

GENERAL ASSEMBLY OF NORTH CAROLINA

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HOUSE BILL 434

Committee Substitute Favorable 4/24/97

Senate Pensions & Retirement and Insurance Committee Substitute Adopted 6/12/97

Short Title: Federal Health Insurance Changes/AB.

(Public)

Sponsors:

Referred to:

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO CONFORM NORTH CAROLINA HEALTH INSURANCE LAWS TO RECENTLY ENACTED FEDERAL LAWS CONCERNING HEALTH INSURANCE UNDERWRITING AND PORTABILITY, MATERNITY COVERAGE, AND COVERAGE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. Article 68 of Chapter 58 of the General Statutes is amended as follows:

(a) By repealing G.S. 58-68-1, 58-68-5, 58-68-10, 58-68-15, and 58-68-20.

(b) By rewriting the Article heading to read:

~~"NORTH CAROLINA HEALTH INSURANCE TRUST COMMISSION."~~  
**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY."**

(c) By adding the following Part A and Part B:

**"PART A. GROUP MARKET REFORMS.**

**"SUBPART 1. PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS.**

**"§ 58-68-25. Definitions; excepted benefits; employer size rule.**

1 (a) Definitions. – In addition to other definitions throughout this Article, the  
2 following definitions and their cognates apply in this Article:

3 (1) 'Bona fide association'. – With respect to health insurance coverage  
4 offered in this State, an association that:

5 a. Has been actively in existence for at least five years.

6 b. Has been formed and maintained in good faith for purposes other  
7 than obtaining insurance.

8 c. Does not condition membership in the association on any health  
9 status-related factor relating to an individual (including an  
10 employee of an employer or a dependent of an employee).

11 d. Makes health insurance coverage offered through the association  
12 available to all members regardless of any health status-related  
13 factor relating to the members (or individuals eligible for  
14 coverage through a member).

15 e. Does not make health insurance coverage offered through the  
16 association available other than in connection with a member of  
17 the association.

18 f. Meets the additional requirements as may be imposed under State  
19 law.

20 (2) 'COBRA continuation provision'. – Any of the following:

21 a. Section 4980B of the Internal Revenue Code of 1986, other than  
22 subdivision (f)(1) of the section insofar as it relates to pediatric  
23 vaccines.

24 b. Part 6 of subtitle B of title I of the Employee Retirement Income  
25 Security Act of 1974, other than section 609 of the Act.

26 c. Title XXII of the Public Health Service Act (42 U.S.C.S. §  
27 300bb, et seq.,) as requirements for certain group health plans for  
28 certain State and local employees.

29 d. Article 53 of this Chapter or the health insurance continuation  
30 law of another state.

31 (3) 'Employee'. – The meaning given the term under section 3(6) of the  
32 Employee Retirement Income Security Act of 1974.

33 (4) 'Employer'. – The meaning given the term under section 3(5) of the  
34 Employee Retirement Income Security Act of 1974, except that the term  
35 shall include only employers of two or more employees.

36 (5) 'Health insurance coverage' or 'coverage' or 'health insurance plan' or  
37 'plan'. – Benefits consisting of medical care, provided directly through  
38 insurance or otherwise and including items and services paid for as  
39 medical care, under any accident and health insurance policy or  
40 certificate, hospital or medical service plan contract, or health  
41 maintenance organization contract, written by a health insurer.

42 (6) 'Health insurer'. – An insurance company subject to this Chapter, a  
43 hospital or medical service corporation subject to Article 65 of this

- 1 Chapter, a health maintenance organization subject to Article 67 of this  
2 Chapter, or a multiple employer welfare arrangement subject to Article  
3 49 of this Chapter, that offers and issues health insurance coverage.
- 4 (7) 'Health status-related factor'. – Any of the factors described in G.S. 58-  
5 68-35(a)(1).
- 6 (8) 'Individual health insurance coverage'. – Health insurance coverage  
7 offered to individuals in the individual market.
- 8 (9) 'Individual market'. – The market for health insurance coverage offered  
9 to individuals.
- 10 (10) 'Large employer'. – An employer who employed an average of at least  
11 51 employees on business days during the preceding calendar year and  
12 who employs at least two employees on the first day of the health  
13 insurance plan year.
- 14 (11) 'Large group market'. – The health insurance market under which  
15 individuals obtain health insurance coverage, directly or through any  
16 arrangement, on behalf of themselves and their dependents through a  
17 group health insurance plan maintained by a large employer.
- 18 (12) 'Medical care'. – Amounts paid for:
- 19 a. The diagnosis, cure, mitigation, treatment, or prevention of  
20 disease, or amounts paid for the purpose of affecting any  
21 structure or function of the body.
- 22 b. Amounts paid for transportation primarily for and essential to  
23 medical care referred to in sub-subdivision a. of this subdivision.
- 24 c. Amounts paid for insurance covering medical care referred to in  
25 sub-subdivisions a. and b. of this subdivision.
- 26 (13) 'Network plan'. – Health insurance coverage of a health insurer under  
27 which the financing and delivery of medical care (including items and  
28 services paid for as medical care) are provided, in whole or in part,  
29 through a defined set of health care providers under contract with the  
30 health insurer.
- 31 (14) 'Participant'. – The meaning given the term under section 3(7) of the  
32 Employee Retirement Income Security Act of 1974.
- 33 (15) 'Placed for adoption'. – The assumption and retention by a person of a  
34 legal obligation for total or partial support of a child in anticipation of  
35 adoption of the child. The child's placement with the person terminates  
36 upon the termination of the legal obligation.
- 37 (16) 'Small employer'. – The meaning given to the term in G.S. 58-50-  
38 110(22).
- 39 (17) 'Small group market'. – The health insurance market under which  
40 individuals obtain health insurance coverage, directly or through any  
41 arrangement, on behalf of themselves and their dependents through a  
42 group health insurance plan maintained by a small employer.

1       **(b) Excepted Benefits.** – For the purposes of this Article, ‘excepted benefits’ means  
2 benefits under one or more or any combination of the following:

3           **(1) Benefits not subject to requirements.** –

4           a. Coverage only for accident or disability income insurance or any  
5 combination of these.

6           b. Coverage issued as a supplement to liability insurance.

7           c. Liability insurance, including general liability insurance and  
8 automobile liability insurance.

9           d. Workers' compensation or similar insurance.

10          e. Automobile medical payment insurance.

11          f. Credit-only insurance.

12          g. Coverage for on-site medical clinics.

13          h. Other similar insurance coverage, specified in federal  
14 regulations, under which benefits for medical care are secondary  
15 or incidental to other insurance benefits.

16          **(2) Benefits not subject to requirements if offered separately.** –

17          a. Limited scope dental or vision benefits.

18          b. Benefits for long-term care, nursing care, home health care,  
19 community-based care, or any combination of these.

20          c. The other similar, limited benefits as are specified in federal  
21 regulations.

22          **(3) Benefits not subject to requirements if offered as independent,**  
23 **noncoordinated benefits.** –

24          a. Coverage only for a specified disease or illness.

25          b. Hospital indemnity or other fixed indemnity insurance.

26          **(4) Benefits not subject to requirements if offered as separate insurance**  
27 **policy.** – Medicare supplemental health insurance (as defined under  
28 section 1882(g)(1) of the Social Security Act), coverage supplemental to  
29 the coverage provided under chapter 55 of title 10, United States Code,  
30 and similar supplemental coverage provided to coverage under a group  
31 health insurance plan.

32       **(c) Application of certain rules in determination of employer size.** – For the  
33 purposes of this Article:

34           **(1) Application of aggregation rule for employers.** – All persons treated as a  
35 single employer under subsection (b), (c), (m), or (o) of section 414 of  
36 the Internal Revenue Code of 1986 shall be treated as one employer.

37           **(2) Employers not in existence in preceding year.** – In the case of an  
38 employer that was not in existence throughout the preceding calendar  
39 year, the determination of whether the employer is a small or large  
40 employer shall be based on the average number of employees that it is  
41 reasonably expected the employer will employ on business days in the  
42 current calendar year.

- 1           (3) Predecessors. – Any reference in this subsection to an employer shall  
2           include a reference to any predecessor of the employer.

3 **"§ 58-68-30. Increased portability through limitation on preexisting condition**  
4 **exclusions.**

5           (a) Limitation on Preexisting Condition Exclusion Period; Crediting for Periods of  
6 Previous Coverage. – Subject to subsection (d) of this section, a group health insurer  
7 may, with respect to a participant or beneficiary, impose a preexisting condition  
8 exclusion only if:

9           (1) The exclusion relates to a condition, whether physical or mental,  
10 regardless of the cause of the condition, for which medical advice,  
11 diagnosis, care, or treatment was recommended or received within the  
12 six-month period ending on the enrollment date.

13           (2) The exclusion extends for a period of not more than 12 months, or 18  
14 months in the case of a late enrollee, after the enrollment date.

15           (3) The period of any preexisting condition exclusion is reduced by the  
16 aggregate of the periods of creditable coverage, if any, applicable to the  
17 participant or beneficiary as of the enrollment date.

18           (b) Definitions. – For the purposes of this Part:

19           (1) Preexisting condition exclusion. –

20           a. In general. – ‘Preexisting condition exclusion’ means, with  
21 respect to coverage, a limitation or exclusion of benefits relating  
22 to a condition based on the fact that the condition was present  
23 before the date of enrollment for the coverage, whether or not  
24 any medical advice, diagnosis, care, or treatment was  
25 recommended or received before the date.

26           b. Treatment of genetic information. – Genetic information shall not  
27 be treated as a condition described in subdivision (a)(1) of this  
28 subsection in the absence of a diagnosis of the condition related  
29 to the information.

30           (2) Enrollment date. – With respect to an individual covered under a group  
31 health insurance plan, the date of enrollment of the individual in the  
32 coverage or, if earlier, the first day of the waiting period for the  
33 enrollment.

34           (3) Late enrollee. – With respect to coverage under a group health insurance  
35 plan, a participant or beneficiary who enrolls under the plan other than  
36 during:

37           a. The first period in which the individual is eligible to enroll under  
38 the plan, or

39           b. A special enrollment period under subsection (f) of this section.

40           (4) Waiting period. – With respect to a group health insurance plan and an  
41 individual who is a potential participant or beneficiary in the plan, the  
42 period that must pass with respect to the individual before the individual  
43 is eligible to be covered for benefits under the terms of the plan.

1       (c) Rules Relating to Crediting Previous Coverage. –

2       (1) Creditable coverage defined. – For the purposes of this Article,  
3       'creditable coverage' means, with respect to an individual, coverage of  
4       the individual under any of the following:

5       a. A self-funded employer group health plan under the Employee  
6       Retirement Income Security Act of 1974.

7       b. Group or individual health insurance coverage.

8       c. Part A or part B of title XVIII of the Social Security Act.

9       d. Title XIX of the Social Security Act, other than coverage  
10       consisting solely of benefits under section 1928.

11       e. Chapter 55 of title 10, United States Code.

12       f. A medical care program of the Indian Health Service or of a  
13       tribal organization.

14       g. A State health benefits risk pool.

15       h. A health plan offered under chapter 89 of title 5, United States  
16       Code.

17       i. A public health plan (as defined in federal regulations).

18       j. A health benefit plan under section 5(e) of the Peace Corps Act  
19       (22 U.S.C. § 2504(e)).

20       'Creditable coverage' does not include coverage consisting solely of  
21       coverage of excepted benefits.

22       (2) Not counting periods before significant breaks in coverage. –

23       a. In general. – A period of creditable coverage shall not be  
24       counted, with respect to enrollment of an individual under a  
25       group health insurance plan, if, after the period and before the  
26       enrollment date, there was a 63-day period during all of which  
27       the individual was not covered under any creditable coverage.

28       b. Waiting period not treated as a break in coverage. – For the  
29       purposes of sub-subdivision a. of this subdivision and  
30       subdivision (d)(4) of this subsection, any period that an  
31       individual is in a waiting period for any coverage under a group  
32       health insurance plan or is in an affiliation period shall not be  
33       taken into account in determining the continuous period under  
34       sub-subdivision a. of this subdivision.

35       c. Time spent on short term limited duration health insurance not  
36       treated as a break in coverage. – For the purposes of sub-  
37       subdivision a. of this subdivision, any period that an individual  
38       is enrolled on a short term limited duration health insurance  
39       policy shall not be taken into account in determining the  
40       continuous period under sub-subdivision. a. of this subdivision  
41       so long as the period of time spent on the short term limited  
42       duration health insurance policy or policies does not exceed 12  
43       months.

