GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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HOUSE BILL 803

Short Title: Health Insur./Risk Pool. (Public)

Sponsors: Representatives Gardner, Brawley; and Allred.

Referred to: Insurance.

April 3, 1997

A BILL TO BE ENTITLED

AN ACT TO ENACT THE NORTH CAROLINA COMPREHENSIVE HEALTH INSURANCE RISK POOL ACT.

The General Assembly of North Carolina enacts:

Section 1. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-50-160. Title and reference.**

This section and G.S. 58-50-165 through G.S. 58-50-210 are known and may be cited as the North Carolina Comprehensive Health Insurance Risk Pool Act, referred to in those sections as 'this Act'.

"**§ 58-50-165. Purpose.**

The purpose of this Act is to establish a health insurance plan that makes available health insurance coverage to those North Carolina citizens who, because of health conditions, are unable to secure health insurance. It is also the purpose of this Act to provide an acceptable alternative mechanism as allowed under the Health Insurance Portability and Accountability Act of 1996 for providing portable and accessible individual health insurance coverage for eligible individuals.

"**§ 58-50-170. Definitions.**

As used in this Act, unless the context clearly requires otherwise, the term:

(1) 'Agent' means a person who is licensed to sell health insurance in this State or a third-party administrator.
(2) 'Board' means the board of directors of the Pool.
(3) 'Covered person' means any individual resident of this State, excluding dependents, who is eligible to receive benefits from any insurer.
(4) 'Health benefit plan' means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a multiple employer welfare arrangement (MEWA) or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115, that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. Health benefit plan does not mean accident only, specified disease only, fixed indemnity, credit, or disability insurance; coverage of Medicare services pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
(5) 'Health maintenance organization' means any organization authorized under Article 67 of this Chapter to operate a health maintenance organization in this State.
(6) 'Insurer' or 'insurance company' means any entity that provides health insurance in this State. The term includes a nonprofit health care services plan, fraternal benefit society, health maintenance organization, to the extent consistent with federal law any self-insurance arrangement covered by ERISA that provides health care benefits in this State, any other entity providing a plan of health insurance or health benefits subject to regulation under this Chapter, and any reinsurer reinsuring health insurance in this State.
(7) 'Medicare' means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C, § 1395, et seq., as amended.
(8) 'Plan' means the health benefit plan adopted by the Board pursuant to this Act.
(9) 'Pool' means the North Carolina Comprehensive Health Insurance Risk Pool.
(10) 'Resident' means any individual who has been legally domiciled in this State for a period of at least 180 days and continues to be domiciled in this State.

(11) 'Third-party administrator' or 'TPA' means any entity licensed as a TPA under Article 56 of this Chapter and paying or processing health insurance claims for a resident of this State.

"**§ 58-50-175. Eligibility for coverage; maximum lifetime benefits; termination of coverage; unfair trade practices by insurers, agents, brokers, or employers.**

(a) Any individual who is and continues to be a resident of this State shall be eligible for coverage under the Plan approved by the Board if evidence is provided of at least one of the following:

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

(2) A refusal by an insurer to issue insurance except with material underwriting restriction; or

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

(b) The Board shall develop a procedure for eligibility for coverage by the Pool for any natural person who changes domicile to this State and who at the time domicile is established in this State is insured by an organization similar to the Pool. The eligible maximum lifetime benefits for the covered person shall not exceed the lifetime benefits available through the Pool, less any benefits received from a similar organization in the former domiciliary state.

(c) The Board shall adopt a list of medical or health conditions for which an individual shall be eligible for plan coverage without applying for health insurance under subsection (a) of this section. Individuals who can demonstrate the existence or history of any medical or health conditions on the list adopted by the Board shall not be required to provide the evidence specified in subsection (a) of this section. The Board may amend the list from time to time as it deems appropriate.

(d) An individual is not eligible for coverage under the Plan approved by the Board if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a policy issued under the Plan, or would be eligible to have coverage if the person elected to obtain it, except that an individual may maintain coverage under the Plan for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the policy issued under the Plan;

(2) The individual is determined to be eligible for health care benefits under the State plan under Title XIX of the Social Security Act (Medicaid);

(3) The individual previously terminated coverage under the Plan unless 12 months have elapsed since the individual's latest termination under the Plan;

(4) The Plan has paid out five hundred thousand dollars ($500,000) in benefits on behalf of the individual. The lifetime maximum benefits under the Plan shall be five hundred thousand dollars ($500,000);

(5) The individual is an inmate or resident of a public institution; or

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

(e) The coverage of any individual under the Plan shall cease:

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

(2) Upon the death of the individual;

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

(4) At the option of the Board, 30 days after the Board makes an inquiry concerning the individual's eligibility or place of residence to which the individual does not reply.

