GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

H **1**

HOUSE BILL 761*

Short Title: Small Employer Group Health Ins. Act. (Public)

Sponsors: Representatives Beard; Hurley and Lineberry.

Referred to: Commerce.

April 15, 1991

A BILL TO BE ENTITLED

AN ACT TO PROVIDE GROUP HEALTH INSURANCE COVERAGE FOR ALL EMPLOYEES OF SMALL EMPLOYERS.

The General Assembly of North Carolina enacts:

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

"**ARTICLE 53A.**

"**SMALL EMPLOYER GROUP HEALTH INSURANCE COVERAGE.**

"**§ 58-53A-5. Short title.**

This Article shall be known and may be cited as the North Carolina Small Employer Group Health Coverage Act.

"**§ 58-53A-10. Legislative intent.**

The intent of this Article is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

"**§ 58-53A-15. Definitions.**

As used in this Article, unless the context requires otherwise:

(1) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-53A-30, based upon the person's examination, including a review of the appropriate records and of the actuarial

assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefits plans.

(2) 'Adjusted average market price' means the approximate arithmetic mean of all premium rates, as established by the Board, for small employer health care plans sold to groups with similar case characteristics by all carriers selling small employer health care plans in North Carolina.

(3) 'Ambulatory Surgical Center' means an Ambulatory Surgical Center licensed under G.S. 131E-145 **et seq.**

(4) 'Base premium rate' means for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefits plans with the same or similar coverage.

(5) 'Board' means the board of directors of the Pool.

(6) 'Carrier' means any person who provides health benefits plans in this State. For the purposes of this Article, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization ('HMO'), a multiple employer welfare arrangement or any other person responsible for the payment of benefits or provision of services.

(7) 'Case characteristics' means demographic or other objective characteristics of a small employer, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer; provided, however, that claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of this Article.

(8) 'Class of business' means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

a. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefits plans:

1. Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

2. Have been acquired from another small employer carrier as a distinct grouping of plans; or

3. Are provided through an association with membership of not less than 10 small employers which has been formed for purposes other than obtaining insurance;

b. A small employer carrier may establish no more than two additional groupings under each of the sub-subdivisions in sub-subdivision a. above on the basis of underwriting criteria which

are expected to produce substantial variation in the health care costs.

c. The Commissioner may approve the establishment of additional distinct groupings upon application to the Commissioner and a finding by the Commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

(9) 'Commissioner' means the Commissioner of Insurance.

(10) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-53A-50.

(11) 'Department' means the North Carolina Department of Insurance.

(12) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.

(13) 'Eligible employee' means an employee who works on a full-time basis, with a normal work week of 30 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if they are included as employees under a health care plan of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis.

(14) 'Health benefits plan' means any hospital or medical expense policy or certificate, nonprofit hospital or medical service corporation contract, health, hospital, or medical service corporation plan contract, HMO subscriber contract offered by an employer, plan provided by a MEWA or a plan provided by another benefit arrangement, to the extent permitted by ERISA, which is issued as group coverage, subject to G.S. 58-53A-20. The term does not include accident only, credit, disability, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement insurance policies, long-term care insurance, dental only, vision only, 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.

(15) 'Hospital' means, for the purposes of determining the service fee established in G.S. 58-53A-45, a hospital licensed under G.S. 131E-75 **et seq.**, excluding those owned, operated, or created by the State of North Carolina, the Department of Veterans Affairs or any other agency of the United States of America.

(16) 'Impaired insurer' shall have the same meaning as prescribed in G.S. 58-62-20(6).

(17) 'Index rate' means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(18) 'Initial enrollment period' means the period of time during which an individual is first eligible to enroll in a small employer health benefit plan. Such period of time shall not be less than 30 days commencing on the day following the end of any service waiting period required by the small employer of all eligible employees before the eligible employees can participate in a health benefit plan.

(19) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period provided under the terms of such plan, provided an eligible employee or dependent shall not be considered a late enrollee if:

a. The individual:

1. Was covered under another employer-provided health benefit plan at the time the individual was eligible to enroll;

2. States, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment;

3. Has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and

4. Requests enrollment within 31 days after the termination of coverage under another employer health benefit plan; or

b. The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

c. A court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within 31 days after issuance of such court order.

