GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

SESSION LAW 2005-223
HOUSE BILL 737

AN ACT TO REQUIRE THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT EMPLOYER-BASED, LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS EXPERIENCE TO DEVELOP THE INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE PROPRIETOR FROM THE FULL-TIME BASIS FOR THIRTY-HOUR WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES; CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER TO REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP OF INSURERS; TECHNICALLY CORRECT AN OMISSION REGARDING PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; DECREASE THE TOTAL NUMBER OF MEMBERS THAT SERVE ON THE SMALL EMPLOYER REINSURANCE POOL BOARD FROM NINE TO FIVE; ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE; TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT; AMEND THE UTILIZATION REVIEW LAWS TO CLARIFY THAT SUCH LAWS PLAINLY APPLY TO INDIVIDUAL INSURANCE COVERAGE AS WELL AS GROUP COVERAGE; TO REMOVE FROM THE UNIFORM CREDENTIALING STATUTE AN UNNECESSARY PROVISION; ENSURE THAT COVERED PERSONS RECEIVING EXTERNAL REVIEW KNOW WHAT INFORMATION THEIR INSURER PROVIDES TO THE EXTERNAL REVIEW ORGANIZATION PERFORMING THE REVIEW; AND ELIMINATE EXTERNAL REVIEW OUTSIDE OF NORMAL BUSINESS HOURS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-51-80(1a) reads as rewritten:

"(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have

voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members. The premium rates for each association policy shall be developed, and applied to the certificates thereunder, on an actuarially sound basis.

c. Repealed by Session Laws 1997-259, s. 8."

SECTION 1.(b) G.S. 58-51-95 is amended by adding the following new subsection to read:

"**§ 58-51-95. Approval by Commissioner of forms, classification and rates; hearing; exceptions.**

…

"(g) For policies subject to this section, an individual health insurer shall not increase an individual's renewal premium for continued health insurance coverage under the terms of the individual's health insurance policy based on any health status-related factors in relation to the individual or a dependent of the individual, including:

(1) Health status.
(2) Medical condition (including physical and mental illnesses).
(3) Claims experience.
(4) Duration from issue.
(5) Receipt of health care.
(6) Medical history.
(7) Genetic information."

SECTION 2.(a) G.S. 58-65-60 is amended by adding the following new subsection to read:

"**§ 58-65-60. Subscribers' contracts; required and prohibited provisions.**

…

"(e3) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

SECTION 2.(b) G.S. 58-67-85 is amended by adding the following new subsection to read:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

…

"(d1) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

SECTION 2.(c) G.S. 58-51-80(c) reads as rewritten:

"**§ 58-51-80. Group accident and health insurance defined.**

…

"(c) The term "employees" as used in this section shall be deemed to include, for the purposes of insurance hereunder, employees of a single employer, the officers,

managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. With the exception of disability income insurance, employees shall be added to the 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 who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. The term "employer" as used herein may be deemed to include the State of North Carolina, any county, municipality or corporation, or the proper officers, as such, of any unincorporated municipality or any department or subdivision of the State, county, such corporation, or municipality determined by conditions pertaining to the employment. When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

SECTION 3. G.S. 58-51-30(b) reads as rewritten:

"**§ 58-51-30. Policies to cover newborn infants, foster children, and adopted children.**

…

"(b) Every health benefit plan, as defined in ~~G.S. 58-3-167,~~G.S. 58-51-115(a)(1), that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Every health benefit plan shall extend coverage to a foster child or adopted child without requirements for prior notification unless an additional premium charge to add the foster child or adopted child is due. If an additional premium charge is due to cover the foster child or adopted child, the health benefit plan shall cover the foster child or adopted child upon placement in the foster home or placement for adoption if the foster child or adopted child is enrolled within 30 days after the placement in the foster home or placement for adoption."

SECTION 4.(a) G.S. 58-51-15(a)(2) reads as rewritten:

"**§ 58-51-15. Accident and health policy provisions.**

(a) Required Provisions. – Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

…

(2) A provision in the substance of the following language:

TIME LIMIT ON CERTAIN DEFENSES:

a. After two years from the date of issue or reinstatement of this policy no misstatements except fraudulent misstatements made

by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provision may be used in its entirety only in major or catastrophe hospitalization policies and major medical policies each affording benefits of five thousand dollars ($5,000) or more for any one sickness or injury; disability income policies affording benefits of one hundred dollars ($100.00) or more per month for not less than 12 months; and franchise policies. Other policies to which this section applies must delete the words "except fraudulent misstatements."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(b), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

1. Until at least age 50 or,
2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE."

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy _____ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." ~~Credit~~ Except for the excepted benefits described in G.S. 58-68-25(b), credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-68-30."

