GENERAL ASSEMBLY OF NORTH CAROLINA

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HOUSE BILL 729*
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Short Title: Small Emplr. Hlth. Insur. Assist. (Public)

Sponsors:

Referred to:

April 5, 1993

A BILL TO BE ENTITLED

AN ACT TO PROMOTE THE CREATION OF HEALTH PLAN PURCHASING ALLIANCES TO PROVIDE ACCESS TO HEALTH BENEFITS FOR EMPLOYEES OF SMALL EMPLOYER GROUPS AND SELF-EMPLOYED INDIVIDUALS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 143 of the General Statutes is amended by adding a new Article to read:

"**ARTICLE 64.**

"**HEALTH CARE PURCHASING ALLIANCE ACT.**

"**§ 143-591. Purpose and intent.**

The purpose and intent of this Article is to increase the affordability, efficiency, and fairness of health coverage for small employers.

The Article promotes the development of voluntary purchasing Alliances to provide affordable health care coverage for self-employed individuals and employees of participating small employers in the manner of large employer groups. The Alliances will allow members to benefit from the contracting expertise and the administrative savings that can result from the pooling of small employers and self-employed individuals.

These Alliances will make available through their contracting processes a choice of Accountable Health Carriers that arrange for quality health services in a cost-effective manner. The Article establishes rules for fair competition among competing

Accountable Health Carriers. These rules include the offering of comparable benefits by competing Accountable Health Carriers, risk assessment, and risk adjustment to assure competition based on a fair allocation of risk among Accountable Health Carriers, and the providing of data that measures clinical outcomes and other valid areas of Accountable Health Carrier performance.

Carriers throughout the health coverage market for small employers are required to use adjusted community rating, guarantee the continuity of coverage, adhere to limitations on the use of preexisting conditions, abolish individual medical underwriting, and follow rules limiting the use of participation requirements.

"**§ 143-592. Definitions.**

As used in this Article:

(1) 'Accountable Health Carrier' means a carrier registered with the Board pursuant to G.S. 143-596.

(2) 'Adjusted community rating' means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments only for the following demographic factors: age, gender, number of family members covered, and geographic areas, as determined pursuant to G. S. 58-50-130(b).

(3) 'Alliance' means a State-chartered, nonprofit organization that provides health insurance purchasing services to member small employers in a market area regarding qualified health care plans offered by Accountable Health Carriers established pursuant to G.S. 143-599.

(4) 'Alliance Board' means the Alliance Board of Directors for a market area established pursuant to G.S. 143-597.

(5) 'Antitrust laws' means federal and State laws intended to protect commerce from unlawful restraints, monopolies, and unfair business practices.

(6) 'Board' means the State Health Plan Purchasing Alliance Board.

(7) 'Carrier' means that as defined in G.S. 58-50-110(5).

(8) 'Community sponsor' means an organization that assumes responsibility for serving as the host for an Alliance in a market area.

(9) 'Dependent' means that as defined in G.S. 58-50-110(9).

(10) 'Eligible employee' means that as defined in G.S. 58-50-110(10).

(11) 'Employee enrollee' means an eligible employee or dependent of an eligible employee who is enrolled in a qualified health care plan.

(12) 'Fund' means the State Health Plan Purchasing Alliance Fund established under G.S. 143-605.

(13) 'Grievance procedure' means an established set of rules that specify a process for appeal of an organizational decision.

(14) 'Health benefit plan' means that as defined in G.S. 58-50-110(11).

(15) 'Late enrollee' means an eligible employee or a dependent of an eligible employee who requests enrollment in a qualified health care plan after the initial enrollment period for a member small employer, provided the enrollment is consistent with the Alliance's rules for

initial enrollment and provided that the initial enrollment period shall extend for 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 least the minimum level of benefits in qualified health care plans established pursuant to G.S. 58-50-120 at the time the individual was eligible to enroll and either:

1. Lost coverage under another health plan as a result of termination of employment, the termination of coverage under another health plan, or the death of a spouse or divorce and requests enrollment in a qualified health care plan within 30 days after termination of coverage; or

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

b. The individual elects a different health plan offered through an 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 that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days of his or her marriage or the birth or adoption of a child.

(16) 'Lowest cost plan' means the lowest cost qualified health care plan selected by a member small employer and offered to the employer's employee enrollees.

(17) 'Market area' means a clearly defined, nonoverlapping, and exclusive geographical area determined by the Board for the purpose of defining the region in which an Alliance shall operate.

(18) 'Member small employer' means a small employer who enrolls in an Alliance.

(19) 'Preexisting condition provision' means that as defined in G.S. 58-50-110(17).

(20) 'Premium' means that as defined in G.S. 58-50-110(18).

(21) 'Qualified health care plans' means the basic or standard health care plans offered by an Accountable Health Carrier to member small employers and as authorized by the Small Employer Carrier Committee pursuant to G.S. 58-50-120.

(22) 'Risk adjustment mechanism' means the process established pursuant to G.S. 143-603.

(23) 'Self-employed individual' means that as defined in G.S. 58-50-110(21a).
(24) 'Service area' means a geographic region in which a carrier is licensed to operate.
(25) 'Small employer' means that as defined in G.S. 58-50-110(22).

"**§ 143-593. Health benefit plans subject to Article.**

A health benefit plan is subject to this Article if it provides health benefits for small employers and if any of the following conditions are met:

(1) Any part of the premiums or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage or adjustments or otherwise, by a small employer for any portion of the premium;
(2) The health benefit plan is treated by the employer or any of the covered self-employed individuals as part of a plan or program for the purposes of Sections 106, 125, or 162 of the United States Internal Revenue Code; or
(3) The small employer has permitted payroll deductions for the eligible enrollees for the health benefit plans.