(20) 'Member' means all carriers providing health benefits plans in this State.

(21) 'MEWA' means a multiple employer welfare arrangement as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, except for any such arrangement that is fully insured within the meaning of Section 514(b)(6) of that Act, as amended.

(22) 'New business premium rate' means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefits plans with the same or similar coverage.

(23) 'Plan of operation' means the plan of operation of the Pool, including articles, bylaws, and operating rules, adopted by the Board pursuant to G.S. 58-53A-40.

(24) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool as created by G.S. 58-53A-40.

(25) 'Preexisting conditions provision' means a policy provision that excludes coverage for charges or expenses incurred, during a specific period following the insured's effective date of coverage, as to a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinary prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment, was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

(26) 'Premium' includes insurance premiums or other fees charged for a health benefits plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(27) 'Private Pay Patient' means a natural person whose inpatient day or outpatient admission is not covered by insurance or by any other plan of medical coverage or whose charges for treatment of injury or sickness are not compensable by his or her employer or any accident or health coverage arrangement.

(28) 'Provider' means a hospital or an ambulatory surgical center.

(29) 'Rating period' means the 12-month calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(30) 'Service fee' means the service fee established in G.S. 58-53A-45.

(31) 'Service waiting period' means a period of time after full-time employment begins before an eligible employee first can enroll in any applicable health benefit plan offered by the small employer.

(32) 'Small employer' means any person, firm, corporation, partnership, or association actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than 25 eligible employees and not less than five eligible employees, the majority of whom are employed within the State of North Carolina. The term includes companies that are affiliated companies. Except as otherwise provided, the provisions of this Article which apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this section.

(33) 'Small employer carrier' means any carrier that offers group health benefits plans or arrangements covering eligible employees of one or more small employers.

(34) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers pursuant to G.S. 58-53A-25 and approved by the Commissioner in accordance with G.S. 58-53A-45.

(35) 'Third party payer' means any carrier or other person or entity, subject to the exceptions in G.S. 58-53A-45, which is responsible for payment of the service fee to the provider. In the event of dual coverage, the primary coverage shall be responsible for the service fee.

"**§ 58-53A-20. Plans subject to this Article.**

Any group accident and health benefits plan shall be subject to the provisions of this Article if it provides accident and health benefits for small employers and if any one of the following conditions is met:

(1) Any portion of the premium or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The health benefits plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 162 or section 106 of the Internal Revenue Code.

"**§ 58-53A-25. Standard health care plans.**

(a) In order to improve the availability and affordability of health benefits coverage for small employers, the Committee shall recommend to the Commissioner a standard health care plan which 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. They shall provide:

(1) A maximum payment per covered person for all covered medical expenses incurred during the entire time the person is covered under any standard health care plan or plans issued pursuant to this Article of two hundred fifty thousand dollars ($250,000);

(2) Payment of benefits at the rate of eighty percent (80%) of covered medical expenses that are in excess of the deductible until twenty percent (20%) of the expenses in a calendar year reach five thousand dollars ($5,000) after which benefits will be paid at the rate of one hundred percent (100%) during the remainder of that calendar year; provided, however, that benefit payments for outpatient treatment of mental illness will not be higher than fifty percent (50%) if the Committee recommends that those benefits be payable;

(3) A deductible of five hundred dollars ($500.00) for covered medical expenses incurred in each calendar year;

(4) A maximum hospital covered room and board rate equal to the dollar amount established in G.S. 58-53-90(a)(1)a.;

(5) A physician fee schedule to be established by the Committee setting the maximum covered medical expenses for charges made by physicians; and

(6) Any other provisions, limitations, and exclusions that may be selected by the Committee.

(b) The Committee shall submit the recommended plan to the Commissioner for approval within 180 days after the appointment of the Committee pursuant to G.S. 58-53A-50. The standard health care plan may include cost containment features including, but not limited to:

(1) Preferred provider provisions;

(2) Utilization review of medical necessity of hospital and physician services;

(3) Case management benefit alternatives; and

(4) Other managed care provisions.

