GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S **D**

SENATE DRS35324-LN-285 (5/10)

Short Title:	Healthy NC.	(Public)
Sponsors:	Senator Kerr.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ENACT THE "HEALTHY NC" PROGRAM TO FACILITATE THE AVAILABILITY OF AFFORDABLE ACCIDENT AND HEALTH INSURANCE COVERAGE TO SMALL EMPLOYERS, SELF-EMPLOYED INDIVIDUALS, AND UNINSURED WORKERS; AND TO APPROPRIATE FUNDS FOR THE IMPLEMENTATION OF THIS ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 1, 2008, Article 50 of Chapter 58 of the General Statutes is amended by adding the following new Part to read:

"Part 6. Healthy NC Program.

"**§ 58-50-160. Definitions.**

The following definitions apply in this Part:

(1) 'Adjusted community rate'. – A method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for age, gender, family composition, and geographic areas.

(2) 'Claims corridor'. – Claims paid by the participating insurer on behalf of a covered member in a given calendar year in excess of fifteen thousand dollars ($15,000) and less than seventy-five thousand dollars ($75,000).

(3) 'Claims threshold'. – The aggregate amount that a participating insurer must pay out before reaching the applicable claims corridor and before becoming eligible for reimbursement from the Fund on behalf of a covered member in a given calendar year.

(4) 'Dependent'. – The spouse or child of a covered individual. 'Dependent child' includes a child who is under the age of 19 or is a full-time student under the age of 23.

(5) 'Health benefit plan'. – Defined in G.S. 58-3-167, except that for purposes of this Part a 'health benefit plan' does not include a plan provided by a multiple employer welfare arrangement.

(6) 'Insurer'. – Defined in G.S. 58-3-167(b), except that an 'insurer' does not include a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(7) 'Part-time worker'. – Any person employed less than 30 hours weekly.

(8) 'Participating insurer'. – An insurer that offers a qualifying health insurance contract. For purposes of this Part, 'participating insurer' includes the insurer's brokers, agents, producers, or third-party administrators, as applicable.

(9) 'Premium'. – Insurance premiums or other fees charged for qualifying health insurance contracts including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the contract.

(10) 'Program'. – The Healthy NC Program established under this Part.

(11) 'Qualifying health insurance contract'. – Either a group health insurance contract approved by the Commissioner and purchased under the Program by a qualifying small employer, including a self-employed individual, or an individual health insurance contract approved by the Commissioner and purchased under the Program by an uninsured employed individual, or both a group or individual contract, as the context requires.

(12) 'Qualifying individual'. – An uninsured employed individual or a self-employed individual that qualifies to purchase a qualifying individual health insurance contract under the Program.

(13) 'Qualifying small employer'. – An employer that meets the requirements of G.S. 58-50-170.

(14) 'Stop Loss Fund' or 'Fund'. – A Fund that meets the requirements of G.S. 58-50-200.

"**§ 58-50-165. Standardized health insurance contracts for qualifying small employers and individuals.**

(a) Every insurer that offers individual health benefit plans, group health benefit plans, or both, and that is among the 15 insurers with the highest health benefit plan market share in the individual or group market in this State, as measured by premiums for the individual or group market, as applicable, as of the end of the previous calendar year, shall offer qualifying group health insurance contracts and qualifying individual health insurance contracts to qualifying small employers and individuals in accordance with G.S. 58-50-170, 58-50-175, and 58-50-180. Coverage offered shall include dependent coverage. If at the time of offering coverage, an insurer does not participate in both the individual and group health insurance markets in this State, then the insurer may choose to offer a qualifying health insurance contract in only the health insurance market that the insurer serves. Qualifying health insurance contracts offered under this

Part shall be reasonably comparable in covered services and benefit levels to standard health plans offered under G.S. 58-50-125.

(b) Contracts issued pursuant to this Part by participating insurers may provide for in-network and out-of-network provider services.