"**§ 143-594. Jurisdiction of the Department of Insurance.**

Nothing in this Article shall be deemed to be in conflict with or in limitation of the duties and powers granted to the Commissioner of Insurance under Chapter 58 of the General Statutes. The Board and Alliances established under this Article shall bring to the attention of the Department of Insurance any suspected or alleged violations of this Article.

"**§ 143-595. Establishment of the Board; membership; terms; personnel.**

(a) There is established the State Health Plan Purchasing Alliance Board. The Board shall be established within the Department of Administration for administrative, organizational, and budgetary purposes only. The Department of Administration shall provide administrative and staff support to the Board. The Department of Insurance shall provide technical assistance as requested by the Board.

(b) The Board shall consist of 11 members, as follows:

(1) Three appointed by the Governor, at least one of whom shall be an owner or manager of a member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;
(2) Three appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, in accordance with G.S. 120-121, at least one of whom shall be an owner or manager of a member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;
(3) Three appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121, at least one of whom shall be an owner or manager of a

member small employer of an Alliance operating in North Carolina; and at least one of whom shall be an employee enrollee of an Alliance operating in North Carolina;

(4) The Lieutenant Governor or his or her representative; and

(5) The Commissioner of Insurance or his or her representative.

(c) Members of the Board who are not officers or employees of the State shall receive compensation of two hundred dollars ($200.00) for each day or part of a day of service plus reimbursement for travel and subsistence expenses at the rates specified in G.S. 138-5. Members of the Board who are officers or employees of the State shall receive reimbursement for travel and subsistence at the rates specified in G.S. 138-6.

(d) Appointed members shall serve for four-year terms except that the initial terms of:

(1) Two members appointed by the Governor, two members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one member appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, shall expire January 1, 1995; and

(2) One member appointed by the Governor, one member appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and two members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, shall expire January 1, 1997.

(e) At the end of a term, a member shall continue to serve until a successor is appointed. A member who is appointed after a term has begun serves only for the remainder of the term and until a successor is appointed. A member who serves two consecutive full four-year terms shall not be reappointed until four years after completion of those terms. A vacancy in a legislative appointment shall be filled in accordance with G.S. 120-122.

(f) The Board shall elect officers biennially. Officers shall serve no more than two consecutive terms in an office.

(g) The Board shall appoint an executive director who shall serve at the pleasure of the Board. The executive director shall administer the affairs of the Board. The executive director may employ and direct staff necessary to carry out the provisions of this Article. Staff of the Board shall be covered under the State Personnel Act.

(h) The Board shall meet as needed at the times and places it determines. Such meetings and procedures shall be governed by the procedures and policies set forth in the North Carolina Open Meetings Law, Article 33C of Chapter 143 of the General Statutes. A majority of the fully authorized membership of the Board is a quorum.

(i) No Board members or their spouses shall be employed by, affiliated with an agent of, or otherwise a representative of any carrier or health care provider.

(j) No individual shall be appointed to or remain a member of the Board if the individual, the individual's spouse, or the individual and spouse together, held securities or are otherwise the beneficiaries of securities worth ten thousand dollars ($10,000) or more at fair market value as of December 31 of the preceding year in a single health

care business or aggregated among multiple health care businesses. For the purposes of this subsection, the term, 'health care business':

(1) Includes an association, corporation, enterprise, joint venture, organization, partnership, proprietorship, trust, and every other business interest that provides or insures human health care.

(2) Does not include a widely held investment fund, regulated investment company, or pension or deferred compensation plan if neither the individual nor the individual's spouse has the ability to exercise control over the financial interests held by the fund.

"**§ 143-596. Duties of the Board.**

The Board shall:

(1) Establish no less than four and no more than 12 market areas in this State. In establishing such market areas, the Board shall ensure that every location is a part of a market area. To the largest extent possible, the Board should consider metropolitan standard areas and other existing markets. The Board may redefine market areas where it determines there will be insufficient numbers of enrollees, health care providers, or qualifying Accountable Health Carriers to make such requirements feasible. Any such modifications are subject to annual review by the Board.

(2) Accept applications by carriers to qualify as Accountable Health Carriers, determine the eligibility of carriers to become Accountable Health Carriers according to criteria described in G.S. 143-599, and designate carriers as Accountable Health Carriers.

(3) Establish Alliances with community sponsors pursuant to G.S. 143-597 for each market area determined by the Board.

(4) Conduct annual reviews of the performance of each Alliance to ensure that the Alliance is in compliance with this Article. To assist the Board in its review, each Alliance shall submit data to the Board quarterly including, but not limited to, employer enrollment by employer size; industry sector; previous insurance status and number of employees within each insurance status; number of total eligible employers in the market area participating in the Alliance; number of insured lives by county and insured category, including employees, dependents and other insured categories, represented by Alliance members; profiles of potential employer membership by county; premium ranges for each qualified health care plan for Alliance member categories; type and resolution of member grievances; surcharges; and Alliance financial statements. A summary of this annual review shall be provided to the General Assembly and each Alliance.

(5) Develop standard enrollment procedures to be used in enrolling small employers and their eligible employees.

