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Short Title: Small Employer Group Health Reform.

(Public)

Sponsors:

Referred to:

April 19, 1991

A BILL TO BE ENTITLED

AN ACT TO REFORM THE SMALL EMPLOYER GROUP ACCIDENT AND HEALTH INSURANCE MARKETPLACE IN THE STATE OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Section 1. Article 50 of Chapter 58 of the General Statutes is amended by adding the following sections to read:

§ 58-50-100. Title and reference.

This section and G.S. 58-50-105 through G.S. 58-50-150 are known and may be cited as the North Carolina Small Employer Group Health Coverage Reform Act, referred to in those sections as 'this Act'.

§ 58-50-105. Purpose and intent.

The purpose and intent of this Act is to promote the availability of accident and health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group accident and health insurance marketplace.

§ 58-50-110. Definitions.

As used in this Act:

- (1) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the

- 1 provisions of G.S. 58-50-130, based upon the person's examination,
2 including a review of the appropriate records and of the actuarial
3 assumptions and methods used by the small employer carrier in
4 establishing premium rates for applicable health benefit plans.
- 5 (2) 'Base premium rate' means for each class of business as to a rating
6 period, the lowest premium rate charged or that could have been
7 charged under a rating system for that class of business, by the small
8 employer carrier to small employers with similar case characteristics
9 for health benefit plans with the same or similar coverage.
- 10 (3) 'Basic health care plan' means a health care plan for small employers
11 that is lower in cost than a standard health care plan and is required to
12 be offered by all small employer carriers pursuant to G.S. 58-50-125
13 and approved by the Commissioner in accordance with G.S. 58-50-
14 125.
- 15 (4) 'Board' means the board of directors of the Pool.
- 16 (5) 'Carrier' means any person that provides one or more health benefit
17 plans in this State, including a licensed insurance company, a prepaid
18 hospital or medical service plan, a health maintenance organization
19 (HMO), and a multiple employer welfare arrangement.
- 20 (6) 'Case characteristics' means demographic or other objective
21 characteristics of a small employer, as determined by a small employer
22 carrier, that are considered by the small employer carrier in the
23 determination of premium rates for the small employer; but does not
24 mean claim experience, health status, and duration of coverage since
25 issue.
- 26 (7) 'Class of business' means all or a distinct grouping of small employers
27 as shown on the records of a small employer carrier.
- 28 (8) 'Committee' means the Small Employer Carrier Committee as created
29 by G.S. 58-50-120.
- 30 (9) 'Dependent' means the spouse or child of an eligible employee, subject
31 to applicable terms of the health care plan covering the employee.
- 32 (10) 'Eligible employee' means an employee who works for a small
33 employer on a full-time basis, with a normal work week of 30 or more
34 hours, including a sole proprietor, a partner or a partnership, or an
35 independent contractor, if included as an employee under a health care
36 plan of a small employer; but does not include employees who work
37 on a part-time, temporary, or substitute basis.
- 38 (11) 'Health benefit plan' means any accident and health insurance policy or
39 certificate; nonprofit hospital or medical service corporation contract;
40 health, hospital, or medical service corporation plan contract; HMO
41 subscriber contract plan provided by a MEWA or plan provided by
42 another benefit arrangement, to the extent permitted by ERISA, subject
43 to G.S. 58-50-115. Health benefit plan does not mean accident only,
44 credit, or disability insurance; coverage of Medicare services pursuant

1 to contracts with the United States government; Medicare supplement
2 or long-term care insurance; dental only or vision only insurance;
3 coverage issued as a supplement to liability insurance; insurance
4 arising out of a workers' compensation or similar law; automobile
5 medical payment insurance; or insurance under which benefits are
6 payable with or without regard to fault and that is statutorily required
7 to be contained in any liability insurance policy or equivalent self-
8 insurance.

9 (12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-
10 20(6) or G.S. 58-62-16(8).

11 (13) 'Index rate' means, for each class of business as to a rating period for
12 small employers with similar case characteristics, the arithmetic
13 average of the applicable base premium rate and the corresponding
14 highest premium rate.

15 (14) 'Late enrollee' means an eligible employee or dependent who requests
16 enrollment in a health benefit plan of a small employer following the
17 initial enrollment period provided under the terms of the health benefit
18 plan; provided that the initial enrollment period shall be a period of at
19 least 30 days. However, an eligible employee or dependent shall not
20 be considered a late enrollee if:

21 a. The individual:

22 1. Was covered under another employer health benefit plan
23 at the time the individual was eligible to enroll;

24 2. Stated, at the time of the initial enrollment, that coverage
25 under another employer health benefit plan was the
26 reason for declining enrollment;

27 3. Has lost coverage under another employer health benefit
28 plan as a result of termination of employment, the
29 termination of the other plan's coverage, death of a
30 spouse, or divorce; and

31 4. Requests enrollment within 30 days after termination of
32 coverage provided under another employer health benefit
33 plan;

34 b. The individual is employed by an employer that offers multiple
35 health benefit plans and the individual elects a different plan
36 during an open enrollment period; or

37 c. A court has ordered coverage be provided for a spouse or minor
38 child under a covered employee's health benefit plan and
39 request for enrollment is made within 30 days after issuance of
40 such court order.

