

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

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SENATE BILL 797*

Short Title: Small Employer Group Health Reform.

(Public)

Sponsors: Senator Odom.

Referred to: Insurance.

April 24, 1991

A BILL TO BE ENTITLED

AN ACT TO REFORM THE SMALL EMPLOYER GROUP HEALTH INSURANCE
MARKETPLACE IN THE STATE OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Section 1. Article 50 of Chapter 58 of the General Statutes is amended by
adding the following sections to read:

"§ 58-50-100. Title and reference.

This section and G.S. 58-50-105 through G.S. 58-50-150 are known and may be
cited as the North Carolina Small Employer Group Health Coverage Reform Act,
referred to in those sections as 'this Act'.

"§ 58-50-105. Purpose and intent.

The purpose and intent of this Act is to promote the availability of health insurance
coverage to small employers, to prevent abusive rating practices, to require disclosure of
rating practices to purchasers, to establish rules for continuity of coverage for employers
and covered individuals, and to improve the efficiency and fairness of the small group
health insurance marketplace.

"§ 58-50-110. Definitions.

As used in this Act:

- (1) 'Actuarial certification' means a written statement by a member of the
American Academy of Actuaries or other individual acceptable to the
Commissioner that a small employer carrier is in compliance with the
provisions of G.S. 58-50-130, based upon the person's examination,
including a review of the appropriate records and of the actuarial

- 1 assumptions and methods used by the small employer carrier in
2 establishing premium rates for applicable health benefit plans.
- 3 (2) 'Base premium rate' means for each class of business as to a rating
4 period, the lowest premium rate charged or that could have been
5 charged under a rating system for that class of business, by the small
6 employer carrier to small employers with similar case characteristics
7 for health benefit plans with the same or similar coverage.
- 8 (3) 'Basic health care plan' means a health care plan for small employers
9 that is lower in cost than a standard health care plan and is required to
10 be offered by all small employer carriers pursuant to G.S. 58-50-125
11 and approved by the Commissioner in accordance with G.S. 58-50-
12 125.
- 13 (4) 'Board' means the board of directors of the Pool.
- 14 (5) 'Carrier' means any person that provides one or more health benefit
15 plans in this State, including a licensed insurance company, a prepaid
16 hospital or medical service plan, a health maintenance organization
17 ('HMO'), and a multiple employer welfare arrangement.
- 18 (6) 'Case characteristics' means demographic or other objective
19 characteristics of a small employer, as determined by a small employer
20 carrier, that are considered by the small employer carrier in the
21 determination of premium rates for the small employer; but does not
22 mean claim experience, health status, and duration of coverage since
23 issue.
- 24 (7) 'Class of business' means all or a distinct grouping of small employers
25 as shown on the records of a small employer carrier.
- 26 (8) 'Committee' means the Small Employer Carrier Committee as created
27 by G.S. 58-50-120.
- 28 (9) 'Dependent' means the spouse or child of an eligible employee, subject
29 to applicable terms of the health care plan covering the employee.
- 30 (10) 'Eligible employee' means an employee who works for a small
31 employer on a full-time basis, with a normal work week of 30 or more
32 hours, including a sole proprietor, a partner or a partnership, or an
33 independent contractor, if included as an employee under a health care
34 plan of a small employer; but does not include employees who work
35 on a part-time, temporary, or substitute basis.
- 36 (11) 'Health benefit plan' means any accident or health insurance policy or
37 certificate; nonprofit hospital or medical service corporation contract;
38 health, hospital, or medical service corporation plan contract; HMO
39 subscriber contract plan provided by a MEWA or plan provided by
40 another benefit arrangement, to the extent permitted by ERISA, subject
41 to G.S. 58-50-115. 'Health benefit plan' does not mean accident only,
42 credit, or disability insurance; coverage of Medicare services pursuant
43 to contracts with the United States government; Medicare supplement
44 or long-term care insurance; dental only or vision only insurance;

1 coverage issued as a supplement to liability insurance; insurance
2 arising out of a workers' compensation or similar law; automobile
3 medical payment insurance; or insurance under which benefits are
4 payable with or without regard to fault and that is statutorily required
5 to be contained in any liability insurance policy or equivalent self-
6 insurance.

7 (12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-
8 20(6) or G.S. 58-62-16(8).

9 (13) 'Index rate' means, for each class of business as to a rating period for
10 small employers with similar case characteristics, the arithmetic
11 average of the applicable base premium rate and the corresponding
12 highest premium rate.

13 (14) 'Late enrollee' means an eligible employee or dependent who requests
14 enrollment in a health benefit plan of a small employer following the
15 initial enrollment period provided under the terms of the health benefit
16 plan; provided that the initial enrollment period shall be a period of at
17 least 30 days. However, an eligible employee or dependent shall not
18 be considered a late enrollee if:

19 a. The individual:

20 1. Was covered under another employer health benefit plan
21 at the time the individual was eligible to enroll;

22 2. Stated, at the time of the initial enrollment, that coverage
23 under another employer health benefit plan was the
24 reason for declining enrollment;

25 3. Has lost coverage under another employer health benefit
26 plan as a result of termination of employment, the
27 termination of the other plan's coverage, death of a
28 spouse, or divorce; and

29 4. Requests enrollment within 30 days after termination of
30 coverage provided under another employer health benefit
31 plan;

32 b. The individual is employed by an employer that offers multiple
33 health benefit plans and the individual elects a different plan
34 during an open enrollment period; or

35 c. A court has ordered coverage be provided for a spouse or minor
36 child under a covered employee's health benefit plan and
37 request for enrollment is made within 30 days after issuance of
38 such court order.

