GENERAL ASSEMBLY OF NORTH CAROLINA
1991 SESSION

CHAPTER 630
HOUSE BILL 1037

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 provisions of G.S. 58-50-130, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) 'Base premium rate' means for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(3) 'Basic health care plan' means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

(4) 'Board' means the board of directors of the Pool.

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.

(6) 'Case characteristics' means demographic or other objective characteristics of a small employer, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer; but does not mean claim experience, health status, and duration of coverage since issue.

(7) 'Class of business' means all or a distinct grouping of small employers as shown on the records of a small employer carrier.

(8) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-50-120.

(9) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(10) 'Eligible employee' means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

(11) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not mean accident only, specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only 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.

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

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

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

a. The individual:

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

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

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

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

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

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

(15) 'New business premium rate' means, for each class of business as to a rating period, the lowest premium rate charged, offered, or that could have been charged by a small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(16) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) 'Preexisting-conditions provision' means a policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

(18) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) 'Rating period' means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) 'Risk-assuming carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) 'Reinsuring carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(22) 'Small employer' means any person actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding year, employed no more than 25 eligible employees and not less than three eligible employees, the majority of whom are employed within this State. Small employer includes companies that are affiliated companies, as defined in G.S. 58-19-5(1) or that are eligible to file a combined tax return under Chapter 105 of the General Statutes or under the Internal Revenue Code. Except as otherwise provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this section.

(23) 'Small employer carrier' means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.

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

For the purposes of this Act, companies that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier except that any insurance company, hospital service plan, or medical service plan that is an affiliate of an HMO located in North Carolina or any HMO located in North Carolina that is an affiliate of an insurance company, a health service corporation, or a medical service corporation may treat the HMO as a separate carrier and each HMO that operates only one HMO in a service area of North Carolina may be considered a separate carrier.

"**§ 58-50-113. Distinct groupings.**

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

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

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

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

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

(c) The Commissioner may approve the establishment of additional distinct groupings upon application to the Commissioner and the Commissioner's determination that the action would enhance the efficiency and fairness of the small employer marketplace.

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

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

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

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

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

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

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

(b) Subject to the Commissioner's approval, the Committee shall recommend the form and level of coverages to be made available by small employer carriers in accordance with the provisions of G.S. 58-50-125(a). The Committee shall recommend benefit levels, cost-sharing factors, exclusions, and limitations for the basic and standard health care plans. One basic health care plan and one standard health care plan shall contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of HMOs, including any restrictions imposed by federal law. The Committee shall submit the plans to the Commissioner for approval within 180 days after the Committee's appointment according to this section. The plans may include cost containment features such as: utilization review of health care services, including review of medical necessity of hospital and physician services; case management benefit alternatives; selective contracting with hospitals, physicians, and

other health care providers; reasonable benefit differentials applicable to participating and nonparticipating providers; and other managed care provisions.

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

(1) Registration by each carrier with the Department of its intention to be a small employer carrier under this Act.

(2) Publication by the Department, the Committee, or the Pool of a list of all small employer carriers, including a potential requirement applicable to agents, brokers, third-party administrators, and carriers that no health benefit plan may be sold to a small employer by a carrier not so identified as a small employer carrier.

(3) The availability of a broadly publicized toll-free telephone number for access by small employers to information concerning this Act.

(4) To the extent deemed to be necessary by the Committee to assure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers, agents, brokers, and third-party administrators about health benefit plans issued; provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to small employers.

(5) Registration by agents, brokers, and third-party administrators of their intention to be such for health benefit plans marketed to small employers under this Act.

(6) Methods concerning periodic demonstration by small employer carriers, agents, brokers, and third-party administrators that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this Act.

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

(d) Within three years after September 1, 1991, the Committee shall conduct a study of the effectiveness of the provisions of this Act, recommend further improvements to achieve greater stability, accessibility, and affordability in the small employer marketplace, and submit it to the Commissioner.