(c) After the Commissioner's approval of the plans submitted by the Committee pursuant to subsection (b) of this section, and in lieu of any contrary procedure established by this Article, any small employer carrier may certify to the Commissioner, in the form and manner prescribed by the Commissioner, that the standard health care plan filed by the carrier is in substantial compliance with the provisions in the corresponding approved Committee plan. Upon receipt by the Commissioner of the certification, the carrier may use the certified plan until the continued use is disapproved, after notice and hearing.

(d) Except as expressly provided for in this Article, no law requiring the coverage or the offer of coverage of a health care service or benefit and no law requiring the reimbursement, utilization, or consideration of a specific category of a licensed or certified health care practitioner shall apply to any health benefit plan offered or delivered to a small employer.

(e) Within 180 days after approval by the Commissioner of the standard health care plan submitted by the Committee, every small employer carrier shall, as a condition of transacting business in this State, offer small employers the standard health care plan. Every small employer which elects to be covered under this plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued the plan by the small employer carrier.

(f) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsection (e) of this section from a group already covered under a health benefits plan except for coverage that is to commence following the group's next policy anniversary date or regularly scheduled open enrollment period.

(g) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsection (e) of this section where the Commissioner finds that acceptance of an application or applications would result in the carrier being declared an impaired insurer.

(h) Every small employer carrier shall fairly market the standard health care plan to all small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

(i) No HMO shall be required to offer coverage or accept applications pursuant to subsection (e) of this section in any of the following cases:

(1) To a group, where the group is not physically located in the HMO's approved service areas;

(2) To an employee, where the employee does not reside within the HMO's approved service areas; or

(3) Within an area, where the HMO reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity, within that area in its network of providers, to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. An HMO that does not offer coverage pursuant to subdivision (3) of this subsection may not offer coverage in the applicable area to new employer groups with more than 25 eligible employees until the later of (i) 90 days after that closure or (ii) the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers.

(j) Premiums paid by a small employer for a standard health care plan which is reinsured by the carrier with the Pool will not be subject to the premium tax provided in G.S. 105-228.5.

(k) The provisions of subsections (c), (e), (g), (i) and (j) of this section shall apply to all health benefits plans delivered, issued for delivery, renewed or continued in this State or covering persons residing in this State on or after the date the program becomes operational, as designated by the Commissioner. For purposes of this subdivision, the date a health benefits plan is continued shall be the anniversary date of the issuance of health benefits plans.

"**§ 58-53A-30. Health benefits plans, provisions.**

(a) Health benefits plans covering small employers shall be subject to the following provisions:

(1) Except in the case of a late enrollee, any preexisting conditions provision may not exclude coverage for a period beyond 12 months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage or as to a pregnancy existing on the effective day of coverage.

(2) In determining whether a preexisting condition provision applies to an eligible employee or dependent, all plans and arrangements shall credit the time the person was covered under a previous group health benefits plan if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan, and the previous

coverage ended due to involuntary termination of employment for reasons other than gross misconduct.

(3) The plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except: (i) for nonpayment of the required premiums by the policyholder or contract holder; (ii) for fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives; (iii) for noncompliance with plan provisions; (iv) when the number of enrollees covered under the plan is less than the number of insureds or percentage of enrollees required by participation requirements under the plan; or (v) when the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

(4) Late enrollees may be excluded from coverage for the greater of 18 months or an 18-month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months.

(5) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage, provided however, that participation and contribution requirements may vary among small employers only by the size of the small employer group.

(6) Premium rates for health benefits plans subject to this Article shall be subject to the following provisions:

a. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty-five percent (25%), adjusted pro rata for periods less than a year.

b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than thirty-five percent (35%) of the index rate, adjusted pro rata for rating periods of less than a year.

c. The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following: (i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case where a small employer carrier is not issuing any new policies, but is only renewing policies, the carrier shall use the percentage change in the base premium rate; (ii) any adjustment, not to exceed twenty-five percent

(25%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the small employer as determined from the small employer carrier's rate manual for the class of business; and (iii) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

d. Any adjustment in rates charged by a small employer carrier caused by reinsurance pursuant to this Article is not subject to the rating limitations set forth in this section. Premium rates charged by a small employer carrier for any coverage reinsured by the Pool may equal but not exceed the premium rate set by the Pool.

e. Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers in accordance with G.S. 58-53A-40.

f. In any case where a small employer carrier utilizes industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than fifteen percent (15%) of such coverage.

g. In the case of health benefit plans issued prior to the effective date of this Article, a premium rate for a rating period, adjusted pro rata for rating periods of less than a year, may exceed the ranges set forth in subdivisions (a)(6)a. and b. of this section for a period of three years following the effective date of this Article. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following: (i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case where a small employer carrier is not issuing any new policies, but is only renewing policies, the small employer carrier shall use the percentage change in the base premium rate, and (ii) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

h. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(7) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage since issue.

