GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S **D**

SENATE DRS35285-LN-38 (1/23)

Short Title:	Health Insurance Risk Pool/Healthy NC.	(Public)
Sponsors:	Senator Dalton.	
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; TO CREATE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO HELP MEET THE HEALTH INSURANCE COVERAGE NEEDS OF INDIVIDUALS WHO CANNOT OBTAIN AFFORDABLE HEALTH INSURANCE BECAUSE OF HIGH-RISK HEALTH CONDITIONS; AND TO APPROPRIATE FUNDS FOR THE IMPLEMENTATION OF THIS ACT.

The General Assembly of North Carolina enacts:

PART 1. HEALTHY NC PROGRAM

SECTION 1.1. 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) 'Claims corridor'. – Claims paid 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).

(2) 'Claims threshold'. – The aggregate amount that a participating insurer must pay out as claims paid 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.

(3) 'Community rated'. – 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.

(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.

(6) 'Insurer'. – An insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, and a health maintenance organization organized under Article 67 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, or an individual health insurance contract approved by the Commissioner and purchased under the Program by a self-employed individual or 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 qualifies to purchase a qualifying group health insurance contract under the Program.

(14) 'Stop Loss Fund' or 'Fund'. – Either the Small Employer Stop Loss Fund, or the Qualifying Individual Stop Loss Fund, or both, as the context requires.

"**§ 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 this State, shall offer qualifying group health insurance contracts and qualifying individual health insurance contracts in accordance with this Part. 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 at least comparable in coverage to health plans offered in the North Carolina small group or non-group market.

(b) Notwithstanding any other provision of this Chapter, the contracts issued pursuant to this Part by participating insurers shall provide only network plan benefits, except for emergency care or where services are not available through a plan provider. As used in this Part, `network plan' has the meaning applied under G.S. 58-68-25.

(c) All coverage under a qualifying health insurance contract is subject to a preexisting condition limitation in accordance with G.S. 58-51-15. The underwriting of the 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 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 may elect to include coverage for the qualifying individual's dependents under the qualifying individual health insurance contract.

(e) A benefit plan under a qualifying 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.

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

(g) Rates under qualifying health insurance contracts may be increased as authorized under G.S. 58-51-95 and applicable rules regarding rate revision requests.

(h) 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, approve the contracts and rates.

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

(a) In order to be eligible to purchase or renew a qualifying health insurance contract under this Part, an applicant shall be a small employer:

(1) That employs not more than 25 eligible employees, at least 30% of which earn wages of not more than twelve dollars ($12.00) per hour. 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 group health insurance coverage 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 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 the qualifying health insurance contract. The employer premium contribution must be the same percentage for all covered employees.

(b) An employer shall cease to be a qualifying small employer if any health insurance that provides benefits on an expense-reimbursed or prepaid basis 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.

(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) The 12-month period set forth in subdivision (a)(2) of this section may be adjusted by the Commissioner from 12 months to 18 months if the Commissioner determines that the 12-month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying individual health insurance contracts.

(f) If an employee of a qualifying small employer has been covered as a dependent under another health benefit plan, or has had individual coverage, the prior coverage shall be credited against the 12-month waiting period on pre-existing conditions under the Program.

(g) As used in this Part, the term 'eligible employee' means an employee who works for a qualifying small employer on a full-time basis with a normal work week of 30 or more hours. 'Eligible employee' does not include employees who work on a temporary or substitute basis. In applying minimum participation requirements to a small employer, the insurer shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the Program.

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

(a) As used in this Part, the term "self-employed individual" means an individual or sole proprietor, including an independent contractor, who derives a majority of the individual's income from a trade or business carried on by the individual or sole

proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F, and which generated taxable income in one of the two previous years.

(b) In order to be eligible to purchase or renew a qualifying individual health insurance contract under this Part, an applicant 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 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 benefits 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;

(4) Is a resident of North Carolina. Documentation of residency, which may include 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.

(c) The 12-month period set forth in subdivision (b)(1) of this section may be adjusted by the Commissioner from 12 months to 18 months if the Commissioner determines that the 12-month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying individual health insurance contracts.

"**§ 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 Part, 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 on an expense-reimbursed or prepaid basis 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 in force or who would not be eligible to obtain health insurance under an employer-provided group health benefits 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 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.

