

Part B. Individual Market Reforms.

**§ 58-68-60. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.**

- (a) **Guaranteed Availability.** –
- (1) In general. – Subject to the succeeding subsections of this section, each health insurer that offers health insurance coverage in the individual market in this State shall not, with respect to an eligible individual desiring to enroll in individual health insurance coverage:
    - a. Decline to offer the coverage to, or deny enrollment of, the individual; or
    - b. Impose any preexisting condition exclusion with respect to the coverage.
  - (2) Reserved.
- (b) **Eligible Individual Defined.** – In this Part, "eligible individual" means an individual:
- (1) (i) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);
  - (2) Who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of the Act (or any successor program), and does not have other health insurance coverage;
  - (3) With respect to whom the most recent coverage within the coverage period described in subdivision (1)(i) was not terminated based on a factor described in G.S. 58-68-45(b)(1) or (b)(2);
  - (4) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under Article 53 of this Chapter, who elected the coverage; and
  - (5) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program.
- (c) **Alternative Coverage Permitted.** –
- (1) In general. – In the case of health insurance coverage offered in this State, a health insurer may elect to limit the coverage offered under subsection (a) of this section as long as it offers at least two different policy forms of health insurance coverage both of which:
    - a. Are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the health insurer; and
    - b. Meet the requirement of subdivision (2) or (3) of this subsection, as elected by the health insurer.For the purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.
  - (2) **Choice of most popular policy forms.** – The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers the policy forms for individual health insurance coverage with the largest, and next to largest,

premium volume of all the policy forms offered by the health insurer in this State or applicable marketing or service area (as may be prescribed by rules or regulations) by the health insurer in the individual market in the period involved.

- (3) Choice of two policy forms with representative coverage. –
    - a. In general. – The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers a lower-level coverage policy form (as described in sub-subdivision b. of this subdivision) and a higher-level coverage policy form (as described in sub-subdivision c. of this subdivision) each of which includes benefits substantially similar to other individual health insurance coverage offered by the health insurer in this State.
    - b. Lower-level of coverage described. – A policy form is described in this sub-subdivision if the actuarial value of the benefits under the coverage is at least eighty-five percent (85%) but not greater than one hundred percent (100%) of a weighted average (described in sub-subdivision d. of this subdivision).
    - c. Higher-level of coverage described. – A policy form is described in this sub-subdivision if: (i) the actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of the coverage described in sub-subdivision b. of this subdivision offered by the health insurer in the area involved; and (ii) the actuarial value of the benefits under the coverage is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of a weighted average (described in sub-subdivision d. of this subdivision).
    - d. Weighted average. – For the purposes of this subdivision, the weighted average described in this sub-subdivision is the average actuarial value of the benefits provided by all the health insurance coverage issued, as elected by the health insurer, either by that health insurer or by all health insurers in this State in the individual market during the previous year, not including coverage issued under this section, weighted by enrollment for the different coverage.
  - (4) Election. – The health insurer elections under this subsection shall apply uniformly to all eligible individuals in this State for that health insurer. The election shall be effective for policies offered during a period of not less than two years.
  - (5) Assumptions. – For the purposes of subdivision (3) of this subsection, the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.
- (d) Special Rules for Network Plans. –
- (1) In general. – In the case of a health insurer that offers health insurance coverage in the individual market through a network plan, the health insurer may:
    - a. Limit the individuals who may be enrolled under the coverage to those who live, reside, or work within the service area for the network plan; and

- b. Within the service area of the plan, deny the coverage to the individuals if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and (ii) it is applying this subdivision uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.
  - (2) 180-day suspension upon denial of coverage. – A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subdivision, shall not offer coverage in the individual market within the service area for a period of 180 days after the coverage is denied.
- (e) Application of Financial Capacity Limits. –
  - (1) In general. – A health insurer may deny health insurance coverage in the individual market to an eligible individual if the health insurer has demonstrated to the Commissioner that:
    - a. It does not have the financial reserves necessary to underwrite additional coverage; and
    - b. It is applying this subdivision uniformly to all individuals in the individual market in this State consistent with this Chapter and without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.
  - (2) 180-day suspension upon denial of coverage. – A health insurer, upon denying individual health insurance coverage in any service area in accordance with subdivision (1) of this subsection, shall not offer the coverage in the individual market within the service area for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.
- (f) Market Requirements. –
  - (1) In general. – Subsection (a) of this section does not require that a health insurer offering health insurance coverage only in connection with ERISA group health plans or through one or more bona fide associations, or both, offer the health insurance coverage in the individual market.
  - (2) Conversion policies. – A health insurer offering health insurance coverage in connection with group health plans under title XXVII of the federal Public Health Service Act shall not be deemed to be a health insurer offering individual health insurance coverage solely because the health insurer offers a conversion policy.
- (g) Construction. – Nothing in this section shall be construed:
  - (1) To restrict the amount of the premium rates that a health insurer may charge an individual for health insurance coverage provided in the individual market under this Chapter; or
  - (2) To prevent a health insurer offering health insurance coverage in the individual market from establishing premium discounts or rebates or

modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(h) Other Definitions. – As used in this section:

(1) "Church plan". – The meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(2) "Governmental plan". –

a. The meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

b. Federal governmental plan. – A governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government.

c. Nonfederal governmental plan. – A governmental plan that is not a federal governmental plan.

(i) Rights of Replacement Coverage Upon Termination. – Subsection (a) of this section shall apply to an eligible individual whose coverage issued under this section is terminated by a health insurer under G.S. 58-68-65(c)(2) the application for the replacement coverage is dated not more than 63 days following the termination date.

(j) Waiting Period. – In determining the length of any break in coverage for an individual as prescribed in G.S. 58-68-60(b)(1)(i), a significant break in coverage does not occur during the waiting period. The "waiting period" is defined as the period that begins on the date the individual submits a substantially complete application for coverage and ends on:

(1) The date coverage begins, if the application results in coverage, or

(2) The date on which the application is denied by the issuer or the date on which the offer for coverage lapses, if the application does not result in coverage. (1997-259, s. 1(c); 1999-132, s. 4.7; 2005-224, s. 3; 2009-382, s. 5.)