GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 1389

Short Title:	High-Risk Health Insurance Pool.	(Public)
Sponsors:	Senator Ballantine.	
Referred to:	Insurance and Consumer Protection.	

June 13, 2002

1 A BILL TO BE ENTITLED
2 AN ACT TO MAKE AVAILABLE COMPREHENSIVE HEALTH INSURANCE
3 FOR HIGH-RISK INDIVIDUALS THROUGH A HIGH-RISK POOL.
4 WHEREAS, health insurance programs that guarantee access for the
5 uninsured population are an important safety net for individuals who have been denied
6 health insurance coverage because of a preexisting medical condition; and
7 WHEREAS, catastrophic medical costs remain a leading cause of bankruptcy
8 in the United States, to wit, approximately forty percent of the bankruptcy filings in
9 1999, roughly 500,000 Americans, were due to huge medical expenses; and
10 WHEREAS, the problems of those Americans who are unable to purchase
11 insurance protection that they desperately need are severe and unnecessarily threaten the
12 health and financial future of thousands of families; and
13 WHEREAS, the number of North Carolinians who are medically uninsurable
14 represents approximately one percent of the State's population; and
15 WHEREAS, health insurance high-risk pools serve two important roles –
16 they provide guaranteed access to insurance that enables people to protect themselves
17 from catastrophic medical bills, and high-risk pools are increasingly recognized for the
18 role they play in keeping the individual insurance markets viable for companies to
19 compete in; Now, therefore,
20 The General Assembly of North Carolina enacts:
21 **SECTION 1.** Article 50 of Chapter 58 of the General Statutes is amended by
22 adding the following new Part to read:
23 "Part 6. North Carolina Health Insurance High-Risk Pool.
24 "**§ 58-50-160. Definitions.**
25 As used in this Part, unless the context clearly requires otherwise, the term:
26 (1) 'Board' means the board of directors of the Pool.
27 (2) 'Health benefit plan' has the meaning applied in G.S. 58-3-167.

1 (3) 'Insurer' has the meaning applied in G.S. 58-37-5 and includes
2 'reinsurer' as that term is defined in G.S. 58-9-2.
3 (4) 'Member' means each insurer participating in the Pool.
4 (5) 'Plan' means the Comprehensive Health Benefit Plan for High-Risk
5 Individuals offered under the North Carolina Health Insurance
6 High-Risk Pool as created in this Part.
7 (6) 'Plan of operation' means the articles, bylaws, and operating rules and
8 procedures adopted by the Board in accordance with this Part.
9 (7) 'Pool' means the North Carolina Health Insurance High-Risk Pool
10 established in accordance with this Part.
11 "**§ 58-50-161. High-Risk Pool established; purpose; coverage not an entitlement.**
12 (a) Title of Act; Purpose. – This Act shall be known and may be cited as the
13 North Carolina Health Insurance High-Risk Pool Act. The purpose of this Act is to
14 make comprehensive health insurance available to individuals with high-risk health
15 conditions.
16 (b) Pool Established. – There is created a nonprofit entity to be known as the
17 North Carolina Health Insurance High-Risk Pool. All insurers issuing health benefit
18 plans in this State on and after January 1, 2002, are members of the Pool.
19 (c) Board of Directors. – At its initial organizational meeting, the Pool shall
20 select a board of directors in accordance with this section and subject to the
21 Commissioner's approval. If the initial Board is not elected at the organizational
22 meeting, the Commissioner shall appoint the initial Board within 30 days of the initial
23 organizational meeting. The Board shall consist of seven directors. Of the seven, one
24 shall represent consumers and two shall represent businesses other than the insurance
25 industry. The Board shall include at least two domestic insurance companies selling
26 health insurance in this State, including the domestic company selling the largest
27 amount of health insurance in this State.
28 (d) Plan of Operation. – The Board shall submit to the Commissioner a plan of
29 operation and any amendments necessary or suitable to assume the fair, reasonable, and
30 equitable administration of the Pool. The Commissioner shall approve the plan of
31 operation if it assures the fair, reasonable, and equitable administration of the Pool. The
32 plan of operation shall become effective upon approval in writing by the Commissioner
33 consistent with the date on which the coverage under this section shall be made
34 available. If the Board fails to submit a suitable plan of operation within 180 days after
35 its appointment, or at any time thereafter fails to submit suitable amendments to the plan
36 of operation, the Commissioner shall adopt and implement a plan of operation or
37 amendment, as appropriate. The Commissioner shall amend any plan of operation he
38 adopts, as necessary, after a plan of operation is submitted by the Board and approved
39 by the Commissioner. The plan of operation shall establish the following procedures
40 for:
41 (1) Handling and accounting of assets and moneys of the Pool, and for an
42 annual financial reporting to the Commissioner.

