GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

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SENATE BILL 696*

Short Title: Small Emplr. Hlth. Insur. Assist. (Public)

Sponsors: Senators Seymour; Warren, Marshall, Ward, Martin of Guilford, Jordan, Parnell, Speed, Hunt, Martin of Pitt, Hoyle, Richardson, Edwards, Walker, Carpenter, Smith, Sands, Soles, Cooper, Hartsell, Ballance, Cochrane, Gunter, Sherron, Tally, and Allran.

Referred to: Insurance.

April 5, 1993

A BILL TO BE ENTITLED

AN ACT TO PROMOTE THE CREATION OF HEALTH PLAN PURCHASING ALLIANCES TO PROVIDE ACCESS TO HEALTH BENEFITS FOR EMPLOYEES OF SMALL EMPLOYER GROUPS AND SELF-EMPLOYED INDIVIDUALS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 143 of the General Statutes is amended by adding the following new Article to read:

"**ARTICLE 64.**

"HEALTH CARE PURCHASING ALLIANCE ACT.

"**§ 143-591. Purpose and intent.**

The purpose and intent of this act is to improve the competitiveness, efficiency and fairness of the small employer health coverage market, and to help make coverage more affordable by promoting the establishment of health plan purchasing alliances as sponsors for small employers and self-employed individuals; by establishing a choice of competing accountable health plans for employees of small employer groups, their dependents, and self-employed individuals; and by establishing rules for fair competition among competing accountable health plans. These rules include: the offering of comparable benefits by competing accountable health plans; risk assessment and risk adjustment to assure competition based on a fair allocation of risks among

accountable health plans; and the availability of data that measures health plan performance, including valid measures of clinical outcomes.

This act promotes the development of purchasing alliances to provide health benefits coverage to self-employed individuals and to employees of participating employers in the manner of a single large group. Carriers in the small employer health purchasing alliance market are required to use community rating; to guarantee the issuance and renewability of health benefits coverage; to guarantee the continuity of coverage; to adhere to limitations on the exclusion of preexisting conditions, waiting periods, individual medical underwriting, and lifetime maximums; and to adhere to rules regarding minimum participation requirements.

Voluntary health plan purchasing alliances will make available through their contracting processes a choice of accountable health plans that provide, arrange, or pay for quality health services in a cost-effective manner. These purchasing alliances will provide participants with the benefits of their contracting expertise and the administrative savings that can result from the pooling of small employers and self-employed individuals.

"**§ 143-592. Definitions.**

As used in this act:

(1) 'Accountable health plan' or 'AHP' means a carrier registered with the Board pursuant to G.S. 143-595.

(2) 'Alliance' means a nonprofit organization comprised of small employers and self-employed individuals formed for the purpose of purchasing accountable health plans to provide health care coverage for eligible employees and their dependents.

(3) 'Basic health care plans' means the basic health care plans lower in cost than standard health care plans, adopted by the Small Employer Carrier Committee pursuant to G.S. 58-50-120 and offered to small employers in this State.

(4) 'Board' means the State Health Plan Purchasing Alliance Board.

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, or a health maintenance organization (HMO).

(6) 'Community rating method' means a system of fixing rates of payment to the alliance for an accountable health plan on a per-person or per-family basis. The rate charged may vary by market areas and demographic characteristics established by the Board and with the number of persons in the family, but such rates must be equivalent for all employers of member small employers and their dependents, self-employed individuals and families of similar composition receiving the same level of benefits within the health plan purchasing alliances.

(7) 'Community sponsor' means an organization that assumes responsibility for assisting and serving as the host for an Alliance on a local or regional basis.

(8) 'Dependent' means the dependent of an eligible employee, subject to terms established by the Board.

(9) 'Eligible employee' means any employee of a member small employer who is actively engaged on a full-time basis in the conduct of the business of the member small employer with a normal work week of at least 30 hours, who has met any applicable requirements of the member small employer as to the period of employment before an employee is eligible for health benefits coverage not to exceed 90 days. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the member small employer's business, and if they are included as employees under a health plan of a member small employer, but does not include employees who work on a part-time, temporary or substitute basis, or have been employed by the member small employer for less than 30 days.