(c) All coverage under a qualifying health insurance contract is subject to a preexisting condition limitation in accordance with G.S. 58-68-30(b). The underwriting of qualifying health insurance contracts may not utilize exclusionary riders on specific conditions or health-related issues to limit coverage on an individual based upon the individual's health status.

(d) A benefit plan under a qualifying group health insurance contract is subject to applicable continuation, conversion, and renewability requirements of Articles 53 and 68 of this Chapter, and COBRA, as defined under G.S. 58-68-25.

(e) A qualifying health insurance contract shall provide at least a 31-day grace period for payment of premiums.

(f) Rates under qualifying health insurance contracts may be increased as authorized under G.S. 58-51-95 and applicable rules, and in compliance with G.S. 58-68-35, regarding rate revision requests.

(g) Qualifying health insurance contracts, and the rates under the contracts, are subject to the prior approval of the Commissioner. The Commissioner shall review all health insurance contracts and rates for Program contracts submitted by participating insurers, and, if the contracts and rates comply with this Part and all other applicable law, approve the contracts and rates.

"**§ 58-50-170. Eligibility for small employers.**

(a) In order for a participating insurer to be eligible to receive reimbursement under G.S. 58-50-200, to the extent funds are available, for claims paid by the participating insurer under a qualified health insurance plan, the employer shall be a small employer:

(1) That employs not more than 25 eligible employees, at least thirty percent (30%) of whom earn wages of not more than twelve dollars ($12.00) per hour. This wage limit may be increased annually based on increases in the Consumer Price Index. Of the employees eligible for coverage, at least seventy-five percent (75%) must participate in group health insurance coverage through the Program;

(2) That has not provided a group health benefit plan covering its employees during the 12-month period prior to application for a qualifying group health insurance contract under the Program. Small employer applicants shall be considered to have provided group health insurance if they have arranged for group health insurance coverage (insured or self-insured) on behalf of their employees and contributed an average of not less than fifty dollars ($50.00) per employee per month;

(3) Whose principal place of business is located in this State; and

(4) That contributes on behalf of participating employees at least fifty percent (50%) of the premium for employee coverage for the

qualifying health insurance contract. The employer premium contribution must be the same percentage for all covered employees, except that an employer may make a higher premium contribution for employees earning twelve dollars ($12.00) per hour, or less, as adjusted by the employer according to the Consumer Price Index.

(b) An employer shall cease to be a qualifying small employer if any health insurance under a health benefit plan that provides benefits covering the employer's employees, other than qualifying group health insurance purchased pursuant to this Part, is purchased by or on behalf of the employer or otherwise takes effect subsequent to the purchase of qualifying group health insurance under the Program. Eligibility shall cease on the first day of the first month that the other coverage is in effect for an entire month.

(c) Qualifying small employers are not required to offer coverage to part-time workers who work less than the required number of work hours to qualify as employees. However, if part-time workers are included as eligible employees for the purpose of meeting the eligibility requirements of this section, then coverage must be offered to part-time workers.

(d) Qualifying small employers may impose waiting periods that newly hired workers must satisfy in advance of obtaining coverage under the qualifying group health insurance contract. The waiting period shall not exceed 90 days from the date of hire and must be the same for all newly hired workers. Employees shall be added to the group not later than 90 days after the first day of employment.

(e) A qualifying small employer that elects to provide coverage offered under the Program shall make coverage under the qualifying group health insurance contract available to dependents of employees. A dependent who is enrolled in Medicare is ineligible for coverage under this Part unless coverage is required by federal law. Dependents of an employee who is enrolled in Medicare will be eligible for dependent coverage provided the dependent is not also enrolled in Medicare. A qualifying individual that meets the requirements of G.S. 58-50-175 or G.S. 58-50-180 may elect to include coverage for the qualifying individual's dependents under the qualifying individual health insurance contract.

(f) If an employee or a dependent of an employee of a qualifying small employer has creditable coverage as defined in G.S. 58-68-30(c)(1), the creditable coverage shall be credited against the 12-month waiting period on preexisting conditions under the Program in compliance with G.S. 58-68-30.