39 (15) 'New business premium rate' means, for each class of business as to a
40 rating period, the lowest premium rate charged, offered, or that could
41 have been charged by a small employer carrier to small employers
42 with similar case characteristics for newly issued health benefit plans
43 with the same or similar coverage.

- 1 (16) 'Pool' means the North Carolina Small Employer Health Reinsurance
2 Pool created in G.S. 58-50-150.
- 3 (17) 'Preexisting conditions provision' means a policy provision that
4 excludes coverage for charges or expenses incurred during a specified
5 period following the insured's effective date of coverage, for a
6 condition that, during a specified period immediately preceding the
7 effective date of coverage, had manifested itself in such a manner as
8 would cause an ordinary prudent person to seek diagnosis, care, or
9 treatment, or for which medical advice, diagnosis, care, or treatment
10 was recommended or received as to that condition or as to pregnancy
11 existing on the effective date of coverage.
- 12 (18) 'Premium' includes insurance premiums or other fee charged for a
13 health benefit plan, including the costs of benefits paid or
14 reimbursements made to or on behalf of persons covered by the plan.
- 15 (19) 'Rating period' means the 12-month calendar period for which
16 premium rates established by a small employer carrier are assumed to
17 be in effect, as determined by the small employer carrier.
- 18 (20) 'Risk-assuming carrier' means a small employer carrier electing to
19 comply with the requirements set forth in G.S. 58-50-140.
- 20 (21) 'Reinsuring carrier' means a small employer carrier electing to comply
21 with the requirements set forth in G.S. 58-50-145.
- 22 (22) 'Small employer' means any person actively engaged in business that,
23 on at least fifty percent (50%) of its working days during the preceding
24 year, employed no more than 25 eligible employees and not less than
25 three eligible employees, the majority of whom are employed within
26 this State. 'Small employer' includes companies that are affiliated
27 companies, as defined in G.S. 58-19-5(1) or that are eligible to file a
28 combined tax return under Chapter 105 of the General Statutes or
29 under the Internal Revenue Code. Except as otherwise provided, the
30 provisions of this Act that apply to a small employer shall continue to
31 apply until the plan anniversary following the date the employer no
32 longer meets the requirements of this section.
- 33 (23) 'Small employer carrier' means any carrier that offers health benefit
34 plans covering eligible employees of one or more small employers.
- 35 (24) 'Standard health care plan' means a health care plan for small
36 employers required to be offered by all small employer carriers
37 pursuant to G.S. 58-50-125 and approved by the Commissioner in
38 accordance with G.S. 58-50-125.

39 **"§ 58-50-112. Affiliated companies; HMOs.**

40 For the purposes of this Act, companies that are affiliated companies or that are
41 eligible to file a consolidated tax return shall be treated as one carrier except that any
42 insurance company, hospital service plan, or medical service plan that is an affiliate of
43 an HMO located in North Carolina or any HMO located in North Carolina that is an
44 affiliate of an insurance company, a health service corporation, or a medical service

1 corporation may treat the HMO as a separate carrier and each HMO that operates only
2 one HMO in a service area of North Carolina may be considered a separate carrier.

3 **"§ 58-50-113. Distinct groupings.**

4 (a) A distinct grouping may only be established by a small employer carrier on
5 the basis that the applicable health benefit plans:

6 (1) Are marketed and sold through individuals and organizations that are
7 not participating in the marketing or sale of other distinct groupings of
8 small employers for the small employer carrier;

9 (2) Have been acquired from another small employer carrier as a distinct
10 grouping of plans; or

11 (3) Are provided through an association with membership of not less than
12 10 small employers that has been formed for purposes other than
13 obtaining insurance;

14 (b) A small employer carrier may establish no more than two additional
15 groupings under subdivision (a)(1), (2), or (3) of this section on the basis of
16 underwriting criteria that are expected to produce substantial variation in the health care
17 costs.

18 (c) The Commissioner may approve the establishment of additional distinct
19 groupings upon application to him and his determination that such action would
20 enhance the efficiency and fairness of the small employer marketplace.

21 **"§ 58-50-115. Health benefit plans subject to Act.**

22 (a) A health benefit plan is subject to this Act if it provides health benefits for
23 small employers and if either of the following conditions are met:

24 (1) Any portion of the premiums or benefits is paid by a small employer or
25 any covered individual is reimbursed, whether through wage
26 adjustments or otherwise, by a small employer for any portion of the
27 premium; or for which the small employer has permitted payroll
28 deduction for the covered individual, whether or not such coverage is
29 issued through a group or individual policy of insurance, and whether
30 or not any portion of the premium is paid by the small employer.

31 (2) The health benefit plan is treated by the employer or any of the
32 covered individuals as part of a plan or program for the purpose of
33 section 162 or section 106 of the Internal Revenue Code.

34 (b) The provisions of G.S. 58-51-95(f) do not apply to individual health
35 insurance policies or contracts to the extent subject to the provisions of this Act.

36 **"§ 58-50-120. Small Employer Carrier Committee.**

37 (a) The Commissioner shall appoint the Small Employer Carrier Committee with
38 fair representation of risk-assuming carriers, reinsuring carriers, and representatives
39 from the insurance agent and small employer communities.

