GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

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HOUSE BILL 610*

Short Title: Small Employer Health Insurance. (Public)

Sponsors: Representatives B. Miller (by request); and Church.

Referred to: Insurance.

March 29, 1993

A BILL TO BE ENTITLED

AN ACT TO PROVIDE GROUP HEALTH INSURANCE TO BUSINESSES COMPRISING MORE THAN TWENTY-FIVE EMPLOYEES; TO MAKE IMPROVEMENTS IN THE NORTH CAROLINA SMALL EMPLOYER GROUP HEALTH COVERAGE REFORM ACT; AND TO PROVIDE FOR UNIFORM CLAIM FORMS FOR HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-110(22) reads as rewritten:

"(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~~ 49 eligible employees and not less than ~~three~~ two 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."

Sec. 2. G.S. 58-51-80(b) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(2) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase 'groups of 50' must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability. <u>In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit payors shall credit the time the person was covered by a previous health benefit payor 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 waiting period under the new coverage.</u>

(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any prior group plan. Credit must be given for that portion of the waiting period which was met under the prior plan."

Sec. 3. G.S. 58-65-60(e) reads as rewritten:

"(e) A hospital service corporation may issue a master group contract with the approval of the Commissioner of Insurance provided such contract and the individual certificates issued to members of the group, shall comply in substance to the other

provisions of this Article and Article 66 of this Chapter. Any such contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in said contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner of Insurance. If such master group contract is issued, altered or modified, the subscribers' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of subscribers thereto.

(1) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for coverage or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase 'groups of 50' must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability. In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit payors shall credit the time the person was covered by a previous health benefit payor 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 waiting period under the new coverage.

(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any prior group plan. Credit must be given for that portion of the waiting period which was met under the prior plan.

(3) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person working 30 hours per week, and who is otherwise eligible for coverage.

(4) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group

contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan."

Sec. 4. G.S. 58-67-85(b) reads as rewritten:

"(b) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase 'groups of 50' must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability. In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit payors shall credit the time the person was covered by a previous health benefit payor 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 waiting period under the new coverage."

Sec. 5. G.S. 58-50-125(d) reads as rewritten:

"(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. If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4). A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible

employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer."

Sec. 6. G.S. 58-50-130(a) reads as rewritten:

"(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. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of such period in the health benefit plan currently held by the small employer.

(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."

Sec. 7. G.S. 58-50-150(g) reads as rewritten:

"(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) are hired after the beginning of the employer's coverage by the ~~member and who are not late enrollees to the plan:~~ member: 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."

Sec. 8. G.S. 58-50-10 is repealed.

Sec. 9. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-170. Uniform claim forms.**

(a) Effective January 1, 1994, all claims submitted by health care providers to health benefit plans shall be submitted on a uniform form or format that shall be developed by the Department and approved by the Commissioner. Additional information beyond that contained on the uniform form or format may be collected subject to rules adopted by the Commissioner. This section applies to the submittal of claims in writing and by electronic means.

(b) After consultation with the North Carolina Industrial Commission, the Commissioner may include workers' compensation insurance policies as 'health benefit plans' for the purpose of administering the provisions of this section.

(c) For purposes of this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; plans provided by MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA; the Teachers' and State Employees' Comprehensive Major Medical Plan; and medical payment coverages under homeowners and automobile insurance policies."

Sec. 10. Sections 1 through 4 and 8 of this act become effective January 1, 1994. The remainder of this act is effective upon ratification.