(g) As used in this Part, the term 'eligible employee' has the meaning applied under G.S. 58-50-110(10). In applying minimum participation requirements to a small employer, the insurer shall not consider employees who have authorized existing coverage in determining whether an applicable participation level is met. 'Authorized existing coverage' means benefits or coverage provided under Medicare, Medicaid, and other government funded programs.

"**§ 58-50-175. Eligibility for self-employed individuals.**

(a) As used in this Part, the term 'self-employed individual' has the meaning applied under G.S. 58-50-110(21a).

(b) In order for a participating insurer to be eligible to receive reimbursement under G.S. 58-50-200, to the extent that funds are available, for claims paid by the participating insurer under a qualifying health insurance contract under this section, the applicant for the qualifying health plan shall be a self-employed individual who is the sole owner and employee of a business and who:

(1) Has a family income not exceeding two hundred fifty percent (250%) of the federal poverty guidelines;

(2) Does not have and has not had health insurance coverage under a health benefit plan with benefits on an expense-reimbursed or prepaid basis during the 12-month period prior to application for coverage under the Program;

(3) Would not be eligible to obtain health insurance under an employer-provided group health benefit plan. An applicant would be considered eligible for an employer-provided group health benefits plan if the applicant is eligible to participate as an employee or as a dependent of an employee in an employer-sponsored health benefit plan (insured or self-insured) and the employer contributes toward the cost of the plan or the payment of the premium for employee coverage.

(4) Is a resident of North Carolina. Documentation of residency, which may include NC Income Tax filed as a resident for the prior year, or a valid North Carolina drivers license or special identification card, must be provided at initial application for a qualifying health insurance contract; and

(5) Is ineligible for Medicare.

"**§ 58-50-180. Eligibility for uninsured employed individuals.**

(a) In order to be eligible to purchase or renew a qualifying individual health insurance contract under this section, an applicant shall be an individual who:

(1) Is a low-income employed person whose employer does not provide group health insurance and has not provided group health insurance with benefits covering employees in effect during the 12-month period prior to the individual's application for health insurance under the Program. Applicants qualifying for individual health insurance contracts may meet the employment requirement by demonstrating that the applicant's spouse (residing in the applicant's household) is an employed person;

(2) Does not have health insurance under a health benefit plan or who would not be eligible to obtain health insurance under an employer-provided group health benefit plan. An applicant would be considered eligible for an employer-provided group health benefits plan if the applicant is eligible to participate in an employer-sponsored health benefit plan (insured or self-insured) and the employer contributes toward the cost of the plan or the payment of the premium;

(3) Is a resident of North Carolina. Documentation of residency, which may include NC Income Tax filed as a resident for the prior year, or a

valid North Carolina drivers license or special identification card, must be provided at initial application for a qualifying health insurance contract; and

(4) Is ineligible for Medicare or Medicaid.

(b) Subdivision (a)(1) of this section is not applicable where an individual had health insurance coverage under a health benefit plan during the previous 12 months, and the coverage was terminated due to:

(1) Loss of employment due to factors other than voluntary separation or change to new employer as described in subdivision (3) of this subsection;

(2) Death of a family member that results in termination of coverage under a health benefit plan contract under which the individual is covered;

(3) Change to a new employer that does not provide a group health benefit plan;

(4) Change of residence so that no employer-based health insurance with benefits on an expense-reimbursed or prepaid basis is available;

(5) Discontinuation of a group health benefit plan contract with benefits covering the qualifying individual as an employee or dependent;

(6) Expiration of the coverage periods established by Article 53 of this Chapter, the continuation provisions of the Employee Retirement Income Security Act, 29 U.S.C. § 1161, et seq., and the Public Health Service Act, 42 U.S.C. § 300bb-1, et seq., established by the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended;

(7) Legal separation, divorce, or annulment that results in termination of coverage under a health insurance contract under which the individual is covered; or

(8) Loss of eligibility under a group health benefit plan.