40 (b) Subject to approval by the Commissioner, the Committee shall recommend
41 the form and level of coverages to be made available by small employer carriers in
42 accordance with the provisions of G.S. 58-50-125(a). The Committee shall recommend
43 benefit levels, cost-sharing factors, exclusions, and limitations for the basic and standard
44 health care plans. One basic health care plan and one standard health care plan shall

1 contain benefit and cost-sharing levels that are consistent with the basic method of
2 operation and the benefit plans of HMOs, including any restrictions imposed by federal
3 law. The Committee shall submit the plans to the Commissioner for his approval within
4 180 days after the appointment of the Committee pursuant to this section; and the plans
5 shall be deemed to be approved unless expressly disapproved by the Commissioner
6 during such 180-day period. Such plans may include cost containment features such as:
7 utilization review of health care services, including review of medical necessity of
8 hospital and physician services; case management benefit alternatives; selective
9 contracting with hospitals, physicians, and other health care providers; reasonable
10 benefit differentials applicable to participating and nonparticipating providers; and other
11 managed care provisions.

12 (c) In order to assure the broadest availability of health benefit plans to small
13 employers, the Committee shall recommend for approval by the Commissioner market
14 conduct and other requirements for carriers, agents, brokers, and third-party
15 administrators, including requirements developed as a result of a request by the
16 Commissioner, relating to the following:

- 17 (1) Registration by each carrier with the Department of its intention to be
18 a small employer carrier under this Act.
- 19 (2) Publication by the Department, the Committee, or the Pool of a list of
20 all small employer carriers, including a potential requirement
21 applicable to agents, brokers, third-party administrators, and carriers
22 that no health benefit plan may be sold to a small employer by a carrier
23 not so identified as a small employer carrier.
- 24 (3) The availability of a broadly publicized toll free telephone number for
25 access by small employers to information concerning the Act.
- 26 (4) To the extent deemed to be necessary by the Committee to assure the
27 fair distribution of high-risk individuals and groups among carriers,
28 periodic reports by carriers, agents, brokers, and third-party
29 administrators about health benefit plans issued; provided that
30 reporting requirements shall be limited to information concerning case
31 characteristics and numbers of health benefit plans in various
32 categories marketed or issued to small employers.
- 33 (5) Registration by agents, brokers, and third-party administrators of their
34 intention to be such for health benefit plans marketed to small
35 employers under this Act.
- 36 (6) Methods concerning periodic demonstration by small employer
37 carriers, agents, brokers, and third-party administrators that they are
38 marketing and issuing health benefit plans to small employers in
39 fulfillment of the purposes of this Act.

40 (d) Within three years after January 1, 1992, the Committee shall conduct a study
41 of the effectiveness of the provisions of this Act, recommend further improvements to
42 achieve greater stability, accessibility, and affordability in the small employer
43 marketplace, and submit it to the Commissioner.

44 **"§ 58-50-125. Health care plans; formation; approval; offerings.**

1 (a) In order to improve the availability and affordability of health benefits
2 coverage for small employers, the Committee shall recommend to the Commissioner
3 two plans of coverage, one of which shall be a basic health care plan and the second of
4 which shall be a standard health care plan. Each plan of coverage shall be in two forms,
5 one of which shall be in the form of insurance and the second of which shall be
6 consistent with the basic method of operation and benefit plans of HMOs, including
7 federally qualified HMOs. The Committee shall submit the recommended plans to the
8 Commissioner for approval within 180 days after the appointment of the Committee
9 pursuant to G.S. 58-50-150. The Committee shall take into consideration the levels of
10 health benefit plans provided in North Carolina, and appropriate medical and economic
11 factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. Such
12 plans may include cost containment features such as, but not limited to: preferred
13 provider provisions; utilization review of medical necessity of hospital and physician
14 services; case management benefit alternatives; or other managed care provisions.

15 (b) After the Commissioner's approval of the plans submitted by the Committee
16 pursuant to subsection (a) of this section and in lieu of any contrary procedure
17 established by this Chapter, any small employer carrier may certify to the
18 Commissioner, in the form and manner prescribed by the Commissioner, that the basic
19 and standard health care plans filed by the carrier are in substantial compliance with the
20 provisions of the corresponding approved Committee plans. Upon receipt by the
21 Commissioner of the certification, the carrier may use the certified plans unless their use
22 is disapproved by the Commissioner.

23 (c) Any health benefit plan issued to a small employer in this State is not
24 required to provide coverage that meets the requirements of other provisions of this
25 Chapter that mandate either coverage or the offer of coverage by the type or level of
26 health care services or health care provider.

27 (d) Within 180 days after the Commissioner's approval under subsection (b) of
28 this section, every small employer carrier shall, as a condition of transacting business in
29 this State, offer small employers at least one basic and one standard health care plan.
30 Every small employer that elects to be covered under such a plan and agrees to make the
31 required premium payments and to satisfy the other provisions of the plan shall be
32 issued such a plan by the small employer carrier. The premium payment requirements
33 utilized in connection with basic and standard health care plans may address the
34 potential credit risk of small employers that elect coverage in accordance with this
35 subsection by means of payment security provisions that are reasonably related to the
36 risk and are uniformly applied.