41 (15) 'New business premium rate' means, for each class of business as to a
42 rating period, the lowest premium rate charged, offered, or that could
43 have been charged by a small employer carrier to small employers

- 1 with similar case characteristics for newly issued health benefit plans
2 with the same or similar coverage.
- 3 (16) 'Pool' means the North Carolina Small Employer Health Reinsurance
4 Pool created in G.S. 58-50-150.
- 5 (17) 'Preexisting-conditions provision' means a policy provision that limits
6 or excludes coverage for charges or expenses incurred during a
7 specified period following the insured's effective date of coverage, for
8 a condition that, during a specified period immediately preceding the
9 effective date of coverage, had manifested itself in such a manner as
10 would cause an ordinary prudent person to seek diagnosis, care, or
11 treatment, or for which medical advice, diagnosis, care, or treatment
12 was recommended or received as to that condition or as to pregnancy
13 existing on the effective date of coverage.
- 14 (18) 'Premium' includes insurance premiums or other fees charged for a
15 health benefit plan, including the costs of benefits paid or
16 reimbursements made to or on behalf of persons covered by the plan.
- 17 (19) 'Rating period' means the calendar period for which premium rates
18 established by a small employer carrier are assumed to be in effect, as
19 determined by the small employer carrier.
- 20 (20) 'Risk-assuming carrier' means a small employer carrier electing to
21 comply with the requirements set forth in G.S. 58-50-140.
- 22 (21) 'Reinsuring carrier' means a small employer carrier electing to comply
23 with the requirements set forth in G.S. 58-50-145.
- 24 (22) 'Small employer' means any person actively engaged in business that,
25 on at least fifty percent (50%) of its working days during the preceding
26 year, employed no more than 25 eligible employees and not less than
27 three eligible employees, the majority of whom are employed within
28 this State. Small employer includes companies that are affiliated
29 companies, as defined in G.S. 58-19-5(1) or that are eligible to file a
30 combined tax return under Chapter 105 of the General Statutes or
31 under the Internal Revenue Code. Except as otherwise provided, the
32 provisions of this Act that apply to a small employer shall continue to
33 apply until the plan anniversary following the date the employer no
34 longer meets the requirements of this section.
- 35 (23) 'Small employer carrier' means any carrier that offers health benefit
36 plans covering eligible employees of one or more small employers.
- 37 (24) 'Standard health care plan' means a health care plan for small
38 employers required to be offered by all small employer carriers
39 pursuant to G.S. 58-50-125 and approved by the Commissioner in
40 accordance with G.S. 58-50-125.

41 **"§ 58-50-112. Affiliated companies; HMOs.**

42 For the purposes of this Act, companies that are affiliated companies or that are
43 eligible to file a consolidated tax return shall be treated as one carrier except that any
44 insurance company, hospital service plan, or medical service plan that is an affiliate of

1 an HMO located in North Carolina or any HMO located in North Carolina that is an
2 affiliate of an insurance company, a health service corporation, or a medical service
3 corporation may treat the HMO as a separate carrier and each HMO that operates only
4 one HMO in a service area of North Carolina may be considered a separate carrier.

5 **"§ 58-50-113. Distinct groupings.**

6 (a) A distinct grouping may only be established by a small employer carrier on
7 the basis that the applicable health benefit plans:

8 (1) Are marketed and sold through individuals and organizations that are
9 not participating in the marketing or sale of other distinct groupings of
10 small employers for the small employer carrier;

11 (2) Have been acquired from another small employer carrier as a distinct
12 grouping of plans; or

13 (3) Are provided through an association with membership of not less than
14 10 small employers that has been formed for purposes other than
15 obtaining insurance.

16 (b) A small employer carrier may establish no more than two additional
17 groupings under subdivision (a)(1), (2), or (3) of this section on the basis of
18 underwriting criteria that are expected to produce substantial variation in the health care
19 costs.

20 (c) The Commissioner may approve the establishment of additional distinct
21 groupings upon application to him and his determination that such action would
22 enhance the efficiency and fairness of the small employer marketplace.

23 **"§ 58-50-115. Health benefit plans subject to Act.**

24 (a) A health benefit plan is subject to this Act if it provides health benefits for
25 small employers and if either of the following conditions are met:

26 (1) Any portion of the premiums or benefits is paid by a small employer or
27 any covered individual is reimbursed, whether through wage
28 adjustments or otherwise, by a small employer for any portion of the
29 premium; or for which the small employer has permitted payroll
30 deduction for the covered individual, whether or not such coverage is
31 issued through a group or individual policy of insurance, and whether
32 or not any portion of the premium is paid by the small employer.

33 (2) The health benefit plan is treated by the employer or any of the
34 covered individuals as part of a plan or program for the purpose of
35 section 162 or section 106 of the Internal Revenue Code.

36 (b) The provisions of G.S. 58-51-95(f) do not apply to individual accident and
37 health insurance policies or contracts to the extent subject to the provisions of this Act.

38 **"§ 58-50-120. Small Employer Carrier Committee.**

39 (a) The Commissioner shall appoint the Small Employer Carrier Committee with
40 fair representation of (i) risk-assuming carriers and reinsuring carriers; (ii) the insurance
41 agent and small employer communities; and (iii) consumers who are served by plans
42 covered by this act. Two-thirds of the Committee shall be appointed from among
43 representatives of small employer carriers.

1 (b) Subject to approval by the Commissioner, the Committee shall recommend
2 the form and level of coverages to be made available by small employer carriers in
3 accordance with the provisions of G.S. 58-50-125(a). The Committee shall recommend
4 benefit levels, cost-sharing factors, exclusions, and limitations for the basic and standard
5 health care plans. One basic health care plan and one standard health care plan shall
6 contain benefit and cost-sharing levels that are consistent with the basic method of
7 operation and the benefit plans of HMOs, including any restrictions imposed by federal
8 law. The Committee shall submit the plans to the Commissioner for his approval within
9 180 days after the appointment of the Committee pursuant to this section; and the plans
10 shall be deemed to be approved unless expressly disapproved by the Commissioner
11 during such 180-day period. Such plans may include cost containment features such as:
12 utilization review of health care services, including review of medical necessity of
13 hospital and physician services; case management benefit alternatives; selective
14 contracting with hospitals, physicians, and other health care providers; reasonable
15 benefit differentials applicable to participating and nonparticipating providers; and other
16 managed care provisions.

