GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

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SENATE BILL 626*

Commerce Committee Substitute Adopted 4/5/05
House Committee Substitute Favorable 7/7/05

Short Title: HIPAA Compliance and Fairness.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO BRING NORTH CAROLINA LAW INTO COMPLIANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT; TO PROVIDE SPECIAL ENROLLMENT PERIODS WITHOUT PENALTY FOR PERSONS ENROLLED UNDER A GROUP PLAN WHOSE COVERAGE IS TERMINATED WHEN AN INSURER DISCONTINUES WRITING A CERTAIN TYPE OF GROUP HEALTH INSURANCE COVERAGE THROUGHOUT THAT ENTIRE SMALL OR LARGE GROUP MARKET; AND TO PROVIDE CONTINUED GUARANTEED ISSUE RIGHTS TO A PERSON WHO IS HIPAA ELIGIBLE, WHO IS INSURED IN THE INDIVIDUAL MARKET, AND WHOSE INSURER DISCONTINUES WRITING A CERTAIN TYPE OF HEALTH INSURANCE COVERAGE THROUGHOUT THE ENTIRE INDIVIDUAL MARKET.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-68-30(c) reads as rewritten:

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

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

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

b. Group or individual health insurance coverage.

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

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

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

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

g. A State health benefits risk pool.
h. A health plan offered under chapter 89 of title 5, United States Code.
i. A public health plan (as defined in federal regulations).
j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).
k. ~~The Health Insurance Program for Children established in Part 8 of Chapter 108A of the General Statutes, or any successor program.~~ Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits. However, short-term limited-duration health insurance coverage shall be considered creditable coverage for purposes of this section and G.S. 58-51-15(a)(2)b.

(2) Not counting periods before significant breaks in coverage. –
a. In general. – A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health insurance plan, if, after the period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.
b. Waiting period not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision and subdivision (d)(4) of this subsection, any period that an individual is in a waiting period for any coverage under a group health insurance plan or is in an affiliation period shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.
c. Time spent on short term limited duration health insurance not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision, any period that an individual is enrolled on a short term limited duration health insurance policy shall not be taken into account in determining the continuous period under sub-subdivision. a. of this subdivision so long as the period of time spent on the short term limited duration health insurance policy or policies does not exceed 12 months.
d. For an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period shall not be considered when determining whether a significant break in coverage has occurred.

(3) Method of crediting coverage. –

a. Standard method. – Except as otherwise provided under sub-subdivision b. of this subdivision for the purposes of applying subdivision (a)(3) of this subsection, a group health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.

b. Election of alternative method. – A group health insurer may elect to apply subdivision (a)(3) of this subsection based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations rather than as provided under sub-subdivision a. of this subdivision. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election a group health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

c. Health insurer notice. – In the case of an election under sub-subdivision b. of this subdivision with respect to health insurance coverage in the small or large group market, the health insurer: (i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made the election, and (ii) shall include in the statements a description of the effect of the election.

(4) Establishment of period. – Periods of creditable coverage for an individual shall be established through presentation of certifications described in subsection (e) of this section or in another manner that is specified in federal regulations."

SECTION 2.1. G.S. 58-68-30(f)(1) reads as rewritten:

"(1) Individuals losing other coverage. – A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

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

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

c. ~~The~~ With respect to the employee's or dependent's coverage under a plan described in sub-subdivision ~~a.:~~ a. of this subdivision, at least one of the following applies: (i) the coverage was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) the coverage was not under ~~that~~ a COBRA continuation provision and ~~either~~ the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, ~~death,~~ cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, ~~or~~ reduction in the number of hours of ~~employment;~~ employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; ~~or~~ (iii) the employer terminated contributions toward the ~~coverage were terminated.~~coverage; (iv) the individual lost coverage because the individual no longer resided, lived, or worked in the service area (whether or not within the choice of the individual) if the coverage was offered through an arrangement that did not provide benefits to individuals who no longer reside, live, or work in a service area, and no other benefit package is available to the individual; (v) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vi) a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the ~~date of exhaustion of coverage~~ applicable event described in sub-subdivision ~~c.(i) of this subdivision or termination of coverage or employer contribution described in sub-subdivision c.(ii)~~ c. of this subdivision."

SECTION 2.2. G.S. 58-68-30(f)(1), as amended by Section 2.1 of this bill, reads as rewritten:

"(1) Individuals losing other coverage. – A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

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

b. The employee stated in writing at the time that coverage under the group health plan or health insurance coverage was the

reason for declining enrollment, but only if the health insurer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

c. With respect to the employee's or dependent's coverage described in sub-subdivision a. of this subsection: (i) the coverage was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) the coverage was not under that provision and either the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; (iii) employer contributions toward the coverage were terminated; (iv) in the case of coverage offered through an arrangement that does not provide benefits to individuals who no longer reside, live, or work in a service area, there has been loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (v) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vi) a plan no longer offers any benefits to the class of similarly situated individuals that includes the ~~individual.~~ individual; or (vii) the health insurer terminated coverage under G.S. 58-68-45(c)(2).

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the date of the applicable event described in sub-subdivision c. of this subdivision."

SECTION 3. G.S. 58-68-60 is amended by adding the following new subsections to read:

"(i) Rights of Replacement Coverage Upon Termination. – Subsection (a) of this section shall apply to an eligible individual whose coverage issued under this section is terminated by a health insurer under G.S. 58-68-65(c)(2) the application for the replacement coverage is dated not more than 63 days following the termination date.

(j) Waiting Period. – In determining the length of any break in coverage for an individual as prescribed in G.S. 58-68-60(b)(1)(i), a significant break in coverage does not occur during the waiting period. The "waiting period" is defined as the period that begins on the date the individual submits a substantially complete application for coverage and ends on:

(1) The date coverage begins, if the application results in coverage, or

(2) The date on which the application is denied by the issuer or the date on which the offer for coverage lapses, if the application does not result in coverage."

SECTION 4. G.S. 58-68-30(b) reads as rewritten:

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

(1) Enrollment date. – With respect to an individual covered under a group health insurance plan, the date of enrollment of the individual in the coverage or, if earlier, the first day of the waiting period for the enrollment. An individual's enrollment date does not change if the individual receiving benefits under a group health insurance plan changes benefit packages or if the plan changes health insurers.

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

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

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

(3) Preexisting condition exclusion. –

a. In general. – "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the ~~date of enrollment for the coverage,~~ effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before ~~the date.~~that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

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

(4) Waiting period. –

a. With respect to a group health insurance plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

b. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period.

c. If an individual seeks individual health insurance coverage, a waiting period begins on the date the individual submits a substantially complete application and ends on: (i) the date coverage begins if the application results in coverage; or (ii) the date on which the application is denied by the health insurer or the date on which the offer for coverage lapses if the application does not result in coverage."

SECTION 5. Section 2.1 of this act is effective when it becomes law and applies to all health benefit plans that are delivered, issued for delivery, or renewed on or after that date. Sections 2.2 and 3 of this act become effective January 1, 2006, and apply to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. The remainder of this act is effective when it becomes law and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.