(f) The Board may terminate immediately the coverage of any individual who ceases to meet the eligibility requirements of this Act.

(g) It shall constitute an unfair trade practice for any insurer, insurance agent or broker, employer, or third-party administrator to refer an individual employee to the Pool, or to arrange for an individual employee to apply to the Pool, for the purpose of separating the employee from a group health benefits plan provided in connection with the employee's employment.

"**§ 58-50-180. Pool created; insurer membership required; board of directors established.**

(a) There is created the North Carolina Comprehensive Health Insurance Risk Pool. As a condition of doing business in this State, every insurer shall participate as a member of the Pool. The Pool shall become effective October 1, 1997. Policies approved under the Plan shall be available for sale January 1, 1998.

(b) There is established the board of directors of the North Carolina Comprehensive Health Insurance Risk Pool. The Pool shall be operated under the supervision and administration of the Board, and shall be located for budgetary purposes only, within the Department of Insurance. The Board shall consist of seven members, as follows:

(1) Two members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, one of whom shall be a representative of a health maintenance organization or nonprofit health services organization licensed to do business in this State, and one of whom shall be a member of the general public who is not associated with the medical profession, a hospital, or an insurer;

(2) Two members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, one of whom shall be a representative of a health insurance company doing business in this State other than a health maintenance organization and

nonprofit health services organization, and one of whom shall be a public member who is an uninsurable person or who is an advocate for uninsurable persons;

(3) Two members appointed by the Governor, one of whom represents hospitals and one of whom is a member of a health-related profession; and

(4) The Commissioner of Insurance shall serve ex officio.

(c) The initial members of the Board shall serve staggered terms, as follows:

(1) One of the members appointed by the Speaker of the House of Representative shall be appointed for an initial term of one year; the other member appointed by the Speaker shall be appointed for an initial term of three years;

(2) One of the members appointed by the President Pro Tempore of the Senate shall be appointed for an initial term of one year; the other member appointed by the President Pro Tempore of the Senate shall be appointed for an initial term of three years; and

(3) One of the members appointed by the Governor shall be appointed for an initial term of one year; the other member appointed by the Governor shall be appointed for an initial term of two years.

All terms after the initial term shall be for three years.

(d) The Board shall elect one of its members as Chair.

(e) Members of the Board, other than the Commissioner of Insurance, may be reimbursed from monies of the Pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the board of directors, but shall not otherwise be compensated for their services. The Commissioner of Insurance may be compensated for service on the Board as authorized under State law.

(f) Individual Board members shall not be liable and shall be immune from suit at law or equity for any conduct performed in good faith and which is within the subject matter of which they have been given jurisdiction under this Act.

"**§ 58-50-185. Powers and duties of the Board.**

(a) The Board shall have the following powers and duties:

(1) Hire an executive director and other employees who shall serve at the pleasure of the Board and perform such duties as the Board delegates. The salary of the executive director and other employees shall be determined by the Board and shall be paid from Pool funds.

(2) Establish administrative and accounting procedures for the operation of the Pool. Procedures shall address the handling, accounting, and auditing of assets, monies, and claims of the Plan and the administering TPA.

(3) Adopt rules pursuant to Chapter 150B of the General Statutes.

(4) Select and contract with a third-party administrator in accordance with G.S. 58-50-190.

(5) Collect assessments as authorized under G.S. 58-50-195 from insurers for claims paid under the Plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the Board. Assessments shall be collected quarterly pursuant to the plan of operation approved by the Board. In addition to the collection of assessments authorized under G.S. 58-50-195, the Board shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments shall be equal in amount for all insurers, but shall not exceed one hundred dollars ($100.00) per insurer for all such assessments. Assessments are due and payable within 30 days of receipt of the assessment notice by the insurer.

(6) Ensure that all policy forms issued by the Pool conform to standard forms developed by the Pool and approved by the Commissioner of Insurance.