17 (c) In order to assure the broadest availability of health benefit plans to small
18 employers, the Committee shall recommend for approval by the Commissioner market
19 conduct and other requirements for carriers, agents, brokers, and third-party
20 administrators, including requirements developed as a result of a request by the
21 Commissioner, relating to the following:

- 22 (1) Registration by each carrier with the Department of its intention to be
23 a small employer carrier under this Act.
- 24 (2) Publication by the Department, the Committee, or the Pool of a list of
25 all small employer carriers, including a potential requirement
26 applicable to agents, brokers, third-party administrators, and carriers
27 that no health benefit plan may be sold to a small employer by a carrier
28 not so identified as a small employer carrier.
- 29 (3) The availability of a broadly publicized toll-free telephone number for
30 access by small employers to information concerning this Act.
- 31 (4) To the extent deemed to be necessary by the Committee to assure the
32 fair distribution of high-risk individuals and groups among carriers,
33 periodic reports by carriers, agents, brokers, and third-party
34 administrators about health benefit plans issued; provided that
35 reporting requirements shall be limited to information concerning case
36 characteristics and numbers of health benefit plans in various
37 categories marketed or issued to small employers.
- 38 (5) Registration by agents, brokers, and third-party administrators of their
39 intention to be such for health benefit plans marketed to small
40 employers under this Act.
- 41 (6) Methods concerning periodic demonstration by small employer
42 carriers, agents, brokers, and third-party administrators that they are
43 marketing and issuing health benefit plans to small employers in
44 fulfillment of the purposes of this Act.

1 (7) Establishing standards for those conditions under which a carrier
2 would not be required to write business received from a particular
3 agent or broker.

4 (d) Within three years after January 1, 1992, the Committee shall conduct a study
5 of the effectiveness of the provisions of this Act, recommend further improvements to
6 achieve greater stability, accessibility, and affordability in the small employer
7 marketplace, and submit it to the Commissioner.

8 **"§ 58-50-125. Health care plans; formation; approval; offerings.**

9 (a) In order to improve the availability and affordability of health benefits
10 coverage for small employers, the Committee shall recommend to the Commissioner
11 two plans of coverage, one of which shall be a basic health care plan and the second of
12 which shall be a standard health care plan. Each plan of coverage shall be in two forms,
13 one of which shall be in the form of insurance and the second of which shall be
14 consistent with the basic method of operation and benefit plans of HMOs, including
15 federally qualified HMOs. The Committee shall submit the recommended plans to the
16 Commissioner for approval within 180 days after the appointment of the Committee
17 pursuant to G.S. 58-50-150. The Committee shall take into consideration the levels of
18 health benefit plans provided in North Carolina, and appropriate medical and economic
19 factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. Such
20 plans may include cost containment features such as, but not limited to: preferred
21 provider provisions; utilization review of medical necessity of hospital and physician
22 services; case management benefit alternatives; or other managed care provisions.

23 (b) After the Commissioner's approval of the plans submitted by the Committee
24 pursuant to subsection (a) of this section and in lieu of any contrary procedure
25 established by this Chapter, any small employer carrier may certify to the
26 Commissioner, in the form and manner prescribed by the Commissioner, that the basic
27 and standard health care plans filed by the carrier are in substantial compliance with the
28 provisions of the corresponding approved Committee plans. Upon receipt by the
29 Commissioner of the certification, the carrier may use the certified plans unless their use
30 is disapproved by the Commissioner.

31 (c) The plans developed under this section are not required to provide coverage
32 that meets the requirements of other provisions of this Chapter that mandate either
33 coverage or the offer of coverage by the type or level of health care services or health
34 care provider.

35 (d) Within 180 days after the Commissioner's approval under subsection (b) of
36 this section, every small employer carrier shall, as a condition of transacting business in
37 this State, offer small employers at least one basic and one standard health care plan.
38 Every small employer that elects to be covered under such a plan and agrees to make the
39 required premium payments and to satisfy the other provisions of the plan shall be
40 issued such a plan by the small employer carrier. The premium payment requirements
41 utilized in connection with basic and standard health care plans may address the
42 potential credit risk of small employers that elect coverage in accordance with this
43 subsection by means of payment security provisions that are reasonably related to the
44 risk and are uniformly applied.

1 (e) No small employer carrier is required to offer coverage or accept applications
2 pursuant to subsection (d) of this section:

3 (1) From a group already covered under a health benefit plan except for
4 coverage that is to commence following the group's anniversary date,
5 but this subsection shall not be construed to prohibit a group from
6 seeking coverage or a small employer carrier from issuing coverage to
7 a group prior to its anniversary date; or

8 (2) If the Commissioner determines that acceptance of an application or
9 applications would result in the carrier being declared an impaired
10 insurer; or

11 (3) To groups of fewer than five eligible employees where the small
12 employer carrier does not utilize preexisting-conditions provisions in
13 all health benefit plans it issues to any small employers.

14 Should a small employer carrier who does not use preexisting conditions choose to
15 market to groups of less than five, then it shall immediately notify the Commissioner
16 and the Board, and it shall do so consistently and equally to all such small employer
17 groups.

18 (f) Every small employer carrier shall fairly market the basic and standard health
19 care plan to all small employers in the geographic areas in which the carrier makes
20 coverage available or provides benefits.

