GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 797

Short Title: Health and Life Insurance Amendments. (Public)

Sponsors: Senator Miller.

Referred to: Pensions & Retirement and Insurance.

April 10, 1997

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS SUBSTANTIVE AMENDMENTS TO LAWS RELATING TO SMALL EMPLOYER GROUP HEALTH INSURANCE, GROUP HEALTH INSURANCE CONTINUATION, MEDICARE SUPPLEMENT INSURANCE, GROUP LIFE INSURANCE POLICIES, LIFE INSURANCE SALES, AND UNFAIR TRADE PRACTICES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-3-150(b) reads as rewritten:

"(b) With respect to group and blanket accident and health insurance, group life insurance, and group annuity policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State and the application or enrollment form used to solicit the group insurance or annuity certificate to each insured person in this State shall be filed with and approved by the Commissioner pursuant to subsection (a) of this section. Group certificates, applications, or enrollment forms shall conform with all applicable provisions of this Chapter."

Section 2. G.S. 58-50-110(14) reads as rewritten:

"(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health

benefit plan in effect at the time the employee first became eligible; provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual was covered under a public or private health benefit plan that provided, at the time the individual was eligible to enroll, ~~the same required level of~~ benefits ~~in~~ that were similar to or that exceeded the basic and standard health care plans adopted pursuant to G.S. 58-50-120 and either the individual:

1. Lost coverage under another health plan as a result of termination of employment, termination of a spouse's health plan coverage, or the death of a spouse or divorce and requests enrollment in ~~a basic or standard~~ the individual's employer's health care plan within 30 days after termination of coverage provided under another health plan; or

2. Stated, in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining coverage;

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

b. The individual elects a different health plan offered through the Alliance during an open enrollment period;

c. An eligible employee requests enrollment within 30 days of becoming an employee of a member small employer;

d. A court has ordered coverage be provided for a spouse ~~or minor child~~ under a covered employee's health benefit plan and the request for enrollment for the spouse is made within 30 days after issuance of the court order; ~~or~~

d1. A court has ordered coverage be provided for a minor child under a covered employee's health benefit plan and the minor child is enrolled under G.S. 58-51-120; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days of the individual or employee's marriage or the ~~birth~~ birth, foster placement, or adoption of a child."

Section 3. G.S. 58-50-110(21a) reads as rewritten:

"(21a) 'Self-employed individual' means an individual or sole proprietor who derives a majority of ~~his or her~~ the individual's income from a trade or business ~~carried on by the individual or sole proprietor which results in taxable income as indicated on~~ through which the individual or sole proprietor has attempted to earn taxable income and for which the individual has filed IRS form 1040, Schedule C or F ~~and which generated taxable income in one of the two previous years.~~ for the previous taxable

year. For a newly established trade or business, the individual or sole proprietor shall certify the intention to file the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the current taxable year."

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

"(a) To improve the availability and affordability of health benefits coverage for small employers, the Committee shall recommend to the Commissioner two plans of coverage, one of which shall be a basic health care plan and the second of which shall be a standard health care plan. Each plan of coverage shall be in two forms, one of which shall be in the form of insurance and the second of which shall be consistent with the basic method of operation and benefit plans of HMOs, including federally qualified HMOs. ~~On or before January 1, 1992, the Committee shall file a progress report with the Commissioner. The Committee shall submit the recommended plans to the Commissioner for approval within 180 days after the appointment of the Committee under G.S. 58-50-120.~~ The Committee may also recommend a preferred provider version of the standard health care plan that incorporates reasonable benefit differentials applicable to participating and nonparticipating health care providers. The Committee shall take into consideration the levels of health benefit plans provided in North Carolina, and appropriate medical and economic factors, and shall establish benefit levels, cost sharing, exclusions, and limitations. Notwithstanding subsection (c) of this section, in developing and approving the plans, the Committee and the Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. The Committee shall file with the Commissioner its findings and recommendations, and reasons for the findings and recommendations, if it does not provide for coverage by any type of health care provider specified in G.S. 58-50-30. The recommended plans may include cost containment features such as, but not limited to: preferred provider provisions; utilization review of medical necessity of hospital and physician services; case management benefit alternatives; or other managed care provisions."

Section 5. G.S. 58-50-125(d) reads as rewritten:

"(d) Within 180 days after the Commissioner's approval under subsection (b) of this section, every small employer carrier shall, as a condition of transacting business in this State, offer small employers at least one basic and one standard health care plan. This offer shall include the preferred provider version of the standard health care plan if the small employer is located in an area serviced by a provider network of the carrier, and the carrier provides a preferred provider benefit plan to small employers in that area. Every small employer that elects to be covered under such a plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier. The premium payment requirements used in connection with basic and standard health care plans may address the potential credit risk of small employers that elect coverage in accordance with this subsection by means of payment security provisions that are reasonably related to the risk and are uniformly applied.

If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4). A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer."

Section 6. G.S. 58-50-130(b)(1) reads as rewritten:

"(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employee's or dependent's age as determined in accordance with subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this subsection. Premium rates charged during a rating period to small employers with similar case characteristics for same coverage shall not vary from the adjusted community rate by more than twenty percent (20%) for any reason, including differences in administrative costs and claims experience. A small employer carrier shall use its entire book of North Carolina small employer health insurance business when developing the community rate and adjustment factors used in this section. The adjusted community rating methodology, the rating factors, and any amendments to the methodology or factors shall be filed with the Commissioner before they are used in this State."