(7) Develop and implement a program to publicize the existence of the Plan, the eligibility requirements for the Plan, and the procedures for enrollment in the Plan, and to maintain public awareness of the Plan and any changes thereto.

(8) The Board may take any of the following legal actions necessary or proper to implement this Act:

a. For the recovery of any monies due the Pool under this Act;

b. For the recovery or collection of assessments due the Pool;

c. To avoid payment of improper claims against the Pool or the coverage provided by or through the Pool;

d. To recover any amounts erroneously or improperly paid by the Pool; and

e. To recover any amounts paid by the Pool as a result of mistake of fact or law.

(9) Enter into contracts as necessary or proper to carry out the provisions of this Act, including contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions.

(10) Establish, and modify from time to time as authorized and appropriate, rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(11) Issue policies of insurance in accordance with the requirements of this Act.

(12) Establish and appoint committees necessary to provide technical assistance in the operation of the Pool.

(13) Adopt rules, conditions, and procedures for reinsuring risks of member insurers desiring to issue plan coverages to individuals otherwise eligible for plan coverages in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(14) Prepare and distribute application forms and enrollment instruction forms to insurance providers and to the general public. Forms shall be approved by the Commissioner of Insurance.

(15) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the health benefit plan more cost-effective.

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

(17) Establish procedures under which applicants for coverage under the Plan and individuals covered under the Plan may file grievances for review by a grievance committee appointed by the Board. Grievances reviewed shall be reported to the Board for Board action. The Board shall retain written grievances for not less than three years.

(18) Create a Plan fund, under management of the Board, to fund administrative, claim, and other expenses of the Plan.

(19) Adopt bylaws and other policies and procedures as may be necessary and proper for the execution of its powers, duties, and obligations under the Plan.

"**§ 58-50-190. Selection of Plan administrator; term, powers, and duties and compensation of administrator.**

(a) The Board shall select, through a competitive bidding process, a third-party administrator to administer the Plan. The Board shall evaluate the bid submitted based on criteria established by the Board, which criteria shall include but not be limited to:

(1) The bidder's proven ability to handle large group accident and health insurance;

(2) The efficiency of the insurer's claims-paying procedures; and

(3) An estimate of total charges for administering the Plan.

(b) The TPA selected to administer the Plan shall serve for three years. At least one year prior to the expiration of each three-year period of service by the TPA, the Board shall invite all licensed TPAs in the State, including the current administering TPA, to submit bids to serve as the TPA for the succeeding three-year period. The

selection of the administering TPA for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(c) The administering TPA shall:

(1) Perform all eligibility and administrative claims-payment functions relating to the Plan.

(2) Establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made periodically as determined by the Board.

(3) Perform all necessary functions to assure timely payment of benefits to persons covered under the Plan, including:

a. Making available information relating to the proper manner of submitting a claim for benefits under the Plan and distributing forms upon which submissions shall be made;

b. Evaluating the eligibility of each claim for payment under the Plan; and

c. Notifying each claimant within 45 days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected, or compromised.

The Board shall establish reasonable reimbursement amounts for services covered under the Plan.

(4) Submit regular reports to the Board regarding the operation of the Plan. The frequency, content, and form of the reports shall be as determined by the Board.

(5) Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to reinsurance operations of the Pool, and the incurred losses of the year and report this information to the Pool.

(6) Pay claims expenses from the premium payments received from or on behalf of persons covered under the Plan. If the payments by the TPA for claims expenses exceed the portion of premiums allocated by the Board for payment of claims expenses, the Board shall provide the TPA with additional funds for payment of claims expenses.

(d) The TPA shall be paid, as provided in the contract of the Pool, for its direct and indirect expenses incurred in the performance of its services. As used in this subsection, the term ‘direct and indirect expenses' includes that portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the TPA which are approved by the Board as allocable to the administration of the Plan and included in the bid specifications.

"**§ 58-50-195. Assessments against insurers.**

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the Pool, the Board shall assess the member insurers at such time and for such

amounts as the Board finds necessary. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Each member insurer shall be assessed an amount not to exceed one dollar ($1.00) per covered person insured or reinsured by each insurer per month. There shall not be such assessment on any insurer on policies or contracts insuring federal or State employees.