SECTION 4.(b) G.S. 58-51-15(h) reads as rewritten:

"**§ 58-51-15. Accident and health policy provisions.**

…

"(h) Preexisting Condition Exclusion Clarification. – Sub-subdivision (a)(2)b. of this section does not apply ~~to:~~to policies issued to eligible individuals under G.S. 58-68-60.

~~(1) Policies issued to eligible individuals under G.S. 58-68-60.~~

~~(2) Excepted benefits as described in G.S. 58-68-25(b).~~"

SECTION 5. G.S. 58-50-150(b) reads as rewritten:

"**§ 58-50-150. North Carolina Small Employer Health Reinsurance 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~~ five 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~~ 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~~ Four 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."

SECTION 6. G.S. 58-54-45(a) reads as rewritten:

"**§ 58-54-45. By reason of disability.**

(a) In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plans A, C, and J available to persons eligible for Medicare by reason of disability before age 65. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision."

SECTION 7. G.S. 58-3-100(c) reads as rewritten:

"**§ 58-3-100. Insurance company licensing provisions.**

…

(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be one of the following:

(1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.
(2) Payment of the claim.
(3) A bona fide written offer of settlement.
(4) A written denial of the claim.

A claimant includes an insured, a beneficiary of a life or annuity contract, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer, HMO, service corporation, or MEWA. With respect to a claim under an accident, health, or disability policy, if the acknowledgement sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgement includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225."

SECTION 8. G.S. 58-50-61(a) is amended by adding the following new subdivision to read:

"**§ 58-50-61. Utilization review.**

(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

…

(2a) 'Certificate of coverage' includes a policy of insurance issued to an individual person or a franchise policy issued pursuant to G.S. 58-51-90.

…."

SECTION 9. G.S. 58-3-230(a) reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care ~~practitioner, or applicant for licensure as a health care practitioner,~~ practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application."

SECTION 10.(a) G.S. 58-50-80(b)(4) reads as rewritten:

"**§ 58-50-80. Standard external review.**

…

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:

…

(4) Notify the insurer in writing whether the request for external review has been accepted. If the request has been accepted, the notice shall direct the insurer or its designee utilization review organization to provide to the assigned ~~organization,~~organization and to the covered person or authorized representative who made the request for external review on behalf of the covered person, within seven days of receipt of the notice, the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision."

SECTION 10.(b) G.S. 58-50-82(c) reads as rewritten:

"**§ 58-50-82. Expedited external review.**

…

(c) As soon as possible, but within the same day of receiving notice under subdivision (b)(2) of this section that the request has been assigned to a review organization, the insurer or its designee utilization review organization shall provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method. A copy of the same information shall be sent by the same means or other expeditious means to the covered person or the covered person's representative who made the request for expedited external review."

SECTION 11. The first sentence of G.S. 58-50-82(b) reads as rewritten:

"**§ 58-50-82. Expedited external review.**

…

(b) Within three business days of receiving a request for an expedited external review, the Commissioner shall complete all of the following:".

SECTION 12. G.S. 58-50-82(e) reads as rewritten:

"**§ 58-50-82. Expedited external review.**

…

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than four business days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification, noncertification appeal decision, or second-level grievance review decision and notify the covered person, the covered person's provider

who performed or requested the service, the insurer, and the Commissioner of the decision. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62."

SECTION 13. Sections 1 through 4 of this act become effective January 1, 2006, and apply to policies or certificates issued or renewed on or after that date. Sections 9 through 12 of this act become effective October 1, 2005, and apply to policies or certificates issued or renewed on or after that date. The remainder of this act is effective when it becomes law and applies to policies or certificates issued or renewed on or after that date.

In the General Assembly read three times and ratified this the 18th day of July, 2005.

s/ Beverly E. Perdue
President of the Senate

s/ James B. Black
Speaker of the House of Representatives

s/ Michael F. Easley
Governor

Approved 2:59 p.m. this 27th day of July, 2005