(8) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

a. The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of such small employer;

b. Provisions concerning such small employer carrier's right to change premium rates;

c. Provisions relating to renewability of policies and contracts; and

d. Provisions affecting any preexisting conditions provision.

(9) a. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

b. Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this Article and that the rating methods of the small employer carrier are actuarially sound. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

c. A small employer carrier shall make the information and documentation described in subdivision a. of this subsection available to the Commissioner upon request. Except in cases of violation of this Article, the information shall be considered proprietary and trade secret information and shall not be 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.

(b) The provisions of subdivisions (1), (3), (5), (6), (7), (8), and (9) of subsection (a) of this section shall apply to health benefits plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the effective date of this Article. The provisions of subdivisions (2) and (4) of subsection (a) of this section shall apply to all health benefits plans delivered, issued for delivery, renewed or continued in this State or covering persons residing in this State on or after the date the program becomes operational, as designated by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued shall be the anniversary date of the issuance of the health benefit plan.

"**§ 58-53A-35. Small employer carriers, regulations.**

(a) Small employer carriers may reinsure any standard health care plan in accordance with the restrictions set forth in G.S. 58-53A-40.

(b) Any small employer carrier that ceases to write, administer, or otherwise provide small group coverage to employers in this State shall continue to be governed by this Article with respect to business conducted under this Article which was transacted prior to the effective date of termination and which remains in force.

(c) Each small employer carrier shall conduct business with its policyholders, members and subscribers, and administer claims for coverage reinsured by the Pool, in the same manner as it would administer health claims which it writes without reinsurance.

"**§ 58-53A-40. North Carolina Small Employer Health Reinsurance Pool.**

(a) Board; membership. –

(1) There is hereby created a nonprofit entity to be known as the North Carolina Small Employer Health Reinsurance Pool. All carriers and MEWAs issuing or providing health benefits coverage in this State on and after the effective date of this Article, shall be members of the Pool.

(2) Within 30 days of the effective date of this Article, the Commissioner shall give notice to all carriers of the time and place for the initial organizational meeting, which shall take place within 60 days of the notice from the Commissioner. The members shall select the initial Board, subject to approval by the Commissioner. The Board shall consist of nine members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The voting rights to determine Board membership shall be weighted based upon net health insurance premiums derived from this State in the previous calendar year. The Board shall at times, to the extent possible, include at least one domestic insurance company licensed to transact health insurance, one HMO, and one nonprofit hospital or medical service plan. Two-thirds of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented.

(3) If the initial Board is not elected at the organizational meeting, the Commissioner shall appoint the initial Board within 15 days of the organizational meeting.

(b) Board; submission of plan of operation. –

(1) Within 180 days after the appointment of the initial Board, the Board shall submit to the Commissioner a plan of operation and thereafter any amendments thereto as are necessary or suitable to assure the fair, reasonable, and equitable administration of the Pool. The Commissioner shall, after notice and hearing, approve the plan of operation if it is suitable to assure the fair, reasonable, and equitable

administration of the Pool, and provides for the sharing of Pool gains or losses on an equitable proportionate basis in accordance with the provisions of subsection (j) of this section. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this section shall be made available. If the Board fails to submit a suitable plan of operation within 180 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Commissioner shall, after notice and hearing, adopt and promulgate a plan of operation or amendment, as appropriate. Any plans of operation, or amendments thereto, submitted to the Commissioner by the Board pursuant to this subsection shall be deemed approved by the Commissioner if not expressly disapproved in writing by the Commissioner within 90 days of its receipt by the Commissioner.