- 1           (3) Method of crediting coverage. –  
2           a. Standard method. – Except as otherwise provided under sub-  
3           subdivision b. of this subdivision for the purposes of applying  
4           subdivision (a)(3) of this subsection, a group health insurer shall  
5           count a period of creditable coverage without regard to the  
6           specific benefits covered during the period.  
7           b. Election of alternative method. – A group health insurer may  
8           elect to apply subdivision (a)(3) of this subsection based on  
9           coverage of benefits within each of several classes or categories  
10           of benefits specified in federal regulations rather than as provided  
11           under sub-subdivision a. of this subdivision. This election shall  
12           be made on a uniform basis for all participants and beneficiaries.  
13           Under this election a group health insurer shall count a period of  
14           creditable coverage with respect to any class or category of  
15           benefits if any level of benefits is covered within the class or  
16           category.  
17           c. Health insurer notice. – In the case of an election under sub-  
18           subdivision b. of this subdivision with respect to health insurance  
19           coverage in the small or large group market, the health insurer:  
20           (i) shall prominently state in any disclosure statements  
21           concerning the coverage, and to each employer at the time of the  
22           offer or sale of the coverage, that the health insurer has made the  
23           election, and (ii) shall include in the statements a description of  
24           the effect of the election.  
25           (4) Establishment of period. – Periods of creditable coverage for an  
26           individual shall be established through presentation of certifications  
27           described in subsection (e) of this section or in another manner that is  
28           specified in federal regulations.  
29           (d) Exceptions. –  
30           (1) Exclusion not applicable to certain newborns. – Subject to subdivision  
31           (4) of this subsection, a group health insurer shall not impose any  
32           preexisting condition exclusion in the case of an individual who, as of  
33           the last day of the 30-day period beginning with the individual's date of  
34           birth, is covered under creditable coverage.  
35           (2) Exclusion not applicable to certain adopted children. – Subject to  
36           subdivision (4) of this subsection, a group health insurer shall not  
37           impose any preexisting condition exclusion in the case of a child who is  
38           adopted or placed for adoption before attaining 18 years of age and who,  
39           as of the last day of the 30-day period beginning on the date of the  
40           adoption or placement for adoption, is covered under creditable  
41           coverage. The previous sentence does not apply to coverage before the  
42           date of the adoption or placement for adoption.

- 1           (3) Exclusion not applicable to pregnancy. – A group health insurer shall  
2           not impose any preexisting condition exclusion relating to pregnancy as  
3           a preexisting condition.
- 4           (4) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection  
5           shall no longer apply to an individual after the end of the first 63-day  
6           period during all of which the individual was not covered under any  
7           creditable coverage.
- 8       (e) Certifications and Disclosure of Coverage. –
- 9           (1) Requirement for certification of period of creditable coverage. –
- 10           a. In general. – A group health insurer shall provide the certification  
11           described in sub-subdivision b. of this subdivision: (i) at the time  
12           an individual ceases to be covered under the plan or otherwise  
13           becomes covered under a COBRA continuation provision, (ii) in  
14           the case of an individual becoming covered under a COBRA  
15           continuation provision, at the time the individual ceases to be  
16           covered under the COBRA continuation provision, and (iii) on  
17           the request on behalf of an individual made not later than 24  
18           months after the date of cessation of the coverage described in  
19           clause (i) or (ii) of this sub-subdivision, whichever is later.  
20           The certification under clause (i) of this sub-subdivision may be  
21           provided, to the extent practicable, at a time consistent with notices  
22           required under any applicable COBRA continuation provision.
- 23           b. Certification. – The certification described in this sub-  
24           subdivision is a written certification of: (i) the period of  
25           creditable coverage of the individual under the plan and any  
26           coverage under the COBRA continuation provision, and (ii) any  
27           waiting period and affiliation period, if applicable, imposed with  
28           respect to the individual for any coverage under the plan.
- 29           (2) Disclosure of information on previous benefits. – In the case of an  
30           election described in sub-subdivision (c)(3)b. of this subsection by a  
31           group health insurer, if the health insurer enrolls an individual for  
32           coverage under the plan and the individual provides a certification of  
33           coverage of the individual under subdivision (1) of this subsection:
- 34           a. Upon request of the health insurer, the entity that issued the  
35           certification provided by the individual shall promptly disclose  
36           to the requesting plan or health insurer information on coverage  
37           of classes and categories of health benefits available under the  
38           entity's coverage.
- 39           b. The entity may charge the requesting plan or health insurer for  
40           the reasonable cost of disclosing the information.
- 41       (f) Special Enrollment Periods. –
- 42           (1) Individuals losing other coverage. – A group health insurer shall permit  
43           an employee who is eligible, but not enrolled, for coverage under the



1 terms of the plan (or a dependent of the employee if the dependent is  
2 eligible, but not enrolled, for coverage under the terms) to enroll for  
3 coverage under the terms of the plan if each of the following conditions  
4 is met:

5 a. The employee or dependent was covered under an ERISA group  
6 health plan or had health insurance coverage at the time coverage  
7 was previously offered to the employee or dependent.

8 b. The employee stated in writing at the time that coverage under  
9 the group health plan or health insurance coverage was the  
10 reason for declining enrollment, but only if the health insurer  
11 required the statement at the time and provided the employee  
12 with notice of the requirement and the consequences of the  
13 requirement at the time.

14 c. The employee's or dependent's coverage described in sub-  
15 subdivision a.: (i) was under a COBRA continuation provision  
16 and the coverage under the provision was exhausted; (ii) was not  
17 under that provision and either the coverage was terminated  
18 because of loss of eligibility for the coverage, including legal  
19 separation, divorce, death, termination of employment, or  
20 reduction in the number of hours of employment; or (iii)  
21 employer contributions toward the coverage were terminated.

22 d. Under the terms of the plan, the employee requests the  
23 enrollment not later than 30 days after the date of exhaustion of  
24 coverage described in sub-subdivision c.(i) of this subdivision or  
25 termination of coverage or employer contribution described in  
26 sub-subdivision c.(ii) of this subdivision.

27 (2) For dependent beneficiaries. –

28 a. In general. – If: (i) a group health insurance plan makes  
29 coverage available with respect to a dependent of an individual,  
30 (ii) the individual is a participant under the plan (or has met any  
31 waiting period applicable to becoming a participant under the  
32 plan and is eligible to be enrolled under the plan but for a failure  
33 to enroll during a previous enrollment period), and (iii) a person  
34 becomes the dependent of the individual through marriage, birth,  
35 or adoption or placement for adoption,

36 The plan shall provide for a dependent special enrollment period  
37 described in sub-subdivision b. of this subdivision during which the  
38 person (or, if not otherwise enrolled, the individual) may be enrolled  
39 under the plan as a dependent of the individual, and in the case of the  
40 birth or adoption of a child, the spouse of the individual may be enrolled  
41 as a dependent of the individual if the spouse is otherwise eligible for  
42 coverage.

1           b. Dependent special enrollment period. – A dependent special  
2           enrollment period under this sub-subdivision shall be a period of  
3           not less than 30 days and shall begin on the later of: (i) the date  
4           dependent coverage is made available, or (ii) the date of the  
5           marriage, birth, or adoption or placement for adoption described  
6           in sub-subdivision a.(iii) of this subdivision.

7           c. No waiting period. – If an individual seeks to enroll a dependent  
8           during the first 30 days of the dependent's special enrollment  
9           period, the coverage of the dependent shall become effective: (i)  
10           in the case of marriage, not later than the first day of the first  
11           month beginning after the date the completed request for  
12           enrollment is received; (ii) in the case of a dependent's birth, as  
13           of the date of the birth; or (iii) in the case of a dependent's  
14           adoption or placement for adoption, the date of the adoption or  
15           placement for adoption.

16       (g) Use of Affiliation Period by HMO as Alternative to Preexisting Condition  
17       Exclusion. –

18           (1) In general. – A health maintenance organization that does not impose  
19           any preexisting condition exclusion allowed under subsection (a) of this  
20           section with respect to any particular coverage option may impose an  
21           affiliation period for the coverage option, but only if:

22           a. The period is applied uniformly without regard to any health  
23           status-related factors.

24           b. The period does not exceed two months (or three months in the  
25           case of a late enrollee).

26           (2) Affiliation period. –

27           a. Defined. – For the purposes of this Subpart, 'affiliation period'  
28           means a period that, under the terms of the health insurance  
29           coverage offered by the health maintenance organization, must  
30           expire before the health insurance coverage becomes effective.  
31           The health maintenance organization is not required to provide  
32           health care services or benefits during the period and no premium  
33           shall be charged to the participant or beneficiary for any  
34           coverage during the period.

35           b. Beginning. – The period shall begin on the enrollment date.

36           c. Runs concurrently with waiting periods. – An affiliation period  
37           under a plan shall run concurrently with any waiting period under  
38           the plan.

39           (3) Alternative methods. – A health maintenance organization described in  
40           subdivision (1) of this subsection may use alternative methods, as  
41           approved by the Commissioner, from those described in that  
42           subdivision, to address adverse selection.

1 **"§ 58-68-35. Prohibiting discrimination against individual participants and**  
2 **beneficiaries based on health status.**

3 (a) In Eligibility To Enroll. –

4 (1) In general. – Subject to subdivision (2) of this subsection, a group health  
5 insurer shall not establish rules for eligibility, including continued  
6 eligibility, of any individual to enroll under the terms of the health  
7 insurer's plan based on any of the following health status-related factors  
8 in relation to the individual or a dependent of the individual:

9 a. Health status.

10 b. Medical condition (including both physical and mental illnesses).

11 c. Claims experience.

12 d. Receipt of health care.

13 e. Medical history.

14 f. Genetic information.

15 g. Evidence of insurability (including conditions arising out of acts  
16 of domestic violence).

17 h. Disability.

18 (2) No application to benefits or exclusions. – To the extent consistent with  
19 G.S. 58-68-30, subdivision (1) of this subsection shall not be construed:

20 a. To require a group health insurance plan to provide particular  
21 benefits other than those provided under the terms of the plan, or

22 b. To prevent the plan from establishing limitations or restrictions  
23 on the amount, level, extent, or nature of the benefits or coverage  
24 for similarly situated individuals enrolled in the plan.

25 (3) Construction. – For the purposes of subdivision (1) of this subsection,  
26 rules for eligibility to enroll under a plan include rules defining any  
27 applicable waiting periods for the enrollment.

28 (b) In Premium Contributions. –

29 (1) In general. – A group health insurance plan shall not require any  
30 individual (as a condition of enrollment or continued enrollment under  
31 the plan) to pay a premium or contribution that is greater than the  
32 premium or contribution for a similarly situated individual enrolled in  
33 the plan on the basis of any health status-related factor in relation to the  
34 individual or to an individual enrolled under the plan as a dependent of  
35 individual.

36 (2) Construction. – Nothing in subdivision (1) of this subsection shall be  
37 construed:

38 a. To restrict the amount that an employer may be charged for  
39 coverage under a group health insurance plan; or

40 b. To prevent a group health insurer from establishing premium  
41 discounts or modifying otherwise applicable copayments or  
42 deductibles in return for adherence to programs of health  
43 promotion and disease prevention.

1 **"SUBPART 2. HEALTH INSURANCE AVAILABILITY AND RENEWABILITY.**  
2 **"§ 58-68-40. Guaranteed availability of coverage for employers in the small group**  
3 **market.**

4 (a) Issuance of Coverage in the Small Group Market. –

5 (1) In general. – Subject to subsections (c) through (f) of this section, each  
6 health insurer that offers health insurance coverage in the small group  
7 market in this State:

8 a. Must accept every small employer that applies for the coverage;  
9 and

10 b. Must accept for enrollment under the coverage every eligible  
11 individual who applies for enrollment during the period in which  
12 the individual first becomes eligible to enroll under the terms of  
13 the group health insurance plan and shall not place any restriction  
14 that is inconsistent with G.S. 58-68-35 on an eligible individual  
15 being a participant or beneficiary.

16 (2) Eligible individual defined. – For the purposes of this section, ‘eligible  
17 individual’ means, with respect to a health insurer that offers health  
18 insurance coverage to a small employer in the small group market, such  
19 an individual in relation to the employer as shall be determined:

20 a. In accordance with the terms of the plan,

21 b. As provided by the health insurer under rules of the health  
22 insurer that are uniformly applicable in this State to small  
23 employers in the small group market, and

24 c. In accordance with all applicable State laws governing the health  
25 insurer and the market.

26 (b) Special Rules for Network Plans. –

27 (1) In general. – In the case of a health insurer that offers health insurance  
28 coverage in the small group market through a network plan, the health  
29 insurer may:

30 a. Limit the employers that may apply for coverage to those with  
31 eligible individuals who live, work, or reside in the service area  
32 for the network plan; and

33 b. Within the service area of the network plan, deny coverage to the  
34 employers if the health insurer has demonstrated to the  
35 Commissioner that: (i) it will not have the capacity to deliver  
36 services adequately to enrollees of any additional groups because  
37 of its obligations to existing group contract holders and enrollees,  
38 and (ii) it is applying this subdivision uniformly to all employers  
39 without regard to the claims experience of those employers and  
40 their employees (and their dependents) or any health status-  
41 related factor relating to the employees and dependents.