37 (e) No small employer carrier is required to offer coverage or accept applications
38 pursuant to subsection (d) of this section:

- 39 (1) From a group already covered under a health benefit plan except for
40 coverage that is to commence following the group's anniversary date,
41 but this subsection shall not be construed to prohibit a group from
42 seeking coverage or a small employer carrier from issuing coverage to
43 a group prior to its anniversary date; or

1 (2) If the Commissioner determines that acceptance of an application or
2 applications would result in the carrier being declared an impaired
3 insurer; or

4 (3) To groups of fewer than three eligible employees where the small
5 employer carrier does not utilize preexisting conditions provisions in
6 the health benefit plans it issues to any small employers.

7 (f) Every small employer carrier shall fairly market the basic and standard health
8 care plan to all small employers in the geographic areas in which the carrier makes
9 coverage available or provides benefits.

10 (g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is
11 required to offer coverage or accept applications pursuant to subsection (d) of this
12 section in the case of any of the following:

13 (1) To a group, where the group is not physically located in the HMO's
14 approved service areas;

15 (2) To an employee, where the employee does not reside within the
16 HMO's approved service areas;

17 (3) Within an area, where the HMO reasonably anticipates, and
18 demonstrates to the satisfaction of the Commissioner, that it will not
19 have the capacity within that area and its network of providers to
20 deliver services adequately to the enrollees of those groups because of
21 its obligations to existing group contract holders and enrollees. An
22 HMO that does not offer coverage pursuant to subdivision (3) of this
23 subsection may not offer coverage in the applicable area to new
24 employer groups with more than 25 eligible employees until the later
25 of 90 days after that closure or the date on which the carrier notifies
26 the Commissioner that it has regained capacity to deliver services to
27 small employers.

28 (h) The provisions of subsections (b), (d), and (g) and subdivision (e)(2) of this
29 section apply to every health benefit plan delivered, issued for delivery, renewed, or
30 continued in this State or covering persons residing in this State on or after the date the
31 plan becomes operational, as determined by the Commissioner. For purposes of this
32 subsection, the date a health benefit plan is continued is the anniversary date of the
33 issuance of the health benefit plan.

34 **"§ 58-50-130. Required health care plan provisions.**

35 (a) Health benefit plans covering small employers are subject to the following
36 provisions:

37 (1) Except in the case of a late enrollee, any preexisting-conditions
38 provision may not exclude coverage for a period beyond 12 months
39 following the insured's effective date of coverage and may only relate
40 to conditions manifesting themselves in such a manner as would cause
41 an ordinarily prudent person to seek medical advice, diagnosis, care, or
42 treatment or for which medical advice, diagnosis, care or treatment
43 was recommended or received during the six months immediately

- 1 preceding the effective date of coverage or as to a pregnancy existing
2 on the effective date of coverage.
- 3 (2) In determining whether a preexisting-conditions provision applies to
4 an eligible employee or to a dependent, all health benefit plans shall
5 credit the time the person was covered under a previous group health
6 benefit plan if the previous coverage was continuous to a date not
7 more than 30 days prior to the effective date of the new coverage,
8 exclusive of any applicable waiting period under such plan.
- 9 (3) The health benefit plan is renewable with respect to all eligible
10 employees or dependents at the option of the policyholder or
11 contractholder except:
- 12 a. For nonpayment of the required premiums by the policyholder
13 or contractholder;
- 14 b. For fraud or misrepresentation of the policyholder or
15 contractholder or, with respect to coverage of individual
16 enrollees, the enrollees or their representatives;
- 17 c. For noncompliance with plan provisions that have been
18 approved by the Commissioner;
- 19 d. When the number of enrollees covered under the plan is less
20 than the number of insureds or percentage of enrollees required
21 by participation requirements under the plan; or
- 22 e. When the policyholder or contractholder is no longer actively
23 engaged in the business in which it was engaged on the
24 effective date of the plan.
- 25 (4) Late enrollees may be excluded from coverage for the greater of 18
26 months or an 18-month preexisting-condition exclusion; provided that
27 if both a period of exclusion from coverage and a preexisting-
28 condition exclusion are applicable to a late enrollee, the combined
29 period shall not exceed 18 months.
- 30 (5) A carrier may continue to enforce reasonable employer participation
31 and contribution requirements on small employers applying for
32 coverage; provided, however, that participation and contribution
33 requirements may vary among small employers only by the size of the
34 small employer group.
- 35 (b) Premium rates for health benefit plans subject to this Act are subject to the
36 following provisions:
- 37 (1) The index rate for a rating period for any class of business shall not
38 exceed the index rate for any other class of business by more than
39 twenty percent (20%), adjusted pro rata for any rating period of less
40 than one year.
- 41 (2) For a class of business, the premium rates charged during a rating
42 period to small employers with similar case characteristics for the
43 same or similar coverage, or the rates that could be charged to such
44 employers under the rating system for that class of business shall not

