GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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HOUSE BILL 360*

Committee Substitute Favorable 4/24/01
Committee Substitute #2 Favorable 4/25/01

Short Title: Health Insurance Omnibus Changes. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAW ON STIPULATIONS AS TO JURISDICTION AND LIMITATIONS OF ACTION AND THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; CLARIFY THE HMO POINT-OF-SERVICE LAW; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS; TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS; TO CLARIFY THE LAWS ON RECONSTRUCTIVE SURGERY NOTICES; AND TO CLARIFY THE LAW ON DEEMER PROVISIONS.

The General Assembly of North Carolina enacts:

PART I. JURISDICTION AND LIMITATION OF ACTIONS IN HEALTH INSURANCE POLICIES

SECTION 1. G.S. 58-3-35 reads as rewritten:

"**§ 58-3-35. Stipulations as to jurisdiction and limitation of actions.**

(a) ~~No company or order, domestic or foreign, authorized to do business in this State under Articles 1 through 64 of~~ No insurer, self-insurer, service corporation, HMO, or MEWA licensed under this ~~Chapter, may~~ Chapter shall make any condition or stipulation in its insurance contracts or policies concerning the court or jurisdiction ~~wherein~~ in which any suit or action ~~thereon~~ on the contract may be brought.

(b) ~~may be brought, nor may it~~ No insurer, self-insurer, service corporation, HMO, or MEWA licensed under this Chapter shall limit the time within which ~~such~~ any suit or action referred to in subsection (a) of this section may be commenced to less than one year after the cause of action accrues or to less than six months from any time at which a plaintiff takes a nonsuit to an action begun within the legal time. ~~All conditions and stipulations forbidden by this section are void.~~

(c) All conditions and stipulations forbidden by this section are void."

PART II. PREFERRED PROVIDER PLAN CLARIFICATION

SECTION 2.1 G.S. 58-50-56(a)(3) reads as rewritten:

"(3) "Preferred provider benefit plan" means a health benefit plan offered by an insurer in which covered services are available from health care providers who are under a contract with the insurer in accordance with this section and in which enrollees are given incentives through differentials in deductibles, coinsurance, or copayments to obtain covered health care services from contracted health care providers. ~~both of the following features are present:~~

~~a. Utilization review or quality management programs are used to manage the provision of covered health care services; andservices.~~

~~b. Enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those furnished by participating providers, and health care services are provided by preferred providers under a contract pursuant to this section.~~"

SECTION 2.2. G.S. 58-3-191(c) reads as rewritten:

"(c) For purposes of this section, "health benefit plan" or "plan" means (i) health maintenance organization (HMO) subscriber contracts and (ii) insurance company or hospital and medical service corporation preferred provider benefit plans ~~in which utilization review or quality management programs are used to manage the provision of covered health care services, and enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those provided by participating providers.~~as defined in G.S. 58-50-56."

PART III. SMALL EMPLOYER RATE GUARANTEES

SECTION 3. G.S. 58-50-130(b)(3) reads as rewritten:

"(3) ~~Small employer carriers~~ A small employer carrier shall not modify the premium rate ~~for~~ charged to a small employer or a small employer group member, including changes in rates related to the increasing age of a group member, for 12 months from the initial issue date or renewal date, unless the group is composite rated and composition of the group changed by twenty percent (20%) or more or benefits are changed. The percentage increase in the premium rate charged to a small employer for a new rating period ~~may~~ shall not exceed the sum of the following:

a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period, and

b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer, and

c. Any adjustment because of change in coverage or change in case characteristics of the small employer group."

PART IV. PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION

SECTION 4. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-16. Promotion of alcohol and narcotic screening and intervention.**

G.S. 58-51-15(b)(11) does not apply to an accident or health insurance policy that provides hospital, medical, or surgical expense coverage."

PART V. NEWBORN AND FOSTER CHILD COVERAGE

SECTION 5. G.S. 58-31-30(b) reads as rewritten:

"(b) Every health benefit plan, as defined in G.S. 58-51-115(a)(1), 58-3-167, 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 shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home. Every health benefit plan shall extend coverage to a foster child without requirements for prior notification unless an additional premium charge to

add the foster child is due. If an additional premium charge is due to cover the foster child, the health benefit plan shall cover the foster child upon placement in the foster home if the foster child is enrolled within 30 days after the placement in the foster home."

PART VI. SUCCESSOR PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY

SECTION 6. G.S. 58-51-110(b) reads as rewritten:

"(b) Whenever a contract described in subsection (a) of this section is replaced by another group contract within 15 days of termination of coverage of the previous group contract, the liability of the succeeding insurer for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding insurer's plan of ~~benefits with respect to classes eligible and activity at work and nonconfinement rules must~~ benefits, regardless of any other provisions of the new group contract relating to active employment or hospital confinement or pregnancy, shall be covered by the succeeding insurer's plan of benefits; and

(2) Each person not covered under the succeeding insurer's plan of benefits in accordance with subdivision (b)(1) of this section must nevertheless be covered by the succeeding insurer 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 insurer's plan."