(6) Establish conditions of participation for small employers and self-employed individuals which shall conform to the requirements of this Article and G. S. 58-50-125(d) and include, but not be limited to, the following:

a. Assurances that the member small employer is a valid small employer group and is not formed for the purpose of securing health benefits coverage. This assurance must include requirements that sole proprietors and self-employed individuals have been in business for a reasonable period of time as established by the Board, have provided filings to verify employment status, and have provided other evidence, in the Board's discretion, to ensure that the individual is working;

b. A member small employer who opts to pay eighty percent (80%) or more of the cost of coverage may choose to offer a single qualified health care plan to its eligible employees. Eligible employees of other member small employers shall have the choice of at least two qualified health care plans. All member small employers may offer the qualified health care plans of more than one Accountable Health Carrier. The Board and Alliances shall encourage all member small employers to consider offering more than one Accountable Health Carrier;

c. Minimum employer contribution requirements that shall be an amount not less than fifty percent (50%) of the premium for an employee's coverage of the lowest cost plan. The Alliance shall require that the employer contribute the same dollar amount for each employee regardless of the qualified health care plan chosen by the employee;

d. A mechanism that will provide for participation if an employer chooses not to participate but one hundred percent (100%) of the eligible employees who are not covered under a health benefit plan elect to purchase their coverage through the Alliance; and

e. Prepayment of premiums or other mechanisms to assure that payment will be made for coverage.

(7) Ensure that any small employer or any employee of a small employer who meets the requirements established by the Board pursuant to subdivision (6) of this section may purchase health care coverage through an Alliance.

(8) Assure compliance with this Article by Alliances, small employers, and employee enrollees.

(9) Have the authority to request carrier information about the financial condition of the carrier consistent with the financial information required to be submitted by the carrier to the Department of Insurance.

(10) Assure fair and affirmative marketing of the qualified health care plans consistent with standards established by the Department of Insurance, the Small Employer Carrier Committee, and G.S. 143-602.

(11) Adopt rules in compliance with Chapter 150B of the General Statutes as necessary to administer the provisions of this Article.

(12) Appoint advisory committees that shall include persons with expertise in health benefits management and representatives of Accountable Health Carriers.

(13) Develop uniform standards for the data that Alliances collect from Accountable Health Carriers. In formulating such standards, the Board shall strive for consistency with health care data collection activities underway in North Carolina and nationally. Any data collection requirements promulgated by the Board shall be based on a study of their feasibility and cost-effectiveness, including their consistency with national standards for electronic data interchange, and their necessity for supporting the evaluation of Accountable Health Carriers and their provider networks with respect to cost containment, quality, control of expensive technology, and customer satisfaction. All enrollee satisfaction surveys employed by Alliances shall be in a standardized format promulgated by the Board.

(14) Have the authority to sue or be sued, including taking action necessary for securing legal remedies on behalf of, or against Alliances, member small employers, or employee enrollees and dependants of those employees.

(15) Have the authority to receive and accept grants or funds from any public or private agency and receive and accept contributions from any source of money, property, labor, or any other thing of value.

(16) Develop and implement standardized forms for use by Accountable Health Carriers in conformance with applicable national standards.

(17) Review, and limit if necessary, surcharges charged by each Alliance for administrative costs.

(18) Develop guidelines for any authorized marketing materials to be used in providing member small employers and their eligible employees with information regarding Accountable Health Carriers and their respective qualified health care plans in accordance with G.S. 143-602. Such guidelines shall be consistent with standards established by the Department of Insurance and the Small Employer Carrier Committee.

(19) Develop grievance procedures to be used in resolving disputes between member small employers and Alliances. A member small employer, Alliance or Accountable Health Carrier may appeal to the Board any grievance that is not resolved.

(20) Receive, review, and act on appeals of grievances not resolved.

(21) Analyze information collected from Accountable Health Carriers and other sources and report findings that assist consumers, Alliances,

Accountable Health Carriers, or health care providers in improving the delivery or purchase of cost-effective health care.

(22) Report annually on the operation of the Board to the Joint Legislative Commission on Governmental Operations and the Governor.

"**§ 143-597. Alliances authorized.**

(a) The Board is authorized to create a single Alliance within each designated market area for the benefit of its member small employers. Each Alliance shall be operated as a State-chartered, nonprofit private organization.

(b) Each Alliance shall operate under the supervision of an Alliance Board of Directors, which shall consist of 11 members. The majority of members on each Alliance Board shall be small employers.

(1) The Board shall initially appoint six members for a term of two years. The community sponsor shall initially appoint five members for a term of two years. In so doing, the Board and community sponsor shall consider, among other things, whether all member small employers are fairly represented and assure that a majority of the Alliance Board shall be small employers.

(2) Subsequent members of the Alliance Board of Directors shall be elected pursuant to the Alliance Board's bylaws.

(c) Each Alliance Board shall adopt bylaws that shall include a procedure for the election of Alliance Board members by the Alliance's member small employers.

(d) Of the initially elected members of each Alliance Board, six members shall be designated to serve two-year terms and the remaining five members shall have four-year terms. Thereafter, the term of an elected member shall be four years.

(e) Vacancies on an Alliance Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members. A member to fill a vacancy may serve for the remainder of the term and until a qualified successor is elected for a new term.

(f) A member who serves two consecutive full four-year terms shall not be reelected for four years after completion of those terms.

(g) Members of the Alliance Board shall be bound by the financial interest restrictions set forth for Board members in G.S. 143-595(i) and (j).

(h) The Alliance Board shall elect officers from among its members every two years. Officers shall not serve more than two consecutive terms in an office.

(i) The Alliance Board shall meet at times and places as it determines necessary to operate the Alliance in accordance with this section and G.S. 143-598. Such meetings shall be governed by the procedures and polices set forth by the North Carolina Open Meetings Law, Article 33C of Chapter 143 of the General Statutes.

(j) There shall be no liability on the part of, and no cause of action of any nature shall arise against any member of the Alliance Board, or its employees or agents, for any action taken in good faith by them in the performance of their powers and duties as defined under G.S. 143-598.

(k) The Alliance Board shall have the powers and duties regarding operation of the Alliance set forth in G.S. 143-598.