42 (2) 180-day suspension upon denial of coverage. – A health insurer, upon  
43 denying health insurance coverage in any service area in accordance

- 1                   with sub-subdivision (1)b. of this subsection, shall not offer coverage in  
2                   the small group market within the service area for a period of 180 days  
3                   after the date the coverage is denied.
- 4       (c)   Application of Financial Capacity Limits. –
- 5           (1)   In general. – A health insurer may deny health insurance coverage in the  
6           small group market if the health insurer has demonstrated to the  
7           Commissioner that:
- 8               a.   It does not have the financial reserves necessary to underwrite  
9               additional coverage; and
- 10              b.   It is applying this subdivision uniformly to all employers in the  
11              small group market in the State consistent with this Chapter and  
12              without regard to the claims experience of those employers and  
13              their employees (and their dependents) or any health status-  
14              related factor relating to the employees and dependents.
- 15           (2)   180-day suspension upon denial of coverage. – A health insurer upon  
16           denying health insurance coverage in accordance with subdivision (1) of  
17           this subsection shall not offer coverage in the small group market in the  
18           State for a period of 180 days after the date the coverage is denied or  
19           until the health insurer has demonstrated to the Commissioner that the  
20           health insurer has sufficient financial reserves to underwrite additional  
21           coverage, whichever is later. The Commissioner may apply this  
22           subsection on a service-area-specific basis.
- 23       (d)   Exception to Requirement for Failure to Meet Certain Minimum Participation  
24       or Contribution Rules. –
- 25           (1)   In general. – Subsection (a) of this section does not preclude a health  
26           insurer from establishing employer contribution rules or group  
27           participation rules for the offering of health insurance coverage in  
28           connection with a group health insurance plan in the small group  
29           market, as allowed under this Chapter.
- 30           (2)   Rules defined. – For the purposes of subdivision (1) of this subsection:
- 31               a.   'Employer contribution rule' means a requirement relating to the  
32               minimum level or amount of employer contribution toward the  
33               premium for enrollment of participants and beneficiaries; and
- 34               b.   'Group participation rule' means a requirement relating to the  
35               minimum number of participants or beneficiaries that must be  
36               enrolled in relation to a specified percentage or number of  
37               eligible individuals or employees of an employer.
- 38       (e)   Exception for Coverage Offered Only to Bona Fide Association Members. –  
39       Subsection (a) of this section does not apply to:
- 40           (1)   Health insurance coverage offered by a health insurer if the coverage is  
41           made available in the small group market only through one or more  
42           bona fide associations.
- 43           (2)   A self-employed individual as defined in G.S. 58-50-110(21a).

1 "§ 58-68-45. Guaranteed renewability of coverage for employers in the group  
2 market.

3 (a) In General. – Except as provided in this section, if a health insurer offers health  
4 insurance coverage in the small or large group market, the health insurer must renew or  
5 continue in force the coverage at the option of the employer.

6 (b) General Exceptions. – A health insurer may nonrenew or discontinue health  
7 insurance coverage in the small or large group market based only on one or more of the  
8 following:

9 (1) Nonpayment of premiums. – The policyholder has failed to pay  
10 premiums or contributions in accordance with the terms of the health  
11 insurance coverage or the health insurer has not received timely  
12 premium payments.

13 (2) Fraud. – The policyholder has performed an act or practice that  
14 constitutes fraud or made an intentional misrepresentation of material  
15 fact under the terms of the coverage.

16 (3) Violation of participation or contribution rules. – The policyholder has  
17 failed to comply with a material plan provision relating to employer  
18 contribution or group participation rules, as permitted under G.S. 58-68-  
19 40(e) in the case of the small group market or pursuant to this Chapter  
20 in the case of the large group market.

21 (4) Termination of coverage. – The health insurer is ceasing to offer  
22 coverage in the market in accordance with subsection (c) of this section  
23 and this Chapter.

24 (5) Movement outside service area. – In the case of a health insurer that  
25 offers health insurance coverage in the market through a network plan,  
26 there is no longer any enrollee in connection with the network plan who  
27 lives, resides, or works in the service area of the health insurer or in the  
28 area for which the health insurer is authorized to do business and, in the  
29 case of the small group market, the health insurer would deny  
30 enrollment with respect to the network plan under G.S. 58-68-40(c)(1)a.

31 (6) Association membership ceases. – In the case of health insurance  
32 coverage that is made available in the small or large group market only  
33 through one or more bona fide associations, the membership of an  
34 employer in the association, on the basis of which the coverage is  
35 provided, ceases but only if the coverage is terminated under this  
36 subdivision uniformly without regard to any health status-related factor  
37 relating to any covered individual.

38 (c) Requirements for Uniform Termination of Coverage. –

39 (1) Particular type of coverage not offered. – In any case in which a health  
40 insurer decides to discontinue offering a particular type of group health  
41 insurance coverage offered in the small or large group market, coverage  
42 of the type may be discontinued by the health insurer in accordance with  
43 this Chapter in the market only if:

- 1           a.     The health insurer provides notice to each policyholder provided  
2           coverage of this type in the market and to the participants and  
3           beneficiaries covered under the coverage of the discontinuation  
4           at least 90 days before the date of the discontinuation of the  
5           coverage;
- 6           b.     The health insurer offers to each policyholder provided coverage  
7           of this type in the market the option to purchase all, or in the case  
8           of the large group market, any other health insurance coverage  
9           currently being offered by the health insurer to a group health  
10          insurance plan in the market; and
- 11          c.     In exercising the option to discontinue coverage of this type and  
12          in offering the option of coverage under sub-subdivision b. of  
13          this subdivision, the health insurer acts uniformly without regard  
14          to the claims experience of those sponsors or any health status-  
15          related factor relating to any participants or beneficiaries covered  
16          or new participants or beneficiaries who may become eligible for  
17          the coverage.
- 18          (2)    Discontinuance of all coverage. –
- 19           a.     In general. – In any case in which a health insurer elects to  
20           discontinue offering all health insurance coverage in the small  
21           group market or the large group market, or both markets, in this  
22           State, health insurance coverage may be discontinued by the  
23           health insurer only in accordance with this Chapter and if: (i) the  
24           health insurer provides notice to the Commissioner and to each  
25           policyholder and to the participants and beneficiaries covered  
26           under the coverage of the discontinuation at least 180 days before  
27           the date of the discontinuation of the coverage; and (ii) all health  
28           insurance issued or delivered for issuance in this State in the  
29           market or markets are discontinued and coverage under the  
30           health insurance coverage in the market or markets is not  
31           renewed.
- 32           b.     Prohibition on market reentry. – In the case of a discontinuation  
33           under sub-subdivision a. of this subdivision in a market, the  
34           health insurer shall not provide for the issuance of any health  
35           insurance coverage in that market in this State during the five-  
36           year period beginning on the date of the discontinuation of the  
37           last health insurance coverage not so renewed.
- 38          (d)    Exception for Uniform Modification of Coverage. – At the time of coverage  
39          renewal, a health insurer may modify the health insurance coverage for a product offered  
40          to a group health insurance plan:
- 41           (1)    In the large group market; or
- 42           (2)    In the small group market if, for coverage that is available in the market  
43           other than only through one or more bona fide associations, the

1                    modification is consistent with this Chapter and effective on a uniform  
2                    basis among group health insurance plans with that product.

3            (e)    Application to Coverage Offered Only Through Associations. – In applying  
4 this section in the case of health insurance coverage that is made available by a health  
5 insurer in the small or large group market to employers only through one or more  
6 associations, a reference to ‘policyholder’ is deemed, with respect to coverage provided to  
7 an employer member of the association, to include a reference to the employer.

8    **"§ 58-68-50. Disclosure of information.**

9            (a)    Disclosure of Information by Health Insurers. – In connection with the offering  
10 of any health insurance coverage to a small employer, a health insurer:

11            (1)    Shall make a reasonable disclosure to the employer, as part of its  
12 solicitation and sales materials, of the availability of information  
13 described in subsection (b) of this section, and

14            (2)    Shall upon request of the small employer, provide the information.

15            (b)    Information Described. –

16            (1)    In general. – Subject to subdivision (3) of this subsection, with respect  
17 to a health insurer offering health insurance coverage to a small  
18 employer, information described in this subsection is information  
19 concerning:

20            a.        The provisions of the coverage concerning the health insurer's  
21 right to change premium rates and the factors that may affect  
22 changes in premium rates;

23            b.        The provisions of the coverage relating to renewability of  
24 coverage;

25            c.        The provisions of the coverage relating to any preexisting  
26 condition exclusion; and

27            d.        The benefits and premiums available under all health insurance  
28 coverage for which the employer is qualified.

29            (2)    Form of information. – Information under this subsection shall be  
30 provided to small employers in a manner determined to be  
31 understandable by the average small employer, and shall be sufficient to  
32 reasonably inform small employers of their rights and obligations under  
33 the health insurance coverage.

34            (3)    Exception. – A health insurer is not required under this section to  
35 disclose any information that is proprietary and trade secret information  
36 under applicable law.

37                    **"SUBPART 3. EXCLUSION OF PLANS.**

38    **"§ 58-68-55. Exclusion of certain plans.**

39            (a)    Exception for Certain Benefits. – The requirements of Subparts 1 and 2 of this  
40 Part do not apply to any group health insurance coverage in relation to its provision of  
41 excepted benefits described in G.S. 58-68-25(b)(1).

42            (b)    Exception for Certain Benefits if Certain Conditions Met. –



- 1           (1) Limited, excepted benefits. – The requirements of Subparts 1 and 2 of  
2 this Part do not apply to any group health insurance plan in relation to  
3 its provision of excepted benefits described in G.S. 58-68-25(b)(2) if the  
4 benefits:  
5           a. Are provided under a separate policy, certificate, or contract of  
6 insurance; or  
7           b. Are otherwise not an integral part of the plan.  
8           (2) Noncoordinated, excepted benefits. – The requirements of Subparts 1  
9 and 2 of this Part do not apply to any group health insurance plan in  
10 relation to its provision of excepted benefits described in G.S. 58-68-  
11 25(b)(3) if all of the following conditions are met:  
12           a. The benefits are provided under a separate policy, certificate, or  
13 contract of insurance.  
14           b. There is no coordination between the provision of the benefits  
15 and any exclusion of benefits under any group health insurance  
16 plan maintained by the same policyholder.  
17           c. The benefits are paid with respect to an event without regard to  
18 whether benefits are provided with respect to that event under  
19 any group health insurance plan maintained by the same  
20 policyholder.  
21           (3) Supplemental, excepted benefits. – The requirements of this Part do not  
22 apply to any group health insurance plan in relation to its provision of  
23 excepted benefits described in G.S. 58-68-25(b)(4) if the benefits are  
24 provided under a separate policy, certificate, or contract of insurance.

25           **"PART B – INDIVIDUAL MARKET REFORMS.**

26 **"§ 58-68-60. Guaranteed availability of individual health insurance coverage to**  
27 **certain individuals with prior group coverage.**

28           (a) Guaranteed Availability. –

- 29           (1) In general. – Subject to the succeeding subsections of this section, each  
30 health insurer that offers health insurance coverage in the individual  
31 market in this State shall not, with respect to an eligible individual  
32 desiring to enroll in individual health insurance coverage:

- 33           a. Decline to offer the coverage to, or deny enrollment of, the  
34 individual; or  
35           b. Impose any preexisting condition exclusion with respect to the  
36 coverage.

37           (b) Eligible Individual Defined. – In this Part, ‘eligible individual’ means an  
38 individual:

- 39           (1)(i) For whom, as of the date on which the individual seeks coverage under  
40 this section, the aggregate of the periods of creditable coverage is 18 or  
41 more months and (ii) whose most recent prior creditable coverage was  
42 under an ERISA group health plan, governmental plan, or church plan  
43 (or health insurance coverage offered in connection with any such plan);

- 1           (2) Who is not eligible for coverage under (i) an ERISA group health plan,  
2 (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a  
3 State plan under title XIX of the Act (or any successor program), and  
4 does not have other health insurance coverage;
- 5           (3) With respect to whom the most recent coverage within the coverage  
6 period described in subdivision (1)(i) was not terminated based on a  
7 factor described in G.S. 58-68-45(b)(1) or (b)(2);
- 8           (4) If the individual had been offered the option of continuation coverage  
9 under a COBRA continuation provision or under Article 53 of this  
10 Chapter, who elected the coverage; and
- 11           (5) Who, if the individual elected the continuation coverage, has exhausted  
12 the continuation coverage under the provision or program.
- 13       (c) Alternative Coverage Permitted. –
- 14           (1) In general. – In the case of health insurance coverage offered in this  
15 State, a health insurer may elect to limit the coverage offered under  
16 subsection (a) of this section as long as it offers at least two different  
17 policy forms of health insurance coverage both of which:
- 18           a. Are designed for, made generally available to, and actively  
19 marketed to, and enroll both eligible and other individuals by the  
20 health insurer; and
- 21           b. Meet the requirement of subdivision (2) or (3) of this subsection,  
22 as elected by the health insurer.
- 23       For the purposes of this subsection, policy forms that have different cost-sharing  
24 arrangements or different riders shall be considered to be different policy forms.
- 25           (2) Choice of most popular policy forms. – The requirement of this  
26 subdivision is met, for health insurance coverage policy forms offered  
27 by a health insurer in the individual market, if the health insurer offers  
28 the policy forms for individual health insurance coverage with the  
29 largest, and next to largest, premium volume of all the policy forms  
30 offered by the health insurer in this State or applicable marketing or  
31 service area (as may be prescribed by rules or regulations) by the health  
32 insurer in the individual market in the period involved.
- 33           (3) Choice of two policy forms with representative coverage. –
- 34           a. In general. – The requirement of this subdivision is met, for  
35 health insurance coverage policy forms offered by a health  
36 insurer in the individual market, if the health insurer offers a  
37 lower-level coverage policy form (as described in sub-  
38 subdivision b. of this subdivision) and a higher-level coverage  
39 policy form (as described in sub-subdivision c. of this  
40 subdivision) each of which includes benefits substantially similar  
41 to other individual health insurance coverage offered by the  
42 health insurer in this State.