21 (g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is
22 required to offer coverage or accept applications pursuant to subsection (d) of this
23 section in the case of any of the following:

24 (1) To a group, where the group is not physically located in the HMO's
25 approved service areas;

26 (2) To an employee, where the employee does not reside within the
27 HMO's approved service areas;

28 (3) Within an area, where the HMO reasonably anticipates, and
29 demonstrates to the satisfaction of the Commissioner, that it will not
30 have the capacity within that area and its network of providers to
31 deliver services adequately to the enrollees of those groups because of
32 its obligations to existing group contract holders and enrollees.

33 An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may
34 not offer coverage in the applicable area to new employer groups with more than 25
35 eligible employees until the later of 90 days after that closure or the date on which the
36 carrier notifies the Commissioner that it has regained capacity to deliver services to
37 small employers.

38 (h) The provisions of subsections (b), (d), and (g) and subdivision (e)(2) of this
39 section apply to every health benefit plan delivered, issued for delivery, renewed, or
40 continued in this State or covering persons residing in this State on or after the date the
41 plan becomes operational, as determined by the Commissioner. For purposes of this
42 subsection, the date a health benefit plan is continued is the anniversary date of the
43 issuance of the health benefit plan.

44 **"§ 58-50-130. Required health care plan provisions.**

1 (a) Health benefit plans covering small employers are subject to the following
2 provisions:

3 (1) Except in the case of a late enrollee, any preexisting-conditions
4 provision may not limit or exclude coverage for a period beyond 12
5 months following the insured's effective date of coverage and may
6 only relate to conditions manifesting themselves in such a manner as
7 would cause an ordinarily prudent person to seek medical advice,
8 diagnosis, care, or treatment or for which medical advice, diagnosis,
9 care, or treatment was recommended or received during the 12 months
10 immediately preceding the effective date of coverage or as to a
11 pregnancy existing on the effective date of coverage.

12 (2) In determining whether a preexisting-conditions provision applies to
13 an eligible employee or to a dependent, all health benefit plans shall
14 credit the time the person was covered under a previous group health
15 benefit plan if the previous coverage was continuous to a date not
16 more than 30 days prior to the effective date of the new coverage,
17 exclusive of any applicable waiting period under such plan.

18 (3) The health benefit plan is renewable with respect to all eligible
19 employees or dependents at the option of the policyholder or contract
20 holder except:

21 a. For nonpayment of the required premiums by the policyholder
22 or contract holder;

23 b. For fraud or misrepresentation of the policyholder or contract
24 holder or, with respect to coverage of individual enrollees, the
25 enrollees or their representatives;

26 c. For noncompliance with plan provisions that have been
27 approved by the Commissioner;

28 d. When the number of enrollees covered under the plan is less
29 than the number of insureds or percentage of enrollees required
30 by participation requirements under the plan; or

31 e. When the policyholder or contract holder is no longer actively
32 engaged in the business in which it was engaged on the
33 effective date of the plan.

34 f. When the small employer carrier ceases to write new business
35 in the small employer market, provided, however, that the
36 following conditions are satisfied:

37 1. Notice of the decision to cease writing new business in
38 the small employer market is provided to the Department
39 and either the policyholder, contract holder, or employer;
40 and

41 2. Health benefit plans subject to this Act shall not be
42 cancelled for 180 days after the date of the notice
43 required under paragraph 1 above and for that business
44 of a small employer carrier which remains in force, any

1 small employer carrier that ceases to write new business
2 in the small employer market shall continue to be
3 governed by this Act with respect to business conducted
4 under this Act; and

- 5 3. A small employer carrier that ceases to write new
6 business in the small employer market in this State after
7 January 1, 1992, shall be prohibited from writing new
8 business in the small employer market in this State for a
9 period of five years from the date of notice to the
10 Commissioner.

11 In the case of an HMO doing business in the small employer market in
12 one service area of this State, the rules set forth in this subdivision
13 shall apply to the HMO's operations in the service area, unless the
14 provisions of G.S. 58-50-125(g) apply.

- 15 (4) Late enrollees may be excluded from coverage for the greater of 18
16 months or an 18-month preexisting-condition exclusion; provided that
17 if both a period of exclusion from coverage and a preexisting-
18 condition exclusion are applicable to a late enrollee, the combined
19 period shall not exceed 18 months.

- 20 (5) A carrier may continue to enforce reasonable employer participation
21 and contribution requirements on small employers applying for
22 coverage; provided, however, that participation and contribution
23 requirements may vary among small employers only by the size of the
24 small employer group.

25 (b) Premium rates for health benefit plans subject to this Act are subject to the
26 following provisions:

- 27 (1) The index rate for a rating period for any class of business shall not
28 exceed the index rate for any other class of business by more than
29 twenty-five percent (25%), adjusted pro rata for any rating period of
30 less than one year.

- 31 (2) For a class of business, the premium rates charged during a rating
32 period to small employers with similar case characteristics for the
33 same or similar coverage, or the rates that could be charged to such
34 employers under the rating system for that class of business shall not
35 vary from the index rate by more than thirty-five percent (35%) of the
36 index rate, adjusted pro rata for any rating period of less than one year.