(b) Subdivision (a)(1) of this section is not applicable where an individual had health insurance coverage 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 insurance contract under which the individual is covered;

(3) Change to a new employer that does not provide group health insurance with benefits on an expense-reimbursed or prepaid basis;

(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 insurance contract with benefits on an expense-reimbursed or prepaid basis 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) The 12-month period set forth in subdivision (a)(1) of this section may be adjusted by the Commissioner from 12 months to 18 months if the Commissioner determines that the 12-month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying individual health insurance contracts.

(d) As used in this Part, 'employed person' means, for purposes of determining eligibility for qualifying individual health insurance contracts, a person employed on a full-time or part-time basis either currently or 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 shall 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 as required by the participating insurer.

(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 a contract will not be renewed or will be terminated based on ineligibility, 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 termination or nonrenewal. 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. 58-50-165, 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 with a written notice of denial 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 enrollment in the Program as provided in G.S. 58-50-165, participating insurers shall notify applicants that enrollment has been suspended and shall maintain a waiting list of applicants to be filled in the order of receipt in the event that enrollment 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 review and revise or update periodically the information required in this subdivision and shall submit the revisions and updates to the Commissioner on a timely basis.

(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.

(d) If a group covered under the Program becomes ineligible, coverage under the Program shall be terminated consistent with G.S. 58-68-45(b).

"**§ 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 comparable to those provided in health plans offered in the North Carolina small group or non-group market.

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.

(c) Appeal and grievance rights under G.S. 58-60-61 and G.S. 58-50-62 apply to covered benefits under the Program.

"**§ 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 community-rated 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 within the proposed community-rated region selected by the participating insurer 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 2006, 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 Fund, 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 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.

(i) Each participating insurer shall submit a request for reimbursement from the Fund 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 Fund. 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 Fund 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 exceeds 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 Fund 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. The data shall be furnished in a form prescribed by the Commissioner. Each participating insurer shall provide the Commissioner with monthly reports of the total enrollment under the qualifying group health insurance contracts and the qualifying individual health insurance contracts issued pursuant to this Part. The reports shall be in a form prescribed by the Commissioner.

(m) The Commissioner shall separately estimate the per-member annual cost of total claims reimbursement from the Fund or 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 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-member annual cost of total claims reimbursement from the Fund.

(o) The Commissioner shall suspend the enrollment 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 any enrollment suspensions as soon as practicable after receipt of all enrollment data. 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) The premiums for qualifying health insurance contracts must factor in the availability of reimbursement from the Fund.

(u) 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 licensed 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.

(v) 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).

"**§ 58-50-205. Stop loss insurance.**

(a) An insurer authorized to issue stop loss policies under this Chapter may issue stop loss insurance as provided in this section provided that the stop loss insurance policy does not otherwise violate this Chapter.

(b) A stop loss insurance policy whereby the stop loss insurer agrees to pay claims or indemnify a participating insurer for losses incurred under a qualifying group health insurance contract in excess of specified loss limits for individual claims or for all claims combined, or any similar arrangement shall clearly describe:

(1) The entire money or other consideration for the policy;
(2) The time at which the insurance takes effect and terminates;
(3) The specified per-claim, per-employee, or aggregate amount of claims above which payment or reimbursement is to be made by the insurer; and
(4) The payments to be made by the insurer once the specified stop loss thresholds have been exceeded.

"**§ 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.

(f) Participating insurers may reinsure their Program business in whole or in part if they determine it would favorably impact premium rates. The impact of the reinsurance shall be factored into the premium rates for affected qualifying group health insurance premiums and qualifying individual health insurance premiums.

"**§ 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 number of qualifying individual health insurance contracts issued that do not provide coverage for dependents;
(3) The number of qualifying small employer health insurance contracts where the employer elects not to make dependent coverage available to employees;

(4) The total number of primary insureds, the total number of dependents covered, and the total number of child dependents covered;
(5) Total premium earned and per-member-per-month premium earned for all contracts covered by the Fund for the reporting period;
(6) Claims payment data on a calendar year/paid basis, reported individually for each covered member or for each covered member for whom the participating insurer has paid claims eligible for reimbursement;
(7) Total claims for reimbursement year-to-date; and
(8) 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.

(c) A participating insurer shall use a coding system to ensure the privacy of insured individuals. Personally identifying information shall not be submitted with claims data.

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

(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. 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.

"**§ 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 States to implement this Part.

"**§ 58-50-235. Right to amend.**

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

SECTION 1.2. 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.

PART 2. NORTH CAROLINA HEALTH INSURANCE RISK POOL

SECTION 2.1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 7. North Carolina Health Insurance Risk Pool.

