

**§ 58-67-50. Evidence of coverage and premiums for health care services.**

- (a) (1) Every enrollee residing in this State is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a hospital or medical service corporation, whether by option or otherwise, the insurer or the hospital or medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.
- (2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Commissioner.
- (3) An evidence of coverage shall contain:
- a. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in G.S. 58-67-65(a); and
  - b. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate of:
    1. The health care services and insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;
    2. Any limitations on the services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;
    3. Where and in what manner information is available as to how services may be obtained;
    4. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;
    5. A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints;
    6. A description of the reasons, if any, for which an enrollee's enrollment may be terminated for cause, which reasons may include behavior that seriously impairs the health maintenance organization's ability to provide services or an inability to establish and maintain a satisfactory physician-patient relationship after reasonable efforts to do so have been made.
- Any subsequent change may be evidenced in a separate document issued to the enrollee.
- (4) A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of subsection (b) unless it is subject to the jurisdiction of the Commissioner under the laws governing health insurance or hospital or medical service corporations in which event the filing and approval

provisions of such laws shall apply. To the extent, however, that such provisions do not apply the requirements in subsection (c) shall be applicable.

- (b) (1) Premium approval. – No schedule of premiums for coverage for health care services, or any amendment to the schedule, shall be used in conjunction with any health care plan until a copy of the schedule or amendment has been filed with and approved by the Commissioner.
- (2) Individual coverage. – Premiums shall be established in accordance with actuarial principles for various categories of enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any premium revisions for nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 months. As an alternative to giving this guarantee for nongroup enrollee coverage, the premium or premium revisions may be made applicable to all similar categories of enrollee coverage at one time if the health maintenance organization chooses to apply for the premium revision with respect to the categories of coverages no more frequently than once in any 12-month period. The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the HMO has given written notice of the premium revision to the enrollee 45 days before the effective date of the revision. The enrollee must then pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision. In adopting the rules under this subsection, the Commissioner may require identification of the types of rating methodologies used by filers and may also address standards for data in HMO rate filings for initial filings, filings by recently licensed HMOs, and rate revision filings; data requirements for service area expansion requests; policy reserves used in rating; incurred loss ratio standards; and other recognized actuarial principles of the NAIC, the American Academy of Actuaries, and the Society of Actuaries.
- (3) Group coverage. – Employer group premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate, or unfairly discriminatory, and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any revisions to the premiums for employer group coverage shall be guaranteed for a period of not less than 12 months. No premium revision shall become effective for any category of group coverage unless the HMO has given written notice of the premium revision to the master group contract holder upon receipt of the group's finalized benefits or 45 days before the effective date of the revision, whichever is earlier. The

master group contract holder thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision.

(c) The Commissioner shall, within a reasonable period, approve any form if the requirements of subsection (a) of this section are met and any schedule of premiums if the requirements of subsection (b) of this section are met. It shall be unlawful to issue the form or to use the schedule of premiums until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing for forms and within 45 days after the filing for premiums, they shall be deemed to be approved.

(d) The Commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(e) Every health maintenance organization shall provide at least minimum cost and utilization information for group contracts of 100 or more subscribers on an annual basis when requested by the group. Such information shall be compiled in accordance with the Data Collection Form developed by the Standardized HMO Data Form Task Force as endorsed by the Washington Business Group on Health and the Group Health Association of America on November 19, 1986, and any subsequent amendments. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1987, c. 631, s. 9; 1989, c. 485, s. 59; 1991, c. 195, s. 1; c. 644, s. 13; c. 720, s. 36; 1995, c. 193, s. 59; 1997-474, s. 3; 1997-519, s. 1.3; 2001-334, ss. 8.1, 17.4; 2001-487, ss. 106(a), 106(b); 2008-124, s. 5.3; 2009-173, s. 1.)