GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

H **3**

HOUSE BILL 985*
Committee Substitute Favorable 5/8/89
Committee Substitute #2 Favorable 8/8/89

Short Title: N.C. Health Insurance Pool. (Public)

Sponsors:

Referred to:

April 3, 1989

A BILL TO BE ENTITLED

AN ACT TO CREATE THE NORTH CAROLINA HEALTH INSURANCE POOL.

The General Assembly of North Carolina enacts:

Section 1. Chapter 58 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 51.

"NORTH CAROLINA HEALTH INSURANCE POOL.

"§ 58-790. Purpose.

The purpose of this Article is to establish a mechanism through which adequate levels of health insurance coverages can be made available to residents of this State who are otherwise unable to obtain such coverage because of their health.

"§ 58-791. Definitions.

As used in this Article:

(1) 'Benefits plan' means the coverages to be offered by the Pool to eligible persons pursuant to G.S. 58-796.

(2) 'Board' means the Board of Directors of the Pool.

(3) 'Health insurance' means a hospital and medical expense-incurred policy, nonprofit hospital or medical service corporation contract, and health maintenance organization subscriber contract. The term does not include short term, accident, or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment

insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) 'Health maintenance organization' means any person who undertakes to provide or arrange for one or more health plans and is regulated by Chapter 57B of the General Statutes.

(5) 'Insurance arrangement' means any plan, program, contract, or any other arrangement under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

(6) 'Insured' means any individual resident of this State who is eligible to receive benefits from any insurer or insurance arrangement as defined in this section.

(7) 'Insurer' means any insurance company licensed to write health insurance in this State; any hospital, medical, or dental service corporation formed under Chapter 57 of the General Statutes; health maintenance organizations formed under Chapter 57B of the General Statutes; and all other health benefit providers not regulated by any other State or federal agency.

(8) 'Medicare' means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. §1395 **et seq.**, as amended.

(9) 'Member' means each insurer and insurance arrangement participating in the Pool.

(10) 'Plan' means the plan of operation of the Pool, including articles, bylaws, and operating rules, adopted by the Board pursuant to G.S. 58-793.

(11) 'Pool' means the North Carolina Health Insurance Pool created in G.S. 58-792.

"**§ 58-792. Creation and operation of the Pool.**

(a) There is created a nonprofit entity to be known as the North Carolina Health Insurance Pool. All insurers issuing health insurance in this State and all insurance arrangements providing health plan benefits in this State on and after January 1, 1990, shall be members of the Pool, except as otherwise provided for in this Article. The Pool shall be governed by the Board.

(b) The Commissioner shall, within 90 days after January 1, 1990, give notice to all insurers and insurance arrangements of the time and place for the initial organizational meetings of the Board. The Commissioner shall appoint the Board members, all of whom shall serve at the pleasure of the Commissioner. The Board shall at all times, to the extent possible, include representatives from at least one domestic and one foreign insurance company licensed to write health insurance in this State; one domestic nonprofit hospital, medical, or dental service plan; one health maintenance organization; one third party administrator; one licensed health insurance agent; the

Commissioner; and one member of the general public who is not associated with the medical profession, a hospital, or an insurer.

(c) The Board shall submit to the Commissioner a Plan for the Pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Pool. The Commissioner shall, after notice and hearing, approve the Plan; provided such is determined to be suitable to assure the fair, reasonable, and equitable administration of the Pool, and provides for the sharing of Pool gains or losses on an equitable, proportionate basis. The Plan shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Article must be made available. If the Board fails to submit a Plan within 190 days after its creation, or at any time thereafter fails to submit suitable amendments to the Plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Article. Such rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Board and approved by the Commissioner.

(d) In its Plan the Board shall:

(1) Establish procedures for the handling and accounting of assets and monies of the Pool;

(2) Establish procedures for the determination of needed funding to provide for claims to be paid under the Plan, administrative expenses, and needed reserves.

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

(e) The Board and Pool shall have the general powers and authority granted under the laws of this State to insurance companies licensed to transact the health insurance and the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Article; including the authority, with the approval of the Commissioner, to enter into contracts with similar pools 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 for recovery of any assessments for, on behalf of, or against Pool members.

(3) Take such legal action as necessary to avoid the payment of improper claims against the Pool or the coverage provided by or through the Pool.

(4) Establish 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 shall not be unreasonable in relation to the coverage provided, the risk

experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate approved risk factors.