PART VII. CONTINUATION ELECTION PERIOD

SECTION 7.1. G.S. 58-53-10 reads as rewritten:

"**§ 58-53-10. Eligibility.**

Continuation shall only be available to an employee or member who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately ~~prior to~~ before the date of termination. The employee or member may elect continuation for a period of not fewer than 60 days after the date of termination or loss of eligibility. The employee or member shall make the first contribution upon the election to continue coverage; and the coverage shall be retroactive to the date of termination or loss of eligibility."

SECTION 7.2. G.S. 58-53-30 reads as rewritten:

"**§ 58-53-30. Payment of premiums.**

An employee or member electing continuation must pay to the group policyholder or his employer, in advance, the amount of contribution required by the policyholder or employer, but not more than one hundred two percent (102%) of the full group rate for

the insurance applicable under the group policy on the due date of each payment. The employee or member may not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member must make a written election of continuation, on a form furnished by the group ~~policyholder, and pay the first contribution, in advance, to the policyholder or employer on or before the date on which employee's or member's insurance would otherwise terminate.~~policyholder or by the insurer."

PART VIII. HMO GROUP COVERAGE PREMIUM CHANGE NOTICE

SECTION 8.1. G.S. 58-67-50(b) reads as rewritten:

"(b) (1) Premium approval. – No schedule of premiums for ~~enrollee~~ coverage for health care services, or any amendment ~~thereto, may~~ to the schedule, shall be used in conjunction with any health care plan until a copy of ~~such schedule, or amendment thereto,~~ the schedule or amendment has been filed with and approved by the Commissioner.

(2) Individual coverage. – Premiums shall ~~Such premiums may~~ be established in accordance with actuarial principles for various categories of ~~enrollees, provided that premiums~~ enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of ~~his~~ the enrollee's health. ~~However, the premiums~~ Premiums shall not be excessive, inadequate, or unfairly discriminatory; and ~~must~~ shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. ~~Such~~ The premiums or any revisions ~~thereto~~ to the premiums with respect to nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 ~~months; or as an~~ months. As an alternative to giving ~~such~~ this guarantee ~~with respect only to~~ for nongroup enrollee coverage, ~~such~~ the premium or premium revisions may be made applicable to all similar category of enrollee coverage at one time if the health maintenance organization chooses to apply for ~~such~~ the premium revision with respect to such categories of coverages no more frequently than once in any 12-month period. ~~Such~~ The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the ~~corporation~~ HMO has given written notice of the premium revision to the enrollee 45 days ~~prior to~~ before the effective date of ~~such~~ the revision. The enrollee thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may ~~promulgate~~ adopt reasonable rules, after notice and hearing, to require the ~~submission~~ submittal of supporting data and such information ~~as is~~

~~deemed~~ as the Commissioner considers necessary to determine whether ~~such~~ the rate revisions meet ~~these standards.~~the standards in this subdivision.

(3) Group coverage. – Employer group premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate, or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any revisions to the premiums for employer group coverage shall be guaranteed for a period of not less than 12 months. No premium revision shall become effective for any category of group coverage unless the HMO has given written notice of the premium revision to the master group contract holder upon receipt of the group's finalized benefits or 45 days before the effective date of the revision, whichever is earlier. The master group contract holder thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision."

SECTION 8.2. G.S. 58-67-35(a)(6) reads as rewritten:

"(6) The offering and contracting for the provision or arranging of, in addition to health care services, of:

a. Additional health care services;

b. Indemnity benefits, covering out-of-area or emergency services;

c. Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or hospital or medical service corporations; and

d. Point-of-service products, for which an HMO may pre-certify out-of-plan covered services on the same basis as it pre-certifies in-plan covered services, and for which the Commissioner shall adopt rules governing:

1. The percentage of an HMO's total health care expenditures for out-of-plan covered services for all of its members that may be spent on those services, which may not exceed twenty percent (20%);

2. Product limitations, which may provide for payment differentials for services rendered by providers who are not in an HMO network, subject to G.S. 58-3-200(d).

3. Deposit and other financial requirements; and

4. Other requirements for marketing and administering those products."

PART IX. HIPAA COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE

SECTION 9. G.S. 58-68-30(d) reads as rewritten:

"(d) Exceptions. –

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. – A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5) Condition first diagnosed under previous coverage. – A group health insurer shall not impose any preexisting condition exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and the condition was covered under the qualifying previous coverage or prior creditable coverage; provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than 63 days before the enrollment date for the new coverage."