Section 7. G.S. 58-50-130(b)(3) reads as rewritten:

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

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

b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim ~~experience, health status, or duration of coverage~~

experience or health status of the employees or dependents of the small employer, and

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

Section 8. G.S. 58-50-130(g) reads as rewritten:

"(g) A small employer carrier shall make the information and documentation described in subsection (e) of this section available to the Commissioner upon request. Except in cases of violations of this Act, the information is proprietary and trade secret information and is not subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction. Nothing in this section affects the Commissioner's authority to approve rates before their use under G.S. 58-65-60(e) or G.S. 58-67-50(c)."

Section 9. G.S. 58-50-135(a) reads as rewritten:

"(a) Every small employer carrier shall elect either to become a risk-assuming carrier and comply with the provisions of G.S. 58-50-140 or become a reinsuring carrier and comply with the provisions of G.S. 58-50-145. The election shall be binding for a five-year period except that ~~the~~ a newly licensed carrier's initial election ~~shall be made within 60 days after January 1, 1992, and~~ shall be made for two years. The Commissioner may, for good cause, permit a carrier to modify its election during the five-year period. All carriers under common ownership or control must make the same election in this State; provided, however, that the Commissioner may, for good cause, permit an affiliated carrier to make a separate election."

Section 10. G.S. 58-53-25 reads as rewritten:

"**§ 58-53-25. Notification to employee.**

In addition to the notification requirement set forth in G.S. 58-53-40, notification may be included on insurance identification cards or may be given by the employer, orally or in writing as a part of the exit process from the employment. The employer shall notify the employee or member when the employee or member loses eligibility for continuation under this Part."

Section 11. Article 54 of Chapter 58 of the General Statutes is amended by adding two new sections to read:

"**§ 58-54-45. By reason of disability.**

In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plan A available to persons eligible for Medicare by reason of disability before age 65. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B.

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

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

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

(2) Establishing a uniform methodology for calculating and reporting loss ratios.
(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.
(4) Establishing standards for Medicare Select policies and certificates."

Section 12. Article 58 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-58-136. Additional group life insurance policies.**

(a) A licensed life insurance company may issue a policy to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations, other than an association specified in G.S. 58-58-135. The association shall:

(1) Have at the outset a minimum of 500 persons;
(2) Have been organized and maintained in good faith for purposes other than that of obtaining insurance;
(3) Have been in active existence for at least five years;
(4) Not condition membership in the association on any health status-related factor of any individual, including an employee of a member employer or a dependent of an employee;
(5) Not make insurance coverage through the association available other than in connection with membership in the association; and
(6) Have a constitution and bylaws that provide that:
a. The association holds regular meetings not less often than annually to further purposes of the members.
b. Except for credit unions, the association collects dues or solicits contributions from members.
c. The members have voting privileges and representation on the association's governing board and committees.

(b) The policy described in subsection (a) of this section is subject to the following requirements:

(1) The policy may insure (i) members of the association or a class of members, (ii) employees of the association or a class of employees, (iii) employees of association members or a class of employees, or (iv) any combination of those persons listed in (i) through (iii) of this subdivision, for the benefit of persons other than the employees of the employer.
(2) The premium for the policy shall be paid from funds contributed by (i) the association, (ii) employer members, (iii) both the association and employer members, (iv) the covered persons, or (v) both the covered persons and the association or employer members.
(3) A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must

insure all eligible persons, except those who reject the coverage, in writing.

(c) A licensed life insurance company may issue a policy to a credit union or to a trustee or trustees or an agent designated by two or more credit unions. The credit union, trustee, or agent shall be deemed the policyholder, to insure members of the credit union for the benefit of persons other than the credit union, trustee, or agent or any of the officials, subject to the following requirements:

(1) The members eligible for insurance shall be all of the members of the credit union, or all of any class thereof.

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision (3) of this subsection, shall insure all eligible members.

(3) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer."

Section 13. G.S. 58-60-5 reads as rewritten:

"**§ 58-60-5. Scope of Article; exemptions.**

(a) Except as ~~hereafter exempted,~~ otherwise provided in this Article, this Article ~~shall apply~~ applies to any solicitation, negotiation or procurement of life insurance occurring within this State. This Article ~~shall apply~~ applies to any issuer of a life insurance ~~contract~~ contract, including fraternal benefit societies.

(b) Unless otherwise specifically included, this Article ~~shall~~ does not apply to:

(1) Annuities,

(2) Credit life insurance,

(3) Group life insurance,

(4) Life insurance policies issued in connection with pension and welfare plans as defined by and ~~which~~ that are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA),

(5) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

(c) The policy summary in this Article is not required for policies that are sold subject to rules adopted by the Commissioner for life insurance illustrations."

Section 14. G.S. 58-63-5 reads as rewritten:

"**§ 58-63-5. Definitions.**

When used in this Article:

(1) Repealed by Session Laws 1991, c. 720, s. 6.

(2) 'Person' ~~shall mean~~ means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of ~~insurance, including agents,~~ insurance under Articles 1 through 63, 65, and 67 of this Chapter; and includes brokers, limited representatives, and adjusters."

Section 15. Sections 1, 4 through 7, 10 through 12, and 14 of this act become effective October 1, 1997. The remainder of this act is effective when it becomes law.