(c) As used in this Part, 'low-income employed person' means, for purposes of determining eligibility for qualifying individual health insurance contracts, a person that is employed currently on a full-time or part-time basis and has been employed on a full-time or part-time basis for at least 90 days in the preceding year for which the employed person received monetary compensation, and whose family income does not exceed two hundred fifty percent (250%) of the federal poverty guidelines.

"**§ 58-50-185. Enrollment; applications; duties of participating insurers; health plan contact information.**

(a) Applications for qualifying health insurance contracts may be made directly to the participating insurers. Participating insurers shall accept any standardized application form that may be required by the Commissioner. Participating insurers must accept applications for qualifying group health insurance contracts and qualifying individual health insurance contracts from any qualifying individual and any qualifying small employer at all times throughout the year.

(b) An applicant for a qualifying health insurance contract shall provide to the participating insurer at the time of initial application, and annually thereafter,

certification that the applicant meets the requirements of a qualifying small employer or qualifying individual, as applicable. The applicant shall submit documentation in support of the certification. Acceptable documentation shall be that required by the Commissioner.

(c) In addition to other duties required by this Part, participating insurers shall do the following:

(1) Provide all necessary information and enrollment forms when requested by applicants.

(2) Collect eligibility certifications required under this Part and necessary supporting documentation and be responsible for examination of the certifications and documentation for verification that applicants meet applicable eligibility requirements for initial enrollment and for contract renewals. At least 90 days prior to the annual contract renewal date, the participating insurer shall provide forms necessary for recertification of qualifying health insurance contracts. If the participating insurer determines that an employer or individual is no longer eligible for participation in the Program, the participating insurer shall provide not less than 45 days written notice to that effect to the contract holder and any covered employees. The notice shall clearly state the basis for the eligibility determination. The notice shall also include a description of other coverage options available for purchase from the participating insurer.

(3) Unless the Commissioner suspends enrollment in the Program pursuant to G.S. 58-50-200, the participating insurer shall accept and issue coverage for all applicants meeting eligibility criteria. For all applications submitted on or prior to the 20th day of the month, coverage shall be issued on the first day of the month next succeeding the date a complete application has been submitted. For applications submitted after the 20th day of the month, the participating insurer shall issue coverage not later than the first of the month next following the 20th day.

(4) Provide applicants that have failed to demonstrate eligibility for participation in the Program or for coverage as an uninsured employed individual, written denial of coverage or eligibility to participate in the Program clearly setting forth the basis for the denial.

(5) Submit monthly enrollment reports to the Commissioner detailing total enrollment in the Program. The reports shall identify the participating insurer's total enrollment in the Program as of the first day of the following month and shall be submitted to the Commissioner not later than the 15th day of the following month.

(6) In the event that the Commissioner suspends eligibility for reimbursement under the Program as provided in G.S. 58-50-200, participating insurers shall notify applicants that eligibililty has been

suspended and shall maintain a waiting list of applicants to be filled in the order of receipt in the event that eligibility is reactivated.

(7) Submit to the Commissioner:

a. The name, address, and telephone number of the participating insurer's contact person assigned to the Program;

b. The address and toll-free telephone number to direct consumer inquiries regarding the Program; and

c. The service area in which the Program will be available.

Participating insurers shall submit to the Commissioner information about changes to the information required in sub-paragraphs a., b., and c. of this subdivision. Changes to the contact person's information shall be submitted not later than the date that the changes become effective. Changes to the address and toll-free number for consumer inquiries and service area shall be submitted at least 45 days before the changes become effective.

(8) Market the Program in such a way that information effectively reaches small employers and individuals in the geographic areas in which the participating insurer makes coverage available or provides benefits. Participating insurers shall provide data or other information for the Commissioner's review to ensure that marketing policies and practices comply with this Part. Marketing policies and practices include compensation to agents of the insurer for the sale of Program coverage.