"**§ 143-598. Powers and duties of the Health Plan Purchasing Alliance.**

An Alliance shall have the following powers and duties:

(1) Enter into contracts with Accountable Health Carriers for the provision of qualified health care plans for members of the Alliance pursuant to G.S. 143-599. Each Alliance shall contract with all Accountable Health Carriers which offer qualified health care plans operating in its market area and apply to serve member small employers;

(2) Enter into contracts with small employers pursuant to G.S. 143-600;

(3) Maintain eligibility records as appropriate to carry out the functions of this Article;

(4) Transmit enrollment and eligibility information to Accountable Health Carriers on a timely basis;

(5) Establish procedures for collection of premiums from member small employers, including the share of premiums paid by employee enrollees pursuant to G. S. 143-600;

(6) Pay contracted rates to Accountable Health Carriers on a monthly basis or as otherwise mutually agreed pursuant to G.S. 143-601;

(7) Impose annual surcharges established at the beginning of the fiscal year to be paid monthly by member small employers for necessary costs incurred in connection with the operation of the Alliance. The amount of annual surcharges shall cover any default on insurer premium payments by member small employer.

(8) Provide that in the event a member small employer terminates coverage purchased through the Alliance, the former member small employer shall be ineligible to purchase a qualified health care plan through the Alliance for a period of two years, except as permitted by the Alliance Board and the Board for good cause;

(9) Contract, as authorized by the Alliance Board of Directors, with a qualified third party for any service necessary to carry out the powers and duties as defined in this section, including contracts with agents to assist in contracting with Accountable Health Carriers and small employers and to assist the Alliance in undertaking activities necessary to administer the Alliance, such as marketing and publicizing the availability of the qualified health care plans;

(10) Provide to member small employers clear, standardized information on each Accountable Health Carrier and qualified health care plans offered by each Accountable Health Carrier, including information on price, enrollee costs, quality, patient satisfaction, enrollment, and enrollee responsibilities and obligations; and provide qualified health care plan comparison sheets in accordance with Board rules to be used in providing members and their employees with information regarding coverage that may be obtained through the Accountable Health Carriers;

(11) Appoint an executive director to serve as the chief operating officer of the Alliance, who may employ other staff as needed to administer the Alliance. The executive director shall serve at the pleasure of the Alliance Board;

(12) Establish advisory boards as necessary to assist with carrying out the duties established pursuant to this section;

(13) Establish administrative and accounting procedures for operating the Alliance, providing services to member small employers and employee enrollees, and preparing an annual budget;

(14) Prepare annual reports on the operations of the Alliance, including program and financial operations as required by the Board, and provide for annual internal and independent audits;

(15) Sue or be sued, including taking any legal actions necessary or proper for recovering any penalties for or on behalf of the Alliance;

(16) Maintain records and submit reports to the Board as required; and

(17) Accept and expend funds received through grants, appropriations, or other appropriate and lawful means.

"**§ 143-599. Accountable health carriers.**

(a) By July 1, 1994, the Board shall establish a process whereby a carrier that fulfills the qualifications of subsection (b) of this section shall be designated as an Accountable Health Carrier.

(b) In order to be eligible to be designated as an Accountable Health Carrier, a carrier must be able to demonstrate the following operating characteristics to the Board:

(1) Licensure and in good standing with the Department of Insurance;

(2) Capacity to administer the qualified health care plans;

(3) In the case of a carrier with a contractual obligation to provide or arrange for the covered health services, the ability to provide enrollees with adequate access to covered services within the carrier's service area;

(4) Grievance procedures, including the ability to respond to enrollees' calls, questions, and complaints;

(5) Established utilization management procedures;

(6) Ability to arrange and pay for the appropriate level and type of health care services;

(7) Ability to monitor and evaluate the quality and cost-effectiveness of care;

(8) Ability to assure enrollees with adequate numbers and types of health care providers;

(9) Ability to provide information on enrollee satisfaction based on standard surveys prescribed by the Board; and

(10) Ability to provide information on the types of treatments and outcomes with respect to the clinical health, functional status, and well-being of the enrollees based on standard data elements prescribed by the Board.

Carriers receiving accreditation by nationally recognized accreditation organizations, including, but not limited to, the National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), Joint Commission on Accreditation of Health Care Organizations (JCAHO), or qualification by federal agencies, shall be deemed to be in compliance with the requirements of subdivisions (2) through (10) of this subsection as they pertain to the relevant accreditation activities of the organization.

(c) After notice and hearing, the Board may suspend or revoke the designation as an Accountable Health Carrier of any carrier that fails to maintain compliance with the requirements listed in subsections (b), (d), or (e) of this section.

(d) Each Accountable Health Carrier shall:

(1) Offer qualified health care plans;

(2) Provide for the collection and reporting to the Board and to the appropriate Alliance of information on the performance of Accountable Health Carriers regarding the effectiveness and outcomes in providing selected services; provided, however, that data reporting requirements adopted by the Board shall be consistent with the method of operation of Accountable Health Carriers, shall be consistent with national standards where available, and shall not impose an unreasonable cost for compliance;

(3) Not deny, limit, or condition coverage under qualified health care plans based on health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability of an eligible employee or dependent pursuant to the provisions of this act;

(4) Establish premium rates for each qualified health care plan pursuant to the adjusted community rating method described in G.S. 58-50-130(b);

(5) Comply with all rules regarding rating, underwriting, claims handling, sales, solicitation, licensing, unfair trade practices and other provisions in this act and Chapter 58 of the General Statutes.