- 1 vary from the index rate by more than twenty-five percent (25%) of
2 the index rate, adjusted pro rata for any rating period of less than one
3 year.
- 4 (3) The percentage increase in the premium rate charged to a small
5 employer for a new rating period, adjusted pro rata for any rating
6 period of less than one year, may not exceed the sum of the following:
- 7 a. The percentage change in the new business premium rate
8 measured from the first day of the prior rating period to the first
9 day of the new rating period. In the event a small employer
10 carrier is not issuing any new policies, but is only renewing
11 policies, the carrier shall use the percentage change in the base
12 premium rate.
- 13 b. Any adjustment, not to exceed fifteen percent (15%) annually
14 and adjusted pro rata for any rating period of less than one year,
15 due to the claim experience, health status, or duration of
16 coverage of the employees or dependents of the small employer
17 as determined from the small employer carrier's rate manual for
18 the class of business.
- 19 c. Any adjustment because of a change in coverage or change in
20 the case characteristics of the small employer as determined
21 from the small employer carrier's rate manual for the class of
22 business.
- 23 (4) Any adjustment in rates charged by a small employer carrier electing
24 to be a reinsuring carrier that is caused by reinsurance is subject to the
25 rating limitations set forth in this section.
- 26 (5) Premium rates for health benefit plans shall comply with the
27 requirements of this section notwithstanding any reinsurance
28 premiums and assessments paid or payable by small employer carriers
29 in accordance with G.S. 58-50-150.
- 30 (6) In any case where a small employer carrier utilizes industry as a case
31 characteristic in establishing premium rates, the rate factor associated
32 with any industry classification may not vary from the arithmetic
33 average of the rate factors associated with all industry classifications
34 by greater than fifteen percent (15%) of such coverage.
- 35 (7) In the case of health benefit plans issued before January 1, 1992, a
36 premium rate for a rating period, adjusted pro rata for any rating period
37 of less than one year, may exceed the ranges set forth in subdivisions
38 (b)(1) and (2) of this section for a period of three years after January 1,
39 1992. In such case, the percentage increase in the premium rate
40 charged to a small employer in such a class of business for a new
41 rating period may not exceed the sum of the following:
- 42 a. The percentage change in the new business premium rate
43 measured from the first day of the prior rating period to the first
44 day of the new rating period. In the event a small employer

1 carrier is not issuing any new policies, but is only renewing
2 policies, the small employer carrier shall use the percentage
3 change in the base premium rate.

4 b. Any adjustment because of a change in coverage or change in
5 the case characteristics of the small employer as determined
6 from the carrier's rate manual for the class of business.

7 (8) Small employer carriers shall apply rating factors including case
8 characteristics, consistently with respect to all small employers in a
9 class of business. Adjustments in rates for claims experience, health
10 status, and duration from issue may not be applied individually. Any
11 such adjustment must be applied uniformly to the rate charged for all
12 participants of the small employer.

13 (c) A small employer carrier shall not involuntarily transfer a small employer
14 into or out of a class of business. A small employer carrier shall not offer to transfer a
15 small employer into or out of a class of business unless such offer is made to transfer all
16 small employers in the class of business without regard to case characteristics, claim
17 experience, health status, or duration of coverage since issue.

18 (d) In connection with the offering for sale of any health benefit plan to a small
19 employer, each small employer carrier shall make a reasonable disclosure, as part of its
20 solicitation and sales materials, of:

21 (1) The extent to which premium rates for a specified small employer are
22 established or adjusted in part based upon the actual or expected
23 variation in claims costs or actual or expected variation in health
24 condition of the eligible employees and dependents of such small
25 employer.

26 (2) Provisions concerning such small employer carrier's right to change
27 premium rates and the factors other than claim experience that affect
28 changes in premium rate.

29 (3) Provisions relating to renewability of policies and contracts.

30 (4) Provisions affecting any preexisting conditions provision.

31 (e) Each small employer carrier shall maintain at its principal place of business a
32 complete and detailed description of its rating practices and renewal underwriting
33 practices, including information and documentation that demonstrate that its rating
34 methods and practices are based upon commonly accepted actuarial assumptions and
35 are in accordance with sound actuarial principles.

36 (f) Each small employer carrier shall file with the Commissioner annually on or
37 before March 15 an actuarial certification certifying that it is in compliance with this
38 Act and that its rating methods are actuarially sound. A copy of such certification shall
39 be retained by the small employer carrier at its principal place of business.

40 (g) A small employer carrier shall make the information and documentation
41 described in subsection (e) of this section available to the Commissioner upon request.
42 Except in cases of violations of this Act, the information is proprietary and trade secret
43 information and is not subject to disclosure by the Commissioner to persons outside of

1 the Department except as agreed to by the small employer carrier or as ordered by a
2 court of competent jurisdiction.

3 (h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through
4 (g) of this section apply to health benefit plans delivered, issued for delivery, renewed,
5 or continued in this State or covering persons residing in this State on or after January 1,
6 1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health
7 benefit plans delivered, issued for delivery, renewed, or continued in this State or
8 covering persons residing in this State on or after the date the plan becomes operational,
9 as designated by the Commissioner. For purposes of this subsection, the date a health
10 benefit plan is continued is the anniversary date of the issuance of the health benefit
11 plan.

12 **"§ 58-50-135. Elections by carriers.**

13 (a) Every small employer carrier shall elect to either become a risk-assuming
14 carrier and comply with the provisions of G.S. 58-50-140 or become a reinsuring carrier
15 and comply with the provisions of G.S. 58-50-145. The election shall be binding for a
16 five-year period except that the initial election shall be made within 60 days after
17 January 1, 1992, and shall be made for two years. The Commissioner may, for good
18 cause, permit a carrier to modify its election during the five-year period. All carriers
19 under common ownership or control must make the same election in this State;
20 provided, however, that the Commissioner may, for good cause, permit an affiliated
21 carrier to make a separate election.