(10) 'Employee enrollee' means an eligible employee or dependent who is enrolled in an accountable health plan.

(11) 'Fund' means the State Health Plan Purchasing Alliance Fund established under G.S. 143-602.

(12) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a multiple employer welfare plan or plan provided by another benefit arrangement, to the extent permitted by the Employment Retirement Income Security Act of 1974. Health benefit plan does not mean accident only, specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(13) 'Late enrollee' means an eligible employee, a dependent of an eligible employee, or a self-employed individual who requests enrollment in an accountable health plan following the initial enrollment period for a member small employer or a self-employed individual provided the enrollment is consistent with the alliance's rules for initial enrollment; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, dependent, or self-employed individual shall not be considered a late enrollee if:

a. The person:

1. Was covered under another employer health benefit plan at the time the person was eligible to enroll;
2. Lost coverage under another health plan as a result of termination of employment, the termination of the other health plan's coverage, the death of a spouse or a divorce; and
3. Requests enrollment in an accountable health plan within 30 days after termination of coverage provided under another health plan;

b. The person elects a different health plan offered through the alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days of his or her marriage or the birth or adoption of a child.

(14) 'Lowest cost plan' means the lowest cost health benefit plan in each alliance market area offered by an accountable health plan and which is open to enrollment of new small employer groups.

(15) 'Market area' means a clearly defined and exclusive geographical area determined by the Board for the purpose of determining the actual market for which an alliance shall have access.

(16) 'Member small employer' means a small employer who enrolls with an alliance.

(17) 'Preexisting condition' means a policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

(18) 'Premium' means insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) 'Risk adjustment mechanism' means the process established in G.S. 143-601.

(20) 'Self employed individual' means a person who is self-employed and may or may not have health benefits coverage through any other employer in this State.

(21) 'Service area' means a geographic region in which a carrier is licensed to operate.

(22) 'Small employer' means any person, firm, corporation, partnership or association that is actively engaged in business and that on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed at least two unrelated eligible employees but no more than 49 eligible employees, the majority of whom were employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, an alliance shall determine the size of a small employer annually. Except as otherwise specifically provided, provisions of this act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this definition.

(23) 'Standard health care plans' means the standard health care plans adopted by the Small Employer Carrier Committee pursuant to G.S. 58-50-120 and offered to small employers in this State.

"**§ 143-593. Health benefit plans subject to act.**

A health benefit plan is subject to this act if it provides health benefits for small employers or self-employed individuals and if either of the following conditions are met:

(1) Any part of the premiums or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The health benefit plan is treated by the employer or any of the covered self-employed individuals as part of a plan or program for the purposes of sections 106, 125 or 162 of the United States Internal Revenue Code.

"**§ 143-594. Establishment of the Board; membership; terms; personnel.**

(a) There is established the State Health Plan Purchasing Alliance Board. The Board shall be established within the Department of Administration for administrative, organizational, and budgetary purposes only. The Department of Administration shall provide administrative and staff support to the Board. The Department of Insurance shall provide technical assistance as requested by the Board.

(b) The Board shall consist of eight members, as follows:

(1) Two appointed by the Governor, one of whom shall be an owner or manager of a member small employer of an alliance operating in North Carolina; the other shall be an employee enrollee of an alliance operating in North Carolina;

(2) Two appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, one of whom shall be an employee enrollee of an alliance operating in North Carolina;

(3) Two appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, one of whom shall be an owner or manager of a member small employer operating in North Carolina;

(4) The Lieutenant Governor or his or her representative; and

(5) The Commissioner of Insurance or his or her representative.

(c) Members of the Board who are not officers or employees of the State shall receive compensation of two hundred dollars ($200.00) for each day or part of a day of service plus reimbursement for travel and subsistence expenses at the rates specified in G.S. 138-5. Members of the Board who are officers or employees of the State shall receive reimbursement for travel and subsistence at the rates specified in G.S. 138-6.

