits a substantially complete application and ends on: (i) the date coverage begins if the application results in coverage; or (ii) the date on which the application is denied by the health insurer or the date on which the offer for coverage lapses if the application does not result in coverage.

(c) Rules Relating to Crediting Previous Coverage. –

(1) Creditable coverage defined. – For the purposes of this Article, "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

a. A group health plan.

b. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.

c. Part A or part B of title XVIII of the Social Security Act.

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

e. Chapter 55 of title 10, United States Code.

f. A medical care program of the Indian Health Service or of a tribal organization.

g. A State health benefits risk pool.

h. A health plan offered under chapter 89 of title 5, United States Code.

i. A public health plan (as defined in federal regulations).

j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

k. Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits. However, short-term limited-duration health insurance coverage shall be considered creditable coverage for purposes of this section.

(2) Not counting periods before significant breaks in coverage. –

a. In general. – A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health insurance plan, if, after the period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

b. Waiting period not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision and subdivision (d)(4) of this subsection, any period that an individual is in a waiting period for any coverage under a group health insurance plan or is in an affiliation period shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.

c. Time spent on short term limited duration health insurance not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision, any period that an individual is enrolled on a

short term limited duration health insurance policy shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision so long as the period of time spent on the short term limited duration health insurance policy or policies does not exceed 12 months.

d. For an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period shall not be considered when determining whether a significant break in coverage has occurred.

(3) Method of crediting coverage. –

a. Standard method. – Except as otherwise provided under sub-subdivision b. of this subdivision for the purposes of applying subdivision (a)(3) of this subsection, a group health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.

b. Election of alternative method. – A group health insurer may elect to apply subdivision (a)(3) of this subsection based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations rather than as provided under sub-subdivision a. of this subdivision. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election a group health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

c. Health insurer notice. – In the case of an election under sub-subdivision b. of this subdivision with respect to health insurance coverage in the small or large group market, the health insurer: (i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made the election, and (ii) shall include in the statements a description of the effect of the election.

(4) Establishment of period. – Periods of creditable coverage for an individual shall be established through presentation of certifications described in subsection (e) of this section or in another manner that is specified in federal regulations.

(5) Determination of creditable coverage. –

a. Determination within reasonable time. – If a group health insurer receives creditable coverage information under subsection (e) of this section, the group health insurer shall, within a reasonable time following receipt of the information, make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care.

b. No time limit on presenting evidence of creditable coverage. – A group health insurer shall not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(d) Exceptions. –

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. – A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5) Condition first diagnosed under previous coverage. – A group health insurer shall not impose any preexisting condition exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and the condition was covered under the qualifying previous coverage or prior creditable coverage; provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than 63 days before the enrollment date for the new coverage.

(e) Certifications and Disclosure of Coverage. –

(1) Requirement for certification of period of creditable coverage. –

a. In general. – A group health insurer shall provide the certification described in sub-subdivision b. of this subdivision: (i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, (ii) in the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision, and (iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii) of this sub-subdivision, whichever is later.

The certification under clause (i) of this sub-subdivision may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

b. Certification. – The certification described in this sub-subdivision is a written certification of: (i) the period of creditable coverage of the individual under the plan and any coverage under the COBRA continuation provision, and (ii) any waiting period and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) Disclosure of information on previous benefits. – In the case of an election described in sub-subdivision (c)(3)b. of this subsection by a group health insurer, if the health insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (1) of this subsection:

a. Upon request of the health insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or health insurer information on coverage of classes and categories of health benefits available under the entity's coverage.

b. The entity may charge the requesting plan or health insurer for the reasonable cost of disclosing the information.

(f) Special Enrollment Periods. –

(1) Individuals losing other coverage. – A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

a. The employee or dependent was covered under an ERISA group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

b. The employee stated in writing at the time that coverage under the group health plan or health insurance coverage was the reason for declining enrollment, but only if the health insurer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

c. With respect to the employee's or dependent's coverage described in sub-subdivision a. of this subsection: (i) the coverage was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) the coverage was not under that provision and either the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; (iii) employer contributions toward the coverage were terminated; (iv) in the case of coverage offered through an arrangement that does not provide benefits to individuals who no longer reside, live, or work in a service area, there has been loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is

available to the individual; (v) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vi) a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or (vii) the health insurer terminated coverage under G.S. 58-68-45(c)(2).

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the date of the applicable event described in sub-subdivision c. of this subdivision.

(2) For dependent beneficiaries. –

a. In general. – If: (i) a group health insurance plan makes coverage available with respect to a dependent of an individual, (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and (iii) a person becomes the dependent of the individual through marriage, birth, or adoption or placement for adoption.