- 37 (3) The percentage increase in the premium rate charged to a small
38 employer for a new rating period, adjusted pro rata for any rating
39 period of less than one year, may not exceed the sum of the following:

- 40 a. The percentage change in the new business premium rate
41 measured from the first day of the prior rating period to the first
42 day of the new rating period. In the event a small employer
43 carrier is not issuing any new policies, but is only renewing

- 1 policies, the carrier shall use the percentage change in the base
2 premium rate.
- 3 b. Any adjustment, not to exceed fifteen percent (15%) annually
4 and adjusted pro rata for any rating period of less than one year,
5 due to the claim experience, health status, or duration of
6 coverage of the employees or dependents of the small employer
7 as determined from the small employer carrier's rate manual for
8 the class of business.
- 9 c. Any adjustment because of a change in coverage or change in
10 the case characteristics of the small employer as determined
11 from the small employer carrier's rate manual for the class of
12 business.
- 13 (4) Any adjustment in rates charged by a small employer carrier electing
14 to be a reinsuring carrier that is caused by reinsurance is subject to the
15 rating limitations set forth in this section.
- 16 (5) Premium rates for health benefit plans shall comply with the
17 requirements of this section notwithstanding any reinsurance
18 premiums and assessments paid or payable by small employer carriers
19 in accordance with G.S. 58-50-150.
- 20 (6) In any case where a small employer carrier utilizes industry as a case
21 characteristic in establishing premium rates, the rate factor associated
22 with any industry classification may not vary from the arithmetic
23 average of the rate factors associated with all industry classifications
24 by greater than fifteen percent (15%) of such coverage.
- 25 (7) In the case of health benefit plans issued before January 1, 1992, a
26 premium rate for a rating period, adjusted pro rata for any rating period
27 of less than one year, may exceed the ranges set forth in subdivisions
28 (b)(1) and (2) of this section for a period of three years after January 1,
29 1992. In such case, the percentage increase in the premium rate
30 charged to a small employer in such a class of business for a new
31 rating period may not exceed the sum of the following:
- 32 a. The percentage change in the new business premium rate
33 measured from the first day of the prior rating period to the first
34 day of the new rating period. In the event a small employer
35 carrier is not issuing any new policies, but is only renewing
36 policies, the small employer carrier shall use the percentage
37 change in the base premium rate.
- 38 b. Any adjustment because of a change in coverage or change in
39 the case characteristics of the small employer as determined
40 from the carrier's rate manual for the class of business.
- 41 (8) Small employer carriers shall apply rating factors including case
42 characteristics, consistently with respect to all small employers in a
43 class of business. Adjustments in rates for claims experience, health
44 status, and duration from issue may not be applied individually. Any

1 such adjustment must be applied uniformly to the rate charged for all
2 participants of the small employer.

3 (c) A small employer carrier shall not involuntarily transfer a small employer
4 into or out of a class of business. A small employer carrier shall not offer to transfer a
5 small employer into or out of a class of business unless such offer is made to transfer all
6 small employers in the class of business without regard to case characteristics, claims
7 experience, health status, or duration of coverage since issue.

8 (d) In connection with the offering for sale of any health benefit plan to a small
9 employer, each small employer carrier shall make a reasonable disclosure, as part of its
10 solicitation and sales materials, of:

11 (1) The extent to which premium rates for a specified small employer are
12 established or adjusted in part based upon the actual or expected
13 variation in claims costs or actual or expected variation in health
14 condition of the eligible employees and dependents of such small
15 employer.

16 (2) Provisions concerning such small employer carrier's right to change
17 premium rates and the factors other than claims experience that affect
18 changes in premium rate.

19 (3) Provisions relating to renewability of policies and contracts.

20 (4) Provisions affecting any preexisting conditions provision.

21 (e) Each small employer carrier shall maintain at its principal place of business a
22 complete and detailed description of its rating practices and renewal underwriting
23 practices, including information and documentation that demonstrate that its rating
24 methods and practices are based upon commonly accepted actuarial assumptions and
25 are in accordance with sound actuarial principles.

26 (f) Each small employer carrier shall file with the Commissioner annually on or
27 before March 15 an actuarial certification certifying that it is in compliance with this
28 Act and that its rating methods are actuarially sound. A copy of such certification shall
29 be retained by the small employer carrier at its principal place of business.

30 (g) A small employer carrier shall make the information and documentation
31 described in subsection (e) of this section available to the Commissioner upon request.
32 Except in cases of violations of this Act, the information is proprietary and trade secret
33 information and is not subject to disclosure by the Commissioner to persons outside of
34 the Department except as agreed to by the small employer carrier or as ordered by a
35 court of competent jurisdiction.

36 (h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through
37 (g) of this section apply to health benefit plans delivered, issued for delivery, renewed,
38 or continued in this State or covering persons residing in this State on or after January 1,
39 1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health
40 benefit plans delivered, issued for delivery, renewed, or continued in this State or
41 covering persons residing in this State on or after the date the plan becomes operational,
42 as designated by the Commissioner. For purposes of this subsection, the date a health
43 benefit plan is continued is the anniversary date of the issuance of the health benefit
44 plan.

1 **"§ 58-50-135. Elections by carriers.**

2 (a) Every small employer carrier shall elect to either become a risk-assuming
3 carrier and comply with the provisions of G.S. 58-50-140 or become a reinsuring carrier
4 and comply with the provisions of G.S. 58-50-145. The election shall be binding for a
5 five-year period except that the initial election shall be made within 60 days after
6 January 1, 1992, and shall be made for two years. The Commissioner may, for good
7 cause, permit a carrier to modify its election during the five-year period. All carriers
8 under common ownership or control must make the same election in this State;
9 provided, however, that the Commissioner may, for good cause, permit an affiliated
10 carrier to make a separate election.

11 (b) A small employer carrier that elects to cease participating as a reinsuring
12 carrier and elects to become a risk-assuming carrier is prohibited from reinsuring or
13 continuing to reinsure any small employer health benefit plans pursuant to G.S. 58-50-
14 145 and G.S. 58-50-150 as soon as the carrier becomes a risk-assuming carrier:
15 Provided, however, a reinsuring carrier electing to become a risk-assuming carrier shall
16 pay a prorated assessment based upon business issued as a reinsuring carrier for any
17 portion of the year that the business was reinsured. A small employer carrier that elects
18 to cease participating as a risk-assuming carrier and elects to become a reinsuring
19 carrier shall be permitted to reinsure small employer health benefit plans under the
20 terms set forth in G.S. 58-50-145 and G.S. 58-50-150.