(d) The term of appointed members is four years. The terms shall be staggered as required by the terms provided for members of the Board on January 1, 1994. The terms of the initial members shall expire as follows:

(1) Three on January 1, 1995, one appointee each from the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives; and

(2) Three on January 1, 1997, one appointee each from the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives.

(e) At the end of a term, a member shall continue to serve until a successor is appointed. A member who is appointed after a term has begun serves only for the remainder of the term and until a successor is appointed. A member who serves two consecutive full four-year terms may not be reappointed until four years after completion of those terms.

(f) The Board shall elect officers annually.

(g) The Board shall appoint an executive director for the Board, who shall serve at the pleasure of the Board. The executive director shall administer the affairs of the Board as directed by the Board, and shall direct the staff of the Board. The executive director may employ staff necessary to carry out the provisions of this act. Staff of the Board shall be covered under the State Personnel Act. The Board shall appoint an advisory committee which shall include persons with expertise in health benefits management and representatives of accountable health plans.

(h) The Board shall meet as needed at the times and places it determines. Such meetings and procedures shall be governed by the procedures and policies set forth in the North Carolina Open Meetings Law. A majority of the full authorized membership of the Board is a quorum.

(i) No Board members or their spouses, may be employed by, affiliated with an agent of, or otherwise a representative of any carrier or health care provider.

(j) No person may be appointed to or remain a member of the Board if the prospective appointee or member, or the spouse of the prospective appointee or member, is associated with a health care business either individually or collectively, of securities worth ten thousand dollars ($10,000) or more at fair market value as of December 31 of the preceding year, or constituting five percent (5%) or more of the outstanding stock of the business. For the purposes of this subsection, the term, 'health care business':

(1) Does not include a widely held investment fund, regulated investment company, or pension or deferred compensation plan if the prospective appointee or member, or the spouse of the appointee or member, neither exercises nor has the ability to exercise control over the financial interests held by the fund, and the fund is publicly traded or the fund assets are widely diversified;

(2) Includes an association, corporation, enterprise, joint venture, organization, partnership, proprietorship, trust, and every other business interest that provides or insures human health care for twenty-five percent (25%) or more of its annual income.

"**§ 143-595. Powers of the Board.**

The Board shall have the authority to:

(1) Accept applications by carriers to qualify as accountable health plans; determine the eligibility of carriers to become accountable health plans according to criteria described in G.S. 143-597; and designate qualified carriers as accountable health plans;

(2) Establish alliances, with community sponsors, for a service area determined by the Board;

(3) Establish minimum managed care arrangements required for qualified AHPs;

(4) Establish participation requirements that shall require extension of coverage to all eligible employees of small employers who choose to participate in an alliance, and dependents of those employees, and self-employed individuals that are eligible and choose to participate in an alliance;

(5) Establish conditions of participation for small employers and self-employed individuals that shall conform to the requirements of this act and which shall include, but not be limited to:

a. Assurances that the member small employer is a valid small employer group and is not formed for the purpose of securing health benefits coverage;

b. Minimum employer contribution requirements that shall be an amount not less than fifty percent (50%) of the premium for the employee's coverage of the lowest cost plan, or one hundred

percent (100%) participation by otherwise uninsured eligible employees within the member small employer; and

c. Prepayment of premiums or other mechanisms to assure that payment will be made for coverage.