(2) If the Board fails to submit a suitable plan of operation within 180 days after its appointment, the Commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The Commissioner shall amend or rescind any plan adopted by the Commissioner under this subsection at the time a plan of operation is submitted by the Board and approved by the Commissioner.

(c) Plan of operation. – The plan of operation shall establish procedures for:

(1) The handling and accounting of assets and moneys of the Pool, and for an annual fiscal reporting to the Commissioner;

(2) Filling vacancies on the Board, subject to the approval of the Commissioner;

(3) Selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(4) Reinsuring risks in accordance with the provisions of this Article;

(5) Determining the reinsurance premium rate to be charged in accordance with this Article;

(6) Collecting service fees from third-party payers;

(7) Collecting assessments from members to provide for claims reinsured by the Pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made; and

(8) Any additional matters at the discretion of the Board.

(d) Pool; powers. – The Pool shall have the general powers and authority granted under the laws of North Carolina to insurance companies except the power to issue coverage directly to enrollees. In addition, the Board shall have specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Article, including the authority, with the approval of the Commissioner, to enter into contracts with similar Pools of other states for the joint performance of common

administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper for the recovery of any assessments for, on behalf of, or against members;

(3) Take any legal action necessary to avoid the payment of improper claims against the Pool or the coverage reinsured by the Pool;

(4) Issue various reinsurance policies, in accordance with the requirements of this Article;

(5) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the Pool;

(6) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the Pool;

(7) Collect service fees due the Pool pursuant to G.S. 58-53A-45;

(8) Assess members in accordance with the provisions of subsection (j) of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any future regular assessments;

(9) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the authority of the Pool; and

(10) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default shall be legal investments for insurers and may be carried as admitted assets.

(e) Pool; ceding business and reinsurance to. – Subject to all of the following any member may cede, and the Pool shall reinsure:

(1) Any standard health care plan originally issued or delivered for original issue by a member on or after the effective date of this Article pursuant to the requirements contained in subsection (c) of Section 5;

(2) The standard health care plan only if coverage for all employees and dependents of such employees of a particular group is ceded; carriers may not cede the coverage of only specified individuals covered by a health benefits plan;

(3) A group within 60 days of the commencement of the employer's coverage with the member or within 30 days of any second year plan anniversary date of the commencement of the employer's coverage with the member;

(4) Eligible employees and their dependents who are hired subsequent to the commencement of the employer's coverage by the member and who are not late enrollees to the plan; and

(5) One hundred percent (100%) of the level of coverage provided up to, but not exceeding, the level of coverage in the standard health care plan of the plans which the member elects to reinsure.

The Board shall set rules and procedures for (i) ceding and acceptance of risks, (ii) ensuring that a participating carrier is properly administering any health care coverage ceded to the program, and (iii) establishing minimum standards for ceded business.

The Board shall not reinsure a ceded small group unless it determines that the criteria are reasonable and acceptable to the Board.

(f) Pool; increased premium rates. – Except as provided in subsection (h) of this section, premium rates charged for coverage reinsured by the Pool will be 1.35 times the adjusted average market price established by the Board for the standard health care plan for that classification or group with similar characteristics. The member shall retain a ceding expense equal to fifteen percent (15%) of the reinsurance premium for administrative and other expenses. Each carrier may pay any agent or representative who sells and services the reinsured small group up to three percent (3%) of the reinsurance premium, but no more. Such payment to the agent or representative is included in the fifteen percent (15%) ceding expense to be retained by the carrier.

(g) Pool; reinsurance coverage. – The Pool may issue different types and levels of reinsurance coverage, including 'stop-loss' coverage, and the reinsurance premium shall be adjusted to reflect the type and level of reinsurance coverage issued.

(h) Pool; premium adjusted for cost containment features. – The reinsurance premium may be adjusted to reflect cost containment features of the plan including, but not limited to:

(1) Preferred provider provisions;

(2) Utilization review of medical necessity of hospital and physician services;

(3) Case management benefit alternatives; and

(4) Other managed care provisions or methods of operation.