(6) Issue a qualified health care plan to any member small employer that elects to be covered under a qualified health care plan offered by an Accountable Health Carrier during the open enrollment period established pursuant to subsection (e) of this section;

(7) Renew each qualified health care plan with respect to any member small employer except in the following cases:

a. Nonpayment of the required premiums;

b. Fraud or material misrepresentation of the member small employer, or the employee enrollee, or a dependent of the member small employer or the employee enrollee;

c. Noncompliance by a small employer with requirements regarding employer contribution or participation as required by the Board;

d. Repeated misuse of a provider network provision including, but not limited to, unreasonable refusal of the enrollee to follow a

prescribed course of treatment, or violation of reasonable policies of an Accountable Health Carrier;

e. Election by the Accountable Health Carrier to terminate its contract with an Alliance. In such a case, the Accountable Health Carrier shall:

1. Provide advance notice of its decision in accordance with this sub-subdivision to the Alliance and to the Board;

2. Provide notice of the decision at least 180 days prior to the nonrenewal of any qualified health care plan to the enrollees. Except as provided in sub-subdivision f. of this subdivision an Accountable Health Carrier that elects not to renew a qualified health care plan with an Alliance shall be prohibited from writing new business with the Alliance for a period of three years from the date of notice to the Alliance or until the Alliance invites the carrier to renew participation, whichever is sooner; and

f. Determination by an Alliance, subject to review by the Board, that continuation of coverage would not be in the best interest of the employee enrollees and member small employers or would impair the Accountable Health Carrier's ability to meet its contractual obligations. In this instance, the Alliance shall assist affected employee enrollees in finding replacement coverage;

(8) Provide a procedure for addressing grievances that arise between the Accountable Health Carrier and the Alliance, member small employers, or employee enrollees; and

(e) Each Accountable Health Carrier shall offer an open enrollment period to small employers at the anniversary date of the member small employers' qualified health care plan. The open enrollment period shall be at least 30 consecutive calendar days. Member small employers may choose from the Accountable Health Carriers selected from the qualified health care plans that are offered in the market area in which they reside. An Accountable Health Carrier shall not be required to offer coverage or accept enrollments if:

(1) The eligible employee or dependent does not reside within the Accountable Health Carrier's approved service area;

(2) An Accountable Health Carrier provides 90 days' prior notice that it will not have the capacity to deliver service adequately in a market area to additional enrollees because of its obligations to existing groups and enrollees; or

(3) The Commissioner of Insurance determines that the acceptance of an application or applications would place an Accountable Health Carrier in a financially impaired condition.

(f) An Accountable Health Carrier that cannot offer coverage pursuant to subdivision (2) of subsection (e) of this section shall not offer coverage to or accept applications from a new employer group or an individual until the later of 90 days following such refusal or the date on which the Accountable Health Carrier notifies the Alliance and the Board that it has regained capacity to deliver services to eligible employees and their dependents in the service area. An Accountable Health Carrier that cannot offer coverage pursuant to subdivision (3) of subsection (e) of this section shall not offer coverage or accept applications for any individual or employer group until a determination by the Commissioner of Insurance that acceptance of an application will not put the Accountable Health Carrier in a financially impaired condition.

(g) Nothing in this Article or any other provision of the General Statutes shall prohibit an Accountable Health Carrier from providing a qualified health care plan in an Alliance through a managed care system, and from contracting with particular health care providers or types, classes, or categories of health care providers.

"**§ 143-600. Payment to Alliance by member small employers.**

The contracts between Alliances and member small employers and between Accountable Health Carriers and Alliances shall provide that payment of all premiums shall be transmitted by member small employers on their behalf and on behalf of the employee enrollee, directly to the Alliance for the benefit of the Accountable Health Carrier. Premiums shall be payable on a monthly basis. Alliances may provide for penalties and grace periods for late payment. Nonpayment of premiums by a member small employer or employee enrollee shall constitute a breach of contract and a breach of the insurance policy.

"**§ 143-601. Payment by Alliance to Accountable Health Carriers.**

(a) Under a contract between an Accountable Health Carrier and an Alliance, the Alliance shall forward to each Accountable Health Carrier with enrollees under a qualified health care plan an amount equal to:

(1) Premiums determined by the Accountable Health Carrier's contracted rates; and

(2) Adjustments in payments, if any, resulting from a risk adjustment mechanism determined in accordance with G.S. 143-603.

(b) The Alliances shall pay the Accountable Health Carrier on a monthly basis.

"**§ 143-602. Marketing qualified health care plans.**

(a) Each Alliance shall use efficient and standardized means to notify small employers of the availability of sponsored health coverage through the Alliance.

(b) Each Alliance shall make available to member small employers marketing materials accurately summarizing the benefit plans, rates, cost, and accreditation information that its Accountable Health Carriers offer through the Alliance.

(c) If authorized by the Board, an Accountable Health Carrier may provide, directly or through an agent, broker, or contractor, marketing material relating to health plans offered through the Alliance. Accountable Health Carriers shall not need authorization from an Alliance for advertisement to the public at large through the means of mass media.

(d) Nothing in this section shall be construed to or explicitly prohibit an Alliance or Accountable Health Carrier from using the services of an agent or broker in order to assist in marketing. An Accountable Health Carrier shall not vary compensation or commissions to such agents or brokers based, directly or indirectly, on the anticipated or actual claims experience or health status associated with particular small employers to which each plan is sold.

(e) No Accountable Health Carrier, agent of an Accountable Health Carrier or independent insurance agent shall engage, directly or indirectly, in any activity of marketing practices that would encourage member small employers or eligible employees to:

(1) Refrain from enrolling in the Accountable Health Carrier because of their health status or claim experience; or

(2) Seek coverage from other Accountable Health Carriers because of their health status or claim experience.

(f) An Alliance shall notify the Board of any marketing practices or materials that it finds contrary to the fair and affirmative marketing requirements of this Article. Furthermore, the Board shall monitor compliance with this section, including the conduct of Accountable Health Carriers and their agents, brokers, or contractors, and shall report to the Department of Insurance any unfair trade practices and misleading or unfair conduct that has been reported to the Board by Alliances, agents, consumers, or any other individual. The Department of Insurance shall investigate all reports and, upon a finding of noncompliance with this section or of unfair and misleading practices, shall take action against violators as permitted under Chapter 58 of the General Statutes or this Article. The Board shall forward all reports of cases or abuse to the Department of Insurance for investigation.