The Board shall have the authority to ensure that any small employer or self-employed individual meeting the requirements established by the Board pursuant to this subsection may purchase health benefits coverage through an alliance;

(6) Assure compliance with this act by accountable health plans, alliances, small employers, and employee and self-employed individual enrollees;

(7) Seek to assure fair and affirmative marketing of the basic and standard health care plans;

(8) Designate or realign market areas for alliances and assist in establishing alliances throughout the State;

(9) Adopt rules in compliance with Chapter 150B of the General Statutes as necessary to administer the provisions of this act;

(10) Appoint advisory committees as necessary to provide technical assistance to the Board and to alliances;

(11) Employ staff necessary to administer the provisions of this act;

(12) Gather data necessary to implement the provisions of this act;

(13) Sue or be sued, including taking action necessary for securing legal remedies available for, on behalf of, or against alliances, member small employers, eligible employees and dependents of those employees, self-employed individuals, or any Board member;

(14) Accept and expend funds received through grants, appropriations, or other appropriate and lawful means;

(15) Establish a method of evaluating customer service and equal access to alliance and AHPs, document reported cases of discrimination, and maintain such records for 10 years;

(16) As needed, develop and implement standardized forms for use by AHPs; and

(17) Review and limit, if necessary, surcharges charged by each alliance for administrative costs.

"**§ 143-596. Health plan purchasing alliances authorized; powers.**

A health plan purchasing alliance may be formed subject to the approval of the Board, for the purpose of purchasing health benefits coverage for members of the alliance, their employees and employee dependents. An alliance approved by the Board shall have the following powers and duties:

(1) Enter into contracts with accountable health plans pursuant to G.S. 143-597;

(2) Enter into contracts with member small employers and self-employed individuals pursuant to G.S. 143-598;

(3) Maintain eligibility records as appropriate to carry out the functions of this act;
(4) Establish procedures for collection of premiums from self-employed individuals and member small employers, including remittance of the share of the premium paid by employee enrollees;
(5) Pay accountable health plans their contracted rates on a monthly basis or as otherwise mutually agreed;
(6) Impose annual surcharges, established at the beginning of the fiscal year, to be paid monthly by member small employers and self-employed individuals for necessary costs incurred in connection with the operation of the alliance;
(7) Provide that in the event a member small employer terminates coverage purchased through the alliance, the small employer shall be ineligible to purchase a health benefits plan through the alliance for a period of one year, except as permitted by the alliance advisory board and State Health Plan Purchasing Alliance Board for good cause;
(8) Undertake activities necessary to administer the alliance, including marketing and publicizing the availability of the basic and standard health care plans, and assuring compliance with alliance requirements by accountable health plans, small employers, and employee and individual enrollees;
(9) Enter into contracts with agents to assist in contracting with accountable health plans, member small employers, and/or self-employed individuals and to assist the alliance in undertaking activities necessary to administer the alliance, including marketing and publicizing the availability of the basic and standard health care plans;
(10) Fairly and affirmatively market the basic and standard health care plans;
(11) Develop grievance procedures to be used in resolving disputes between the alliance and member small employers and self-employed individuals;
(12) Establish advisory boards composed of member small employers;
(13) Employ technical and other staff necessary to administer the alliance;
(14) Sue or be sued, including taking any legal actions necessary or proper for recovering any penalties for, on behalf of, or against the alliance;
(15) Accept and expend funds received through grants, appropriations or other appropriate and lawful means; and
(16) Allow any small employer or self-employed individual to purchase health care from an alliance within their market area whether or not the employer is a member of the community sponsor, if applicable.

"**§ 143-597. Accountable health plans (AHPs).**

(a) By July 1, 1994, the Board shall establish a process whereby a carrier that fulfills the qualifications of subsection (b) of this section shall be designated as an AHP. An alliance may enter into a contract with each AHP that qualifies under subsection (b)

of this section. An alliance shall market all basic and standard health care plans registered with the Board by all AHPs that have contracted with an alliance, provided that the AHP has a membership of 10 businesses or five percent (5%) of the total membership of the alliance, whichever is greater, or is a plan being offered for the first time.

(b) In order to be eligible to be designated as an AHP, a carrier HMO must have the following operating characteristics satisfactory to the Board:

(1) Licensed and in good standing with the North Carolina Department of Insurance;

(2) Demonstrated capacity to administer the basic and standard health care plans;

(4) In the case of a carrier with a contractual obligation to provide or arrange for the covered health services, the ability to provide enrollees with adequate access to covered services within the carrier's service area;

(5) A satisfactory grievance procedure; and

(6) Financial solvency, including the ability to assume the risk of providing and paying for covered services, as applicable.