The plan shall provide for a dependent special enrollment period described in sub-subdivision b. of this subdivision during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

b. Dependent special enrollment period. – A dependent special enrollment period under this sub-subdivision shall be a period of not less than 30 days and shall begin on the later of: (i) the date dependent coverage is made available, or (ii) the date of the marriage, birth, or adoption or placement for adoption described in sub-subdivision a.(iii) of this subdivision.

c. No waiting period. – If an individual seeks to enroll a dependent during the first 30 days of the dependent's special enrollment period, the coverage of the dependent shall become effective: (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received; (ii) in the case of a dependent's birth, as of the date of the birth; or (iii) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Treatment of special enrollees.

a. If an individual requests enrollment while the individual is entitled to special enrollment under this subsection, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be considered a late enrollee.

b. Special enrollees shall be offered all of the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in

the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible.

(4) Special rules for application in case of Medicaid or State Children's Health Insurance Program (Title XXI of the Social Security Act). – A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

a. Termination of Medicaid or State Children's Health Insurance Program. – The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State children's health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under such a plan is terminated as a result of the loss of eligibility for such coverage and the employee requests coverage under the group health insurance coverage not later than 60 days after the termination of such coverage.

b. Eligibility for employment assistance under Medicaid or State Children's Health Insurance Program. – The employee or dependent becomes eligible for assistance, with respect to coverage under the group health insurance coverage, under such Medicaid plan or State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(g) Use of Affiliation Period by HMO as Alternative to Preexisting Condition Exclusion. –

(1) In general. – A health maintenance organization that does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for the coverage option, but only if:

a. The period is applied uniformly without regard to any health status-related factors.

b. The period does not exceed two months (or three months in the case of a late enrollee).

(2) Affiliation period. –

a. Defined. – For the purposes of this Subpart, "affiliation period" means a period that, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

b. Beginning. – The period shall begin on the enrollment date.

c. Runs concurrently with waiting periods. – An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods. – A health maintenance organization described in subdivision (1) of this subsection may use alternative methods, as approved by the Commissioner, from those described in that subdivision, to address adverse selection.

(h) General Notice of Preexisting Condition Exclusion. – A group health insurer offering group health insurance coverage subject to a preexisting condition exclusion shall provide a written general notice of preexisting condition exclusion to participants under the plan; and shall not impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until the notice is provided.

A group health insurer shall provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the insurer for enrollment. If the insurer does not distribute these materials, the notice shall be provided by the earliest date following a request for enrollment that the insurer, acting in a reasonable and prompt fashion, can provide the notice.

The general notice of preexisting condition exclusion shall notify participants of the following:

(1) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period, which shall not exceed six months under subdivision (a)(1) of this section; the maximum preexisting condition exclusion period under the plan, which shall not exceed 12 months (18 months for late enrollees) under subdivision (a)(2) of this section; and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage, as described in subsection (c) of this section.

(2) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage, as required by subsection (e) of this section, or through other means as described in federal regulations. This shall include a description of the right of the individual to request a certificate from a prior insurer, if necessary, and a statement that the current insurer will assist in obtaining a certificate from any prior plan or insurer, if necessary.

(3) A person to contact, including an address or telephone number for obtaining additional information or assistance about the preexisting condition exclusion.

Nothing in this subsection affects a group health insurer's responsibility under this section to fully disclose in the master group policy, the certificate or evidence of coverage, and the member handbook the plan's preexisting condition limitation, the rules relating to creditable coverage, including how an individual may provide proof of creditable coverage, and the methods of counting and crediting coverage.

(i) Individual Notice of Period of Preexisting Condition Exclusion. – After an individual has presented evidence of creditable coverage and the group health insurer has made a determination of creditable coverage under subdivision (c)(5) of this section, the group health insurer shall provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. In the notice, the insurer is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A group health insurer is not required to provide this notice if the plan does

not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

The individual notice must be provided by the earliest date following a determination that the group health insurer, acting in a reasonable and prompt fashion, can provide the notice.

A group health insurer shall disclose:

(1) Its determination of any preexisting condition exclusion period that applies to the individual, including the last day on which the preexisting condition exclusion applies.

(2) The basis for that determination, including the source and substance of any information on which the plan or insurer relied.

(3) An explanation of the individual's right to submit additional evidence of creditable coverage.

(4) A description of any applicable appeal procedures established by the group health insurer.

(j) Determination Modification. – Nothing in this section prevents a plan or insurer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that:

(1) A notice of the new determination, consistent with the requirements of subsection (i) of this section, is provided to the individual; and

(2) Until the notice of the new determination is provided, the group health insurer, for purposes of approving access to medical services (such as a presurgery authorization), acts in a manner consistent with the initial determination.

(k) Notice Form and Content. – Any notices required under this section shall be in the form and content and be delivered as prescribed by, in accordance with, or as specified in federal regulations, unless otherwise provided in this Chapter. (1997-259, s. 1(c); 1998-211, s. 7; 2001-334, s. 9; 2005-224, ss. 1, 4, 2.1, 2.2; 2007-298, ss. 2.3-2.5; 2009-382, ss. 4, 23.)