22 (b) A small employer carrier that elects to cease participating as a reinsuring
23 carrier and elects to become a risk-assuming carrier is prohibited from reinsuring or
24 continuing to reinsure any small employer health benefit plans pursuant to G.S. 58-50-
25 145 and G.S. 58-50-150 as soon as the carrier becomes a risk-assuming carrier:
26 Provided, however, a reinsuring carrier electing to become a risk-assuming carrier shall
27 pay a prorated assessment based upon business issued as a reinsuring carrier for any
28 portion of the year that the business was reinsured. A small employer carrier that elects
29 to cease participating as a risk-assuming carrier and elects to become a reinsuring
30 carrier shall be permitted to reinsure small employer health benefit plans under the
31 terms set forth in G.S. 58-50-145 and G.S. 58-50-150.

32 (c) Any small employer carrier that ceases to write, administer, or otherwise
33 provide health benefit plans to employers in this State shall continue to be governed by
34 this Act with respect to business conducted under this Act that was transacted prior to
35 the effective date of termination and that remains in force.

36 **"§ 58-50-140. Risk-assuming carriers.**

37 (a) Any small employer carrier may elect to become a risk-assuming carrier upon
38 application to and approval by the commissioner. A small employer carrier shall not be
39 approved as a risk-assuming carrier if the Commissioner finds that the carrier is not
40 capable of assuming that status pursuant to the criteria set forth in subsection (b) of this
41 section. The carrier shall provide public notice of its application to become a risk-
42 assuming carrier. A small employer carrier's application to be a risk-assuming carrier
43 shall be approved unless disapproved by the Commissioner within 60 days after the
44 carrier's application. A small employer carrier that has had its application to be a risk-

1 assuming carrier disapproved may request and shall be granted a public hearing within
2 60 days after the disapproval.

3 (b) In determining whether or not to approve an application by a small employer
4 carrier to become a risk-assuming carrier, the Commissioner shall consider the carrier's
5 financial condition and the financial condition of its parent or guaranteeing corporation,
6 if any; its history of assuming and managing risk; its ability to assume and manage the
7 risk of enrolling small employers without the protection of the reinsurance provided in
8 G.S. 58-50-150; and its commitment to fairly market to all small employers in its
9 service area.

10 **"§ 58-50-145. Reinsuring carriers.**

11 (a) Any small employer carrier may elect to operate under the provisions of this
12 section and G.S. 58-50-150 as a reinsuring carrier.

13 (b) Each reinsuring carrier shall conduct business with its members and
14 subscribers, and administer claims for coverage reinsured by the Pool, in the same
15 manner as it would administer health claims that it writes without reinsurance.

16 **"§ 58-50-150. North Carolina Small Employer Health Reinsurance Pool.**

17 (a) There is created a nonprofit entity to be known as the North Carolina Small
18 Employer Health Reinsurance Pool. All carriers issuing or providing health benefit
19 plans in this State on and after January 1, 1992, except any small employer carrier
20 electing to be a risk-assuming carrier, are members of the Pool.

21 (b) Within 30 days after January 1, 1992, the Commissioner shall give notice to
22 all carriers of the time and place for the initial organizational meeting, which shall take
23 place within 90 days after the notice from the Commissioner. The members shall select
24 the initial Board, subject to approval by the Commissioner. The Board shall consist of
25 nine members. There shall be no more than two members of the Board representing any
26 one carrier. In determining voting rights at the organizational meeting, each member
27 shall be entitled to vote in person or by proxy. The voting rights to determine Board
28 membership shall be weighted based upon net health benefit plan premium derived from
29 this State in the previous calendar year. The Board shall at all times, to the extent
30 possible, include at least one domestic insurance company licensed to transact health
31 insurance, one HMO, one nonprofit hospital or medical service plan. Six of the
32 members of the Board shall be small employer carriers. In approving selection of the
33 Board, the Commissioner shall assure that all members are fairly represented.

34 (c) If the initial Board is not elected at the organizational meeting, the
35 Commissioner shall appoint the initial Board within 30 days of the organizational
36 meeting.

37 (d) As used in this section, 'plan of operation' includes articles, bylaws, and
38 operating rules of the Pool. Within 180 days after the appointments of the initial Board,
39 the Board shall submit to the Commissioner a plan of operation and any amendments
40 necessary or suitable to assume the fair, reasonable, and equitable administration of the
41 Pool. The Commissioner shall approve the plan of operation if it assures the fair,
42 reasonable, and equitable administration of the Pool and provides for the proportionate
43 basis in accordance with the provisions of subsections (h) through (o) of this section.
44 The plan of operation shall become effective upon approval in writing by the

1 Commissioner consistent with the date on which the coverage under this section shall be
2 made available. If the Board fails to submit a suitable plan of operation within 180 days
3 after its appointment, or at any time thereafter fails to submit suitable amendments to
4 the plan of operation, the Commissioner shall adopt and promulgate a plan of operation
5 or amendment, as appropriate. The Commissioner shall amend any plan of operation he
6 adopts, as necessary, after a plan of operation is submitted by the Board and approved
7 by the Commissioner.

8 (e) The plan of operation shall establish procedures for, among other things:

- 9 (1) Handling and accounting of assets and moneys of the Pool, and for an
10 annual financial reporting to the Commissioner.
- 11 (2) Filling vacancies on the Board, subject to the approval of the
12 Commissioner.
- 13 (3) Selecting an administering carrier and setting forth the powers and
14 duties of the administering carrier.
- 15 (4) Reinsuring risks in accordance with the provisions of this Act.
- 16 (5) Collecting assessments from members subject to assessment to provide
17 for claims reinsured by the Pool and for administrative expenses
18 incurred or estimated to be incurred during the period for which the
19 assessment is made.
- 20 (6) Any additional matters in the discretion of the Board.