21 (c) Any small employer carrier that ceases to write, administer, or otherwise
22 provide health benefit plans to employers in this State shall continue to be governed by
23 this Act with respect to business conducted under this Act that was transacted prior to
24 the effective date of termination and that remains in force.

25 **"§ 58-50-140. Risk-assuming carriers.**

26 (a) Any small employer carrier may elect to become a risk-assuming carrier upon
27 application to and approval by the Commissioner. A small employer carrier shall not be
28 approved as a risk-assuming carrier if the Commissioner finds that the carrier is not
29 capable of assuming that status pursuant to the criteria set forth in subsection (b) of this
30 section. The carrier shall provide public notice of its application to become a risk-
31 assuming carrier. A small employer carrier's application to be a risk-assuming carrier
32 shall be approved unless disapproved by the Commissioner within 60 days after the
33 carrier's application. A small employer carrier that has had its application to be a risk-
34 assuming carrier disapproved may request and shall be granted a public hearing within
35 60 days after the disapproval.

36 (b) In determining whether or not to approve an application by a small employer
37 carrier to become a risk-assuming carrier, the Commissioner shall consider the carrier's
38 financial condition and the financial condition of its parent or guaranteeing corporation,
39 if any; its history of assuming and managing risk; its ability to assume and manage the
40 risk of enrolling small employers without the protection of the reinsurance provided in
41 G.S. 58-50-150; and its commitment to fairly market to all small employers in its
42 service area.

43 **"§ 58-50-145. Reinsuring carriers.**

1 (a) Any small employer carrier may elect to operate under the provisions of this
2 section and G.S. 58-50-150 as a reinsuring carrier.

3 (b) Each reinsuring carrier shall conduct business with its members and
4 subscribers, and administer claims for coverage reinsured by the Pool, in the same
5 manner as it would administer health claims that it writes without reinsurance.

6 **"§ 58-50-150. North Carolina Small Employer Health Reinsurance Pool.**

7 (a) There is created a nonprofit entity to be known as the North Carolina Small
8 Employer Health Reinsurance Pool. All carriers issuing or providing health benefit
9 plans in this State on and after January 1, 1992, except any small employer carrier
10 electing to be a risk-assuming carrier, are members of the Pool.

11 (b) Within 30 days after January 1, 1992, the Commissioner shall give notice to
12 all carriers of the time and place for the initial organizational meeting, which shall take
13 place within 90 days after the notice from the Commissioner. The members shall select
14 the initial Board, subject to approval by the Commissioner. The Board shall consist of
15 nine members. There shall be no more than two members of the Board representing any
16 one carrier. In determining voting rights at the organizational meeting, each member
17 shall be entitled to vote in person or by proxy. The voting rights to determine initial
18 Board membership shall be weighted based upon net group health benefit plan premium
19 derived from this State in the previous calendar year. Thereafter, voting rights shall be
20 based on net group health benefit plan premium derived from small employer business.
21 The Board shall at all times, to the extent possible, include at least one domestic
22 insurance company licensed to transact accident and health insurance, one HMO, one
23 nonprofit hospital or medical service plan. Six of the members of the Board shall be
24 small employer carriers. In approving selection of the Board, the Commissioner shall
25 assure that all members are fairly represented.

26 (c) If the initial Board is not elected at the organizational meeting, the
27 Commissioner shall appoint the initial Board within 30 days of the organizational
28 meeting.

29 (d) As used in this section, 'plan of operation' includes articles, bylaws, and
30 operating rules of the Pool. Within 180 days after the appointment of the initial Board,
31 the Board shall submit to the Commissioner a plan of operation and any amendments
32 necessary or suitable to assume the fair, reasonable, and equitable administration of the
33 Pool. The Commissioner shall approve the plan of operation if it assures the fair,
34 reasonable, and equitable administration of the Pool and provides for the proportionate
35 basis in accordance with the provisions of subsections (h) through (o) of this section.
36 The plan of operation shall become effective upon approval in writing by the
37 Commissioner consistent with the date on which the coverage under this section shall be
38 made available. If the Board fails to submit a suitable plan of operation within 180 days
39 after its appointment, or at any time thereafter fails to submit suitable amendments to
40 the plan of operation, the Commissioner shall adopt and promulgate a plan of operation
41 or amendment, as appropriate. The Commissioner shall amend any plan of operation he
42 adopts, as necessary, after a plan of operation is submitted by the Board and approved
43 by the Commissioner.

44 (e) The plan of operation shall establish procedures for, among other things:

- 1 (1) Handling and accounting of assets and moneys of the Pool, and for an
2 annual financial reporting to the Commissioner.
- 3 (2) Filling vacancies on the Board, subject to the approval of the
4 Commissioner.
- 5 (3) Selecting an administering carrier and setting forth the powers and
6 duties of the administering carrier.
- 7 (4) Reinsuring risks in accordance with the provisions of this Act.
- 8 (5) Collecting assessments from members subject to assessment to provide
9 for claims reinsured by the Pool and for administrative expenses
10 incurred or estimated to be incurred during the period for which the
11 assessment is made.
- 12 (6) Any additional matters in the discretion of the Board.
- 13 (f) The Pool has the general powers and authority granted under the laws of this
14 State to insurance companies licensed to transact accident and health insurance except
15 the power to issue coverage directly to enrollees, and, in addition thereto, the specific
16 authority to do all of the following:
 - 17 (1) Enter into contracts as are necessary or proper to carry out the
18 provisions and purposes of this Act, including the authority, with the
19 approval of the Commissioner, to enter into contracts with similar
20 pools of other states for the joint performance of common
21 administrative functions, or with persons or other organizations for the
22 performance of administrative functions.
 - 23 (2) Sue or be sued, including taking any legal actions necessary or proper
24 for recovery of any assessments for, on behalf of, or against members.
 - 25 (3) Take any legal action necessary to avoid the payment of improper,
26 incorrect, or fraudulent claims against the Pool or the coverage
27 reinsured by the Pool.
 - 28 (4) Issue various reinsurance policies in accordance with the requirements
29 of this section.
 - 30 (5) Establish rules, conditions, and procedures pertaining to the
31 reinsurance of members' risks by the Pool.
 - 32 (6) Establish appropriate rates, rate schedules, rate adjustments, rate
33 classifications, and any other actuarial functions appropriate to the
34 operation of the Pool.
 - 35 (7) Assess members in accordance with the provisions of subsections (h)
36 through (o) of this section; and make advance interim assessments that
37 are reasonable and necessary for organizational and interim operating
38 expenses. Any interim assessments shall be credited as offsets against
39 any regular assessments due following the close of the Pool's fiscal
40 year.
 - 41 (8) Appoint from among members appropriate legal, actuarial, and other
42 committees that are necessary to provide technical assistance in the
43 operation of the Pool, policy, and other contract design, and any other
44 function within the authority of the Pool.

- 1 (9) Borrow money to effect the purposes of the Pool. Any notes or other
2 evidence of indebtedness of the Pool not in default are legal
3 investments for members and may be carried as admitted assets.
- 4 (g) Any member that elects to be a reinsuring carrier may cede, and the Pool
5 shall reinsure the reinsuring carrier, subject to all of the following:
- 6 (1) The Pool shall reinsure any basic and standard health care plan
7 originally issued or delivered for original issue by a reinsuring carrier
8 on or after January 1, 1992, pursuant to the requirements contained in
9 G.S. 58-50-125(d). With respect to a basic or standard health care
10 plan, the Pool shall reinsure the level of coverage provided and, with
11 respect to other plans, the Pool shall reinsure the level of coverage
12 provided in the basic or standard health care plan up to, but not
13 exceeding, the level of coverage provided under either the basic or
14 standard health care plans. Small group business of reinsuring carriers
15 in force prior to January 1, 1992, may not be ceded to the Pool until
16 January 1, 1995, and then only if and when the Board determines that
17 sufficient funding sources are available.
- 18 (2) The Pool shall reinsure eligible employees or their dependents or
19 entire small employer groups according to the following:
- 20 a. With respect to eligible employees and their dependents who
21 either (i) are employed by a small employer as of the date such
22 employer's coverage by the member commences and who enroll
23 in a manner such that they are not considered to be late
24 enrollees to the plan or (ii) hired subsequent to the
25 commencement of the employer's coverage by the member and
26 who are not late enrollees to the plan: Such coverage may be
27 reinsured within 60 days after the commencement of the
28 eligible employees' or dependents' coverage under the plan.
- 29 b. With respect to eligible employees and their dependents, when
30 the entire employer group is eligible for reinsurance: A small
31 employer carrier may reinsure the entire employer group within
32 60 days after the commencement of the group's coverage under
33 the plan.
- 34 c. With respect to any person reinsured, no reinsurance may be
35 provided for a reinsured employee or dependent until five
36 thousand dollars (\$5,000) in benefit payments have been made
37 for services provided during a calendar year for that reinsured
38 employee or dependent, which payments would have been
39 reimbursed through said reinsurance in the absence of said five
40 thousand dollar (\$5,000) deductible. The amount of said
41 deductible shall be periodically reviewed by the Board and
42 adjusted for inflation, as determined by the Board. In addition,
43 the member shall retain ten percent (10%) of the next fifty
44 thousand dollars (\$50,000) of benefit payments during a

1 calendar year and the Pool shall reinsure the remainder;
2 provided that the members' liability under this section shall not
3 exceed ten thousand dollars (\$10,000) in any one calendar year
4 with respect to any one person reinsured. The amount of said
5 member's maximum liability shall be periodically reviewed by
6 the Board and adjusted for inflation, as determined by the
7 Board.

8 d. Reinsurance may be terminated for each reinsured employee or
9 dependent on any plan anniversary.

10 e. Premium rates charged for reinsurance by the program to an
11 HMO that is approved by the Secretary of Health and Human
12 Services as a federally qualified health maintenance
13 organization pursuant to 42 U.S.C. § 300 et seq., shall be
14 reduced to reflect the restrictions and requirements of 42 U.S.C.
15 § 300 et seq.

16 f. Every carrier subject to G.S. 58-50-130 must apply its case
17 management and claims handling techniques, including but not
18 limited to utilization review, individual case management,
19 preferred provider provisions, other managed care provisions or
20 methods of operation, consistently with both reinsured and
21 nonreinsured business.

22 g. Except as otherwise provided in this section, premium rates
23 charged by the Pool for coverage reinsured by the Pool for that
24 classification or group with similar case characteristics and
25 coverage shall be established as follows:

26 1. One and one-half times the rate established by the Pool
27 with respect to the eligible employees and their
28 dependents of a small employer, all of whose coverage is
29 reinsured with the Pool who are reinsured in accordance
30 with this section.

31 2. Five times the rate established by the Pool with respect
32 to an eligible employee or dependent who is reinsured in
33 accordance with this section.

34 (3) The Pool shall reinsure no more than the level of benefits provided in
35 either the basic or standard health care plan established in accordance
36 with G.S. 58-50-125.