"**§ 58-50-190. Covered services; co-payments, deductibles, and other limitations.**

(a) Covered services and deductibles, co-payments, and other limitations on coverage under a qualifying group health insurance and a qualifying individual health insurance contract shall include coverage for mental health services and prescription drugs and shall otherwise be reasonably comparable to standard plans offered under G.S. 58-50-155.

Except as otherwise provided under this Part and Article 68 of this Chapter, the health benefit plans developed under this Part are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider.

(b) Qualifying small employers shall be issued the benefit package under a qualifying group health insurance contract. Qualifying individuals shall be issued the benefit package under a qualifying individual health insurance contract.

"**§ 58-50-195. Premiums.**

Premium rate calculations for qualifying group health insurance contracts and qualifying individual health insurance contracts shall be subject to the following:

(1) Coverage must be on an adjusted community rating basis and include rate tiers for individuals, individual and spouse, and at least one other family tier. The rate differences must be based upon the cost differences for the different family units, and the rate tiers must be

uniformly applied. The rate tier structure used by a participating insurer for the contracts issued to qualifying small employers and to qualifying individuals must be the same.

(2) If geographic rating areas are utilized, the geographic areas must be reasonable and in a given case may include a single county. The geographic areas utilized must be the same for the contracts issued to qualifying small employers and to qualifying individuals. The Commissioner shall not require the inclusion of any specific geographic region so long as the participating insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the participating insurer's adjusted community rates.

(3) Claims experience under contracts issued to qualifying small employers and to qualifying individuals must be pooled for rate-setting purposes. The premium rates for qualifying group health insurance contracts and qualifying individual health insurance contracts must be the same.

"**§ 58-50-200. Stop Loss Funds for standardized health insurance contracts issued to qualifying small employers and qualifying individuals.**

(a) The Commissioner shall establish Funds from which participating insurers may receive reimbursement, to the extent of funds available, for claims paid by the participating insurers. For qualifying group health insurance contracts issued pursuant to this Part, the Fund shall be established as the "Small Employer Stop Loss Fund". The Commissioner shall establish a separate and distinct fund from which participating insurers may receive reimbursement, to the extent of funds available, for claims paid by the participating insurers for members covered under qualifying individual health insurance contracts issued pursuant to this Part. This Fund shall be established as the "Qualifying Individual Stop Loss Fund".

(b) For each qualifying health insurance contract eligible for reimbursement from the Fund, participating insurers shall record and aggregate claims paid on a per member basis. Reimbursement from the applicable Fund shall be calculated based on the per member aggregates.

(c) The Small Employer Stop Loss Fund shall operate separately from the Qualifying Individual Stop Loss Fund. Except as specified in subsection (d) of this section with respect to calendar year 2008, the level of stop loss coverage for the qualifying group health insurance contracts and the qualifying individual health insurance contracts need not be the same. The Funds need not be structured or operated in the same manner, except as specified in this section. The monies available for distribution from the Stop Loss Fund may be reallocated between the Small Employer Stop Loss Fund and the Qualifying Individual Stop Loss Fund if the Commissioner determines that the reallocation is warranted due to enrollment trends.

(d) Commencing on January 1, 2008, participating insurers shall be eligible to receive reimbursement for ninety percent (90%) of claims paid within the applicable claims corridor in the preceding calendar year on behalf of each member covered under

a standardized contract issued pursuant to this Part. Claims paid for members covered under qualifying group health insurance contracts shall be reimbursable from the Small Employer Stop Loss Fund. Claims paid for members covered under qualifying individual health insurance contracts shall be reimbursable from the Qualifying Individual Stop Loss Fund. The Commissioner shall provide for validation of claims against the Funds, including repayment by insurers for claims erroneously paid.

(e) Claims shall be reported and funds shall be distributed from the Fund on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid by the participating insurer that submitted the claim to the Fund on behalf of a covered member reach or exceed seventy-five thousand dollars ($75,000) in a given calendar year, no further claims paid on behalf of the member in that calendar-year shall be eligible for reimbursement from the Fund.