- 1           b. Lower-level of coverage described. – A policy form is described  
2           in this sub-subdivision if the actuarial value of the benefits under  
3           the coverage is at least eighty-five percent (85%) but not greater  
4           than one hundred percent (100%) of a weighted average  
5           (described in sub-subdivision d. of this subdivision).
- 6           c. Higher-level of coverage described. – A policy form is described  
7           in this sub-subdivision if: (i) the actuarial value of the benefits  
8           under the coverage is at least fifteen percent (15%) greater than  
9           the actuarial value of the coverage described in sub-subdivision  
10           b. of this subdivision offered by the health insurer in the area  
11           involved; and (ii) the actuarial value of the benefits under the  
12           coverage is at least one hundred percent (100%) but not greater  
13           than one hundred twenty percent (120%) of a weighted average  
14           (described in sub-subdivision d. of this subdivision).
- 15           d. Weighted average. – For the purposes of this subdivision, the  
16           weighted average described in this sub-subdivision is the average  
17           actuarial value of the benefits provided by all the health  
18           insurance coverage issued, as elected by the health insurer, either  
19           by that health insurer or by all health insurers in this State in the  
20           individual market during the previous year, not including  
21           coverage issued under this section, weighted by enrollment for  
22           the different coverage.
- 23           (4) Election. – The health insurer elections under this subsection shall apply  
24           uniformly to all eligible individuals in this State for that health insurer.  
25           The election shall be effective for policies offered during a period of not  
26           less than two years.
- 27           (5) Assumptions. – For the purposes of subdivision (3) of this subsection,  
28           the actuarial value of benefits provided under individual health  
29           insurance coverage shall be calculated based on a standardized  
30           population and a set of standardized utilization and cost factors.
- 31           (d) Special Rules for Network Plans. –
- 32           (1) In general. – In the case of a health insurer that offers health insurance  
33           coverage in the individual market through a network plan, the health  
34           insurer may:
- 35           a. Limit the individuals who may be enrolled under the coverage to  
36           those who live, reside, or work within the service area for the  
37           network plan; and
- 38           b. Within the service area of the plan, deny the coverage to the  
39           individuals if the health insurer has demonstrated to the  
40           Commissioner that: (i) it will not have the capacity to deliver  
41           services adequately to additional individual enrollees because of  
42           its obligations to existing group contract holders and enrollees  
43           and individual enrollees, and (ii) it is applying this subdivision

1 uniformly to individuals without regard to any health status-  
2 related factor of the individuals and without regard to whether  
3 the individuals are eligible individuals.

4 (2) 180-day suspension upon denial of coverage. – A health insurer, upon  
5 denying health insurance coverage in any service area in accordance  
6 with sub-subdivision (1)b. of this subdivision, shall not offer coverage  
7 in the individual market within the service area for a period of 180 days  
8 after the coverage is denied.

9 (e) Application of Financial Capacity Limits. –

10 (1) In general. – A health insurer may deny health insurance coverage in the  
11 individual market to an eligible individual if the health insurer has  
12 demonstrated to the Commissioner that:

13 a. It does not have the financial reserves necessary to underwrite  
14 additional coverage; and

15 b. It is applying this subdivision uniformly to all individuals in the  
16 individual market in this State consistent with this Chapter and  
17 without regard to any health status-related factor of the  
18 individuals and without regard to whether the individuals are  
19 eligible individuals.

20 (2) 180-day suspension upon denial of coverage. – A health insurer, upon  
21 denying individual health insurance coverage in any service area in  
22 accordance with subdivision (1) of this subsection, shall not offer the  
23 coverage in the individual market within the service area for a period of  
24 180 days after the date the coverage is denied or until the health insurer  
25 has demonstrated to the Commissioner that the health insurer has  
26 sufficient financial reserves to underwrite additional coverage,  
27 whichever is later.

28 (f) Market Requirements. –

29 (1) In general. – Subsection (a) of this section does not require that a health  
30 insurer offering health insurance coverage only in connection with  
31 ERISA group health plans or through one or more bona fide  
32 associations, or both, offer the health insurance coverage in the  
33 individual market.

34 (2) Conversion policies. – A health insurer offering health insurance  
35 coverage in connection with group health plans under title XXVII of the  
36 federal Public Health Service Act shall not be deemed to be a health  
37 insurer offering individual health insurance coverage solely because the  
38 health insurer offers a conversion policy.

39 (g) Construction. – Nothing in this section shall be construed:

40 (1) To restrict the amount of the premium rates that a health insurer may  
41 charge an individual for health insurance coverage provided in the  
42 individual market under this Chapter; or

- 1           (2) To prevent a health insurer offering health insurance coverage in the  
2 individual market from establishing premium discounts or rebates or  
3 modifying otherwise applicable copayments or deductibles in return for  
4 adherence to programs of health promotion and disease prevention.
- 5       (h) Other Definitions. – As used in this section:
- 6           (1) 'Church plan'. – The meaning given the term under section 3(33) of the  
7 Employee Retirement Income Security Act of 1974.
- 8           (2) 'Governmental plan'. –
- 9               a. The meaning given the term under section 3(32) of the Employee  
10 Retirement Income Security Act of 1974 and any federal  
11 governmental plan.
- 12               b. Federal governmental plan. – A governmental plan established or  
13 maintained for its employees by the government of the United  
14 States or by any agency or instrumentality of the government.
- 15               c. Nonfederal governmental plan. – A governmental plan that is not  
16 a federal governmental plan.

17 **"§ 58-68-65. Guaranteed renewability of individual health insurance coverage.**

18       (a) In General. – Except as provided in this section, a health insurer that provides  
19 individual health insurance coverage to an individual shall renew or continue in force the  
20 coverage at the option of the individual.

21       (b) General Exceptions. – A health insurer may nonrenew or discontinue health  
22 insurance coverage of an individual in the individual market based only on one or more  
23 of the following:

- 24           (1) Nonpayment of premiums. – The individual has failed to pay premiums  
25 or contributions in accordance with the terms of the health insurance  
26 coverage or the health insurer has not received timely premium  
27 payments.
- 28           (2) Fraud. – The individual has performed an act or practice that constitutes  
29 fraud or made an intentional misrepresentation of material fact under the  
30 terms of the coverage.
- 31           (3) Termination of plan. – The health insurer is ceasing to offer coverage in  
32 the individual market in accordance with subsection (c) of this section  
33 and this Chapter.
- 34           (4) Movement outside service area. – In the case of a health insurer that  
35 offers health insurance coverage in the market through a network plan,  
36 the individual no longer resides, lives, or works in the service area (or in  
37 an area for which the health insurer is authorized to do business) but  
38 only if the coverage is terminated under this subdivision uniformly  
39 without regard to any health status-related factor of covered individuals.
- 40           (5) Association membership ceases. – In the case of health insurance  
41 coverage that is made available in the individual market only through  
42 one or more bona fide associations, the membership of the individual in  
43 the association (on the basis of which the coverage is provided) ceases

1           but only if the coverage is terminated under this subdivision uniformly  
2           without regard to any health status-related factor of covered individuals.

3       (c) Requirements for Uniform Termination of Coverage. –

4       (1) Particular type of coverage not offered. – In any case in which a health  
5       insurer decides to discontinue offering a particular type of health  
6       insurance coverage offered in the individual market, coverage of the  
7       type may be discontinued by the health insurer only if:

8       a. The health insurer provides notice, notwithstanding G.S. 58-51-  
9       20 or G.S. 58-55-60(c)(3)b, to each covered individual provided  
10       coverage of this type in the market of the discontinuation at least  
11       90 days before the date of the discontinuation of the coverage;

12       b. The health insurer offers to each individual in the individual  
13       market provided coverage of this type, the option to purchase any  
14       other individual health insurance coverage currently being  
15       offered by the health insurer for individuals in the market; and

16       c. In exercising the option to discontinue coverage of this type and  
17       in offering the option of coverage under sub-subdivision b. of  
18       this subdivision, the health insurer acts uniformly without regard  
19       to any health status-related factor of enrolled individuals or  
20       individuals who may become eligible for the coverage.

21       (2) Discontinuance of all coverage. –

22       a. In general. – Subject to sub-subdivision c. of this subdivision, in  
23       any case in which a health insurer elects to discontinue offering  
24       all health insurance coverage in the individual market in this  
25       State, health insurance coverage may be discontinued by the  
26       health insurer only if: (i) the health insurer provides notice to the  
27       Commissioner and to each individual of the discontinuation at  
28       least 180 days before the date of the expiration of the coverage,  
29       and (ii) all health insurance coverage issued or delivered for  
30       issuance in this State in the market is discontinued and the health  
31       insurance coverage in the market is not renewed.

32       b. Prohibition on market reentry. – In the case of a discontinuation  
33       under sub-subdivision a. of this subdivision in the individual  
34       market, the health insurer shall not provide for the issuance of  
35       any health insurance coverage in the market and this State during  
36       the five-year period beginning on the date of the discontinuation  
37       of the last health insurance coverage not so renewed.

38       (d) Exception for Uniform Modification of Coverage. – At the time of coverage  
39       renewal, a health insurer may modify the health insurance coverage for a policy form  
40       offered to individuals in the individual market as long as the modification is consistent  
41       with State law and effective on a uniform basis among all individuals with that policy  
42       form.

1       (e) Application to Coverage Offered Only Through Associations. – In applying  
2 this section in the case of health insurance coverage that is made available by a health  
3 insurer in the individual market to individuals only through one or more associations, a  
4 reference to an ‘individual’ is deemed to include a reference to the association of which  
5 the individual is a member.

6 **"§ 58-68-70. Certification of coverage.**

7       G.S. 58-68-30(e) applies to health insurance coverage offered by a health insurer in  
8 the individual market in the same manner that it applies to health insurance coverage  
9 offered by a health insurer in the small or large group market.

10 **"§ 58-68-75. General exceptions.**

11       (a) Exception for Certain Benefits. – This Part does not apply to any health  
12 insurance coverage in relation to its provision of excepted benefits described in G.S. 58-  
13 68-25(b)(1).

14       (b) Exception for Certain Benefits if Certain Conditions Met. – This Part does not  
15 apply to any health insurance coverage in relation to its provision of excepted benefits  
16 described in G.S. 58-68-25(b)(2), (3), or (4) if the benefits are provided under a separate  
17 policy, certificate, or contract of insurance."

18       Section 2. G.S. 58-50-110 reads as rewritten:

19 **"§ 58-50-110. Definitions.**

20       As used in this Act:

21       (1) ‘Accountable health carrier’ means that as defined in G.S. 143-622(1).

22       (1a) ‘Actuarial certification’ means a written statement by a member of the  
23 American Academy of Actuaries or other individual acceptable to the  
24 Commissioner that a small employer carrier is in compliance with the  
25 provisions of G.S. 58-50-130, and to the extent applicable, the  
26 provisions of Article 68 of this Chapter, based upon the person's  
27 examination, including a review of the appropriate records and of the  
28 actuarial assumptions and methods used by the small employer carrier  
29 in establishing premium rates for applicable health benefit plans.

30       (1b) ‘Adjusted community rating’ means a method used to develop carrier  
31 premiums which spreads financial risk across a large population and  
32 allows adjustments for the following demographic factors: age, gender,  
33 family composition, and geographic areas, as determined pursuant to  
34 G.S. 58-50-130(b).

35       (2) Repealed by Session Laws 1993, c. 529, s. 3.3.

36       (3) ‘Basic health care plan’ means a health care plan for small employers  
37 that is lower in cost than a standard health care plan and is required to  
38 be offered by all small employer carriers pursuant to G.S. 58-50-125  
39 and approved by the Commissioner in accordance with G.S. 58-50-125.

40       (4) ‘Board’ means the board of directors of the Pool.

41       (5) ‘Carrier’ means any person that provides one or more health benefit  
42 plans in this State, including a licensed insurance company, a prepaid

- 1 hospital or medical service plan, a health maintenance organization  
2 (HMO), and a multiple employer welfare arrangement.
- 3 (5a) 'Case characteristics' means the demographic factors age, gender,  
4 family size, and geographic location.
- 5 (6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.
- 6 (8) 'Committee' means the Small Employer Carrier Committee as created  
7 by G.S. 58-50-120.
- 8 (9) 'Dependent' means the spouse or child of an eligible employee, subject  
9 to applicable terms of the health care plan covering the employee.
- 10 (10) 'Eligible employee' means an employee who works for a small  
11 employer on a full-time basis, with a normal work week of 30 or more  
12 hours, including a sole proprietor, a partner or a partnership, or an  
13 independent contractor, if included as an employee under a health care  
14 plan of a small employer; but does not include employees who work on  
15 a part-time, temporary, or substitute basis.
- 16 (11) 'Health benefit plan' means any accident and health insurance policy or  
17 certificate; nonprofit hospital or medical service corporation contract;  
18 health, hospital, or medical service corporation plan contract; HMO  
19 subscriber contract; plan provided by a MEWA or plan provided by  
20 another benefit arrangement, to the extent permitted by ERISA, subject  
21 to G.S. 58-50-115. Health benefit plan does not ~~mean accident only,~~  
22 ~~specified disease only, fixed indemnity, credit, or disability insurance;~~  
23 ~~coverage of Medicare services pursuant to contracts with the United~~  
24 ~~States government; Medicare supplement or long term care insurance;~~  
25 ~~dental only or vision only insurance; coverage issued as a supplement to~~  
26 ~~liability insurance; insurance arising out of a workers' compensation or~~  
27 ~~similar law; automobile medical payment insurance; or insurance under~~  
28 ~~which benefits are payable with or without regard to fault and that is~~  
29 ~~statutorily required to be contained in any liability insurance policy or~~  
30 ~~equivalent self insurance. include benefits described in G.S. 58-68-~~  
31 ~~25(b).~~
- 32 (12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-  
33 20(6) or G.S. 58-62-16(8).
- 34 (13) Repealed by Session Laws 1993, c. 529, s. 3.3.
- 35 (14) 'Late enrollee' means an eligible employee or dependent who requests  
36 enrollment in a health benefit plan of a small employer after the end of  
37 the initial enrollment period provided under the terms of the health  
38 benefit plan in effect at the time the employee first became eligible;  
39 provided that the initial enrollment period shall be a period of at least 30  
40 consecutive calendar days. However, an eligible employee or dependent  
41 shall not be considered a late enrollee if:
- 42 a. The individual was covered under a public or private health  
43 benefit plan that provided, at the time the individual was eligible