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

(a) To improve the availability and affordability of health benefits coverage for small employers, the Committee shall recommend to the Commissioner two plans of coverage, one of which shall be a basic health care plan and the second of which shall be a standard health care plan. Each plan of coverage shall be in two forms, one of which shall be in the form of insurance and the second of which shall be consistent with the basic method of operation and benefit plans of HMOs, including federally qualified

HMOs. On or before January 1, 1992, the Committee shall file a progress report with the Commissioner. The Committee shall submit the recommended plans to the Commissioner for approval within 180 days after the appointment of the Committee under G.S. 58-50-120. The Committee shall take into consideration the levels of health benefit plans provided in North Carolina, and appropriate medical and economic factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. Notwithstanding subsection (c) of this section, in developing and approving the plans, the Committee and the Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. The Committee shall file with the Commissioner its findings and recommendations, and reasons for the findings and recommendations, if it does not provide for coverage by any type of health care provider specified in G.S. 58-50-30. The recommended plans may include cost containment features such as, but not limited to: preferred provider provisions; utilization review of medical necessity of hospital and physician services; case management benefit alternatives; or other managed care provisions.

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

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

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

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

(1) From a group already covered under a health benefit plan except for coverage that is to begin after the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group before its anniversary date; or

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

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

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

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

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

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

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

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

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

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

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

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

(1) Except in the case of a late enrollee, any preexisting-conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or for which medical advice, diagnosis,

care, or treatment was recommended or received during the 12 months immediately before the effective date of coverage or as to a pregnancy existing on the effective date of coverage.

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

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

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

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

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

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

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

f. When the small employer carrier stops writing new business in the small employer market, if:

1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and

2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.

A small employer carrier that stops writing new business in the small employer market in this State after January 1, 1992, shall be prohibited from writing new business in the small employer market in this State for a period of five years from the date of notice to the Commissioner. In the case of an HMO doing business in the small employer market in one service area of this State, the rules set forth in this subdivision

shall apply to the HMO's operations in the service area, unless the provisions of G.S. 58-50-125(g) apply.

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

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

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

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

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

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

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the carrier shall use the percentage change in the base premium rate.

b. Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for any rating period of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.

c. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(4) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier that is caused by reinsurance is subject to the rating limitations set forth in this section.

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with G.S. 58-50-150.

(6) In any case where a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than fifteen percent (15%) of coverage.

(7) In the case of health benefit plans issued before January 1, 1992, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may exceed the ranges set forth in subdivisions (b)(1) and (2) of this section for a period of three years after January 1, 1992. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the small employer carrier shall use the percentage change in the base premium rate.

b. Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(8) Small employer carriers shall apply rating factors including case characteristics, consistently with respect to all small employers in a class of business. Adjustments in rates for claims experience, health status, and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer.

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

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

(1) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected

variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of the small employer.

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

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

(4) Provisions affecting any preexisting conditions provision.

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

(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

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

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

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

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

(b) A small employer carrier that elects to stop participating as a reinsuring carrier and to become a risk-assuming carrier shall not reinsure or continue to reinsure

any small employer health benefit plans under G.S. 58-50-145 and G.S. 58-50-150 as soon as the carrier becomes a risk-assuming carrier; however, a reinsuring carrier electing to become a risk-assuming carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any part of the year that the business was reinsured. A small employer carrier that elects to stop participating as a risk-assuming carrier and to become a reinsuring carrier may reinsure small employer health benefit plans under the provisions of G.S. 58-50-145 and G.S. 58-50-150.

(c) Any small employer carrier that stops writing, administering, or otherwise providing health benefit plans to employers in this State shall continue to be governed by this Act with respect to business conducted under this Act that was transacted before the effective date of termination and that remains in force.