"**§ 58-50-245. Definitions.**

For the purposes of this Part:

(1) "Administrator" means the Pool Administrator selected by the Board in accordance with this Part.

(2) "Benefit plan" means coverage offered by the Pool to eligible individuals.

(3) "Board" means the Board of Directors of the Pool.

(4) "Commissioner." – The Commissioner of Insurance.

(5) "Covered person" means any individual resident of this State, excluding dependents, who is eligible to receive health benefits from any insurer.

(6) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(7) "Creditable coverage" – Same meaning as in G.S. 58-68-30(c)(1).

(8) "Dependent" means a resident spouse or unmarried child under the age of 19 years, a child who is a full-time student under the age of 23 years and who is financially dependent upon the parent, a child who is over 18 years of age and for whom a person may be obligated to pay child

support, or a child of any age who is disabled and dependent upon the parent.

(9) "Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Pool.

(10) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(11) "Federally defined eligible individual". – Same meaning as "eligible individual" as prescribed in G.S. 58-68-60(b).

(12) "Governmental plan". – Same meaning as prescribed in G.S. 58-68-60(h)(2).

(13) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(14) "Health insurance coverage". – Same meaning as prescribed in G.S. 58-68-25(a)(5). Health insurance coverage does not include benefits described in G.S. 58-68-25(b).

(15) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers or employees, but does not include health care services covered through an insurer.

(16) "Insured" means an individual who is a resident of this State and a citizen of the United States, and who is eligible to receive benefits from the Pool. The term "insured" includes dependents and family members, as applicable.

(17) "Insurer" means any entity that provides health insurance coverage in this State. For the purposes of this Part, insurer includes:

a. An insurance company;

b. A hospital or medical service corporation;

c. A health maintenance organization;

d. A multiple employer welfare arrangement;

e. The Teachers' and State Employee's Comprehensive Major Medical Plan; and

f. Any other nongovernmental entity providing a health benefit plan subject to State insurance regulation.

(18) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and

c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(19) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(20) "Pool" means the North Carolina Health Insurance Risk Pool.

(21) "Resident" means an individual who:

a. Has been legally domiciled in this State for a period of at least 30 days, except that for a federally defined eligible individual, there shall not be a 30-day requirement;

b. Is legally domiciled in this State on the date of application to the Pool and who is eligible for enrollment in the Pool as a result of the Health Insurance Portability and Accountability Act of 1996; or

c. Is legally domiciled in this State on the date of application to the Pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986.

(22) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

(23) "Trade Adjustment Assistance Program (TAA). – Title II of the Trade Act of 2002, P.L. 107-210.

(24) 'Trust Fund". – The North Carolina Health Insurance Risk Pool Trust Fund, established under this Part.

"**§ 58-50-250. Risk Pool established; board of directors; plan of operation.**

(a) High-Risk Pool Established. – There is hereby created a nonprofit entity to be known as the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.

(b) Board of Directors Appointment; Membership. – The Board of Directors of the North Carolina Health Insurance Risk Pool shall consist of the Commissioner of Insurance, who shall serve as an ex officio nonvoting member of the Board, and seven members appointed as follows:

(1) Two members of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the Pool. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member. The two members of the general public shall be appointed by the General Assembly, as follows:

a. One member upon the recommendation of the President Pro Tempore of the Senate.

b. One member upon the recommendation of the Speaker of the House of Representatives.

(2) Five members appointed by the Commissioner of Insurance, as follows:

a. Two who are insurers, at least one of whom covers the largest number of persons in the State, as recommended by the State's largest insurer.

b. One who is licensed to sell health insurance in this State.

c. One who represents the medical provider community, as recommended by the North Carolina Medical Society.

d. One who represents small business, as recommended by the North Carolina Citizens for Business and Industry.

(c) Board of Directors; Terms of Appointment; Vacancies; Compensation. – The initial Board members shall be appointed as follows: two of the members to serve a term of three years; three of the members to serve a term of one year; and two of the members to serve a term of two years. Subsequent Board members shall serve for terms of three years. A Board member's term shall continue until the member's successor is appointed by the original appointing authority. The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Each appointing authority shall fill membership vacancies created by the appointing authority's appointee in membership and may remove members from the Board for cause. Board members shall receive travel allowance under G.S. 138-6 when traveling to and from meetings of the Board, but shall receive subsistence allowance or per diem under G.S. 138-5

(d) Plan of Operation. – The Board shall submit to the Commissioner a Plan of Operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Part must be made available. If the Board fails to submit a suitable Plan of Operation within 180 days after the appointment of the Board of Directors, or at any time thereafter fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary rules necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner. The Plan of Operation shall:

(1) Establish procedures for operation of the Pool.