1 to enroll, benefits equal to or exceeding the same required level  
2 of benefits in the basic ~~and or~~ standard health care plans adopted  
3 pursuant to G.S. 58-50-120 and either the individual:

- 4 1. Lost coverage under another health plan as a result of  
5 termination of employment, termination of a spouse's  
6 health plan coverage, or the death of a spouse or divorce  
7 and requests enrollment in a ~~basic or standard health care~~  
8 ~~plan~~ health benefit plan within 30 days after termination  
9 of coverage provided under another health plan; or  
10 2. Stated, in writing, during the enrollment period that  
11 coverage under another employer health benefit plan was  
12 the reason for declining coverage;  
13 3, 4. Repealed by Session Laws 1993, c. 529, s. 3.3.  
14 b. The individual elects a different health plan offered through the  
15 Alliance during an open enrollment period;  
16 c. An eligible employee requests enrollment within 30 days of  
17 becoming an employee of a member small employer;  
18 d. A court has ordered coverage be provided for a spouse or minor  
19 child under a covered employee's health benefit plan and the  
20 request for enrollment for a spouse is made within 30 days after  
21 issuance of the court ~~order;~~ order. A minor child shall be  
22 enrolled in accordance with the requirements of G.S. 58-51-120;  
23 or  
24 e. The individual or employee enrollee makes a request for  
25 enrollment of the spouse or child within 30 days ~~of~~ after the  
26 ~~individual~~ individual's or employee's marriage or the ~~birth or~~  
27 ~~adoption~~ birth, adoption, or placement for adoption of a child.  
28 (15) Repealed by Session Laws 1993, c. 529, s. 3.3.  
29 (16) 'Pool' means the North Carolina Small Employer Health Reinsurance  
30 Pool created in G.S. 58-50-150.  
31 (17) 'Preexisting-conditions provision' means a ~~policy provision that limits~~  
32 ~~or excludes coverage for charges or expenses incurred during a~~  
33 ~~specified period following the insured's effective date of coverage, for a~~  
34 ~~condition that, during a specified period immediately preceding the~~  
35 ~~effective date of coverage, had manifested itself in a manner that would~~  
36 ~~cause an ordinary prudent person to seek diagnosis, care, or treatment,~~  
37 ~~or for which medical advice, diagnosis, care, or treatment was~~  
38 ~~recommended or received as to that condition or as to pregnancy~~  
39 ~~existing on the effective date of coverage.~~ preexisting-condition  
40 provision as defined in G.S. 58-68-30.  
41 (18) 'Premium' includes insurance premiums or other fees charged for a  
42 health benefit plan, including the costs of benefits paid or  
43 reimbursements made to or on behalf of persons covered by the plan.

- 1 (19) 'Rating period' means the calendar period for which premium rates  
2 established by a small employer carrier are assumed to be in effect, as  
3 determined by the small employer carrier.
- 4 (20) 'Risk-assuming carrier' means a small employer carrier electing to  
5 comply with the requirements set forth in G.S. 58-50-140.
- 6 (21) 'Reinsuring carrier' means a small employer carrier electing to comply  
7 with the requirements set forth in G.S. 58-50-145.
- 8 (21a) 'Self-employed individual' means an individual or sole proprietor who  
9 derives a majority of his or her income from a trade or business carried  
10 on by the individual or sole proprietor which results in taxable income  
11 as indicated on IRS form 1040, Schedule C or F and which generated  
12 taxable income in one of the two previous years.
- 13 (22) 'Small employer' means any individual actively engaged in business  
14 that, on at least fifty percent (50%) of its working days during the  
15 preceding calendar quarter, employed no more than ~~49~~50 eligible  
16 employees, the majority of whom are employed within this State, and is  
17 not formed primarily for purposes of buying health insurance and in  
18 which a bona fide employer-employee relationship exists. In  
19 determining the number of eligible employees, companies that are  
20 affiliated companies, or that are eligible to file a combined tax return for  
21 purposes of taxation by this State, shall be considered one employer.  
22 Subsequent to the issuance of a health benefit plan to a small employer  
23 and for the purpose of determining eligibility, the size of a small  
24 employer shall be determined annually. Except as otherwise specifically  
25 provided, the provisions of this Act that apply to a small employer shall  
26 continue to apply until the plan anniversary following the date the small  
27 employer no longer meets the requirements of this definition. For  
28 purposes of this Act, the term small employer includes self-employed  
29 individuals.
- 30 (23) 'Small employer carrier' means any carrier that offers health benefit  
31 plans covering eligible employees of one or more small employers.
- 32 (24) 'Standard health care plan' means a health care plan for small employers  
33 required to be offered by all small employer carriers under G.S. 58-50-  
34 125 and approved by the Commissioner in accordance with G.S. 58-50-  
35 125."

36 Section 3. G.S. 58-50-125(c) reads as rewritten:

37 "(c) ~~The Except as provided under Article 68 of this Chapter, the plans developed~~  
38 under this section are not required to provide coverage that meets the requirements of  
39 other provisions of this Chapter that mandate either coverage or the offer of coverage by  
40 the type or level of health care services or health care provider."

41 Section 4. G.S. 58-50-125(g) reads as rewritten:

1       "(g) No HMO operating as either a risk-assuming carrier or a reinsuring carrier is  
2 required to offer coverage or accept applications under subsection (d) of this section in  
3 the case of any of the following:

- 4           (1) To a group that is not physically located in the HMO's approved service  
5            areas;
- 6           (2) To an employee who does not reside within the HMO's approved  
7            service areas;
- 8           (3) Within an area, where the HMO can reasonably anticipate, and  
9            demonstrate, to the Commissioner's satisfaction, that it will not have the  
10           capacity within that area and its network of providers to deliver services  
11           adequately to the enrollees of those groups because of its obligations to  
12           existing group contract holders and enrollees.

13       An HMO that does not offer coverage pursuant to subdivision (3) of this subsection  
14 may not offer coverage in the applicable area to new employer groups with more than 49  
15 eligible employees until the later of 90 days after that closure or the date on which the  
16 carrier notifies the Commissioner that it has regained capacity to deliver services to small  
17 employers."

18       Section 5. G.S. 58-50-130(a) reads as rewritten:

19       "(a) Health benefit plans covering small employers are subject to the following  
20 provisions:

- 21           ~~(1) Except in the case of a late enrollee, any preexisting conditions~~  
22           ~~provision may not limit or exclude coverage for a period beyond 12~~  
23           ~~months following the insured's initial effective date of coverage and~~  
24           ~~must define preexisting conditions as "those conditions for which~~  
25           ~~medical advice or treatment was received or recommended or that could~~  
26           ~~be medically documented within the 12-month period immediately~~  
27           ~~preceding the effective date of the person's coverage".~~
- 28           ~~(2) In determining whether a preexisting conditions provision applies to an~~  
29           ~~eligible employee or to a dependent, all health benefit plans shall credit~~  
30           ~~the time the person was covered under a previous health benefit plan if~~  
31           ~~the previous coverage was continuous to a date not more than 60 days~~  
32           ~~before the effective date of the new coverage, exclusive of any~~  
33           ~~applicable waiting period under the plan. As used in this subdivision~~  
34           ~~with respect to previous coverage, the meaning of "health benefit~~  
35           ~~plan" is not limited to the definition in G.S. 58-50-115, but includes any~~  
36           ~~health benefit plan provided by a health insurer, as that term is defined~~  
37           ~~in G.S. 58-51-115(a), or any government plan or program providing~~  
38           ~~health benefits or health care.~~
- 39           ~~(3) The health benefit plan is renewable with respect to all eligible~~  
40           ~~employees or dependents at the option of the policyholder or contract~~  
41           ~~holder except:~~
  - 42            a. ~~For nonpayment of the required premiums by the policyholder or~~  
43            ~~contract holder;~~

- 1           b.     ~~For fraud or misrepresentation of the policyholder or contract~~  
2           ~~holder or, with respect to coverage of individual enrollees, the~~  
3           ~~enrollees, or their representatives;~~  
4           e.     ~~For noncompliance with plan provisions that have been approved~~  
5           ~~by the Commissioner;~~  
6           d.     ~~When the number of enrollees covered under the plan is less than~~  
7           ~~the number of insureds or percentage of enrollees required by~~  
8           ~~participation requirements under the plan; or~~  
9           e.     ~~When the policyholder or contract holder is no longer actively~~  
10           ~~engaged in the business in which it was engaged on the effective~~  
11           ~~date of the plan.~~  
12           f.     ~~When the small employer carrier stops writing new business in~~  
13           ~~the small employer market, if:~~  
14           1.     ~~It provides notice to the Department and either to the~~  
15           ~~policyholder, contract holder, or employer, of its decision~~  
16           ~~to stop writing new business in the small employer~~  
17           ~~market; and~~  
18           2.     ~~It does not cancel health benefit plans subject to this Act~~  
19           ~~for 180 days after the date of the notice required under~~  
20           ~~paragraph 1; and for that business of the carrier that~~  
21           ~~remains in force, the carrier shall continue to be governed~~  
22           ~~by this Act with respect to business conducted under this~~  
23           ~~Act.~~

24           ~~A small employer carrier that stops writing new business in the small~~  
25           ~~employer market in this State after January 1, 1992, shall be prohibited~~  
26           ~~from writing new business in the small employer market in this State for~~  
27           ~~a period of five years from the date of notice to the Commissioner. In~~  
28           ~~the case of an HMO doing business in the small employer market in one~~  
29           ~~service area of this State, the rules set forth in this subdivision shall~~  
30           ~~apply to the HMO's operations in the service area, unless the provisions~~  
31           ~~of G.S. 58-50-125(g) apply.~~

- 32           (4)   ~~Late enrollees may be excluded from coverage for the greater of 18~~  
33           ~~months or an 18-month preexisting condition exclusion; however, if~~  
34           ~~both a period of exclusion from coverage and a preexisting condition~~  
35           ~~exclusion are applicable to a late enrollee, the combined period shall not~~  
36           ~~exceed 18 months. If a period of exclusion from coverage is applied, a~~  
37           ~~late enrollee shall be enrolled at the end of such period in the health~~  
38           ~~benefit plan currently held by the small employer.~~

- 39           (4a)  A carrier may continue to enforce reasonable employer participation and  
40           contribution requirements on small employers applying for coverage;  
41           however, participation and contribution requirements may vary among  
42           small employers only by the size of the small employer group and shall  
43           not differ because of the health benefit plan involved. In applying

1 minimum participation requirements to a small employer, a small  
2 employer carrier shall not consider employees or dependents who have  
3 qualifying existing coverage in determining whether an applicable  
4 participation level is met. 'Qualifying existing coverage' means benefits  
5 or coverage provided under: (i) Medicare, Medicaid, and other  
6 government funded programs; or (ii) an employer-based health  
7 insurance or health benefit arrangement, including a self-insured plan,  
8 that provides benefits similar to or in excess of benefits provided under  
9 the basic health care plan. An accountable health carrier shall not  
10 enforce participation or contribution requirements on member small  
11 employers, as defined in G.S. 143-622(18), unless those requirements  
12 meet with the standards adopted by the State Health Plan Purchasing  
13 Alliance Board.

14 (5) Notwithstanding any other provision of this Chapter, no small employer  
15 carrier, insurer, subsidiary ~~or~~ of an insurer, or controlled individual of  
16 an insurance holding company shall act as an administrator or claims  
17 paying agent, as opposed to an insurer, on behalf of small groups which,  
18 if they purchased insurance, would be subject to this section. No small  
19 employer carrier, insurer, subsidiary of an insurer, or controlled  
20 individual of an insurance holding company shall provide stop loss,  
21 catastrophic, or reinsurance coverage to small employers that does not  
22 comply with the underwriting, rating, and other applicable standards in  
23 this Act.

24 (6) If a small employer carrier offers coverage to a small employer, the  
25 small employer carrier shall offer coverage to all eligible employees of a  
26 small employer and their dependents. A small employer carrier shall not  
27 offer coverage to only certain individuals in a small employer group  
28 except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).

29 ~~(7) A small employer carrier shall not modify any health benefit plan with  
30 respect to a small employer, any eligible employee, or dependent  
31 through riders, endorsements, or otherwise, in order to restrict or  
32 exclude coverage for certain diseases or medical conditions otherwise  
33 covered by the health benefit plan.~~

34 ~~(8) In the case of an eligible employee or dependent of an eligible employee  
35 who was excluded from or denied coverage by a small employer carrier  
36 on or before August 14, 1992, the small employer carrier shall provide  
37 an opportunity for such eligible employee or dependent to enroll in the  
38 health benefit plan currently held by the small employer not later than  
39 the next plan anniversary on or after August 14, 1992.~~

40 (9) The health benefit plan must meet the applicable requirements of Article  
41 68 of this Chapter."