(2) Filling vacancies on the Board, subject to the Commissioner's approval.
(3) Selecting a Plan administrator and setting forth the powers and duties of the administrator.
(4) Collecting assessments from members subject to assessment and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.
(5) Any additional matters in the Board's discretion.

(e) General Powers and Duties. – 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 Part, 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.
(4) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the Pool's operation.
(5) Assess members as authorized by and in accordance with the laws of this State 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.
(6) 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.
(7) 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.

(f) Additional Authority. – In addition to its general powers, the Board may take measures to contain insurance costs subject to the approval of the Commissioner or the Commissioner's designee, including:

(1) Provide for and employ cost containment measures and requirements, including preadmission screening, second surgical opinion, concurrent

utilization review, and individual case management for the purpose of making the Plan more cost effective.

(2) Design, utilize, contract, or otherwise arrange for delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, or other limited network provider arrangements.

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

"**§ 58-50-162 through 168:** Reserved.

SECTION 2.(a) Part 6 of Article 50 of Chapter 58 of the General Statutes, as enacted by this act, is amended by adding the following new sections to read:

"**§ 58-50-162. Eligibility for Plan coverage under the North Carolina Health Insurance High-Risk Pool.**

(a) Any individual person who is and continues to be a resident of this State is eligible for Plan coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer; or

(2) A refusal by an insurer to issue insurance except at a rate exceeding the Plan rate.

(b) Any federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident shall be eligible for Plan coverage.

(c) A rejection or refusal by an insurer offering only stop loss, excess of loss, or reinsurance coverage with respect to an applicant under subsection (a) of this section shall not be sufficient evidence under this subsection.

(d) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Plan coverage without applying for health insurance pursuant to subsection (a) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list adopted by the Board shall not be required to provide the evidence specified in subsection (a) of this section. The list shall be effective on the first day of the operation of the Plan and may be amended from time to time as may be appropriate.

(e) Each resident dependent of a person who is eligible for Plan coverage shall also be eligible for Plan coverage.

(f) A person is not eligible for coverage under the Plan if:

(1) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a Plan policy, or would be eligible to have coverage if the person elected to obtain it; except that:

a. A person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a Plan policy; and

b. A person may maintain Plan coverage for the period of time the person is satisfying a preexisting condition waiting period under

another health insurance policy intended to replace the Plan policy;

(2) The person is determined to be eligible for enrollment in the State Medical Assistance Plan;

(3) The person has previously terminated Plan coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual;

(4) The Plan has paid out two million dollars ($2,000,000) in benefits on behalf of the person;

(5) The person is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual; or

(6) The person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(g) Coverage under the Plan shall cease:

(1) On the date a person is no longer a resident of this State;

(2) On the date a person requests coverage to end;

(3) Upon the death of the covered person;

(4) On the date State law requires cancellation of the Plan policy; or

(5) At the option of the Plan, 30 days after the Plan makes any inquiry concerning the person's eligibility or residence to which the person does not reply.

(h) Except as provided in subsection (g) of this section, a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the Plan period for which the necessary premiums have been paid.

"**§ 58-50-163. Unfair referral to Pool.**

It is an unfair trade practice under G.S. 75-1-1 for an insurer, insurance agent, insurance broker, or third-party administrator to refer an individual employee to the Plan or arrange for an individual employee to apply to the Plan for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

"**§ 58-50-164. Plan administrator.**

(a) The Board shall select a plan administrator through a competitive bidding process to administer the Plan. The board shall evaluate bids submitted based on criteria established by the Board. The criteria shall include:

(1) The Plan administrator's proven ability to handle health insurance coverage to individuals.

(2) The efficiency and timeliness of the Plan administrator's claim processing procedures.