(2) Establish procedures for selecting a Pool administrator in accordance with G.S. 58-50-185.

(3) Establish procedures to create a fund for administrative expenses, which shall be managed by the Board.

(4) Establish procedures for the collection, handling, accounting, and auditing of assets, monies, and claims of the Pool and the Pool administrator.

(5) Develop and implement a program to publicize the existence of the Pool, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the Pool.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board. The grievances shall be reported to the Board after completion of the review. The Board shall retain all written complaints regarding the Pool for at least three years.

(7) Provide for other matters as may be necessary and proper for the execution of the Board's powers, duties, and obligations under this Part.

(h) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Pool.

(3) Take legal action as necessary to:

a. Avoid the payment of improper claims against the Pool or the coverage provided by or through the Plan.

b. Recover any amounts erroneously or improperly paid by the Plan.

c. Recover any amounts paid by the Pool as a result of mistake of fact or law.

d. Recover other amounts due the Pool.

(4) Establish rates and rate schedules in accordance with this Part.

(5) Issue policies of insurance in accordance with the requirements of this Part.

(6) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(7) Establish policies, conditions, and procedures for reinsuring risks of participating insurers desiring to issue Pool coverage in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(8) Employ and fix the compensation of employees.

(9) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(10) Provide for reinsurance of risks incurred by the Pool.
(11) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.
(12) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.
(14) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.
(15) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool.
(16) Assess insurers in accordance with 58-50-290.

(i) The Board shall operate the Pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed the total income the Pool expects to receive from policy premiums and other revenue available to the Pool. The financing mechanisms recommended to and approved by the General Assembly shall provide for a means to adjust those mechanisms annually, or more frequently if necessary, in order to assure that the Pool has the financial capacity to insure the projected number of enrollees.

(j) The Board shall make an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate. The report shall summarize the activities of the Pool in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses.

(k) Neither the Board nor its employees are liable for any obligations of the Pool. No current or former member or employee of the Board is liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Part, unless such act or omission constitutes willful or wanton misconduct. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

"**§ 58-50-255. Administrator.**

(a) The Board shall select through a competitive bidding process one or more insurers or a third-party administrator to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.
(2) Efficiency and timeliness of the claim processing procedures.
(3) Estimated total charges for administering the Pool.

(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.

(5) Financial condition and stability.

(b) The Administrator shall serve for a period specified in the contract between the Pool and the Administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the Pool and the Administrator. At least one year before the expiration of each period of service by an Administrator, the Board shall invite eligible entities, including the current Administrator, to submit bids to serve as the Administrator. Selection of the Administrator for the succeeding period shall be made at least six months before the end of the current period.

(c) The Administrator shall perform such functions relating to the Pool as may be assigned to it, including:

(1) Determination of eligibility.

(2) Payment of claims.

(3) Establishment of a premium billing procedure for collection of premiums from individuals covered under the Pool.

(4) Other necessary functions to assure timely payment of benefits to covered persons under the Pool.

(d) The Administrator shall submit regular reports to the Board regarding the operation of the Pool. The contract between the Board and the Administrator shall specify the frequency, content, and form of the report.

(e) Following the close of each calendar year, the Administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Commissioner on a form prescribed by the Commissioner.

(f) The Administrator shall be paid as provided in the contract between the Board and the Administrator.

"**§ 58-50-260. Risk Pool rates.**

(a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for the coverage. Initial Pool rates may not be less than one hundred fifty percent (150%) and may not exceed two hundred percent (200%) of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall

Pool rates exceed two hundred percent (200%) of rates applicable to individual standard risks.

(c) The Pool shall submit all rates and rate schedules to the Commissioner for approval, and the Commissioner must approve the rates and rate schedules before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules, shall consider the factors provided in this section.

"**§ 58-50-265. Eligibility for Pool coverage.**

(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility;

(2) Two offers to issue insurance only with conditional riders;

(3) Refusal by two insurers to issue insurance except at a rate exceeding the Pool rate;

(4) Diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible for Pool coverage without applying for other health insurance coverage;

(5) In the case of an individual who is eligible for coverage under the Health Insurance Portability and Accountability Act of 1996, the individual's maintenance of health insurance coverage, of which the most recent coverage was through an employer-sponsored plan, for the previous 18 months with no gap in coverage greater than 63 days and exhaustion of any available COBRA or State continuation benefits; or

(6) An individual who is legally domiciled in this State and is eligible for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.