42 Section 6. G.S. 58-50-130(d) reads as written:

1       "(d) In connection with the offering for sale of any health benefit plan to a small  
2 employer, each small employer carrier shall make a reasonable disclosure, as part of its  
3 solicitation and sales ~~materials, of: materials,~~ of the following and shall provide this  
4 information to the small employer upon request:

- 5           (1) Repealed by Session Laws 1993, c. 529, s. 3.7.
- 6           (2) Provisions concerning the small employer carrier's right to change  
7 premium rates and the factors other than claims experience that affect  
8 changes in premium rates.
- 9           (3) Provisions relating to renewability of policies and contracts.
- 10          (4) Provisions affecting any preexisting conditions provision.
- 11          (5) The benefits available and premiums charged under all health benefit  
12 plans for which the small employer is eligible."

13 Section 7. G.S. 58-51-15(a)(2)b. reads as rewritten:

14       "b. This policy contains a provision limiting coverage for preexisting  
15 conditions for individuals who are not eligible for guaranteed  
16 availability of coverage under G. S. 58-68-60. Preexisting  
17 conditions must be covered no later than one year after the  
18 effective date of coverage. are covered under this  
19 policy.....(insert number of months or days, not to exceed  
20 one year) after the effective date of coverage. Preexisting  
21 conditions are defined as mean 'those conditions for which  
22 medical ~~advice~~ advice, diagnosis, care, or treatment was received  
23 or recommended or that could be medically documented within  
24 the one-year period immediately preceding the effective date of  
25 the person's coverage.' Preexisting conditions exclusions may  
26 not be implemented by any successor plan as to any covered  
27 persons who have already met all or part of the waiting period  
28 requirements under any previous plan. Credit must be given for  
29 that portion of the waiting period that was met under the previous  
30 plan. As used in this policy, the term "previous plan" includes  
31 any health benefit plan provided by a health insurer, as those  
32 terms are defined in G.S. 58-51-115, or any government plan or  
33 program providing health benefits or health care. In determining  
34 whether a preexisting condition provision applies to an insured  
35 person, all health benefit plans must credit the time the person  
36 was covered under a previous plan if the previous plan's coverage  
37 was continuous to a date not more than 60 days before the  
38 effective date of the new coverage, exclusive of any applicable  
39 waiting period under the new coverage. Credit for having  
40 satisfied some or all of the preexisting condition waiting periods  
41 under previous health benefits coverage shall be given in  
42 accordance with G. S. 58-68-30. This sub-subdivision does not  
43 apply to excepted benefits as described in G. S. 58-68-25(b)."

1 Section 8. G.S. 58-51-80(b) reads as rewritten:

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

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

20 (1a) Under a policy issued to an association or to a trust or to the trustee or  
21 trustees of a fund established, created, or maintained for the benefit of  
22 members of one or more associations. The association or associations  
23 shall have at the outset a minimum of 500 persons and shall have been  
24 organized and maintained in good faith for purposes other than that of  
25 obtaining insurance; shall have been in active existence for at least five  
26 years; and shall have a constitution and bylaws that provide that (i) the  
27 association or associations hold regular meetings not less than annually  
28 to further purposes of the members; (ii) except for credit unions, the  
29 association or associations collect dues or solicit contributions from  
30 members; and (iii) the ~~members~~members, other than associate  
31 members, have voting privileges and representation on the governing  
32 board and committees. The policy is subject to the following  
33 requirements:

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

39 b. The premium for the policy shall be paid from funds contributed  
40 by the association or associations, or by employer members, or  
41 by both, or from funds contributed by the covered persons or  
42 from both the covered persons and the association, associations,  
43 or employer members.

1 e. ~~A policy on which no part of the premium is to be derived from~~  
2 ~~funds contributed by the covered persons specifically for their~~  
3 ~~insurance must insure all eligible persons, except those who~~  
4 ~~reject the coverage, in writing.~~

5 (2) ~~For employer groups of 50 or more persons no evidence of individual~~  
6 ~~insurability may be required at the time the person first becomes eligible~~  
7 ~~for insurance or within 31 days thereafter except for any insurance~~  
8 ~~supplemental to the basic coverage for which evidence of individual~~  
9 ~~insurability may be required. With respect to trustee groups the phrase~~  
10 ~~"groups of 50" must be applied on a participating unit basis for the~~  
11 ~~purpose of requiring individual evidence of insurability.~~

12 (3) ~~Policies may contain a provision limiting coverage for preexisting~~  
13 ~~conditions. Preexisting conditions must be covered no later than 12~~  
14 ~~months after the effective date of coverage. Preexisting conditions are~~  
15 ~~defined as "those conditions for which medical advice or treatment was~~  
16 ~~received or recommended or which could be medically documented~~  
17 ~~within the 12-month period immediately preceding the effective date of~~  
18 ~~the person's coverage." Preexisting conditions exclusions may not be~~  
19 ~~implemented by any successor plan as to any covered persons who have~~  
20 ~~already met all or part of the waiting period requirements under any~~  
21 ~~previous plan. Credit must be given for that portion of the waiting~~  
22 ~~period which was met under the previous plan. As used in this~~  
23 ~~subdivision, a "previous plan" includes any health benefit plan provided~~  
24 ~~by a health insurer, as those terms are defined in G.S. 58-51-115, or any~~  
25 ~~government plan or program providing health benefits or health care.~~  
26 ~~For employer groups of 50 or more persons and for groups under~~  
27 ~~subdivision (1a) of this subsection and under G.S. 58-51-81: In~~  
28 ~~determining whether a preexisting condition provision applies to an~~  
29 ~~eligible employee, association member, student, or to a dependent, all~~  
30 ~~health benefit plans shall credit the time the person was covered under a~~  
31 ~~previous plan if the previous plan's coverage was continuous to a date~~  
32 ~~not more than 60 days before the effective date of the new coverage,~~  
33 ~~exclusive of any applicable waiting period under the new coverage."~~

34 Section 9. G.S. 58-51-80(h) reads as rewritten:

35 "(h) Nothing contained in this section applies to any contract issued by any  
36 corporation defined in Article 65 of this Chapter. Subdivision (b)(3) of this section  
37 applies to MEWAs, as defined in G.S. 58-49-30(a)."

38 Section 10. G.S. 58-53-1 reads as rewritten:

39 **"§ 58-53-1. Definitions.**

40 As used in this Article, the following terms have the meanings specified:

41 (1) 'Group policy' means a group accident and health insurance policy  
42 issued by an insurance company and a group contract issued by a health



1 service corporation or health maintenance organization or similar  
2 corporation or organization.

3 (2) 'Individual policy' or 'converted policy' means an individual health  
4 insurance policy issued by an insurance company or an individual health  
5 ~~services~~ contract issued by a ~~health~~ service corporation or health  
6 maintenance organization or similar corporation or organization.

7 (3) 'Insurance' and 'insured' refer to coverage under a group policy,  
8 individual policy or converted policy on a premium-paying basis, and  
9 do not include coverage provided by reason of a disability extension.

10 (4) " Insurer" means the entity issuing a group policy or an individual or  
11 converted policy.

12 (5) " Medicare" means Title XVIII of the United States Social Security Act  
13 as added by the Social Security Amendments of 1965 or as later  
14 amended or superseded.

15 (5a) 'Member' or 'employee' includes an insured spouse or dependent of a  
16 member or of an employee.

17 (6) 'Premium' includes any premium or other consideration payable for  
18 coverage under a group or individual policy.

19 (7) 'Reasonable and customary' means the most frequently used level of  
20 charge made for the supplies or for a specific service in the geographic  
21 subarea in which such supplies or services are received, of like kind or  
22 by physicians, or other practitioners, with similar qualifications."

23 Section 11. G.S. 58-53-5 reads as rewritten:

24 **"§ 58-53-5. Continuation of group hospital, surgical, and major medical coverage**  
25 **after termination of employment or membership.**

26 A group policy delivered or issued for delivery in this State ~~which~~ that insures  
27 employees or ~~members, other than the members and their dependents, if they have~~  
28 ~~elected to include them, whose eligibility under the group policy does not extend to any~~  
29 ~~employee(s) the insured may have members~~ for hospital, surgical or major medical  
30 insurance on an expense incurred or service basis under ~~Articles 1 through 67 of this~~  
31 Chapter, other than for specific diseases or for accidental injuries only, shall provide that  
32 employees or members whose ~~insurance for these types of coverage under the group~~  
33 policy would otherwise terminate because of termination of active employment or  
34 membership, or termination of membership in the eligible class or classes under the  
35 policy, shall be entitled to continue their hospital, surgical, and medical insurance under  
36 that group policy, for themselves and their eligible spouses and dependents with respect  
37 to whom they were insured on the date of termination, subject to all of the group policy's  
38 terms and conditions ~~applicable to those forms of insurance~~ and to the conditions  
39 specified in this Part. Provided, the terms and conditions set forth in this Part are intended  
40 as minimum requirements and shall not be construed to impose additional or different  
41 requirements upon those group hospital, surgical, or major medical plans ~~already in force,~~  
42 ~~or hereafter placed into effect,~~ that provide continuation benefits equal to or better than  
43 those required in this Part."

1 Section 12. G.S. 58-53-35 reads as rewritten:

2 **"§ 58-53-35. Termination of continuation.**

3 (a) Continuation of insurance under the group policy for any person shall  
4 terminate on the earliest of the following dates:

- 5 (1) The date ~~one year~~ 18 months after the date the employee's or member's  
6 insurance under the policy would otherwise have terminated because of  
7 termination of employment or members;
- 8 (2) The date ending the period for which the employee or member last  
9 makes his required contribution, if he discontinues his contributions;
- 10 (3) The date the employee or member becomes or is eligible to become  
11 covered for similar benefits under any arrangement of coverage for  
12 individuals in a group, whether insured or uninsured;
- 13 (4) The date on which the group policy is terminated or, in the case of a  
14 multiple employer plan, the date his employer terminates participation  
15 under the group master policy. When this occurs the employee or  
16 member shall have the privilege described in G.S. 58-53-45 if the date  
17 of termination precedes that on which his actual continuation of  
18 insurance under that policy would have terminated. The insurer that  
19 insured the group ~~prior to~~ before the date of termination shall make a  
20 converted policy available to the employee or member.

21 (b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the  
22 group policy with another group policy, the employee is entitled to continue under the  
23 successor group policy for any unexpired period of continuation to which the employee is  
24 entitled."

25 Section 13. G.S. 58-53-50 reads as rewritten:

26 **"§ 58-53-50. Restrictions.**

27 A converted policy shall not be available to an employee or member if termination of  
28 his insurance under the group policy occurred because:

- 29 (1) Of termination of employment or membership and either he was not  
30 entitled to continuation of group coverage under Part 1 of this Article or  
31 failed to elect such continuation;
- 32 (2) He failed to make timely payment of any required contribution for the  
33 cost of continuation of insurance;
- 34 (3) He had not been continuously covered under the group policy or for  
35 similar benefits under any other group policy that it replaced during the  
36 period of three consecutive months immediately prior to termination of  
37 active employment ending with such termination;
- 38 (4) The group policy terminated or an employer's participation terminated,  
39 and the insurance is replaced by similar coverage under another group  
40 policy within 31 days of date of termination; or
- 41 (5) He failed to continue his insurance for the entire maximum period of  
42 ~~one year~~ 18 months following termination of active employment as  
43 provided for in Part 1 of this Article, unless that failure to continue was

1 because of change of insurer by the employer and the change of insurer  
2 was consummated during the one year continuation period. In that event  
3 the employee or member shall be entitled to be issued a converted  
4 policy by the insurer that provided the group policy to the employer  
5 before the change of insurer."

6 Section 14. G.S. 58-53-55 reads as rewritten:

7 "**§ 58-53-55. Time limit.**

8 In order to be eligible for conversion, written application and the first premium  
9 payment for the converted policy must be made to the insurer not later than 31 days after  
10 the date of termination of insurance provided under Part 1 of this Article. The effective  
11 date of the converted policy shall be the day following the later of:

- 12 (1) The termination of insurance under the group policy when it is not  
13 replaced by one providing similar coverage within 31 days of the  
14 termination date of the immediately prior group plan; or  
15 (2) The termination of the ~~one year period~~ of continued coverage under the  
16 group policy or policies."

17 Section 15. Article 55 of Chapter 58 of the General Statutes is amended by  
18 adding a new section to read:

19 "**§ 58-55-31. Additional requirements.**

20 (a) No policy shall be used in this State unless it provides for an offer of  
21 nonforfeiture, which shall not be less than an offer of reduced paid-up insurance benefits,  
22 extended term insurance benefits, or a shortened benefit period. No policy shall pay a  
23 cash surrender value unless the dividends or refunds are applied as a reduction of future  
24 premiums or an increase in future benefits.

25 (b) The Commissioner shall adopt rules to provide for annual reports by insurers  
26 of the number of claims denied, number of rescissions, and the percentage of sales  
27 involving the replacement of policies.

28 (c) No policy shall be used in this State unless the insurer has developed a  
29 financial or personal asset suitability test to determine whether or not issuing long-term  
30 care insurance to an applicant is appropriate. For purposes of this section:

- 31 (1) All insurers except those issuing life insurance that accelerates the death  
32 benefit for long-term care shall use the financial or suitability form and  
33 format standards as developed and adopted by the NAIC. A personal  
34 long-term care worksheet and disclosure notice of issues an applicant  
35 should know before buying long-term care insurance shall be completed  
36 and provided before an application is taken.

- 37 (2) Each applicant that does not meet the recommended financial or  
38 personal asset suitability test criteria shall receive a letter of notification  
39 and shall be given an option to waive the results of the financial  
40 suitability test and proceed with the purchase of the policy.