(c) The Board shall make reasonable efforts designed to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the Board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered persons all individuals whose coverage is insured (including by way of excess or stop-loss coverage) in whole or part. The Board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purpose of determining its assessment under this subsection.

(d) Each insurer's assessment may be verified by the Board based on annual statements and other reports deemed to be necessary by the Board. The Board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool, Board, or TPA exceed the actual losses and administrative expenses of the Plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce Plan premiums. As used in this subsection, the term ‘future losses' includes reserves for claims incurred but not reported.

(f) The Commissioner of Insurance may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-200. Insurance of plan coverage; issuance of policies.**

The coverage provided by the Plan shall be directly insured by the Pool, and the policies shall be issued through the administering TPA.

"**§ 58-50-205. Coverage; rates; other sources primary.**

(a) Coverage Offered. – The Plan shall offer in an annually renewable policy the coverage specified in this section for each eligible person. If an eligible person is also eligible for Medicare coverage, the Plan shall not pay or reimburse any person for expenses paid by Medicare. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the Plan. If such coverage is applied for within 60 days after the involuntary termination, and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

(b) Major Medical Expense Coverage. – The Plan shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Except as

provided in G.S. 58-50-210, the coverage to be issued by the Plan, its schedule of benefits, exclusions, and other limitations shall be established by the Board.

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

(d) Coverage Rates. – Rates for coverages issued by the Pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age may apply for individual risks. Standard risk rates for coverages issued by the Pool shall be established by the Board using reasonable actuarial techniques, and shall reflect anticipated experiences and expenses of the coverages for standard risks. Rates are subject to approval by the Commissioner of Insurance. The rating plan established by the Board shall initially provide for rates equal to one hundred fifty percent (150%) of the average standard risk rates. Any changes in the initial rates shall be based on experience of the Plan and shall reflect reasonably anticipated losses and expenses. No rate shall exceed one hundred seventy-five percent (175%) of the standard risk rate.

(e) Other Sources Primary. – The Pool shall be the payer of last resort of benefits whenever any other benefit or source of third-party payment is available. The coverage provided by the Pool shall be considered excess coverage, and benefits otherwise payable under Pool coverage shall be reduced by all amounts paid or payable through any other health insurance and by all hospital and medical expense benefits paid or payable under any short-term, accident, dental-only, vision-only, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(f) Other Coverage. – No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available.

(g) Recovery of Benefits Paid in Error. – The Pool shall have a cause of action against a participant for the recovery of the amount of any benefits paid to the participant which should not have been claimed or recognized as claims because of the provisions of this section or because otherwise not covered. Benefits due from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-210. Certain coverage excluded; annual deductibles.**

(a) Covered expenses under the Plan shall not include the following:

(1) Coverage for any dependent of a person covered under the Plan;

(2) Coverage for routine maternity charges for a pregnancy, except where added as optional coverage with payment of additional premiums;

(3) Coverage for treatment for cosmetic purposes, other than for repair or treatment of any injury or congenital bodily defect to restore normal bodily functions;

(4) Coverage for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid;

(5) Coverage for confinement in a private room to the extent that such is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician; and

(6) Any other coverage excluded by the Board.

(b) The Plan shall provide for a choice of annual deductibles for major medical expenses in the amount of one thousand dollars ($1,000), one thousand five hundred dollars ($1,500), two thousand dollars ($2,000), and five thousand dollars ($5,000). The schedule of premiums and deductibles shall be established by the Board.

Section 2. The Board of Directors of the North Carolina Comprehensive Health Insurance Risk Pool shall report to the 1999 General Assembly, upon its convening. The report shall provide information on the following:

(1) Claims experience of the Plan, including a breakdown of medical conditions for which claims were paid;

(2) Whether availability of the Plan affected employment opportunities for participants;

(3) Whether availability of the Plan affected the receipt of medical assistance benefits by Plan participants;

(4) Data on all complaints received about the Plan including its operation and services; and

(5) Any other information the Board deems significant regarding utilization of the Plan.

Section 3. There is appropriated from the General Fund to the North Carolina Comprehensive Health Insurance Risk Pool the sum of two hundred fifty thousand dollars ($250,000) for the 1997-98 fiscal year and the sum of two hundred fifty thousand dollars ($250,000) for the 1998-99 fiscal year for the initial operations of the Board.

Section 4. This act is effective when it becomes law.