A BILL TO BE ENTITLED
AN ACT TO CREATE GREATER OPPORTUNITIES FOR SMALL EMPLOYERS TO PROVIDE EMPLOYEES ACCESS TO HEALTH INSURANCE.

Whereas, Association Health Plans are regulated by multiple consumer protection provisions contained in the Employee Retirement Income Security Act (ERISA), including provisions under the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act; and

Whereas, under ERISA, the State has been regulating self-insured Association Health Plans in such a way that, in addition to the federal consumer protections that apply to the fully insured Association Health Plans, fully protects the citizens of this State; and

Whereas, new federal Department of Labor regulations regarding Association Health Plans allow for states to provide greater opportunities for small businesses and self-employed individuals to access health benefit plans, while still providing health insurance consumers with the coverage protections established by the foregoing legislation and other provisions of federal law; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. MORE OPPORTUNITIES FOR SMALL EMPLOYERS AND SOLE PROPRIETORS TO ACCESS SELF-INSURED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS/ASSOCIATION HEALTH PLANS.

SECTION 1.(a) G.S. 58-49-40(a) reads as rewritten:
"(a) To qualify for licensure as a MEWA, a MEWA must meet all of the following requirements:

(1) Be a nonprofit.

(2) Established by a trade association, industry association, or professional association of employers or professionals established by a group of employers under an association that (i) has a constitution or bylaws and that bylaws, (ii) has been organized and maintained in good faith for a continuous period of five years for purposes other than that of obtaining or providing insurance, at least two years, and (iii) has at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees.

(3) Operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the MEWA and that is responsible for all

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operations of the MEWA. Except as provided in this subdivision, the trustees
must be owners, partners, officers, directors, or employees of one or more
employers in the MEWA. With the Commissioner's approval, a person who is
not such an owner, partner, officer, director, or employee may serve as a
trustee if that person possesses the expertise required for such service. A
trustee may not be an owner, officer or employee of the administrator or
service company of the MEWA. The trustees have the authority to approve
applications of association members for participation in the MEWA and to
contract with an authorized administrator or service company to administer
the operations of the MEWA.

(4) Neither be neither offered nor advertised to the public generally;

(5) Operated Be operated in accordance with sound actuarial principles.

(6) Have a commonality of interest as described in subsection (h) of this section.

(7) Have at least 500 covered lives.

SECTION 1.(b) G.S. 58-49-40 is amended by adding two new subsections to read:

"(h) A MEWA will be treated as having a commonality of interest if either of the following
is true:

(1) It is established by a group of employers under an association in the same
trade, industry, line of business, or profession.

(2) It is established by employers under an association in the same region or
metropolitan area, provided that region or area is contiguous to the State and
includes the State.

(i) For purposes of this section, a newly created association shall be deemed to have been
organized and maintained for as long as its newest constituent association has been in existence."

SECTION 1.(c) G.S. 58-49-30 is amended by adding a new subsection to read:

"(f) As used in this section, the term "employer" shall include sole proprietors and
self-employed workers."

SECTION 1.(d) G.S. 58-49-50 is amended by adding a new subdivision to read:

"(10a) A copy of the most recent M-1 form as filed with the United States Department
of Labor."

PART II. REGULATIONS IMPACTING FULLY INSURED ASSOCIATION HEALTH
PLANS.

SECTION 2.(a) G.S. 58-51-80(b)(1) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health
insurance shall be delivered or issued for delivery in this State unless the group of persons thereby
insured by the policy or contract conforms to the requirements of the following subdivisions all
of the following requirements:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund
established by an employer or two or more employers in the same industry or
kind of business, or by a principal or two or more principals in the same
industry or kind of business, which employer, principal, or trustee shall be
deemed the policyholder, covering, except as hereinafter provided, only
employees, or agents, of any class or classes thereof determined by conditions
pertaining to employment, or agency, for amounts of insurance based upon
some plan which will preclude individual selection. The premium may be paid
by the employer, by the employer and the employees jointly, or by the
employee; and where the relationship of principal and agent exists, the
premium may be paid by the principal, by the principal and agents, jointly, or
by the agents. If the premium is paid by the employer and the employees
jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis. For the purposes of this subdivision, the term "employer" includes a multiple employer welfare arrangement that has at least 500 covered lives and is classified by the United States Department of Labor as a bona fide group or association under at least one of the following:

2. Any United States Department of Labor advisory opinion addressing circumstances in which the United States Department of Labor will consider a person as able to act directly or indirectly in the interest of direct employers in sponsoring an employee welfare benefit plan."