41 (d) The Commissioner shall adopt standards to handle consumer complaints about  
42 noncompliance with State requirements."

43 Section 16. G.S. 58-65-25 reads as rewritten:

1 **"§ 58-65-25. Hospital, physician and dentist contracts.**

2 (a) Any corporation organized under the provisions of this Article and Article 66  
3 of this Chapter may enter into contracts for the rendering of hospital service to any of its  
4 subscribers by hospitals approved by the American Medical Association and/or the North  
5 Carolina Hospital Association, and may enter into contracts for the furnishing of, or the  
6 payment in whole or in part for, medical and/or dental services rendered to any of its  
7 subscribers by duly licensed physicians and/or dentists. All obligations arising under  
8 contracts issued by such corporations to its subscribers shall be satisfied by payments  
9 made directly to the hospitals or hospitals and/or physicians and/or dentists rendering  
10 such service, or direct to the subscriber or his, her, or their legal representatives upon the  
11 receipt by the corporation from the subscriber of a statement marked paid by the  
12 hospital(s) and/or physician(s) and/or dentist(s) or both rendering such service, and all  
13 such payments heretofore made are hereby ratified. Nothing ~~herein~~ in this section shall  
14 be construed to discriminate against hospitals conducted by other schools of medical  
15 practice.

16 (b) ~~On and after January 1, 1956, all~~ All certificates, plans or contracts issued to  
17 subscribers or other persons by hospital and medical and/or dental service corporations  
18 operating under this Article ~~and Article 66 of this Chapter~~ shall contain in substance a  
19 provision as follows: 'After two years from the date of issue of this certificate, contract or  
20 plan no misstatements, except fraudulent misstatements made by the applicant in the  
21 application for such certificate, contract or plan, shall be used to void said certificate,  
22 contract or plan, or to deny a claim for loss incurred or disability (as therein defined)  
23 commencing after the expiration of such two-year period. ~~No claim for loss incurred or~~  
24 ~~disability (as defined in the certificate, contract or plan) commencing after two years~~  
25 ~~from the date of issue of this certificate, contract or plan shall be reduced or denied on the~~  
26 ~~ground that a disease or physical condition not excluded from coverage by name or~~  
27 ~~specifically described, effective on the date of loss, had existed prior to the effective date~~  
28 ~~of coverage of this certificate, contract or plan.'~~

29 Section 17. G.S. 58-65-60(e) reads as rewritten:

30 "(e) A ~~hospital~~ service corporation may issue a master group contract with the  
31 approval of the Commissioner of Insurance ~~provided such if the contract and the~~  
32 ~~individual certificates issued to members of the group, shall comply~~ group comply in  
33 substance to the other provisions of this Article and Article 66 of this Chapter. ~~Any such~~  
34 The contract may provide for the adjustment of the rate of the premium or benefits  
35 conferred as provided in ~~said the~~ contract, and in accordance with an adjustment schedule  
36 filed with and approved by the ~~Commissioner of Insurance.~~ Commissioner. If ~~such~~  
37 ~~master group the~~ contract is issued, altered or modified, the subscribers' contracts issued  
38 ~~in pursuance thereof under that contract~~ are altered or modified accordingly, all laws and  
39 clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article  
40 and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms  
41 of such contract shall at all times be furnished upon request of subscribers thereto.

42 (1) ~~For employer groups of 50 or more persons no evidence of individual~~  
43 ~~insurability may be required at the time the person first becomes eligible~~

1 for coverage or within 31 days thereafter except for any insurance  
2 supplemental to the basic coverage for which evidence of individual  
3 insurability may be required. With respect to trustee groups the phrase  
4 "groups of 50" must be applied on a participating unit basis for the  
5 purpose of requiring individual evidence of insurability.

6 (2) Employer master group contracts may contain a provision limiting  
7 coverage for preexisting conditions. Preexisting conditions must be  
8 covered no later than 12 months after the effective date of coverage.  
9 Preexisting conditions are defined as "those conditions for which  
10 medical advice or treatment was received or recommended or which  
11 could be medically documented within the 12-month period  
12 immediately preceding the effective date of the person's  
13 coverage." Preexisting conditions exclusions may not be implemented  
14 by any successor plan as to any covered persons who have already met  
15 all or part of the waiting period requirements under any previous plan.  
16 Credit must be given for that portion of the waiting period which was  
17 met under the previous plan. As used in this subdivision, a "previous  
18 plan" includes any health benefit plan provided by a health insurer, as  
19 those terms are defined in G.S. 58-51-115, or any government plan or  
20 program providing health benefits or health care, except that nothing in  
21 this section shall apply to a guaranteed issue product designed for  
22 uninsurables. For employer groups of 50 or more persons: In  
23 determining whether a preexisting condition provision applies to an  
24 eligible employee or to a dependent, all health benefit plans shall credit  
25 the time the person was covered under a previous plan if the previous  
26 plan's coverage was continuous to a date not more than 60 days before  
27 the effective date of the new coverage, exclusive of any applicable  
28 waiting period under the new coverage.

29 (3) (e1) Employees shall be added to the master group coverage no later than 90 days  
30 after their first day of employment. Employment shall be considered continuous and not  
31 be considered broken except for unexcused absences from work for reasons other than  
32 illness or injury. The term 'employee' is defined as a nonseasonal person who works on a  
33 full-time basis, with a normal work week of 30 or more hours and who is otherwise  
34 eligible for coverage, but does not include a person who works on a part-time, temporary,  
35 or substitute basis.

36 (4) (e2) Whenever an employer master group contract replaces another group  
37 contract, whether this contract was issued by a corporation under Articles 1 through 67 of  
38 this Chapter, the liability of the succeeding corporation for insuring persons covered  
39 under the previous group contract is (i) each person is eligible for coverage in accordance  
40 with the succeeding corporation's plan of benefits with respect to classes eligible and  
41 activity at work and nonconfinement rules must be covered by the succeeding  
42 corporation's plan of benefits; and (ii) each person not covered under the succeeding  
43 corporation's plan of benefits in accordance with (i) above must nevertheless be covered

1 by the succeeding corporation if that person was validly covered, including benefit  
2 extension, under the prior plan on the date of discontinuance and if the person is a  
3 member of the class of persons eligible for coverage under the succeeding corporation's  
4 plan."

5 Section 18. G.S. 58-67-85 reads as rewritten:

6 **"§ 58-67-85. Master group contracts, filing requirement; required and prohibited**  
7 **provisions.**

8 (a) A health maintenance organization may issue a master group contract with the  
9 approval of the Commissioner of Insurance provided the contract and the individual  
10 certificates issued to members of the group, shall comply in substance to the other  
11 provisions of this Article. Any such contract may provide for the adjustment of the rate of  
12 the premium or benefits conferred as provided in the contract, and in accordance with an  
13 adjustment schedule filed with and approved by the Commissioner of Insurance. If the  
14 master group contract is issued, altered or modified, the enrollees' contracts issued in  
15 pursuance thereof are altered or modified accordingly, all laws and clauses in the  
16 enrollees' contracts to the contrary notwithstanding. Nothing in this Article shall be  
17 construed to prohibit or prevent the same. Forms of such contract shall at all times be  
18 furnished upon request of enrollees thereto.

19 ~~(b) For employer groups of 50 or more persons no evidence of individual~~  
20 ~~insurability may be required at the time the person first becomes eligible for insurance or~~  
21 ~~within 31 days thereafter except for any insurance supplemental to the basic coverage for~~  
22 ~~which evidence of individual insurability may be required. With respect to trustee~~  
23 ~~groups the phrase "groups of 50" must be applied on a participating unit basis for the~~  
24 ~~purpose of requiring individual evidence of insurability.~~

25 ~~(c) Employer master group contracts may contain a provision limiting coverage~~  
26 ~~for preexisting conditions. Preexisting conditions must be covered no later than 12~~  
27 ~~months after the effective date of coverage. Preexisting conditions are defined as "those~~  
28 ~~conditions for which medical advice or treatment was received or recommended or which~~  
29 ~~could be medically documented within the 12-month period immediately preceding the~~  
30 ~~effective date of the person's coverage." Preexisting conditions exclusions may not be~~  
31 ~~implemented by any successor plan as to any covered persons who have already met all~~  
32 ~~or part of the waiting period requirements under any previous plan. Credit must be given~~  
33 ~~for that portion of the waiting period which was met under the previous plan. As used in~~  
34 ~~this subsection, a "previous plan" includes any health benefit plan provided by a health~~  
35 ~~insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program~~  
36 ~~providing health benefits or health care. In determining whether a preexisting condition~~  
37 ~~provision applies to an eligible employee or to a dependent, all health benefit plans shall~~  
38 ~~credit the time the person was covered under a previous plan if the previous plan's~~  
39 ~~coverage was continuous to a date not more than 60 days before the effective date of the~~  
40 ~~new coverage, exclusive of any applicable waiting period under the new coverage.~~

41 (d) Employees shall be added to the master group coverage no later than 90  
42 days after their first day of employment. Employment shall be considered continuous and  
43 not be considered broken except for unexcused absences from work for reasons other

1 than illness or injury. The term 'employee' is defined as a nonseasonal person who works  
2 on a full-time basis, with a normal work week of 30 or more hours and who is otherwise  
3 eligible for coverage, but does not include a person who works on a part-time, temporary,  
4 or substitute basis.

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

9 (1) Each person who is eligible for coverage in accordance with the  
10 succeeding corporation's plan of benefits with respect to classes eligible  
11 and activity at work and nonconfinement rules must be covered by the  
12 succeeding corporation's plan of benefits; and

13 (2) Each person not covered under the succeeding corporation's plan of  
14 benefits in accordance with (e)(1) must nevertheless be covered by the  
15 succeeding corporation if that person was validly covered, including  
16 benefit extension, under the prior plan on the date of discontinuance and  
17 if the person is a member of the class of persons eligible for coverage  
18 under the succeeding corporation's plan."

19 Section 19. Article 3 of Chapter 58 of the General Statutes is amended by  
20 adding a new section to read:

21 **"§ 58-3-169. Required coverage for minimum hospital stay following birth.**

22 (a) Definitions. – As used in this section:

23 (1) 'Attending providers' includes:

24 a. The obstetrician-gynecologists, pediatricians, family physicians,  
25 and other physicians primarily responsible for the care of a  
26 mother and newborn; and

27 b. The nurse midwives and nurse practitioners primarily responsible  
28 for the care of a mother and her newborn child in accordance  
29 with State licensure and certification laws.

30 (2) 'Health benefit plan' means an accident and health insurance policy or  
31 certificate; a nonprofit hospital or medical service corporation contract;  
32 a health maintenance organization subscriber contract; a plan provided  
33 by a multiple employer welfare arrangement; or a plan provided by  
34 another benefit arrangement, to the extent permitted by the Employee  
35 Retirement Income Security Act of 1974, as amended, or by any waiver  
36 of or other exception to that Act provided under federal law or  
37 regulation. 'Health benefit plan' does not mean any of the following  
38 kinds of insurance:

39 a. Accident,

40 b. Credit,

41 c. Disability income,

42 d. Long-term or nursing home care,

43 e. Medicare supplement.

- 1           f. Specified disease,  
2           g. Dental or vision,  
3           h. Coverage issued as a supplement to liability insurance,  
4           i. Workers' compensation,  
5           j. Medical payments under automobile or homeowners, and  
6           k. Insurance under which benefits are payable with or without  
7           regard to fault and that is statutorily required to be contained in  
8           any liability policy or equivalent self-insurance.  
9           l. Hospital income or indemnity.

10       (3) 'Insurer' means an insurance company subject to this Chapter, a service  
11       corporation organized under Article 65 of this Chapter, a health  
12       maintenance organization organized under Article 67 of this Chapter,  
13       and a multiple employer welfare arrangement subject to Article 49 of  
14       this Chapter.

15       (b) In General. – Except as provided in subsection (c) of this section, an insurer  
16       that provides a health benefit plan that contains maternity benefits, including benefits for  
17       childbirth, shall ensure that coverage is provided with respect to a mother who is a  
18       participant, beneficiary, or policyholder under the plan and her newborn child for a  
19       minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and  
20       a minimum of 96 hours of inpatient length of stay following a cesarean section, without  
21       requiring the attending provider to obtain authorization from the insurer or its  
22       representative.

23       (c) Exception. – Notwithstanding subsection (b) of this section, an insurer is not  
24       required to provide coverage for postdelivery inpatient length of stay for a mother who is  
25       a participant, beneficiary, or policyholder under the insurer's health benefit plan and her  
26       newborn child for the period referred to in subsection (b) of this section if:

- 27           (1) A decision to discharge the mother and her newborn child before the  
28           expiration of the period is made by the attending provider in  
29           consultation with the mother; and  
30           (2) The health benefit plan provides coverage for postdelivery follow-up  
31           care as described in subsections(d) and (e) of this section.

32       (d) Postdelivery Follow-Up Care. – In the case of a decision to discharge a mother  
33       and her newborn child from the inpatient setting before the expiration of 48 hours  
34       following a normal vaginal delivery or 96 hours following a cesarean section, the health  
35       benefit plan shall provide coverage for timely postdelivery care. This health care shall be  
36       provided to a mother and her newborn child by a registered nurse, physician, nurse  
37       practitioner, nurse midwife, or physician assistant experienced in maternal and child  
38       health in:

- 39           (1) The home, a provider's office, a hospital, a birthing center, an  
40           intermediate care facility, a federally qualified health center, a federally  
41           qualified rural health clinic, or a State health department maternity  
42           clinic; or



1           (2) Another setting determined appropriate under federal regulations  
2           promulgated under Title VI of Public Law 104-204.