(c) After notice and hearing, the Board may suspend or revoke the designation as an AHP of any carrier or HMO that fails to maintain compliance with the requirements listed in subsections (b), (d), or (e) of this section.

(d) Each AHP shall:

(1) Provide for coverage of the basic and standard health care plans;

(2) Provide for the collection and reporting to the Board and to the applicable alliance of reasonable information on the performance of AHPs relating to the effectiveness and outcomes in providing selected services; provided, however, that data reporting requirements adopted by the Board shall be consistent with the method of operation of AHPs and shall not impose an unreasonable cost for compliance;

(3) Not deny, limit, or condition coverage under the basic or standard health care plan based on health status, claims experience, receipt of health care, medical history or lack of evidence of insurability of an eligible employee, dependent, or self-employed individual;

(4) Not utilize preexisting condition provisions or waiting periods in either the basic or standard health care plan, except in the case of a late enrollee;

(5) In the case of a late enrollee, be permitted to impose a waiting period or a preexisting condition provision of not more than 12 months;

(6) Not impose lifetime maximums less than two million dollars ($2,000,000) for covered benefits under the basic or standard health care plan;

(7) Establish premium rates for each basic and standard health care plan pursuant to the community rating method;

(8) Issue a basic or standard health care plan to any self-employed individual or eligible employee and their dependents that elect to be covered under an accountable health plan during the open enrollment period established pursuant to subsection (f) of this section;

(9) Renew each basic and standard health care plan with respect to self-employed individuals and all employee enrollees and their dependents except in the following cases:

a. Nonpayment of the required premiums;

b. Fraud or material misrepresentation of the individual, the member small employer, or the employee enrollee or their dependent;

c. Noncompliance by a small employer with employer contribution or participation requirements as required by the Board;

d. Repeated misuse of a provider network provision including, but not limited to, unreasonable refusal of the enrollee to follow a prescribed course of treatment, or violation of reasonable policies of an AHP. In this instance, the alliance shall assist an affected enrollee in finding replacement coverage;

e. Election by the AHP to terminate its contract with an alliance. In such a case the AHP shall:

1. Provide advance notice of its decision under subparagraph e. of this subdivision to the alliance and to the Board;

2. Provide notice of the decision at least 180 days prior to the nonrenewal of any basic or standard health care plan to the enrollees. Except as provided in subparagraph f. of this subdivision, an AHP that elects not to renew a basic or standard health care plan with an alliance shall be prohibited from writing new business with the alliance for a period of five years from the date of notice to the alliance or until the alliance invites the carrier to renew participation, whichever is sooner; and

f. Determination by an alliance, subject to review by the Board, that continuation of coverage would not be in the best interest of the employee enrollees and member small employers or would impair the AHP's ability to meet its contractual obligations. In this instance, the alliance shall assist affected employee enrollees and self-employed individuals in finding replacement coverage.

(10) Provide a procedure for addressing grievances that arise between the AHP and the alliance, member employers, or employee enrollees.

(f) AHPs shall participate in an annual open enrollment period of 30 consecutive days, at staggered dates determined by the alliances, to facilitate an orderly offering of

health plans. Each member small employer shall elect for the group to be covered under either a basic benefit plan or a standard benefit plan. Eligible employees may choose from the AHPs at the benefit level selected for the group that are offered in the market area in which they reside. An AHP shall not be required to offer coverage or accept enrollments:

(1) Where the individual, eligible employee, or dependent does not reside within the AHP's service area;

(2) Within an area where the AHP has been accepting enrollments but reasonably anticipates and provides 90 days notice that it will not have the capacity to deliver service adequately to additional enrollees because of its obligations to existing groups and enrollees; or

(3) Where the North Carolina Commissioner of Insurance determines that the acceptance of an application or applications would place the AHP in a financially impaired condition.