(b) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Pool coverage without applying for health insurance pursuant to subsection (a) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list adopted by the Board shall not be required to provide the evidence specified in subsection (a) of this section. The Board may amend the list as the Board considers appropriate.

(c) Each dependent of an individual who is eligible for Pool coverage shall also be eligible for Pool coverage.

(d) An individual is not eligible for coverage under the Pool if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a Pool policy, or would be eligible to have coverage if the person elected to obtain it; except that:

a. An individual may maintain other coverage for the period of time the individual is satisfying any preexisting condition waiting period under a Pool policy; and

b. An individual may maintain Pool coverage for the period of time the individual is satisfying a preexisting conditions waiting period under another health insurance policy intended to replace the Pool policy.

(2) The individual is determined to be eligible for enrollment in the State Medical Assistance Plan.

(3) The individual has previously terminated Pool coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(4) The Pool has paid out the lifetime maximum benefits, which is one million dollars ($1,000,000) on behalf of the individual.

(5) The individual is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(6) The individual's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(7) The individual has in effect on the date Pool coverage takes effect health insurance coverage from an insurer or insurance arrangement.

(e) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.

(2) On the date an individual requests coverage to end.

(3) Upon the death of the covered individual.

(4) On the date State law requires cancellation of the Pool policy.

(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.

(f) Except as provided in subsection (e) of this section, an individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the Pool period for which the necessary premiums have been paid.

"**§ 58-50-270. Unfair referral to Pool.**

It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

"**§ 58-50-275. Minimum Pool benefits.**

(a) The Pool shall offer at least two types of health insurance coverage for individuals eligible under G.S. 58-50-175. The covered services and benefit levels may vary between the types of coverage, but at least two types of coverage must, at a minimum, cover the benefits and services outlined in the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act and be consistent with comprehensive coverage generally available to persons who are eligible for health insurance other than Medicare.

(b) Subject to approval by the Commissioner, the Board shall establish the health insurance coverage issued by the Pool, including the coverage's schedule of benefits, exclusions, and other limitation of the coverage.

"**§ 58-50-280. Preexisting conditions.**

(a) Pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated; provided, that:

(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool shall be effective from the date on which the prior coverage was terminated; and

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.

"**§ 58-50-285. Nonduplication of benefits.**

(a) The Pool shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(b) The Pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-290. Assessments.**

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the Pool, the Board shall assess member insurers at such time and for such amounts as the Board finds necessary for the efficient and effective operation of the Pool. Assessments shall be due in not less than 30 days after prior written notice to the

member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Each insurer shall be assessed in an amount not to exceed two dollars ($2.00) per covered individual insured or reinsured by each insurer per month. The assessment will be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool.

(c) The Board shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individual all individuals whose coverage is insured (including by way of excess or stop-loss coverage) in whole or in part. The Board shall allow a reinsurer to exclude from its number of covered individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purposes of determining its assessment under this section.

(d) The Board may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Board. The Board may use any reasonable method of estimating the number of covered individuals of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool, Board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-295. Complaint procedures.**

An applicant or participant in coverage from the Pool is entitled to have complaints against the Pool reviewed by a grievance committee appointed by the Board. The grievance committee shall report to the Board after completion of the review of each complaint. The Board shall retain all written complaints regarding the Pool at least until the third anniversary of the date the Pool received the complaint. An applicant or participant may file for external review of the applicant's grievance after having exhausted the Pool's internal grievance procedure. External review shall be conducted in accordance with Part 4 of this Article.

"**§ 58-50-300. North Carolina Health Insurance Risk Pool Trust Fund.**

(a) There is established in the Office of the State Treasurer the North Carolina Health Insurance Risk Pool Trust Fund. All premiums, fees, charges, rebates, assessments, special assessments, refunds, or any other receipts including investment earnings occurring or arising in connection with the Pool shall be deposited into the Trust Fund.

(b) Disbursements from the Trust Fund shall include all amounts required to pay the claims, benefits, and administrative costs of operating the Pool as may be determined by the Executive Director with approval of the Board. Disbursement may be made by warrant drawn on the State Treasurer by the Executive Director, or the Executive Director and the Board may by contract authorize the Administrator to draw the warrant.