"**§ 143-603. Risk adjustment mechanism.**

(a) The Board shall establish a payment mechanism to adjust for the amount of risk covered by each qualified health care plan offered by an Accountable Health Carrier. Risk adjustment shall be based on prospectively determined factors that predict utilization of health care services.

(b) On an annual basis, the Board shall establish a factor that represents the difference between the average risk of persons covered through the Alliance and the risk covered by each qualified health care plan offered by each Accountable Health Carrier through the Alliance. The Board shall apply that factor in determining amounts received by Accountable Health Carriers. This may be done directly or it may be done indirectly by adjusting quoted premiums. The mechanism by which the adjustment is made shall be established after consultation with a technical advisory committee.

(c) In addition to the risk adjustment mechanism described in subsections (a) and (b) of this section, the Board may develop a list of a limited number of high cost diagnoses. The Board may develop a mechanism to protect an Accountable Health Carrier that has a disproportionate share of one or more of the listed diagnoses.

(d) Any payments to Accountable Health Carriers under this section shall be determined on an annual basis. No payments under this section shall be based on claims or the health care costs of an Accountable Health Carrier.

"**§ 143-604. Antitrust protection.**

In addition to the duties described in G.S. 143-596, the Board shall actively supervise the Alliances to ensure that actions affecting market competition are not for private interests, but accomplish the legislative intent of this Article. The Board shall also monitor conduct throughout the small employer market to ensure that the legislative intent of this Article to improve the competitiveness of the small employer health coverage market is not impeded.

"**§ 143-605. State Health Plan Purchasing Alliance Fund.**

(a) There is established in the Office of the State Treasurer, the State Health Plan Purchasing Alliance Fund. The Fund shall be placed in an interest-bearing account and any interest or other income derived from the Fund shall be credited to the Fund. Moneys in the Fund shall be spent only in accordance with subsection (b) of this section. The Fund shall be administered in accordance with the Executive Budget Act.

(b) All money credited to the Fund shall be used as set forth by the Board.

(c) Moneys appropriated by the General Assembly shall be deposited in the Fund and shall become part of the continuation budget of the Department of Administration.

"**§ 143-606. Continuation and conversion of coverage.**

(a) For member small employers not covered by Title III Pub. L. 100-646(26 USC Sec. 4908B et al.), enrollees who lose their health care coverage due to loss of employment shall be offered the option of continuing health care coverage for one year, provided such enrollee pays the entire required premium charged to the enrollee's former employer and remains a resident of the State. An enrollee shall transmit payment of premium payments through the enrollee's former employer, who shall submit it to the respective Alliance.

(b) At the end of one year of continuation coverage, such enrollees shall be offered a conversion option if such option, where available, is available for former group enrollees."

Sec. 2. G.S. 58-50-130(b) reads as rewritten:

"(b) Premium rates for health benefit plans subject to this Act are subject to the following provisions:

(1) 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%),~~ twelve and one-half percent (12.5%), adjusted pro rata for any rating period of less than one year.

(2) 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 that could be charged to those employers under the rating system for that class of business shall not vary from the index rate by more than ~~thirty-five percent (35%)~~ twenty-five percent (25%) of the index rate, adjusted pro rata for any rating period of less than one year.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for any rating period of less than one year, may not exceed the sum of the following:

a. 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. If 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.

b. Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for any rating period of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.

c. Any adjustment because of a 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.

(4) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier that is caused by reinsurance is subject to the rating limitations set forth in this section.

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with G.S. 58-50-150.

(6) In any case where a small employer carrier uses 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%)~~ seven and one-half percent (7 ½%) of coverage.

(7) In the case of health benefit plans issued before January 1, 1992, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may exceed the ranges set forth in subdivisions (b)(1) and (2) of this section for a period of three years after January 1, 1992. 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:

a. 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. If 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.

b. Any adjustment because of a 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.

(8) Small employer carriers shall apply rating factors including case characteristics, consistently with respect to all small employers in a class of business. Adjustments in rates for claims experience, health status, and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer."

Sec. 3. G.S. 58-50-110 reads as rewritten:

"**§ 58-50-110. Definitions.**

As used in this Act:

(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. 58-50-130, 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 benefit plans.

(1a) 'Accountable Health Carrier' means that as defined in G.S. 143-592(1).

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

~~(2) '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 benefit plans with the same or similar coverage.~~

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

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

(5) 'Carrier' means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.

~~(6) '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; but does not~~

~~mean claim experience, health status, and duration of coverage since issue.~~

~~(7) 'Class of business' means all or a distinct grouping of small employers as shown on the records of a small employer carrier.~~

(8) 'Committee' means the Small Employer Carrier Committee as created by G.S. 58-50-120.

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

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

(11) '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 MEWA or plan provided by another benefit arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. 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.

(12) 'Impaired insurer' has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

~~(13) '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.~~

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

~~1.~~ ~~Was~~ individual was covered under ~~another employer~~ a public or private health benefit plan that provided, at the

time the individual was eligible to ~~enroll;~~ enroll, the same required level of benefits in 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 health care plan within 30 days after termination of coverage provided under another health plan; or
2. Stated, ~~at the time of the initial enrollment,~~ in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining ~~enrollment;~~ coverage;
3. ~~Has lost coverage under another employer health benefit plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and~~
4. ~~Requests enrollment within 30 days after termination of coverage provided under another employer health benefit plan;~~

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

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;

~~c.~~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 is made within 30 days after issuance of the court ~~order.~~ order; 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 or adoption of a child.