(5) Assess members of the Pool in accordance with the provisions of this Article; and make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.

(6) Issue policies of health insurance in accordance with the requirements of this Article.

(7) Appoint from among Pool members 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 authority of the Pool.

"**§ 58-793. Eligibility.**

(a) Any individual who is a resident of this State is eligible for Pool coverage if:

(1) Such individual has proof of rejection by at least one insurer of coverage at levels and rates no less favorable than those provided in this Article; or

(2) Such individual is a member of an employer group of 25 individuals or less and the individual has proof of rejection of the group by at least one insurer of coverage at prevailing rates for such group.

(b) The following individuals are not eligible for Pool coverage:

(1) Persons who have on the date of issue of coverage by the Pool, coverage under health insurance or an insurance arrangement;

(2) Any person who, is at the time of Pool application, eligible for health care benefits under State Medicaid law;

(3) Any person who has terminated coverage in the Pool unless 12 months have lapsed since such termination;

(4) Any person on whose behalf the Pool has paid out one million dollars ($1,000,000) in benefits;

(5) Inmates of public institutions and persons eligible for public programs.

(c) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for continuation or conversion may apply for coverage in the Pool. If such coverage is applied for within 45 days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

(d) Any individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

"**§ 58-794. Administrator.**

(a) The Board shall, subject to the approval of the Commissioner, select an insurer or insurers through a competitive bidding process to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board, which shall include:

(1) The insurer's proven ability to handle individual accident and health insurance;
(2) The efficiency of the insurer's claim paying procedures;
(3) An estimate of total charges for administering the Plan; and
(4) The insurer's ability to administer the Pool in a cost-efficient manner.

(b) The administrator shall serve for a period of three years subject to removal for cause.

(c) At least one year prior to the expiration of each three-year period of service by an administrator, the Board shall invite all insurers, including the current administrator, to submit bids to serve as the administrator for the succeeding three-year period. Selection of the administrator for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(d) The administrator shall perform all eligibility and administrative claims payment functions relating to the Pool.

(e) The administrator shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the Board.

(f) The administrator shall perform all necessary functions to assure timely payment of benefits to covered persons under the Pool including:

(1) Making available information relating to the proper manner of submitting a claim for benefits to the Pool and distributing forms upon which submittal shall be made;
(2) Evaluating the eligibility of each claim for payment by the Pool.

(g) The administrator shall submit regular reports to the Board and to the Commissioner regarding the operation of the Pool. The frequency, content, and form of the report shall be determined by the Commissioner.

(h) Following the close of each fiscal 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.

(i) The administrator shall be paid as provided in the Plan for its expenses incurred in the performance of its services.

"**§ 58-795. Assessments and funding.**

(a) Following the close of each fiscal year, the administrator shall determine the net premiums (premiums less reasonable administrative expense allowances), the Pool expenses of administration, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the Board to justify the cost of collection shall not be considered for purposes of determining assessments.

(b) Each insurer's assessment shall be determined by multiplying the total cost of Pool operation by a fraction, the numerator of which equals that insurer's premium or subscriber contract charges for health insurance written in the State during the preceding calendar year; and the denominator of which equals the total of all premiums, subscriber

contract charges written in the State, and one hundred ten percent (110%) of all claims paid by insurance arrangements in the State during the preceding calendar year.

(c) Each insurance arrangement's assessment shall be determined by multiplying the total cost of Pool operation by a fraction, the numerator of which equals one hundred ten percent (110%) of the benefits paid by that insurance arrangement on behalf of insureds in this State during the preceding calendar year; and the denominator of which equals the total of all premiums, subscriber contract charges, and one hundred ten percent (110%) of all benefits paid by insurance arrangements made on behalf of insureds in this State during the preceding calendar year. Insurance arrangements shall report to the Board claims payments made in this State on an annual basis on a form prescribed by the Commissioner.

(d) If assessments and appropriations exceed actual losses and administrative expenses of the Pool, the excess shall be held at interest and used by the Board to offset future losses or to reduce Pool premiums. As used in this subsection, 'future losses' includes reserves for incurred but not reported claims.

(e) Each member's proportion of participation in the Pool shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed by the member with the Board.

(f) One-half of any deficit incurred by the Pool shall be recouped by assessments apportioned under subsection (a) of this section by the Board among members and one-half of said deficit shall be funded by appropriations from the General Fund.

(g) The Board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the Board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (a) of this section. The member receiving such abatement or deferment shall remain liable to the Pool for the deficiency for four years.