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

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

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

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

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

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

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

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

(b) Within 30 days after January 1, 1992, the Commissioner shall give notice to all carriers of the time and place for the initial organizational meeting, which shall take place within 90 days after the notice from the Commissioner. The members shall select the initial Board, subject to the Commissioner's approval. The Board shall consist of

nine members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The voting rights to determine initial Board membership shall be weighted based upon net group health benefit plan premium derived from this State in the previous calendar year. Thereafter, voting rights shall be based on net group health benefit plan premium derived from small employer business. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact accident and health insurance, one HMO, one nonprofit hospital or medical service plan. Six of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented.

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

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

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

(1) Handling and accounting of assets and moneys of the Pool, and for an annual financial reporting to the Commissioner.

(2) Filling vacancies on the Board, subject to the Commissioner's approval.

(3) Selecting an administering carrier and setting forth the powers and duties of the administering carrier.

(4) Reinsuring risks in accordance with the provisions of this Act.

(5) Collecting assessments from members subject to assessment to provide for claims reinsured by the Pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.

(6) Any additional matters in the Board's discretion.

(f) The Pool has the general powers and authority granted under the laws of this State to insurance companies licensed to transact accident and health insurance except

the power to issue coverage directly to enrollees, and, in addition, the specific authority to do all of the following:

(1) Enter into contracts that are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the Commissioner's approval, 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 members.

(3) Take any legal action necessary to avoid the payment of improper, incorrect, or fraudulent claims against the Pool or the coverage reinsured by the Pool.

(4) Issue various reinsurance policies in accordance with the requirements of this section.

(5) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the Pool.

(6) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the Pool's operation.

(7) Assess members in accordance with the provisions of subsections (h) through (o) of this section; and make advance interim assessments that are reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the Pool's fiscal year.

(8) Appoint from among members appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(9) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for members and may be carried as admitted assets.

(g) Any member that elects to be a reinsuring carrier may cede, and the Pool shall reinsure the reinsuring carrier, subject to all of the following:

(1) The Pool shall reinsure any basic and standard health care plan originally issued or delivered for original issue by a reinsuring carrier on or after January 1, 1992, under the requirements in G.S. 58-50-125(d). With respect to a basic or standard health care plan, the Pool shall reinsure the level of coverage provided and, with respect to other plans, the Pool shall reinsure the level of coverage provided in the basic or standard health care plan up to, but not exceeding, the level of coverage provided under either the basic or standard health care plans. Small group business of reinsuring carriers in force before January 1,

1992, may not be ceded to the Pool until January 1, 1995, and then only if and when the Board determines that sufficient funding sources are available.

(2) The Pool shall reinsure eligible employees or their dependents or entire small employer groups according to the following:

a. With respect to eligible employees and their dependents who either (i) are employed by a small employer as of the date such employer's coverage by the member begins and who enroll in a manner such that they are not considered to be late enrollees to the plan, or (ii) hired after the beginning of the employer's coverage by the member and who are not late enrollees to the plan: The coverage may be reinsured within 60 days after the beginning of the eligible employees' or dependents' coverage under the plan.

b. With respect to eligible employees and their dependents, when the entire employer group is eligible for reinsurance: A small employer carrier may reinsure the entire employer group within 60 days after the beginning of the group's coverage under the plan.

c. With respect to any person reinsured, no reinsurance may be provided for a reinsured employee or dependent until five thousand dollars ($5,000) in benefit payments have been made for services provided during a calendar year for that reinsured employee or dependent, which payments would have been reimbursed through the reinsurance in the absence of the five thousand dollar ($5,000) deductible. The Boards shall review periodically the amount of the deductible and adjust it for inflation. In addition, the member shall retain ten percent (10%) of the next fifty thousand dollars ($50,000) of benefit payments during a calendar year and the Pool shall reinsure the remainder; provided that the members' liability under this section shall not exceed ten thousand dollars ($10,000) in any one calendar year with respect to any one person reinsured. The amount of the member's maximum liability shall be periodically reviewed by the Board and adjusted for inflation, as determined by the Board.