~~(15) 'New business premium rate' means, for each class of business as to a rating period, the lowest premium rate charged, offered, or that could have been charged by a small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.~~

(16) 'Pool' means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) 'Preexisting-conditions provision' means a policy provision that limits or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in a manner that 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.

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

(19) 'Rating period' means the 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.

(20) 'Risk-assuming carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) 'Reinsuring carrier' means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

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

(22) 'Small employer' means any ~~person~~ individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding ~~year,~~ calendar quarter, employed no more than ~~25~~ 49 eligible ~~employees and not less than three eligible employees,~~ employees, the majority of whom are employed within this ~~State.~~ State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. ~~Small employer includes companies that are affiliated companies, as defined in G.S. 58-19-5(1) or that are eligible to file a combined tax return under Chapter 105 of the General Statutes or under the Internal Revenue Code.~~ In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this ~~Act~~ Article that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the

requirements of this ~~section.~~ definition. For purposes of this Article, the term small employer includes self-employed individuals.

(23) 'Small employer carrier' means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) 'Standard health care plan' means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125."

Sec. 4. G.S. 58-50-113 is repealed.

Sec. 5. G.S. 58-50-115 reads as rewritten:

"**§ 58-50-115. Health benefit plans subject to ~~Act.~~ Article.**

~~(a)~~ A health benefit plan is subject to this ~~Act~~ Article if it provides health benefits for small employers or self-employed individuals and if any of the following conditions are met:

(1) Any part of the premiums or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage or adjustments or otherwise, by a small employer for any portion of the premium; ~~or for which the small employer has permitted payroll deduction for the covered individual, whether or not the coverage is issued through a group or individual policy of insurance, and whether or not the small employer pays any part of the premium.~~

(2) The health benefit plan is treated by the employer or any of the covered self-employed individuals as part of a plan or program for the purpose of ~~section 162 or section 106~~ sections 106, 125, or 162 of the United States Internal Revenue ~~Code.~~ Code; or

(3) The small employer or self-employed individuals have permitted payroll deductions for the eligible enrollees for the health benefit plans.

~~(b) The provisions of G.S. 58-51-95(f) do not apply to individual accident and health insurance policies or contracts to the extent subject to the provisions of this Act~~."

Sec. 6. G.S. 58-50-125 reads as rewritten:

"**§ 58-50-125. Health care plans; formation; approval; offerings.**

(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 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.

(b) After the Commissioner's approval of the plans submitted by the Committee under subsection (a) of this section and in lieu of any contrary procedure established by this Chapter, any small employer carrier may certify to the Commissioner, in the form and manner prescribed by the Commissioner, that the basic and standard health care plans filed by the carrier are in substantial compliance with the provisions of the corresponding approved Committee plans. Upon receipt by the Commissioner of the certification, the carrier may use the certified plans unless their use is disapproved by the Commissioner.

(c) The plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider.

(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. 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.

(e) No small employer carrier is required to offer coverage or accept applications under subsection (d) of this section:

(1) From a group already covered under a health benefit plan except for coverage that is to begin after the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group before its anniversary date; or

(2) If the Commissioner determines that acceptance of an application or applications would result in the carrier being declared an impaired insurer. ~~insurer; or~~

~~(3) To groups of fewer than five eligible employees where the small employer carrier does not use preexisting conditions provisions in all health benefit plans it issues to any small employers.~~

~~If a small employer carrier who does not use preexisting conditions chooses to market to groups of less than five, then it shall immediately notify the Commissioner and the Board, and it shall do so consistently and equally to all such small employer groups.~~

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

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

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

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

(3) Within an area, where the HMO can reasonably ~~anticipates,~~ anticipate, and ~~demonstrates~~ demonstrate, to the Commissioner's satisfaction, that it will not have the capacity within that area and 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~~ 49 eligible employees until the later of 90 days after that closure or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employers.

(h) The provisions of subsections (b), (d), and (g) and subdivision (e)(2) of this section apply to every health benefit plan delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as determined by the Commissioner. For purposes of this

subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan."

Sec. 7. G.S. 58-50-130 reads as rewritten:

"**§ 58-50-130. Required health care plan provisions.**

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

(1) Except in the case of a late enrollee, any preexisting-conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's initial effective date of ~~coverage and may only relate to conditions manifesting themselves in a manner that 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 before the effective date of coverage or as to a pregnancy existing on the effective date of~~ coverage.

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

(3) The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:

a. For nonpayment of the required premiums by the policyholder or contract holder;

b. For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees, or their representatives;

c. For noncompliance with plan provisions that have been approved by the Commissioner;

d. 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

e. 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.

f. When the small employer carrier stops writing new business in the small employer market, if:

1. It provides notice to the Department and either to the policyholder, contract holder, or employer, of its decision to stop writing new business in the small employer market; and

2. It does not cancel health benefit plans subject to this Act for 180 days after the date of the notice required under paragraph 1; and for that business of the carrier that remains in force, the carrier shall continue to be governed by this Act with respect to business conducted under this Act.

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

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

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

Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary of an insurer, or controlled individual of a holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of a holding company shall provide stop loss, catastrophic, or reinsurance coverage to small groups which, if they were purchased, would be subject to this section.

