GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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HOUSE BILL 1529*

Short Title: HMO Insolvency. (Public)

Sponsors: Representatives Nye, Insko, Nesbitt, and Cunningham.

Referred to: Insurance.

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO PROTECT PERSONS ENROLLED IN AN HMO FROM THE CONSEQUENCES OF THE INSOLVENCY OF THAT HMO BY AUTHORIZING ASSESSMENTS OF REMAINING HMOs IN THE STATE TO PAY FOR UNCOVERED EXPENDITURES OF AND CONTINUATION OF COVERAGE FOR THE ENROLLEES.

The General Assembly of North Carolina enacts:

Section 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-126. Insolvency protection; assessment.**

(a) When an HMO in this State is declared insolvent by a court of competent jurisdiction, the Commissioner may levy an assessment on solvent HMOs doing business in this State to pay claims for uncovered expenditures for enrollees who are residents of this State and to provide continuation of coverage for enrollees not covered under G.S. 58-67-120, 58-67-125, or 58-67-130. Assessments against an HMO may not exceed two percent (2%) of that HMO's average annual premiums received in North Carolina on policies and contracts during the three calendar years immediately preceding the year in which the insolvent HMO was declared insolvent.

(b) To provide the funds necessary to carry out the powers and duties of the Commissioner under this section, the Commissioner shall assess the HMOs at such time

and for such amounts, as the Commissioner finds necessary. Assessments not paid within 30 days of the written notice shall accrue interest at the rate of one percent (1%) per month, or any part thereof. Assessments shall not be made until necessary to implement the purposes of this section. Computation of assessments under this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(c) The Commissioner may use funds obtained under subsection (a) of this section to pay claims for uncovered expenditures for enrollees of an insolvent HMO who are residents of this State, provide for continuation of coverage for enrollees who are residents of this State and are not covered under G.S. 58-67-120, 58-67-125, or 58-67-130, and administrative costs. The Commissioner may by rule prescribe the time, manner, and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver. A receiver or liquidator of an insolvent HMO shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(d) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the Commissioner to the extent of the benefits received. The Commissioner may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon that person. The Commissioner is subrogated to these rights against the assets of an insolvent HMO held by a receiver or liquidator of another jurisdiction.

(e) The assignment of subrogation rights of the Commissioner and allowed claim under this section have the same priority against the assets of the insolvent HMO as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

(f) When assessed funds are unused following the completion of the liquidation of an HMO, the Commissioner will distribute on a pro rata basis any unused amounts received under subsection (a) of this section to the HMOs that have been assessed under this section.

(g) The aggregate coverage of uncovered expenditures under this section shall not exceed three hundred thousand dollars ($300,000) with respect to one individual. Continuation of coverage for an enrollee shall continue for the duration of the contract period for which premiums have been paid and continuation of coverage for an enrollee who is confined in an inpatient facility shall continue until his or her discharge or expiration of benefits. The Commissioner may provide continuation of coverage on any reasonable basis; including continuation of the HMO contract or substitution of indemnity coverage in a form determined by the Commissioner.

(h) The Commissioner may abate or defer, in whole or in part, the assessment of an HMO if, in the Commissioner's opinion, payment of the assessment would endanger the HMO's ability to fulfill its contractual obligations. If an assessment against an HMO 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 HMOs in a manner consistent with the

basis for assessments set forth in this section. An HMO that fails to pay an assessment within 30 days after notice is subject to a civil penalty of not more than one thousand dollars ($1,000) per day, or suspension or revocation of its license, or both.

(i) It is proper for any HMO, in determining its premium rates and policy owner dividends, to consider the amount reasonably necessary to meet its assessment obligations under this section."

Section 2. G.S. 58-30-220(2) reads as rewritten:

"(2) Claims or portions of claims for benefits under policies and for losses incurred, including claims of third parties under liability policies; claims of HMO enrollees and HMO enrollees' beneficiaries; beneficiaries, including situations where an enrollee or beneficiary is liable to a health care provider for services provided under the HMO plan; claims for unearned premiums; claims for funds or consideration held under funding agreements, as defined in G.S. 58-7-16; claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values; and claims of domestic and foreign guaranty associations, including claims for the reasonable administrative expenses of domestic and foreign guaranty associations; but excluding claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements, claims of other insurers for subrogation, and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages."

Section 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act becomes effective January 1, 2001.