(h) Every insurer or any health benefit provider not regulated by any other state or federal agency shall share in the gains or losses of the Pool, but may avoid Pool liability by offering in a publicized fashion for at least one month each year comparable coverage at a rate or price no less favorable and qualifications no more restrictive than provided by G.S. 58-796.

(i) Based upon the determination made by the Board of needed funding to provide for claims to be paid under the Plan, administrative expenses, and needed reserves, the Board shall annually file a report with the Chairpersons of the House and Senate Appropriations Committees and with the Commissioner, recommending appropriations needed to fund one-half of the deficit of the Pool.

"**§ 58-796. Minimum benefits; availability.**

(a) The Pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the Pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under subsection (f) of this section, up to a lifetime

limit of one million dollars ($1,000,000) per covered individual. The maximum limit under this section shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

(b) Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the Pool to be medically necessary:

(1) Hospital services;

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician, or by other licensed professionals at his direction;

(3) Drugs and medical supplies requiring a physician's prescription;

(4) Services of a licensed skilled nursing facility for not more than 120 days during a policy year;

(5) Services of a home health agency up to a maximum of 270 services per year;

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetic;

(9) Prostheses other than dental;

(10) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which it is prescribed;

(11) Diagnostic X rays and laboratory tests;

(12) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) Services of a physical therapist;

(14) Transportation provided by a licensed ambulance or emergency medical or rescue service to the nearest facility qualified to treat the condition;

(15) Services for diagnosis and treatment of mental and nervous disorders; provided that an insured shall be required to make a fifty percent (50%) copayment, and that the payment by the Pool shall not exceed four thousand dollars ($4,000) for outpatient psychiatric treatment.

(c) Covered expenses do not include the following:

(1) Any charge for treatment for cosmetic purposes other than surgery for treatment for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;

(2) Care that is primarily for custodial or domiciliary purposes;

(3) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;

(4) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care provider that exceeds the prevailing charge in the locality or for any charge not medically necessary;

(5) Any charge for services or articles, the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(6) Any expense incurred prior to the effective date of coverage by the Pool for the person on whose behalf the expense is incurred;

(7) Dental care except as provided in subdivision (b)(12) of this section;

(8) Eyeglasses and hearing aids;

(9) Illness or injury due to acts of war;

(10) Services of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible person each policy year;

(11) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(d) Premiums charged for coverages issued by the Pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(e) The Board shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the State comparable to the Pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for Pool coverage shall not be more than one hundred fifty percent (150%) of rates established as applicable for individual standard risks. 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 section. In no event shall Pool rates exceed one hundred seventy-five percent (175%) of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

(f) The Pool coverage defined in this section shall provide a choice of deductibles of either five hundred dollars ($500.00), one thousand dollars ($1,000), or any other amount determined by the Board, per annum per individual; and coinsurance of twenty percent (20%), such coinsurance and deductibles in the aggregate not to exceed three thousand five hundred dollars ($3,500) per individual nor five thousand dollars ($5,000) per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index, with the Commissioner's approval.

(g) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition, which during the six-month period immediately preceding the effective date of coverage, (i) has manifested itself in such a manner as would cause an ordinarily prudent person to seek

diagnosis, care, or treatment; or (ii) for which medical advice, care, or treatment was recommended or received. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated; provided, that application for Pool coverage is made not later than 45 days following such involuntary termination and, in such case, coverage in the Pool shall be effective from the date on which such prior coverage was terminated.

(h) Benefits otherwise payable under Pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, 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 nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program except Medicaid.

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

"**§ 58-797. Collective action.**

Neither the participation in the Pool as members, the establishment of rates, forms, or procedures; nor any other joint or collective action required by this Article shall be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its members.

"**§ 58-798. Plan notice.**

On and after the date that the Pool becomes operational, every insurer licensed in this State shall include a notice of the existence of the Pool in any rejection of any application for health insurance coverage, which rejection was made for reasons of the health of the applicant.

"**§ 58-799. Taxation.**

The Pool is exempt from all taxes except taxes imposed by Article 5 of Chapter 105 of the General Statutes and ad valorem taxes upon real property and personal property owned in this State."

Sec. 2. In the event any provision of this act is held to be invalid by any court of competent jurisdiction, the court's holding as to that provision shall not affect the validity or operation of other provisions of this act; and to that end the provisions of this act are severable.

Sec. 3. This act shall become effective January 1, 1990.