PART X. MEDICARE SUPPLEMENT GUARANTEED ISSUANCE

SECTION 10.1 G.S. 58-54-45 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 ~~Plan A~~ 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.

(b) Persons eligible for Medicare by reason of disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment have the guaranteed right to purchase Medicare Supplement Plans A and C from any insurer within 63 days after the date of termination or disenrollment.

(c) An insurer may develop premium rates specific to the disabled population. No insurer shall discriminate in the pricing of the Medicare supplement plans referred to in this section because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the plan is submitted during an open enrollment or is submitted within 63 days after the managed care plan is terminated. The rates and any applicable rating factors for the Medicare supplement plans referred to in this section shall be filed with and approved by the Commissioner."

SECTION 10.2. Section 39 of S.L. 1998-211 reads as rewritten:

"Section 39. Except as otherwise provided herein, this act is effective as follows: this section and Sections 1, 2, 3, 4, 5, 6, 7, 9.1, 10, 11, 14, 15, 17, 18, 22, 27, 29, 32, 33, 34, 37.1, and 38 of this act are effective when they become law. Sections 9, 12, 13, 19, 20, 21, 23, 24, 25, 28, 30, 31, 35, 36, and 37 of this act become effective November 1, 1998. Sections 8, 16, and 26 of this act become effective January 1, 1999. ~~G.S. 58-54-45, as enacted by Section 13 of this act, expires November 1, 2001.~~"

PART XI. MEDICARE SUPPLEMENT AND LONG-TERM CARE RULES

SECTION 11.1. G.S. 58-54-50 reads as rewritten:

"**§ 58-54-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements.

(2) Establishing a uniform methodology for calculating and reporting loss ratios.

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.

(4) Establishing standards for Medicare Select policies and certificates.

(5) Any other changes required by Congress or the U.S. Department of Health and Human Services, or any successor agency."

SECTION 11.2. Article 55 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-55-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies."

PART XII. SHPPA REPEAL TECHNICAL CORRECTIONS

SECTION 12.1. G.S. 58-50-110(1) is repealed.

SECTION 12.2. G.S. 58-50-110(14) reads as rewritten:

"(14) 'Late enrollee' has the same meaning as defined in G.S. 58-68-30(b)(2); provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. In addition to the special enrollment provisions in G.S. 58-68-30(f), an eligible employee or dependent shall not be considered a late enrollee under a small employer health benefit plan if:

a. Repealed by Session Laws 1998-211, s. 9.

1, 2. Repealed by Session Laws 1998-211, s. 9.

3, 4. Repealed by Session Laws 1993, c. 529, s. 3.3.

b. The individual elects a different health benefit plan offered ~~through the Alliance or~~ by the small employer during an open enrollment period;

c. Repealed by Session Laws 1998-211, s. 9.

d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment for a spouse is made within 30 days after issuance of the court order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or

e. Repealed by Session Laws 1998-211, s. 9."

SECTION 12.3. G.S. 58-50-130(a)(4a) reads as rewritten:

"(4a) 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 and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based

health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. ~~An accountable health carrier shall not enforce participation or contribution requirements on member small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.~~"

PART XIII. RECONSTRUCTIVE SURGERY NOTICES

SECTION 13.1 G.S. 58-51-62(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ policyholder under ~~the~~ an individual policy, contract, or plan and to every certificate holder under a group policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the policyholder or certificate holder."

SECTION 13.2. G.S. 58-65-96(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ subscriber under ~~the~~ an individual certificate, contract, or plan and to every certificate holder under a group policy, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the subscriber or certificate holder."

SECTION 13.3. G.S. 58-67-79(d) reads as rewritten:

"(d) Written notice of the availability of the coverage provided by this section shall be delivered to every ~~individual person insured~~ subscriber under the plan upon enrollment and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the subscriber."

PART XIV. DEEMER PROVISIONS

SECTION 14. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-151. Deemer provisions.**

No entity subject to the Commissioner's jurisdiction and regulation shall be fined or penalized by the Commissioner for using forms, contracts, schedules of premiums, or other documents required to be filed and approved under this Chapter or for executing contracts required to be filed and approved under this Chapter if those forms, contracts, schedules of premiums, or other documents have been by law deemed to have been approved, and the entity has notified the Commissioner before using the filing or executing the contract that the law has deemed the filing or the contract to be approved."

PART XV. SEVERABILITY

SECTION 15. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

PART XVI. EFFECT OF HEADINGS

SECTION 16. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART XVII. EFFECTIVE DATES

SECTION 17. Parts I through X of this act become effective October 1, 2001. The remainder of this act is effective when it becomes law.