1 (3) An estimate of total charges for administering the Plan.
2 (4) The plan administrator's ability to apply effective cost containment
3 programs and procedures and to administer the plan in a cost-efficient
4 manner.
5 (5) The financial condition and stability of the plan administrator.
6 (b) The Plan administrator shall serve for a period specified in the contract
7 between the Plan and the Plan administrator subject to removal for cause and subject to
8 any terms, conditions, and limitations of the contract between the Plan and the Plan
9 administrator. At least one year prior to the expiration of each period of service by a
10 Plan administrator, the board shall invite eligible entities, including the current Plan
11 administrator to submit bids to serve as the Plan administrator. Selection of the Plan
12 administrator for the succeeding period shall be made at least six months prior to the
13 end of the current period.
14 (c) The Plan administrator shall perform such functions relating to the Plan as
15 may be assigned to it, including:
16 (1) Determination of eligibility.
17 (2) Payment of claims.
18 (3) Establishment of a premium-billing procedure for collection of
19 premium from persons covered under the Plan.
20 (4) Other necessary functions to assure timely payment of benefits to
21 covered persons under the Plan.
22 "**§ 58-50-165. Premiums.**
23 (a) The Plan shall establish premium rates for Plan coverage in accordance with
24 this section. Separate schedules of premium rates based on age, sex, and geographical
25 location may apply for individual risks. Premium rates and schedules shall not be
26 applicable until approved by the Commissioner.
27 (b) The Plan, with the assistance of the Commissioner, shall determine a standard
28 risk rate by considering the premium rates charged by other insurers offering health
29 insurance coverage to individuals. The standard risk rate shall be established using
30 reasonable actuarial techniques and shall reflect anticipated experience and expenses for
31 the coverage. Initial rates for Plan coverage shall be not less than one hundred twenty-
32 five percent (125%) and not more than one hundred fifty percent (150%) of rates
33 established as applicable for individual standard risks. Subject to the limits provided in
34 this subsection, subsequent rates shall be established to provide fully for the expected
35 costs of claims including recovery of prior losses, expenses of operation, investment
36 income of claim reserves, and any other cost factors subject to the limitations described
37 in this subsection. In no event shall Plan rates exceed one hundred fifty percent (150%)
38 of rates applicable to individual standard risks.
39 "**§ 58-50-166. Plan benefits; preexisting conditions; nonduplication of benefits.**
40 (a) The Plan shall offer health care coverage consistent with comprehensive
41 coverage to every eligible person who is not eligible for Medicare. The coverage to be
42 issued by the Plan, its schedule of benefits, exclusions, and other limitations shall be
43 established by the Board and subject to the approval of the Commissioner.

(b) In establishing Plan coverage, the Board shall take into consideration the levels of health insurance coverage provided in the State and medical economic factors as may be deemed appropriate, and shall adopt benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance coverage provided through a representative number of large employers in the State.

(c) The Board may adjust any deductibles and coinsurance factors annually according to the Medical Component of the Consumer Price Index.

(d) Plan coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the six-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(e) Subject to subsection (d) of this section, the preexising condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, provided that:

(1) Application for Plan coverage is made not later than 63 days following the involuntary termination and, in such case, coverage in the Plan shall be effective from the date on which the prior coverage was terminated; and
(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Plan coverage.

(f) The Plan shall be the payer of last resort of benefits whenever any other benefit or third-party payment is available. Benefits otherwise payable under Plan coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(g) The Plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the Plan may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-167. Immunity.**

(a) 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 Part may be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its members.