~~(b) Premium rates for health benefit plans subject to this Act are subject to the following provisions:~~

~~(1) 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 any rating period of less than one year.~~

~~(2) 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 that could be charged to those 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 any rating period of less than one year.~~

~~(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for any rating period of less than one year, may not exceed the sum of the following:~~

~~a. 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. If 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.~~

~~b. Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for any rating period of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.~~

~~c. Any adjustment because of a 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.~~

~~(4) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier that is caused by reinsurance is subject to the rating limitations set forth in this section.~~

~~(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with G.S. 58-50-150.~~

~~(6) In any case where a small employer carrier uses 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 coverage.~~

~~(7) In the case of health benefit plans issued before January 1, 1992, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may exceed the ranges set forth in subdivisions (b)(1) and (2) of this section for a period of three years after January 1, 1992. 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:~~

~~a. 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. If 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.~~

~~b. Any adjustment because of a 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.~~

~~(8) Small employer carriers shall apply rating factors including case characteristics, consistently with respect to all small employers in a class of business. Adjustments in rates for claims experience, health status, and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer.~~

(b) For all small employer health benefit plans that are subject to this section and are issued on or after January 1, 1995, premium rates for health benefit plans subject to this section are subject to the following provisions:

(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary 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;

(2) Rating factors related to age, gender, number of family members covered, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review;

(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 composition of the group changed by twenty percent (20%) or more or benefits are changed;

(4) Carriers participating in an Alliance in accordance with the Health Care Purchasing Alliance Act may apply a different community rate to business written in that Alliance;

(5) In the case of health benefit plans issued before January 1, 1995, a premium rate for a rating period, adjusted pro rata for any rating period of less than one year, may vary from the adjusted community rating index line, as determined by the small employer carrier and in accordance with subdivisions (1), (2), (3), and (4) of this subsection, for a period of two years after January 1, 1995, as follows:

a. On January 1, 1995, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the adjusted community rate by

more than twenty percent (20%) of the index rate, adjusted pro rata for any rating period of less than one year;

b. On January 1, 1996, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the adjusted community rate by more than ten percent (10%) of the index rate, adjusted pro rata for any rating period of less than one year; and

c. On January 1, 1997, all small employer benefit plans that are subject to this section and are issued by small employer carriers before January 1, 1997, and that are renewed on or after January 1, 1997, renewal rates shall be based on the same adjusted community rating standard applied to new business.

(6) For the purposes of subsection (b) of this section, a small employer carrier shall not use age brackets of less than five years;

(7) For the purposes of subsection (b) of this section, a carrier shall not apply different geographic rating factors to the rates of small employers located within the same county; and

(8) The Department of Insurance may, by rule, establish regulations to administer this subsection and to assure that rating practices used by small employer carriers are consistent with the purposes of this subsection. Those regulations shall include consideration of differences based on the following:

a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims costs;

b. Except as provided for in sub-subdivision a. above, differences in premium rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates due to the demographics of groups assumed to select particular health benefit plans; and

c. Small employer carriers shall apply allowable rating factors consistently with respect to all small employers. Adjustments in rates for age, gender, and geography shall not be applied individually. Any such adjustment shall be applied uniformly to the rate charged for all employee enrollees of the small employer.

~~(c) A small employer carrier shall not involuntarily transfer a small employer 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 the carrier offers to transfer all~~

~~small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since issue.~~

(d) 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:

~~(1) 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 eligible employees and dependents of the small employer.~~

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.

(3) Provisions relating to renewability of policies and contracts.

(4) Provisions affecting any preexisting conditions provision.

(e) 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.

(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

(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.

(h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through (g) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after January 1, 1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as designated by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan."

Sec. 8. G.S. 58-53-35 reads as rewritten:

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

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

(1) The date ~~three months~~ one year after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participating under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have been terminated. The insurer that insured the group prior to the date of termination shall make a converted policy available to the employee or member.

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

Sec. 8.1. G.S. 120-123 is amended by adding a new subdivision to read:

"(61) The State Health Plan Purchasing Alliance Board, as established by G.S. 143-595."

Sec. 9. The State Health Plan Purchasing Alliance Board shall report not later than January 1, 1995, to the Joint Legislative Commission on Governmental Operations on the following:

(1) The progress achieved in expanding the availability of affordable insurance to employees of small employers;

(2) Employee choice;

(3) The possible need for financial incentives to encourage increased participation;

(4) The demographic factors used to determine the adjusted community rating method;

(5) The possible need to have exclusive purchasing of health insurance through the Alliance for all small employers who choose to purchase health insurance;

(6) Options for including (i) employers with more than 50 employees, and (ii) populations from State and federally financed systems of health coverage;

(7) The need for federal waivers;

(8) Developments in health care reform at the federal level as well as in other states, including, but not limited to, Florida and other states in the southeast region of the United States; and

(9) The need to develop, to the extent feasible and consistent with national standards, standard information to be collected from Accountable Health Carriers on the types of treatments and outcomes with respect to the clinical health, functional status, and well-being of enrollees.

Sec. 10. Within 30 days of ratification of this act, the Governor, the General Assembly upon the recommendation of the Speaker of the House of Representatives, and the General Assembly upon the recommendation of the President Pro Tempore of the Senate shall make their appointments to the State Health Care Purchasing Alliance Board. Those appointments restricted by G.S. 143-594(b) shall be drawn from among persons who own, manage, or are employed by a small employer as defined in G.S. 143-592 who would qualify as a member small employer under this act.

Sec. 11. Of the funds appropriated to the Reserve for Health Care Initiatives in Chapter 321 of the 1993 Session Laws, the sum of four million dollars ($4,000,000) for the 1993-94 fiscal year and the sum of five hundred thousand dollars ($500,000) for the 1994-95 fiscal year shall be used for the initial operation of the Health Care Purchasing Alliance Board and other activities related to the duties and responsibilities of the Alliances and the State Health Purchasing Alliance Board authorized by Section 1 of this act.

Sec. 12. Section 2 of this act becomes effective January 1, 1994. Sections 3 through 7 of this act become effective January 1, 1995. Alliances shall become operational on or after January 1, 1995. The remainder of this act is effective upon ratification.