(f) Claims paid within a calendar year shall be determined by the date of payment rather than date of service or date the claim was incurred. No participating insurer shall delay or defer payment of a claim solely for the purpose of causing the date of payment to fall into a subsequent calendar year.

(g) Participating insurers shall not be entitled to any reimbursement on behalf of a covered member if the claims paid on behalf of that member in a given calendar year do not, in the aggregate, reach the applicable claims threshold. Additionally, claims paid on behalf of a covered member that exceed the claims corridor in a given calendar year shall not be eligible for reimbursement from the Fund.

(h) Claims paid shall not include interest paid out by a participating insurer pursuant to G.S. 58-3-225.

(i) Each participating insurer shall submit a request for reimbursement from the Funds on forms prescribed by the Commissioner. Each of the requests for reimbursement shall be submitted not later than April 1st following the end of the calendar year for which the reimbursement requests are being made. The Commissioner may require participating insurers to submit the claims data in connection with the reimbursement requests as necessary to distribute monies from and oversee the operation of the Funds. The Commissioner shall require data to be reported separately for qualifying group health insurance contracts and qualifying individual health insurance contracts issued pursuant to this Part.

(j) Claims paid that are not submitted for reimbursement prior to April 1st of the calendar year following the year in which the claims are paid shall not be eligible for reimbursement from the Funds and shall not be credited as paid claims in any year for the purpose of determining whether the claims threshold has been reached. If the Commissioner determines that the claims data submitted in conjunction with a reimbursement request is insufficient to make a reimbursement determination, the Commissioner shall make a request for clarification of the data or for the submission of additional data. Participating insurers shall comply with all such requests within 15 business days of receiving the request. If a participating insurer fails to comply with a request for clarification within 15 business days of receiving the request, the Commissioner may deem any affected claims ineligible for reimbursement.

(k) For each Fund, the Commissioner shall calculate the total claims reimbursement amount for all participating insurers for the calendar year for which claims are being reported.

(1) In the event that the total amount requested for reimbursement for a calendar year exceeds funds available for distribution for claims paid during that same calendar year, the Commissioner shall provide for the pro-rata distribution of the available funds. Each participating insurer shall be eligible to receive only such proportionate amount of the available funds as each participating insurer's total eligible claims paid bears to the total eligible claims paid by all participating insurers.

(2) In the event that funds available for distribution for claims paid by all participating insurers during a calendar year exceed the total amount requested for reimbursement by all participating insurers during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year. The excess funds shall be in addition to the monies appropriated to the Funds in the next calendar year.

(l) Upon the request of the Commissioner, each participating insurer shall be required to furnish such data as the Commissioner deems necessary to oversee the operation of the Fund.

(m) The Commissioner shall separately estimate the per-enrollee annual cost of total claims reimbursement from the Fund for qualifying individual health insurance contracts and for qualifying group health insurance contracts based upon available data and appropriate actuarial assumptions. Upon request, each participating insurer shall furnish to the Commissioner on a monthly basis claims experience data for use in the estimations.

(n) The Commissioner shall determine total eligible enrollment under qualifying group health insurance contracts and qualifying individual health insurance contracts. For qualifying group health insurance contracts, the total eligible enrollment shall be determined by dividing the total funds available for distribution from the Fund by the estimated per-member annual cost of total claims reimbursement from the Fund. For qualifying individual health insurance contractors, the total eligible enrollment shall be determined by dividing the total funds available for distribution from the Qualifying Individual Stop Loss Fund by the estimated per-enrollee annual cost of total claims reimbursement from the Fund.

(o) The Commissioner shall suspend eligibility for reimbursement under qualifying group or individual health insurance contracts if the Commissioner determines that the total enrollment reported by all participating insurers under the qualifying group or qualifying individual contracts exceeds the total eligible enrollment for each type of contract, thereby resulting in anticipated annual expenditures from the Fund in excess of the total funds available for distribution from the Fund.