An AHP that cannot offer coverage pursuant to subdivision (2) of this subsection, may not offer coverage to or accept applications from a new employer group or an individual until the later of 90 days following such refusal or the date on which the AHP notifies the alliances and the Board that it has regained capacity to deliver services to eligible employees and their dependents in the service area. An AHP that cannot offer coverage pursuant to subdivision (3) of this subsection may not offer coverage or accept applications for any individual or employer group until a determination by the North Carolina Commissioner of Insurance that acceptance of an application will not put the AHP in a financially impaired condition.

"**§ 143-598. Payment to alliances by member small employers and self-employed individuals.**

The contracts between alliances and member small employers and self-employed individuals shall provide that payment of premiums shall be made by self-employed individuals, employee enrollees, or member small employers on their behalf, directly to the alliance for the benefit of the AHP. Premiums shall be payable on a monthly basis. Alliances may provide for penalties and grace periods for late payment. Nonpayment of premiums by a member small employer shall constitute a breach of contract between an alliance and a member small employer or self-employed individual and the member small employer or self-employed individual shall be liable for any claims to the AHP. Member small employers and self-employed individuals shall provide access to coverage for employee enrollees who leave the small employer for a period of one year after separation at the expense of the former employee enrollee.

"**§ 143-599. Payment by alliances to AHPs.**

(a) Under a contract between an AHP and an alliance, the alliance shall forward to each AHP that has enrollees under either a basic or standard health care plan an amount equal to:

(1) The community rating system, as described in subsection (c) of this section, filed by the AHP for the appropriate health care plan; and

(2) Payments or reductions in payments, if any, resulting from the risk adjustment determined in accordance with G.S. 143-601.

(b) Payment under this section shall be made by the alliance monthly within a reasonable period after receipt of the premium from the self-employed individual, member small employer, or the employee enrollee.

(c) Under the community rating system required under subdivision (1) of this subsection, rates of payment for health services may be determined on a per person or per family basis, as described in subdivision (1) of this subsection, or on a per group basis as described in subdivision (2) of this subsection. An AHP may fix its rates of payment under the system described in subdivisions (1) or (2) of this subsection or under both systems, but an AHP may use only one system for fixing its rates of payment for any one group.

(1) A system of fixing rates of payment for health services may provide that the rates shall be fixed on a per person or per family basis and may vary with the number of persons in a family. Except as otherwise authorized in this subdivision, these rates must be equivalent for all individuals and for all families of similar composition. Rates of payment may be based on either a schedule of rates charged to each employee enrollee or on a per-employee-enrollee-per-month revenue requirement for the AHP. Under the system described in this subdivision, rates of payment may not be varied because of actual or anticipated utilization of services by any small employer or employee enrollee. These provisions do not preclude changes in the rates of payment which are established for new enrollments or reenrollments and which do not apply to existing contracts until the renewal of these contracts.

(2) A system of fixing rates of payments for health services may provide that the rates shall be fixed for individuals and families. Such rates must be equivalent for all individuals in the same alliance and for all families of similar composition.

"**§ 143-600. Marketing basic and standard health care plans.**

(a) Alliances shall establish reasonable standards, subject to review by the Board, for the marketing of the basic and standard health care plans. Unless authorized by an alliance, no AHP, directly or through an employee, agent, broker, third-party administrator, or contractor, shall provide a self-employed individual, member small employer, eligible employee, dependent, or employee enrollee with any marketing material relating to basic or standard health care benefit plans.

(b) Alliances shall use appropriate and efficient means, including, but not limited to, independent insurance agents, to notify small employers and self-employed individuals of the availability of health care plans from an alliance. Alliances shall make available to small employers and self-employed individuals marketing materials which accurately summarize the AHPs' health care plans and rates which are offered through the alliances.

"**§ 143-601. Risk adjustment mechanism.**

(a) The Board shall establish a mechanism to adjust for risk covered by each basic and standard health care plan offered by an AHP. Risk adjustment shall be based on prospectively determined factors that predict utilization of health care services.