37 (4) The Pool may issue different types and levels of reinsurance coverage,
38 including stop-loss coverage; and the reinsurance premium shall be
39 adjusted to reflect the type and level of reinsurance coverage issued.

40 (5) The reinsurance premium shall also be adjusted to reflect cost
41 containment features of the plan of operation that have proven to be
42 effective including, but not limited to: preferred provider provisions,
43 utilization review of medical necessity of hospital and physician

1 services, case management benefit alternatives, and other managed
2 care provisions or methods of operation.

3 (h) Following the close of each fiscal year, the administering carrier shall
4 determine the net premiums, the Pool expenses of administration, and the incurred
5 losses for the year, taking into account investment income and other appropriate gains
6 and losses. Health benefit plan premiums and benefits paid by a member that are less
7 than an amount determined by the Board to justify the cost of collection shall not be
8 considered for purposes of determining assessments. As used in this section, 'net
9 premiums' means health benefit plan premiums for insured plans but does not mean
10 premiums or revenue received by a carrier for Medicare and Medicaid contracts.

11 (i) Any net losses for the year shall be recouped by assessments of members as
12 follows:

13 (1) The Board shall determine an equitable assessment formula for the
14 purpose of recouping assessments of members that takes into
15 consideration both overall market share of small employer carriers that
16 are members of the Pool and the share of new business of the small
17 employer carriers assumed during the preceding calendar year. For the
18 first three years of operation of the Pool, if an assessment is based on
19 an adjustment made, the assessment shall not be less than fifty percent
20 (50%) nor more than one hundred fifty percent (150%) of the amount
21 it would have been if the assessment were based on the proportional
22 relationship of the small employer carrier's total premiums for small
23 employer coverage written in the year to the total premiums of small
24 employer coverage written in the year to the total premiums of small
25 employer coverage written by all small employer carriers in this State
26 in the year. The Board shall also determine whether the assessment
27 base used to determine assessments shall be made on a transitional
28 basis or shall be permanent. In no event shall assessments exceed four
29 percent (4%) of the total health benefit plan premium earned in this
30 State from health benefit plans covering small employers of members
31 during the calendar year coinciding or ending during the fiscal year of
32 the Pool. The Board may change the assessment formula, including an
33 assessment adjustment formula, if applicable, from time to time as
34 appropriate.

35 (2) Health benefit plan premiums and benefits paid by a member that are
36 less than an amount determined by the Board to justify the cost of
37 collection shall not be considered for purposes of determining
38 assessments. For the purposes of this section, health benefit plan
39 premiums earned by MEWAs and other benefit arrangements, to the
40 extent permitted by ERISA, shall be established by adding paid health
41 losses and administrative expenses.

42 (j) If the assessment level is inadequate, the Board may adjust reinsurance
43 thresholds, retention levels, or consider other forms of reinsurance. After the first three
44 full years of operations the Board shall report to the Commissioner on its experience,

1 the effect on reinsurance and small group rates of individual ceding, and
2 recommendations on additional funding sources, if needed. Should legislative or other
3 broader funding alternatives not be found, the Board is authorized to enter into
4 negotiations with representatives of health care providers to resolve any deficit through
5 reductions in future years' payment levels for reinsured plans. Any such
6 recommendations shall take into account the findings of the actuarial study provided for
7 in this subsection. An actuarial study shall be undertaken within the first three years of
8 the Pool's operation to evaluate and measure the relative risks being assumed by
9 differing types of small employer carriers as a result of this Act. Such study shall be
10 developed by three actuaries appointed by the Commissioner, with one representing risk
11 assuming carriers, one representing reinsuring carriers, and one from within the
12 Department.

13 (k) Subject to the approval of the Commissioner, the Board may make an
14 adjustment to the assessment formula for any reinsuring carrier that is an HMO
15 approved as a federally qualified HMO by the Secretary of Health and Human Services
16 pursuant to 42 U.S.C. § 300 for restrictions placed on them other than those for which
17 an adjustment has already been made in subsection (b)(2) or (b)(5) of this section that
18 are not imposed on other small group carriers.

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

23 (m) Each member's proportion of participation in the Pool shall be determined
24 annually by the Board based on financial statements and other reports deemed to be
25 necessary and required by the Board and filed by the member with the Board. All
26 carriers shall report, to the Board, claims payments made and administrative expenses
27 incurred in this State on an annual basis and on a form prescribed by the Commissioner.

28 (n) Provision shall be made in the plan of operation for the imposition of an
29 interest penalty for late payment of assessments.

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

37 (p) Neither the participation in the Pool as members, the establishment of rates,
38 forms, or procedures, nor any other joint or collective action required by this Act shall
39 be the basis of any legal action, criminal or civil liability, or penalty against the Pool or
40 any of its members.

41 (q) Any person or member made a party to any action, suit, or proceeding
42 because the person or member serves or served on the Board or on a committee or is or
43 was an officer or employee of the Pool shall be held harmless and be indemnified by the
44 Pool against all liability and costs, including the amounts of judgments, settlements,

1 fines, or penalties, and expenses and reasonable attorneys' fees incurred in connection
2 with the action, suit, or proceeding. However, the indemnification shall not be provided
3 on any matter in which the person or member is finally adjudged in the action, suit, or
4 proceeding to have committed a breach of duty involving gross negligence, dishonesty,
5 willful misfeasance, or reckless disregard of the responsibilities of service or office.
6 Costs and expenses of the indemnification shall be prorated among and paid for by all
7 members.

8 (r) The Pool is exempt from the taxes imposed by Article 8B of Chapter 105 of
9 the General Statutes."

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

14 Sec. 3. This act becomes effective January 1, 1992.