(p) The Commissioner shall provide participating insurers with notification of the intended eligibility suspensions as soon as practicable after receipt of all enrollment data, but not later than 30 days prior to the effective date of the suspension. The

Commissioner's determination and notification shall be made separately for qualifying group health insurance contracts and for qualifying individual health insurance contracts.

(q) If, at any point during a suspension of enrollment of new qualifying small employers or qualifying individuals, the Commissioner determines that funds are sufficient to provide for the addition of new enrollments, the Commissioner may reactivate new enrollments and shall notify all participating insurers that enrollment of new employers or individuals may again commence. The Commissioner's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.

(r) The suspension of issuance of qualifying group health insurance contracts to new qualifying small employers shall not preclude the addition of new employees of an employer already covered under the contract or new dependents of employees already covered under the contracts.

(s) The suspension of issuance of qualifying individual health insurance contracts to new qualifying individuals shall not preclude the addition of new dependents to an existing qualifying individual health insurance contract.

(t) If the Commissioner deems it appropriate for the proper administration of the Fund, the Commissioner may purchase stop loss insurance or reinsurance in the open market from an insurance company authorized to write this type of insurance in this State. The stop loss insurance or reinsurance may be purchased to the extent funds are available for this purpose.

(u) The Commissioner may access monies from the Fund for the purposes of developing and implementing public education, outreach, and enrollment strategies targeted to small employers and working adults without health insurance. The Commissioner may contract with marketing organizations to perform or provide assistance with the education, outreach, and enrollment strategies. The Commissioner shall determine the amount of funding available for the purposes of this subsection, which in no event shall exceed fifty thousand dollars ($50,000).

(v) The Commissioner shall audit insurers' claims against the Fund as the Commissioner determines necessary. The Commissioner is authorized to contract for audit services using monies from the Fund.

(w) The Commissioner may adjust the 12-month eligibility periods required under G.S. 58-50-170(a)(2), 58-50-175(b)(2), and 58-50-180(a)(1) if the Commissioner determines that the 12-month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying individual or group health insurance contracts.

"**§ 58-50-205. Insurer withdrawal from service area or State.**

If a participating insurer intends to withdraw from a service area, or if the participating insurer leaves the State, the groups and individuals covered by that carrier shall be permitted to transfer to another participating carrier without having to go without coverage and with full credit for any preexisting condition exclusion that has been satisfied.

"**§ 58-50-210. Rating of products eligible for reimbursement; data collection.**

(a) The premium rates established for qualifying health insurance contracts must recognize the availability of reimbursement from the applicable Fund.

(b) Reimbursement from the applicable Fund shall reduce claims expenses for the purposes of calculating loss ratios, premium rates, and premium rate adjustments and for the purposes of determining compliance with this Part.

(c) Initial rate submissions and rate adjustment applications submitted for qualifying health insurance contracts shall contain such information as may be needed in order to assist the Commissioner in determining the anticipated premium rate impact of the availability of reimbursement from the Fund.

(d) Estimates of anticipated receipts from the Fund may be calculated based upon available enrollment data and such other data as may be deemed appropriate by the Commissioner.

(e) Qualifying health insurance contracts under the Program shall be treated as individual products for the purpose of applying loss ratio standards.

"**§ 58-50-215. Data filing requirements.**

(a) The Commissioner shall require the submission of necessary claims data in connection with each participating insurer's annual submission of requests for reimbursement from the Fund. Each participating insurer shall also provide the Commissioner with such additional data as the Commissioner deems necessary to oversee the operation of the Funds and the Program. The Commissioner may require that all data submitted include detail by month on each data point in order to ensure trend detection. Reports pertaining to stop loss reimbursement or loss ratio shall be certified by an officer of the participating insurer company that the report is accurate and complete. Data to be submitted may include:

(1) The total number of contracts issued within the reporting period and the total number of contracts in force that are covered by the Fund;

(2) The total number of primary insureds, the total number of dependents covered, and the total number of child dependents covered;

(3) Total premium earned and per-member-per-month premium earned for all contracts covered by the Fund for the reporting period;

(4) Claims payment data on a monthly incurred/monthly paid basis, reported individually for each covered member or for each covered member for whom the participating insurer has paid claims eligible for reimbursement;

(5) Total claims for reimbursement year-to-date; and

(6) Paid claims continuance tables containing the number of claimants and the total number of claims paid by claimant-dollar intervals. The Commissioner shall provide a written and electronic spreadsheet with specific claimant-dollar intervals and any partitions of paid claims other than by the Fund.