"**§ 58-50-310. Audit.**

The State Auditor shall conduct annually a special audit of the Pool. The State Auditor's report shall include a financial audit and an economic and efficiency audit. The State Auditor shall report the cost of each audit conducted under this Part to the Board and the Comptroller, and the Board shall remit that amount to the Comptroller for deposit to the General Fund.

"**§ 58-50-315. Taxation.**

The Pool established under this Part is exempt from any and all State taxes.

"**§ 58-50-320. Rules.**

The Board may adopt rules, including temporary rules, to implement its duties and responsibilities under this Part. The Commissioner may adopt rules, including temporary rules, to implement the Commissioner's duties and responsibilities under this Part.

"**§ 58-50-325. Collective action.**

The participation in the Pool as participating insurers, the establishment of rates, forms, or procedures, and any other joint or collective action required by this Part may not be the basis of any legal action or criminal or civil liability or penalty against the Pool or any participating insurer."

SECTION 3. There is appropriated from the General Fund to the Reserve for Healthy NC the sum of one hundred thousand dollars ($100,000) for the 2007-2008 fiscal year. These funds shall be used for administrative costs incurred to implement this act.

SECTION 3.1. There is appropriated from the General Fund to the Reserve for Healthy NC the sum of five million dollars ($5,000,000) for the 2008-2009 fiscal year. Theses funds shall be used to pay claims that exceed the claims corridor in accordance with Section 1.1 of this act.

SECTION 3.2. On or before January 1, 2008, the Executive Director shall notify the Centers for Medicare and Medicaid Services that the State has established the North Carolina Health Insurance Risk Pool and shall request that the North Carolina Health Insurance Risk Pool be approved as an acceptable "alternative mechanism" under the federal Health Insurance Portability and Accountability Act in accordance with 45 C.F.R. § 148.128(e).

SECTION 3.3. The Board, as appointed under Section 2.1 of this act, shall monitor methods of financing the Pool to ensure a stable funding source and allow for its continued operation. This monitoring shall include supplementary sources of funding, such as funds obtained from public and private not-for-profit foundations, insurer assessments including special assessments, or other appropriate and available State or non-State funds. The Board shall also review on a regular basis:

(1) The number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.
(2) The number of uninsured individuals who would qualify for coverage under the Pool based on G.S. 58-50-265 and its Plan of Operation.
(3) The cost of coverage under each of the health insurance plans developed by the Board, including administrative costs.
(4) The extent to which assessments meet or exceed amounts necessary for coverage and Board operations.
(5) The status of a request by the State to the Centers for Medicare and Medicaid Services for approval of the North Carolina Health Insurance Risk Pool to be considered an acceptable "alternative mechanism" under the federal Health Insurance Portability and Accountability Act in accordance with 45 C.F.R. § 148.128(e).

The Board shall report its findings and recommendations to the General Assembly on March 1, 2008, and annually thereafter.

SECTION 3.4. The Administrator shall study methods for encouraging healthy behaviors and report its findings to the Board and to the General Assembly not later than one year after initial implementation of the Pool.

SECTION 3.5. Notwithstanding G.S. 58-50-280(a), individuals enrolling in the Pool within six months of the date that enrollment into the Pool first begins shall be subject to a six-month preexisting condition waiting period.

SECTION 3.6. There is appropriated from the General Fund to the North Carolina Health Insurance Risk Pool Trust Fund (Trust Fund), established under this act, the sum of one million dollars ($1,000,000) for the 2007-2008 fiscal year. These funds may be used to support reasonable expenses for personnel to carry out the Board's responsibilities under the Pool and shall be allocated for the reasonable expenses of the Board in conducting its duties under Section 1 of this act that are incurred on or before July 1, 2009. The Trust Fund is subject to the Executive Budget Act, except that Article 3C of Chapter 143 of the General Statutes does not apply to G.S. 58-50-250(e).

Appropriation of the funds from the General Fund to the North Carolina Health Insurance Risk Pool Trust Fund is contingent upon successful application for and award of federal grant funds to implement the Pool. Federal funds received for this purpose shall be deposited to the Trust Fund. Upon receipt of the federal funds, the Board shall, from Trust Fund monies, reimburse the General Fund in the amount of one million dollars ($1,000,000). It is the intent of the General Assembly that in the event the State is not awarded the federal funds anticipated, the General Fund shall be held harmless.

SECTION 4. Section 3 of this act becomes effective July 1, 2007. The remainder of this act is effective when it becomes law. Section 1.1 of this act applies to health insurance contracts issued, delivered, or renewed on and after January 1, 2008.