21 (f) The Pool has the general powers and authority granted under the laws of this
22 State to insurance companies licensed to transact health insurance except the power to
23 issue coverage directly to enrollees, and, in addition thereto, the specific authority to do
24 all of the following:

- 25 (1) Enter into contracts as are necessary or proper to carry out the
26 provisions and purposes of this Act, including the authority, with the
27 approval of the Commissioner, to enter into contracts with similar
28 pools of other states for the joint performance of common
29 administrative functions, or with persons or other organizations for the
30 performance of administrative functions.
- 31 (2) Sue or be sued, including taking any legal actions necessary or proper
32 for recovery of any assessments for, on behalf of, or against members.
- 33 (3) Take any legal action necessary to avoid the payment of improper,
34 incorrect, or fraudulent claims against the Pool or the coverage
35 reinsured by the Pool.
- 36 (4) Issue various reinsurance policies in accordance with the requirements
37 of this section.
- 38 (5) Establish rules, conditions, and procedures pertaining to the
39 reinsurance of members' risks by the Pool.
- 40 (6) Establish appropriate rates, rate schedules, rate adjustments, rate
41 classifications, and any other actuarial functions appropriate to the
42 operation of the Pool.
- 43 (7) Assess members in accordance with the provisions of subsections (h)
44 through (o) of this section; and make advance interim assessments that

- 1 are reasonable and necessary for organizational and interim operating
2 expenses. Any interim assessments shall be credited as offsets against
3 any regular assessments due following the close of the Pool's fiscal
4 year.
- 5 (8) Appoint from among members appropriate legal, actuarial, and other
6 committees that are necessary to provide technical assistance in the
7 operation of the Pool, policy, and other contract design, and any other
8 function within the authority of the Pool.
- 9 (9) Borrow money to effect the purposes of the Pool. Any notes or other
10 evidence of indebtedness of the Pool not in default are legal
11 investments for members and may be carried as admitted assets.
- 12 (g) Any member that elects to be a reinsuring carrier may cede, and the Pool
13 shall reinsure the reinsuring carrier, subject to all of the following:
- 14 (1) The Pool shall reinsure any basic and standard health care plan
15 originally issued or delivered for original issue by a reinsuring carrier
16 on or after January 1, 1992, pursuant to the requirements contained in
17 G.S. 58-50-125(d). With respect to a basic or standard health care
18 plan, the Pool shall reinsure the level of coverage provided and, with
19 respect to other plans, the Pool shall reinsure the level of coverage
20 provided in the basic or standard health care plan up to, but not
21 exceeding, the level of coverage provided under either the basic or
22 standard health care plans.
- 23 (2) The Pool shall reinsure eligible employees or their dependents or
24 entire small employer groups according to the following:
- 25 a. With respect to eligible employees and their dependents who
26 either (i) are employed by a small employer as of the date such
27 employer's coverage by the member commences and who enroll
28 in a manner such that they are not considered to be late
29 enrollees to the plan or (ii) hired subsequent to the
30 commencement of the employer's coverage by the member and
31 who are not late enrollees to the plan: Such coverage may be
32 reinsured within 60 days after the commencement of the
33 eligible employees' or dependents' coverage under the plan.
- 34 b. With respect to eligible employees and their dependents, when
35 the entire employer group is eligible for reinsurance: A small
36 employer carrier may reinsure the entire employer group within
37 60 days after the commencement of the group's coverage under
38 the plan.
- 39 c. With respect to any person reinsured, no reinsurance may be
40 provided for a reinsured employee or dependent until five
41 thousand dollars (\$5,000) in benefit payments have been made
42 for services provided during a calendar year for that reinsured
43 employee or dependent, which payments would have been
44 reimbursed through said reinsurance in the absence of said five

1 thousand dollar (\$5,000) deductible. The amount of said
2 deductible shall be periodically reviewed by the Board and
3 adjusted for inflation, as determined by the Board. In addition,
4 the member shall retain ten percent (10%) of the next fifty
5 thousand dollars (\$50,000) of benefit payments during a
6 calendar year and the Pool shall reinsure the remainder;
7 provided that the members' liability under this section shall not
8 exceed ten thousand dollars (\$10,000) in any one calendar year
9 with respect to any one person reinsured.

10 d. Reinsurance may be terminated for each reinsured employee or
11 dependent on any plan anniversary.

12 e. Premium rates charged for reinsurance by the program to an
13 HMO that is approved by the Secretary of Health and Human
14 Services as a federally qualified health maintenance
15 organization pursuant to 42 U.S.C. § 300 and as such is subject
16 to requirements that limit the amount of risk that may be ceded
17 to the Pool that is more restrictive than subdivision (h)(3) of this
18 section, shall be reduced to reflect that portion of the risk above
19 the amount set forth in subdivision (h)(3) of this section that
20 may not be ceded to the Pool, if any.

21 f. Every carrier subject to G.S. 58-50-130 must apply its case
22 management and claims handling techniques, including but not
23 limited to utilization review, individual case management,
24 preferred provider provisions, other managed care provisions or
25 methods of operation, consistently with both reinsured and
26 nonreinsured business.

27 g. Except as provided in subsection (k) of this section, premium
28 rates charged by the Pool for coverage reinsured by the Pool for
29 that classification or group with similar case characteristics and
30 coverage shall be established as follows:

31 1. 1.5 times the rate established by the Pool with respect to
32 the eligible employees and their dependents of a small
33 employer, all of whose coverage is reinsured with the
34 Pool who are reinsured in accordance with this section.