(b) 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

1 the Pool against all liability and costs, including the amounts of judgments, settlements,
2 fines, or penalties, and expenses and reasonable attorneys' fees incurred in connection
3 with the action, suit, or proceeding. However, the indemnification shall not be provided
4 on any matter in which the person or member is finally adjudged in the action, suit, or
5 proceeding to have committed a breach of duty involving gross negligence, dishonesty,
6 willful misfeasance, or reckless disregard of the responsibilities of service or office.
7 Costs and expenses of the indemnification shall be prorated among and paid for by all
8 members."
9 **SECTION 2.(b)** G.S. 58-50-160, as enacted by this act, is amended by
10 adding the following new subdivisions in alphabetical order to read:
11 (1) 'Affiliation period' means a period which, under the terms of the health
12 insurance coverage offered by a health maintenance organization, must
13 expire before the health insurance coverage becomes effective. The
14 organization is not required to provide health care services or benefits
15 during this period and no premium shall be charged to the participant
16 or beneficiary for any coverage during the period. The period begins
17 on the enrollment date and runs concurrently with any waiting period
18 under the Plan.
19 (2) 'Beneficiary' has the meaning given under section 3(8) of the
20 Employee Retirement Income Security Act of 1974.
21 (3) 'COBRA continuation provision' means:
22 a. Part 6 of subtitle B of Title I of the Employee Retirement
23 Income Security Act of 1974, other than section 609 of the act;
24 b. Section 4908B of the Internal Revenue Code of 1986, other
25 than subsection (f)(1) of the section insofar as it relates to
26 pediatric vaccines;
27 c. Title XXII of the Public Health Service Act.
28 (4) 'Church plan' has the meaning given under section 3(33) of the
29 Employee Retirement Income Security Act of 1974.
30 (5) 'Creditable coverage' has the meaning applied in G.S. 58-68-30.
31 (6) 'Dependent' means a resident spouse or resident unmarried child under
32 the age of 19 years, a child who is a student under the age of 23 years
33 and who is financially dependent upon the parent, or a child of any age
34 who is disabled and dependent upon the parent.
35 (7) 'Employee' has the meaning given under section 3(6) of the Employee
36 Retirement Income Security Act of 1974.
37 (8) 'Enrollment date' means, with respect to an individual covered under a
38 group health plan or health insurance coverage, the date of enrollment
39 of the individual in the plan or coverage or, if earlier, the first day of
40 the waiting period for the enrollment.
41 (9) 'Federally defined eligible individual' means an individual:

1 a. For whom, as of the date on which the individual seeks
2 coverage under this Part, the aggregate of the periods of
3 creditable coverage is 18 or more months;
4 b. Whose most recent prior creditable coverage was under a group
5 health plan, government plan, church plan, or health insurance
6 coverage offered in connection with such a plan;
7 c. Who is not eligible for coverage under a group health plan, Part
8 A or Part B of Title XVIII of the Social Security Act
9 (Medicare), or a State plan under Title XIX of the Social
10 Security Act (Medicaid), or any successor program, and who
11 does not have other health insurance coverage;
12 d. With respect to whom the most recent coverage within the
13 period of aggregate creditable coverage was not terminated
14 based on a factor relating to nonpayment of premiums or fraud;
15 e. Who, if offered the option of continuation coverage under a
16 COBRA continuation provision or under a similar state
17 program, elected this coverage; and
18 f. Who has exhausted continuation coverage under this provision
19 or program, if the individual elected the continuation coverage
20 described in subparagraph e. of this subdivision.
21 (10) 'Government plan' has the meaning given under section 3(32) of the
22 Employee Retirement Income Security Act of 1974 and any
23 governmental plan established or maintained for its employees by the
24 government of the United States or by an agency or instrumentality of
25 the government of the United States.
26 (11) 'Group health plan' means an employee welfare benefit plan as defined
27 in section 3(1) of the Employee Retirement Income Security Act of
28 1974 to the extent that the plan provides medical care and including
29 items and services paid for as medical care to employees or their
30 dependents, as defined under the terms of the Plan directly or through
31 insurance, reimbursement, or otherwise.
32 (12) 'Health maintenance organization' has the meaning applied in 58-67-5.
33 (13) 'Hospital' means an institution operated pursuant to law under the
34 supervision of a staff of duly licensed physicians which is primarily
35 and continuously engaged in providing or operating, either on its
36 premises or in facilities available to the public on a prearranged basis,
37 medical, diagnostic, and other major surgical facilities for the medical
38 care and treatment of sick or injured persons on an inpatient basis for
39 which a charge is made and provides 24-hour nursing service under the
40 supervision of registered nurses.
41 (14) 'Medical care' means amounts paid for:

1 a. The diagnosis, cure, mitigation, treatment, or prevention of
2 disease, or amounts paid for the purpose of affecting any
3 structure or function of the body;
4 b. Transportation primarily for an essential to medical care
5 referred to in sub-subdivision a. of this subdivision; and
6 c. Insurance covering medical care referred to in sub-subdivisions
7 a. and b. of this subdivision.
8 (15) 'Medicare' means coverage under both Parts A and B of Title XVIII of
9 the Social Security Act, 42 U.S.C. § 1395, et seq., as amended.
10 (16) 'Net loss' means the excess of incurred claims plus expenses over the
11 sum of earned premiums, accrued investment income, and other
12 appropriate gains and losses.
13 (17) 'Preexisting condition exclusion' has the meaning applied in G.S.
14 58-68-30.
15 (18) 'Resident' means an individual who is legally domiciled in this State
16 for a period of at least 30 days, except that for a federally defined
17 eligible individual, there shall not be a 30-day requirement.
18 (19) 'Significant break in coverage' means a period of 63 consecutive days
19 during all of which the individual does not have any creditable
20 coverage, except that neither a waiting period nor an affiliation period
21 is taken into account in determining a significant break in coverage.
22 (20) 'Waiting period' has the meaning applied in G.S. 68-38-30."
23 **SECTION 3.(a)** The North Carolina Health Insurance High-Risk Pool
24 established under G.S. 58-50-161, as enacted by this act, shall hold its initial
25 organizational meeting not later than 90 days from the date this act becomes law. In the
26 event the Board of Directors of the Pool is not elected within 90 days from the date this
27 act becomes law, the Commissioner of Insurance shall appoint the Board in accordance
28 with G.S. 58-50-161. The term of Board members appointed under this subsection shall
29 be two years.
30 **SECTION 3.(b)** The Board of Directors of the North Carolina Health
31 Insurance High-Risk Pool, as appointed under Section 3(a) of this act, shall recommend
32 a comprehensive health insurance benefit plan for high-risk individuals and a method
33 for financing the benefit plan. In developing its recommended benefit plan and
34 financing, the Board shall review the Comprehensive Health Insurance Benefit Plan
35 ("Benefit Plan") as enacted in Section 2 of this act. The Board shall also review
36 coverage available under health insurance high-risk pools enacted in other states, the
37 model act of the National Association of Insurance Commissioners for the
38 establishment of high-risk pools, including proposed amendments thereto, and actuarial
39 and other information necessary for the development and financing of a fair, reasonable,
40 and equitable comprehensive health insurance benefit plan. Not later than March 1,
41 2003, the Board shall submit a report of its findings and recommendations to the
42 Commissioner of Insurance and the General Assembly. The report shall include the
43 following:

1 (1) A comprehensive health insurance benefit plan developed by the Board to be made available to high-risk individuals in this State. The plan developed and recommended by the Board may include in whole or in part provisions of the Benefit Plan enacted in Section 2 of this act.
(2) Comparisons of the benefit plan developed by the Board and the Benefit Plan scheduled to become effective January 1, 2004, as enacted in Section 2 of this act.
(3) Method for financing the benefit plan developed by the Board and the rationale for the financing method recommended by the Board. In developing a recommendation for financing, the Board shall consider the following:
a. Premium rates, coinsurance, deductibles, lifetime coverage, and other limitations that provide for a reasonable and affordable benefit plan.
b. Assessments of insurers and reinsurers in this State in a manner that fairly and reasonably spreads the cost of covering high-risk conditions.
c. Non-State funding sources such as funds from the Blue Cross/Blue Shield conversion, Tobacco Settlement funds, or other appropriate and available State or non-State funds.
d. Methods of financing used in other states for high-risk pool coverage and the adequacy of those methods.
(4) Information on all of the following:
a. The estimated number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.
b. The estimated number of those individuals who would qualify for coverage under the plan developed by the Board as compared to those who would qualify under the Benefit Plan enacted in Section 2 of this act.
c. The cost of coverage under the plan developed by the Board and that of the Benefit Plan enacted in Section 2 of this act and the anticipated amount of funding needed to provide coverage under each plan, including administrative costs.

SECTION 4. There is appropriated from the General Fund to the Department of Insurance the sum of seventy-five thousand dollars ($75,000) for the 2002-2003 fiscal year. These funds shall be placed in a special Reserve for Health Insurance High-Risk Pool in the Department and shall be allocated for the reasonable expenses of the Board in developing the Pool benefit plan in accordance with this act.

SECTION 5. Section 2 of this act becomes effective January 1, 2004, only if a method of fully financing the Comprehensive Health Insurance Benefit Plan for High-Risk Individuals established by Section 2 of this act is enacted by the 2003 General Assembly and becomes law. Section 4 of this act becomes effective July 1,

1 2002. The remainder of this act is effective when it becomes law. Nothing in this act
2 obligates the General Assembly to appropriate funds to implement this act.