(b) Data shall be reported separately for each Fund. Data reporting periods may be other than a calendar year, and reporting frequency for some data could be as often as monthly. Claims payment data shall clearly set forth both the date the claim was incurred and the date the claim was paid. Claims payment data may also be requested on

a cumulative basis or in the form of aggregates, categoricals, and averages. The Commissioner shall adopt rules to implement this subsection.

(c) A participating insurer shall use a coding system to ensure the privacy of insured individuals. The coding system should serve only to mask the identity of the claimant.

"**§ 58-50-220. Independent evaluation of Healthy NC Program; reporting requirements.**

(a) An evaluation of the Program shall be conducted annually. The Commissioner shall issue a Request for Proposal for the Program evaluation by an independent contractor. Contracts for the evaluation of the Program are not subject to Article 3C of Chapter 143 of the General Statutes. The Commissioner may access monies from the Fund to pay for the contractor's services. The independent contractor shall include in the evaluation the following:

(1) Program enrollment for the prior calendar year, including enrollment levels over time, enrollment distribution by member type, by health plan, and by county.

(2) The relationship between premium levels and Program enrollment.

(3) Analysis of the Program cost experience.

(4) Surveys of covered members, participating insurers, and qualifying small employers, individuals, and self-employed persons.

(5) Effectiveness of eligibility and other requirements in minimizing adverse selection.

(6) Recommendations for strengthening the viability and effectiveness of the Program.

(b) The Commissioner shall report to the General Assembly annually, upon its convening, on the status of the Program and shall make recommendations for legislative action. The Commissioner's report to the General Assembly may also include findings and recommendations made pursuant to other reporting requirements under this Part.

"**§ 58-50-225. Conflicts with other provisions of this Chapter.**

If a conflict arises between a provision of this Part and another provision of this Chapter, this Part shall control to the extent necessary to implement this Part.

"**§ 58-50-230. Commissioner's duties.**

(a) The Commissioner shall adopt and implement policies, procedures, guidelines, and forms as are necessary to implement this Part and in a way that provides for expedient and efficient administration and minimizes the administrative burden on insurers.

(b) The Commissioner may adopt rules in accordance with Chapter 150B of the General Statutes to implement this Part.

"**§ 58-50-235. Right to amend.**

The General Assembly reserves the right to alter, amend, or repeal this Part."

SECTION 1.1. The Commissioner of Insurance report to the General Assembly in accordance with G.S. 58-50-220 shall include recommendations on the following:

(1) Whether adjustment to the claims corridor is necessary to reduce Program premiums by thirty percent (30%). This recommendation shall be based on actuarial information obtained by the Commissioner for this purpose.

(2) Whether further actions are necessary to inhibit adverse selection under Program coverage, and if so, what specific actions are necessary.

SECTION 2. There is appropriated from the General Fund to the Department of Insurance the sum of three hundred eleven thousand six hundred sixty-three dollars ($311,663) for the 2006-2007 fiscal year. These funds shall be used to support four additional full-time positions in the Department to carry out the Department's responsibilities under the Healthy NC Program.

SECTION 2.1. There is appropriated from the General Fund to the Reserve for Healthy NC the sum of $XX for the 2006-2007 fiscal year. These funds shall be used to pay claims submitted for reimbursement that are within the claims corridor as provided in Section 1 of this act.

SECTION 3. Sections 2 and 2.1 of this act become effective July 1, 2006. The remainder of this act is effective when it becomes law. Carriers required to offer products under the Healthy NC Program established under Section 1 of this act for the initial offering due to their market share shall commence offering the products on January 1, 2008.