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

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

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

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

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

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

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

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

(5) The reinsurance premium shall also be adjusted to reflect cost containment features of the plan of operation that have proven to be effective including, but not limited to: preferred provider provisions, utilization review of medical necessity of hospital and physician services, case management benefit alternatives, and other managed care provisions or methods of operation.

(h) Following the close of each fiscal year, the administering carrier shall determine the net premiums, the Pool expenses of administration, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health benefit plan premiums and benefits paid by a member 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. As used in this section, 'net premiums' means health benefit plan premiums for insured plans but does not mean premiums or revenue received by a carrier for Medicare and Medicaid contracts.

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

(1) The Board shall determine an equitable assessment formula to recoup assessments of members that takes into consideration both overall market share of small employer carriers that are members of the Pool and the share of new business of the small employer carriers assumed

during the preceding calendar year. For the first three years of operation of the Pool, if an assessment is based on an adjustment made, the assessment shall not be less than fifty percent (50%) nor more than one hundred fifty percent (150%) of the amount it would have been if the assessment were based on the proportional relationship of the small employer carrier's total premiums for small employer coverage written in the year to the total premiums of small employer coverage written by all small employer carriers in this State in the year. The Board shall also determine whether the assessment base used to determine assessments shall be made on a transitional basis or shall be permanent. In no event shall assessments exceed four percent (4%) of the total health benefit plan premium earned in this State from health benefit plans covering small employers of members during the calendar year coinciding or ending during the fiscal year of the Pool. The Board may change the assessment formula, including an assessment adjustment formula, if applicable, from time to time as appropriate.

(2) Health benefit plan premiums and benefits paid by a member 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. For the purposes of this section, health benefit plan premiums earned by MEWAs and other benefit arrangements, to the extent permitted by ERISA, shall be established by adding paid health losses and administrative expenses.

(j) If the assessment level is inadequate, the Board may adjust reinsurance thresholds, retention levels, or consider other forms of reinsurance. After the first three full years of operations the Board shall report to the Commissioner on its experience, the effect on reinsurance and small group rates of individual ceding, and recommendations on additional funding sources, if needed. If legislative or other broader funding alternatives are not found, the Board may enter into negotiations with representatives of health care providers to resolve any deficit through reductions in future years' payment levels for reinsured plans. Any such recommendations shall take into account the findings of the actuarial study provided for in this subsection. An actuarial study shall be undertaken within the first three years of the Pool's operation to evaluate and measure the relative risks being assumed by differing types of small employer carriers as a result of this Act. The study shall be developed by three actuaries appointed by the Commissioner, with one representing risk assuming carriers, one representing reinsuring carriers, and one from within the Department.

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

(l) If assessments 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.

(m) The Board shall determine annually each member's proportion of participation in the Pool based on financial statements and other reports that the Board considers to be necessary and requires that the member files with the Board. All carriers shall report, to the Board, claims payments made and administrative expenses incurred in this State on an annual basis and on a form prescribed by the Commissioner.

(n) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(o) The Board may abate or defer, in whole or in part, the assessment of a member if, in the Board's opinion, payment of the assessment would endanger the member's ability 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 the assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this section. The member receiving the abatement or deferment shall remain liable to the Pool for the deficiency.

(p) 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 Act shall be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its members.

(q) Any person or member made a party to any action, suit, or proceeding because the person or member serves or served on the Board or on a committee or is or was an officer or employee of the Pool shall be held harmless and be indemnified by the Pool against all liability and costs, including the amounts of judgments, settlements, fines, or penalties, and expenses and reasonable attorneys' fees incurred in connection with the action, suit, or proceeding. However, the indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of service or office. Costs and expenses of the indemnification shall be prorated among and paid for by all members.

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

Sec. 2. If 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. G.S. 58-50-120 and G.S. 58-50-125, contained in Section 1 of this act, become effective September 1, 1991. The remainder of this act becomes effective January 1, 1992.

In the General Assembly read three times and ratified this the 10th day of July, 1991.

James C. Gardner
President of the Senate

Daniel Blue, Jr.
Speaker of the House of Representatives