SECTION 2.(b) G.S. 58-51-80(b)(1a) reads as rewritten:

"(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy committees. For purposes of this section, a newly created association shall be deemed to have been organized and maintained for as long as its newest constituent association has been in existence. Any policy issued is subject to the following requirements:

...."

SECTION 2.(c) G.S. 58-68-25(a) reads as rewritten:

"§ 58-68-25. Definitions; excepted benefits; employer size rule.

(a) Definitions. – In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

(1) "Bona fide association" means an association.

– With respect to health insurance coverage offered in this State, an association that meets all of the following requirements:

a. Has been actively in existence for at least five years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee).

d. Makes health insurance coverage offered through the association available to all members and individuals eligible for coverage through a member regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member)."

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e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

f. Meets the additional requirements as may be imposed under State law.

(2) “COBRA continuation provision” – Any of the following:

a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.


c. Requirements for certain group health plans for certain State and local employees under Title XXII of the Public Health Service Act (42 U.S.C.S. § 300bb, et seq.) as requirements for certain group health plans for certain State and local employees, Act.

d. Article 53 of this Chapter or the Chapter.

e. The health insurance continuation law of another state.

(3) "Employee" – The meaning given the term under As defined in section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) "Employer" – The meaning given the term under As defined in section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of two or more employees, 1974.

(4a) "Group health insurance coverage" – Health insurance coverage offered in connection with a group health plan.

(4b) "Group health plan" – The meaning given the term under As defined in 45 C.F.R. § 146.145(a).

(4c) "Group market." – The market for health insurance coverage offered in connection with a group health plan.

(5) "Health insurance coverage" or "coverage" or "health insurance plan" or "plan" – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

(6) "Health insurer" – An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that offers and issues health insurance coverage.

(7) "Health status-related factor" – Any of the factors described in G.S. 58-68-35(a)(1).

(8) "Individual health insurance coverage" – Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.

(9) "Individual market" – The market for health insurance coverage offered to individuals.

(10) "Large employer" – An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees one employee on the first day of the health insurance plan year.
"Large group market" – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.

"Medical care" – Amounts paid for any of the following:
   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. Amounts paid for transportation primarily for and essential to medical care referred to in subdivision a. of this subdivision.
   c. Amounts paid for insurance covering medical care referred to in subdivisions a. and b. of this subdivision.

"Network plan" – Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.


"Placed for adoption" – The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.


"Small group market" – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer.

PART III. ALLOW MORE SMALL EMPLOYERS TO PURCHASE STOP-LOSS COVERAGE.

SECTION 3. G.S. 58-50-130(a)(5) reads as rewritten:

"(5) No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than 26-12 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:
   a. Provides direct coverage of health expenses payable to an individual.
   b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012."
c. Has an annual aggregate attachment point lower than the greater of
one of the following:
  1. One hundred twenty percent (120%) of expected claims.
  2. Twenty thousand dollars ($20,000) for plan years beginning in
     2013. For subsequent policy years, the amount shall be indexed
     using the Consumer Price Index for Medical Services for All
     Urban Consumers for the South Region and shall be rounded
     to the nearest whole thousand dollars. The index factor shall be
     the index as of July of the year preceding the change divided
     by the index as of July 2012.

   Nothing in this subsection prohibits an insurer from providing
   additional incentives to small employers with benefits
   promoting a medical home or benefits that provide health care
   screenings, are focused on outcomes and key performance
   indicators, or are reimbursed on an outcomes basis rather than
   a fee-for-service basis."

PART IV. EFFECTIVE DATE

SECTION 4. This act is effective October 1, 2019, and applies to contracts entered
into, amended, or renewed on or after that date, and to licenses issued or renewed on or after that
date.