3 The attending provider in consultation with the mother shall decide the most appropriate  
4 location for follow-up care.

5       (e) Timely Care. – As used in subsection (d) of this section, ‘timely postdelivery  
6 care’ means health care that is provided:

7           (1) Following the discharge of a mother and her newborn child from the  
8           inpatient setting; and

9           (2) In a manner that meets the health care needs of the mother and her  
10           newborn child, that provides for the appropriate monitoring of the  
11           conditions of the mother and child, and that occurs not later than the 72-  
12           hour period immediately following discharge.

13       (f) Prohibitions. – An insurer shall not:

14           (1) Deny enrollment, renewal, or continued coverage with respect to its  
15           health benefit plan to a mother and her newborn child who are  
16           participants, beneficiaries, or policyholders, based on compliance with  
17           this section;

18           (2) Provide monetary payments or rebates to mothers to encourage the  
19           mothers to request less than the minimum coverage required under this  
20           section;

21           (3) Penalize or otherwise reduce or limit the reimbursement of an attending  
22           provider because the provider provided treatment to an individual  
23           policyholder, participant, or beneficiary in accordance with this section;  
24           or

25           (4) Provide monetary or other incentives to an attending provider to induce  
26           the provider to provide treatment to an individual policyholder,  
27           participant, or beneficiary in a manner inconsistent with this section.

28       (g) Effect on Mother. – Nothing in this section requires that a mother who is a  
29 participant, beneficiary, or policyholder covered under this section:

30           (1) Give birth in a hospital; or

31           (2) Stay in the hospital for a fixed period of time following the birth of her  
32           child.

33       (h) Level and Type of Reimbursements. – Nothing in this section prevents an  
34 insurer from negotiating the level and type of reimbursement with an attending provider  
35 for care provided in accordance with this section."

36       Section 20. G.S. 58-3-170 reads as rewritten:

37 **"§ 58-3-170. Requirements for maternity coverage.**

38       (a) Every entity providing a health benefit plan that provides maternity coverage  
39 in this State shall provide benefits for the necessary care and treatment related to  
40 maternity that are no less favorable than benefits for physical illness generally.

41       ~~(a1) A health benefit plan that provides maternity coverage shall provide coverage~~  
42 ~~for inpatient care for a mother and her newly born child for a minimum of forty eight~~

1 ~~(48) hours after vaginal delivery and a minimum of ninety six (96) hours after delivery~~  
2 ~~by caesarean section.~~

3 (b) As used in this section, 'health benefit plans' means accident and health  
4 insurance policies or certificates; nonprofit hospital or medical service corporation  
5 contracts; health, hospital, or medical service corporation plan contracts; health  
6 maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA  
7 or plans provided by other benefit arrangements, to the extent permitted by ERISA."

8 Section 21. G.S. 58-51-55 reads as rewritten:

9 "**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

10 (a) Definitions. – As used in this section, the term:

- 11 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21);  
12 and  
13 (2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-  
14 50

15 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders  
16 DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of  
17 those manuals.

18 (b) Coverage of Physical Illness. – No insurance company licensed in this State  
19 under ~~the provisions of Articles 1 through 64 of this Chapter~~ shall, solely because an  
20 individual to be insured has or had a mental illness or chemical dependency:

- 21 (1) Refuse to issue or deliver to that individual any policy that affords  
22 benefits or coverages for any medical treatment or service for physical  
23 illness or injury;  
24 (2) Have a higher premium rate or charge for physical illness or injury  
25 coverages or benefits for that individual; or  
26 (3) Reduce physical illness or injury coverages or benefits for that  
27 individual.

28 (b1) Coverage of Mental Illness. – A policy that covers both physical illness or  
29 injury and mental illness may not impose a lesser lifetime or annual dollar limitation on  
30 the mental health benefits than on the physical illness or injury benefits, subject to the  
31 following:

- 32 (1) A lifetime limit or annual limit may be made applicable to all benefits  
33 under the policy, without distinguishing the mental health benefits.  
34 (2) If the policy contains lifetime limits only on selected physical illness  
35 and injury benefits, and these benefits do not represent substantially all  
36 of the physical illness and injury benefits under the policy, the insurer  
37 may impose a lifetime limit on the mental health benefits that is based  
38 on a weighted average of the respective lifetime limits on the selected  
39 physical illness and injury benefits. The weighted average shall be  
40 calculated in accordance with rules adopted by the Commissioner.  
41 (3) If the policy contains annual limits only on selected physical illness and  
42 injury benefits, and these benefits do not represent substantially all of  
43 the physical illness and injury benefits under the policy, the insurer may

1 impose an annual limit on the mental health benefits that is based on a  
2 weighted average of the respective annual limits on the selected  
3 physical illness and injury benefits. The weighted average shall be  
4 calculated in accordance with rules adopted by the Commissioner.

5 (4) Except as otherwise provided in this section, the policy may distinguish  
6 between mental illness benefits and physical injury or illness benefits  
7 with respect to other terms of the policy, including coinsurance, limits  
8 on provider visits or days of coverage, and requirements relating to  
9 medical necessity.

10 (5) If the insurer offers two or more benefit package options under a policy,  
11 each package must comply with this subsection.

12 (6) This subsection does not apply to a policy if the insurer can demonstrate  
13 to the Commissioner that compliance will increase the cost of the policy  
14 by one percent (1%) or more.

15 (7) This subsection expires October 1, 2001, but the expiration does not  
16 affect services rendered before that date.

17 (c) Mental Illness or Chemical Dependency Coverage Not Required. – Nothing in  
18 this section prevents any insurance company from excluding from coverage any physical  
19 illness or injury or mental illness or chemical dependency which has existed previous to  
20 coverage of the individual by the insurance company or from refusing to issue or deliver  
21 to that individual any policy because of the underwriting of any physical condition  
22 whether or not related to requires an insurer to offer coverage for mental illness or  
23 chemical dependency.

24 (d) Applicability. – This Subsection (b1) of this section applies only to group  
25 health insurance contracts covering more than 50 employees. The remainder of this  
26 section applies only to group health insurance contracts covering 20 or more employees.  
27 For purposes of this section, 'group health insurance contracts' include MEWAs, as  
28 defined in G.S. 58-49-30(a)."

29 Section 22. G.S. 58-65-90 reads as rewritten:

30 **"§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

31 (a) Definitions. – As used in this section, the term:

32 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21);  
33 and

34 (2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-  
35 75

36 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders  
37 DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of  
38 those manuals.

39 (b) Coverage of Physical Illness. – No hospital, medical, dental or health service  
40 corporation governed by this Chapter shall, solely because an individual to be insured has  
41 or had a mental illness or chemical dependency:

42 (1) Refuse to issue or deliver to that individual any individual or group  
43 hospital, dental, medical or health service subscriber contract in this

- 1 State that affords benefits or coverage for medical treatment or service  
2 for physical illness or injury;
- 3 (2) Have a higher premium rate or charge for physical illness or injury  
4 coverages or benefits for that individual; or
- 5 (3) Reduce physical illness or injury coverages or benefits for that  
6 individual.
- 7 (b1) Coverage of Mental Illness. – A subscriber contract that covers both physical  
8 illness or injury and mental illness may not impose a lesser lifetime or annual dollar  
9 limitation on the mental health benefits than on the physical illness or injury benefits,  
10 subject to the following:
- 11 (1) A lifetime limit or annual limit may be made applicable to all benefits  
12 under the subscriber contract, without distinguishing the mental health  
13 benefits.
- 14 (2) If the subscriber contract contains lifetime limits only on selected  
15 physical illness or injury benefits, and these benefits do not represent  
16 substantially all of the physical illness and injury benefits under the  
17 subscriber contract, the service corporation may impose a lifetime limit  
18 on the mental health benefits that is based on a weighted average of the  
19 respective lifetime limits on the selected physical illness and injury  
20 benefits. The weighted average shall be calculated in accordance with  
21 rules adopted by the Commissioner.
- 22 (3) If the subscriber contract contains annual limits only on selected  
23 physical illness and injury benefits, and these benefits do not represent  
24 substantially all of the physical illness and injury benefits under the  
25 subscriber contract, the service corporation may impose an annual limit  
26 on the mental health benefits that is based on a weighted average of the  
27 respective annual limits on the selected physical illness and injury  
28 benefits. The weighted average shall be calculated in accordance with  
29 rules adopted by the Commissioner.
- 30 (4) Except as otherwise provided in this section, the subscriber contract  
31 may distinguish between mental illness benefits and physical injury or  
32 illness benefits with respect to other terms of the subscriber contract,  
33 including coinsurance, limits on provider visits or days of coverage, and  
34 requirements relating to medical necessity.
- 35 (5) If the service corporation offers two or more benefit package options  
36 under a subscriber contract, each package must comply with this  
37 subsection.
- 38 (6) This subsection does not apply to a subscriber contract if the service  
39 corporation can demonstrate to the Commissioner that compliance will  
40 increase the cost of the subscriber contract by one percent (1%) or more.
- 41 (7) This subsection expires October 1, 2001, but the expiration does not  
42 affect services rendered before that date.

1 (c) Mental Illness or Chemical Dependency Coverage Not Required. – Nothing in  
2 this section ~~prevents any hospital or medical plan from excluding from coverage any~~  
3 ~~physical illness or injury or mental illness or chemical dependency which has existed~~  
4 ~~previous to coverage of the individual by the hospital or medical plan or from refusing to~~  
5 ~~issue or deliver to that individual any policy because of the underwriting of any physical~~  
6 ~~condition whether or not related to~~ requires a service corporation to offer coverage for  
7 mental illness or chemical dependency.

8 (d) Applicability. – ~~This Subsection (b1) of this section applies only to~~  
9 ~~subscriber contracts covering more than 50 employees. The remainder of this section~~  
10 ~~applies only to group contracts covering 20 or more employees."~~

11 Section 23. G.S. 58-67-75 reads as rewritten:

12 **"§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

13 (a) Definitions. – As used in this section, the term:

- 14 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21);  
15 and  
16 (2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-  
17 70

18 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders  
19 DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of  
20 those manuals.

21 (b) Coverage of Physical Illness. – No health maintenance organization governed  
22 by this Chapter shall, solely because an individual has or had a mental illness or chemical  
23 dependency:

- 24 (1) Refuse to enroll that individual in any health care plan covering physical  
25 illness or injury;  
26 (2) Have a higher premium rate or charge for physical illness or injury  
27 coverages or benefits for that individual; or  
28 (3) Reduce physical illness or injury coverages or benefits for that  
29 individual.

30 (b1) Coverage of Mental Illness. – A health care plan that covers both physical  
31 illness or injury and mental illness may not impose a lesser lifetime or annual dollar  
32 limitation on the mental health benefits than on the physical illness or injury benefits,  
33 subject to the following:

- 34 (1) A lifetime limit or annual limit may be made applicable to all benefits  
35 under the plan, without distinguishing the mental health benefits.  
36 (2) If the plan contains lifetime limits only on selected physical illness and  
37 injury benefits, and these benefits do not represent substantially all of  
38 the physical illness and injury benefits under the plan, the HMO may  
39 impose a lifetime limit on the mental health benefits that is based on a  
40 weighted average of the respective lifetime limits on the selected  
41 physical illness and injury benefits. The weighted average shall be  
42 calculated in accordance with rules adopted by the Commissioner.

- 1           (3) If the plan contains annual limits only on selected physical illness and  
2 injury benefits, and these benefits do not represent substantially all of  
3 the physical illness and injury benefits under the plan, the HMO may  
4 impose an annual limit on the mental health benefits that is based on a  
5 weighted average of the respective annual limits on the selected  
6 physical illness and injury benefits. The weighted average shall be  
7 calculated in accordance with rules adopted by the Commissioner.
- 8           (4) Except as otherwise provided in this section, the plan may distinguish  
9 between mental illness benefits and physical injury or illness benefits  
10 with respect to other terms of the plan, including coinsurance, limits on  
11 provider visits or days of coverage, and requirements relating to medical  
12 necessity.
- 13           (5) If the HMO offers two or more benefit package options under a plan,  
14 each package must comply with this subsection.
- 15           (6) This subsection does not apply to a health benefit plan if the HMO can  
16 demonstrate to the Commissioner that compliance will increase the cost  
17 of the plan by one percent (1%) or more.
- 18           (7) This subsection expires October 1, 2001, but the expiration does not  
19 affect services rendered before that date.

20           (c) Mental Illness or Chemical Dependency Coverage Not Required. – Nothing in  
21 this section prevents any health maintenance organization from excluding from coverage  
22 any physical illness or injury or mental illness or chemical dependency which has existed  
23 previous to coverage of the individual by the health maintenance organization or from  
24 refusing to issue or deliver to that individual any policy because of the underwriting of  
25 any physical condition whether or not related to requires an HMO to offer coverage for  
26 mental illness or chemical dependency.

27           (d) Applicability. –This Subsection (b1) of this section applies only to group  
28 contracts covering more than 50 employees. The remainder of this section applies only  
29 to group contracts covering 20 or more employees."

30           Section 24. G. S. 58-3-173 is repealed.

31           Section 25. Sections 1 through 18 of this act apply to all affected contracts that  
32 are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20,  
33 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for  
34 delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal  
35 of a contract is presumed to occur on each anniversary of the date on which coverage was  
36 first effective on the person or persons covered by the contract.

37           Section 26. This act is effective when it becomes law.