(b) The Board shall establish a factor annually that represents the difference between the average risk of persons covered through the alliances and the risk covered by each basic and standard health care plan offered by each AHP through the alliances. The Board shall apply that factor in determining amounts received by AHPs. This may be done directly or it may be done indirectly by adjusting quoted premiums. The mechanism by which the adjustment is made shall be established after consultation with a technical advisory committee.

(c) The Board may, in addition to the risk adjustment mechanism described in (a) and (b) above, develop a list of a limited number of high cost diagnoses. The Board may develop a mechanism to protect an AHP from the catastrophic health care costs of an employee enrollee who develops one of the listed diagnoses, or may protect an AHP that has a disproportionate share of one or more of the listed diagnoses.

(d) Any payments to AHPs under this section shall be determined on an annual basis. No payments under this section may be based on claims or the health care costs of an AHP.

"**§ 143-602. State Health Plan Purchasing Alliance Fund.**

(a) There is established in the Office of the State Treasurer the State Health Plan Purchasing Alliance Fund. The Fund shall be placed in an interest-bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund shall be spent only in accordance with subsection (b) of this section. The Fund shall be administered in accordance with the Executive Budget Act.

(b) All money credited to the Fund shall be used as set forth by the Board.

(c) Moneys appropriated by the General Assembly shall be deposited in the Fund and shall become part of the continuation budget of the Department of Administration."

Sec. 2. G.S. 58-50-110(22) reads as rewritten:

"(22) 'Small employer' means any person actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding year, employed no more than ~~25~~ 49 eligible employees and not less than three eligible employees, the majority of whom are employed within this State. Small employer includes companies that are affiliated companies, as defined in G.S. 58-19-5(1) or that are eligible to file a combined tax return under Chapter 105 of the General Statutes or under the Internal Revenue Code. Except as otherwise provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this section."

Sec. 3. G.S. 58-50-125(g) reads as rewritten:

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

(1) To a group, where the group is not physically located in the HMO's approved service areas;
(2) To an employee, where the employee does not reside within the HMO's approved service areas;
(3) Within an area, where the HMO reasonably anticipates, and demonstrates to the Commissioner's satisfaction, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than ~~25~~ 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers."

Sec. 4. The State Health Plan Purchasing Alliance Board shall report not later than January 1, 1995, to the Joint Legislative Committee on Governmental Operations on the following:

(1) The progress achieved in expanding the availability of affordable insurance to employees of small employers and self-employed individuals;
(2) The prospects for future expansion;
(3) The possible need for further incentives to encourage more participation;
(4) The possible need to require participation from small employers and self-employed individuals;
(5) Developments in health care reform at the federal level as well as in other states, including, but not limited to, Florida and other states in the southeast region of the United States;
(6) The specific elements contributing to the rising costs of health care in North Carolina and the approximate percentage of cost attributable to each of these elements. Elements to be studied shall include but not be limited to:
    a. Excessive or duplicative spending by health care providers,
    b. Administrative costs of health care providers and insurers, and
    c. Medical malpractice litigation;
(7) Additional specific measures that could assist in controlling the cost of health care; and
(8) Options for including (i) employers with more than 50 employees, and (ii) populations from State federally financed systems of health coverage.

Sec. 5. Within 60 days of ratification of this act, the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate shall make their appointments to the State Health Care Purchasing Alliance Board. Those appointments restricted by G.S. 143-594(b) shall be persons who own, manage, or are

employed by a small employer as defined in G.S. 143-592 who would qualify as a member small employer under this act.

Sec. 6. There is appropriated from the General Fund to the State Health Purchasing Alliance Board the sum of four million dollars ($4,000,000) for the 1993-94 fiscal year and the sum of four million dollars ($4,000,000) for the 1994-95 fiscal year for the initial operation of the health care purchasing alliances and other activities related to the duties and responsibilities of the alliances and the Board authorized by Section 1 of this act.

Sec. 7. This act becomes effective July 1, 1993, if and only if funds are appropriated to implement Section 1 of this act.