35 2. 5.0 times the rate established by the Pool with respect to
36 an eligible employee or dependent who is reinsured in
37 accordance with this section.

38 (3) The Pool shall reinsure no more than the level of benefits provided in
39 either the basic or standard health care plan established in accordance
40 with G.S. 58-50-125.

41 (4) The Pool may issue different types and levels of reinsurance coverage,
42 including stop-loss coverage; and the reinsurance premium shall be
43 adjusted to reflect the type and level of reinsurance coverage issued.

1 (5) The reinsurance premium shall also be adjusted to reflect cost
2 containment features of the plan of operation that have proven to be
3 effective including, but not limited to: preferred provider provisions,
4 utilization review of medical necessity of hospital and physician
5 services, case management benefit alternatives, and other managed
6 care provisions or methods of operation.

7 (h) Following the close of each fiscal year, the administering carrier shall
8 determine the net premiums, the Pool expenses of administration, and the incurred
9 losses for the year, taking into account investment income and other appropriate gains
10 and losses. Health benefit plan premiums and benefits paid by a member that are less
11 than an amount determined by the Board to justify the cost of collection shall not be
12 considered for purposes of determining assessments. As used in this section, 'net
13 premiums' means health benefit plan premiums for insured plans but does not mean
14 premiums or revenue received by a carrier for Medicare and Medicaid contracts.

15 (i) Assessments shall first be apportioned by the Board among all members in
16 proportion to their respective shares of the total health benefit plan premiums earned in
17 this State from health benefit plans covering small employers during the calendar year
18 coinciding with or ending during the fiscal year of the program or on any other
19 equitable basis reflecting coverage of small employers as may be provided in the plan of
20 operation.

21 (j) If the assessment level is inadequate, the Board may adjust reinsurance
22 thresholds, retention levels, or consider other forms of reinsurance. After the first two
23 full years of operations the Board shall report to the Commissioner on its experience,
24 the effect on reinsurance and small group rates of individual ceding, and
25 recommendations on additional funding sources, if needed. Any such recommendations
26 shall take into account the findings of the actuarial study provided for in this subsection.
27 An actuarial study shall be undertaken within the first three years of the Pool's operation
28 to evaluate and measure the relative risks being assumed by differing types of small
29 employer carriers as a result of this Act. Such study shall be developed by three
30 actuaries appointed by the Commissioner, with one representing risk assuming carriers,
31 one representing reinsuring carriers, and one from within the Department.

32 (k) Subject to the approval of the Commissioner, the Board may make an
33 adjustment to the assessment formula for any reinsuring carrier that is an HMO
34 approved as a federally qualified HMO by the Secretary of Health and Human Services
35 pursuant to 42 U.S.C. § 300 for restrictions placed on them other than those for which
36 an adjustment has already been made in subsection (b)(2) or (b)(5) of this section that
37 are not imposed on other small group carriers.

38 (l) If assessments exceed actual losses and administrative expenses of the Pool,
39 the excess shall be held at interest and used by the Board to offset future losses or to
40 reduce Pool premiums. As used in this subsection, 'future losses' includes reserves for
41 incurred but not reported claims.

42 (m) Each member's proportion of participation in the Pool shall be determined
43 annually by the Board based on financial statements and other reports deemed to be
44 necessary and required by the Board and filed by the member with the Board. All

1 carriers shall report, to the Board, claims payments made and administrative expenses
2 incurred in this State on an annual basis and on a form prescribed by the Commissioner.

3 (n) Provision shall be made in the plan of operation for the imposition of an
4 interest penalty for late payment of assessments.

5 (o) The Board may abate or defer, in whole or in part, the assessment of a
6 member if, in the opinion of the Board, payment of the assessment would endanger the
7 ability of the member to fulfill its contractual obligations. In the event an assessment
8 against a member is abated or deferred in whole or in part, the amount by which the
9 assessment is abated or deferred may be assessed against the other members in a manner
10 consistent with the basis for assessments set forth in this section. The member receiving
11 the abatement or deferment shall remain liable to the Pool for the deficiency.

12 (p) Neither the participation in the Pool as members, the establishment of rates,
13 forms, or procedures, nor any other joint or collective action required by this Act shall
14 be the basis of any legal action, criminal or civil liability, or penalty against the Pool or
15 any of its members.

16 (q) Any person or member made a party to any action, suit, or proceeding
17 because the person or member serves or served on the Board or on a committee or is or
18 was an officer or employee of the Pool shall be held harmless and be indemnified by the
19 Pool against all liability and costs, including the amounts of judgments, settlements,
20 finances, or penalties, and expenses and reasonable attorneys' fees incurred in connection
21 with the action, suit, or proceeding. However, the indemnification shall not be provided
22 on any matter in which the person or member is finally adjudged in the action, suit, or
23 proceeding to have committed a breach of duty involving gross negligence, dishonesty,
24 willful misfeasance, or reckless disregard of the responsibilities of service or office.
25 Costs and expenses of the indemnification shall be prorated among and paid for by all
26 members.

27 (r) The Pool is exempt from any and all taxes."

28 Sec. 2. In the event any provision of this act is held to be invalid by any court
29 of competent jurisdiction, the court's holding as to that provision shall not affect the
30 validity or operation of other provisions of this act; and to that end the provisions of this
31 act are severable.

32 Sec. 3. This act becomes effective January 1, 1992.