(i) Pool; premium rates to HMO's. – Premium rates charged for reinsurance by the Pool to a HMO that is approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to 42 U.S.C. section 300 **et seq.**, shall be reduced to reflect the restrictions and requirements for 42 U.S.C. section 300 **et seq.**

(j) Pool; annual accounting and assessments. –

(1) Following the close of each fiscal year, the administrating carrier shall determine the net premiums, the Pool expenses of administration, and the incurred losses for the year, taking into account investment income, service fee income, and other appropriate gains and losses. Health insurance premiums and benefits paid by a member that are less than an amount determined by the Board to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this section 'net premiums' means health insurance premiums for insured plans and, paid health losses plus

administrative expenses for other benefits plans, but net premiums shall not include premiums or revenue received by a carrier for Medicare and Medicaid contracts.

(2) Any net loss for the year shall be recouped by assessments of all members. Assessments shall be apportioned by the Board among all members in proportion to their respective share of the total health insurance premiums in this State for all health benefits plans and insurance arrangements during the preceding calendar year, but in no event shall this assessment exceed on a proportionate basis, five percent (5%) of premium for any health benefits coverage reinsured by the Pool by members which cover or insure more than 10 small employer groups and one percent (1%) of premiums for health benefits coverage issued by members that do not cover or insure more than 10 small employer groups; provided that in any case where it appears to the Board that this assessment limit will be exceeded, the Board shall, notwithstanding the provisions of this section, adjust the rates charged for reinsurance so that the assessment limit will not be exceeded for future periods or on a cumulative basis.

(3) If fee income and assessments exceed actual losses and administrative expenses of the Pool, the excess shall be held at interest and used by the Board to offset future losses or to reduce Pool premiums. As used in this paragraph, 'future losses' includes reserves for incurred but not reported claims.

(4) Each member's proportion of participation in the Pool shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed by the member with it. All carriers shall report to the Board claims payments made and administrative expenses incurred in this State on an annual basis on a form prescribed by the Commissioner.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(6) The Board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the Board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth above. The member receiving the abatement or deferment shall remain liable to the Pool for the deficiency.

(k) Pool; legal actions. –

(1) Neither the participation in the Pool as members, the establishment of rates, forms, or procedures, nor any other joint or collective action

required by this Article shall be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its members.

(2) Any person or member made a party to any action, suit, or proceeding because the person or member served on the board or on a committee or was an officer or employee of the Pool shall be held harmless and be indemnified by the Pool against all liability and costs, including the amounts of judgments, settlements, fines, or penalties, and expenses and reasonable attorneys' fees incurred in connection with the action, suit, or proceeding. However, the indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members.

(l) Pool; exempt from taxes. – The Pool shall be exempt from any and all taxes.

"**§ 58-53A-45. Service fees.**

(a) Each patient, except a private pay patient, one covered by Medicare or by any other public program which is directly subsidized by the United States of America, or one covered by an insolvent third party payer, admitted to a hospital for treatment shall be assessed a service fee of two dollars ($2.00) for each day, or portion thereof, during which the patient is confined as an inpatient in that facility. Each hospital in which a patient is confined shall calculate the total service fee due for that patient's period of confinement and shall include the total service fee in the bill for services rendered to the patient. The service charge shall be collected as provided in subsection (c) of this section.

(b) Each patient, except a private pay patient, one covered by Medicare or by any other public program which is directly subsidized by the United States of America, or one covered by an insolvent third party payer, admitted to an ambulatory surgical center or to a hospital for outpatient ambulatory surgical care shall be assessed a service charge of one dollar ($1.00) for each admission to that facility. The service charge shall be included in the bill for services or supplies, or both, rendered to the patient by the ambulatory surgical center or hospital.

(c) Each hospital and ambulatory surgical center shall collect the service fees assessed herein from third party payers. In the event that no payment is made by or on behalf of the patient for services rendered, the fee assessed under this section shall be waived. Each hospital and ambulatory surgical center shall remit to the Pool for each reporting period, as established in the plan of operation of the Pool, but no more frequently than each quarter of a calendar year, the total amount of service fees collected during that reporting period in accordance with the reporting and remittance procedures established by the Board. Failure to pay within 60 days after the end of the reporting period shall cause the hospital or ambulatory surgical center to be liable to the Pool for an amount determined by the Board, not to exceed five hundred dollars ($500.00), plus interest. Any hospital or ambulatory surgical center found to have failed to pay according to this section on three or more occasions during a six-month period

shall be liable for an amount determined by the Board, of no less than five hundred dollars ($500.00) and no more than one thousand five hundred dollars ($1,500) per failure, together with attorneys' fees, interest, and court costs.

(d) The service fees imposed on hospital and ambulatory surgical center patients by this section shall be payable by the patient's third party payer, if any, as applicable; however such fees shall not be payable by an insolvent third party payer. In no event shall a hospital or ambulatory surgical center be required to remit to the Pool uncollected service fees for any patient who is a private pay patient or for any patient whose third party payer is not legally required to pay the service fee.

(e) Service fees assessed to any patient pursuant to this section shall be a mandated benefit of any health benefits plan providing coverage to a resident of North Carolina or providing coverage for treatment provided by a provider located in North Carolina, except that such charges shall not be payable by any third party payer which is insolvent.

(f) Health benefits plans shall provide coverage for the service fees without regard to the patient's obligation for deductibles or copayments. The service fees shall be a mandated benefit of health benefits plans over and above any limits, negotiated per diem or managed care arrangement.

(g) The service fee shall be paid by the third party payer directly to the provider responsible for remitting it to the Pool. The payment shall be made by separate check, or the remittance advice shall clearly state the patient's name, the dates for which the service charge is due, and the amount remitted therefor. Payment shall be mailed within 60 days of receipt of a statement reflecting the amount due. Failure to pay according to this section shall cause the insurer or insurance arrangement to be liable to the health care provider for an amount determined by the Board, not to exceed five hundred dollars ($500.00), plus interest. Any third party payer found to have failed to comply with this section on three or more occasions during a six-month period shall be liable for an amount, determined by the Board, of no less than five hundred dollars ($500.00) and no more than one thousand five hundred dollars ($1,500) per failure, together with attorneys' fees, interest, and court costs.

"**§ 58-53A-50. Small Employer Carrier Committee.**

(a) The Commissioner shall appoint a Small Employer Carrier Committee with fair representation of all small employer carriers. Subject to approval by the Commissioner, the Small Employer Carrier Committee shall recommend the form of the standard health care plan to be made available by small employer carriers in accordance with the provisions of subsection (a) of G.S. 58-53A-45. The Committee shall recommend exclusions and limitations for the standard health care plan. The Committee shall also recommend one standard health care plan containing benefits and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law. The Committee shall submit the plans to the Commissioner for his or her approval within 180 days after the appointment of the Committee pursuant to this section and the plans shall be deemed approved unless expressly disapproved by the Commissioner

during such 180-day time period. Such plans may include cost containment features such as, but not limited to:

(1) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(2) Case management benefit alternatives;

(3) Selective contracting with hospitals, physicians, and other health care providers;

(4) Reasonable benefit differentials applicable to participating and nonparticipating providers; and

(5) Other managed care provisions.

(b) In order to assure the broadest availability of health benefit plans to small employers, the Committee shall recommend for approval by the Commissioner market conduct and other requirements for carriers and agents, including requirements developed as a result of a request by the Commissioner, relating to:

(1) Registration by each carrier with the Department of its intention to be a Small Employer Carrier under this Article;

(2) Publication by the Department or the Committee of a list of all Small Employer Carriers, including a potential requirement applicable to agents and carriers that no health benefit plan may be sold to a small employer by a carrier not so identified as a Small Employer Carrier;

(3) The availability of a broadly publicized toll-free telephone number for access by small employers to information concerning this Article;

(4) To the extent deemed necessary by the Committee to assure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers and agents concerning health benefit plans issued, providing that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed and/or issued to small employers;

(5) Registration by agents of the intention to be agents for health benefit plans marketed to small employers under this Article;

(6) Methods concerning periodic demonstration by small employer carriers and agents that they are marketing and issuing health benefits plans to small employers in fulfillment of the purposes of this Article.

(c) Within three years from the effective date of this Article, the Committee shall conduct a study of the effectiveness of the provisions of this Article, recommend further improvements to achieve greater stability, accessibility, and affordability in the small employer marketplace, and submit it to the Commissioner."

Sec. 2. If any provision of this act is held invalid, the invalidity shall not affect other provisions of this act which can be given effect without the invalid provision.

Sec. 3. This act becomes effective January 1, 1992.