GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 462*

Short Title:	Health Insurance Omnibus Changes-AB.	(Public)
Sponsors:	Senator Wellons.	
Referred to:	Insurance and Consumer Protection.	

March 15, 2001

A BILL TO BE ENTITLED

AN ACT TO EXPRESSLY ALLOW NONBINDING ARBITRATION IN HEALTH INSURANCE POLICIES; CLARIFY THE PREFERRED PROVIDER PLAN LAW; AMEND THE SMALL EMPLOYER RATE GUARANTEE LAW; PROVIDE FOR THE PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION; AMEND THE LAW ON NEWBORN AND FOSTER CHILD COVERAGE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY; PROVIDE FOR A HEALTH INSURANCE CONTINUATION ELECTION PERIOD; REQUIRE AN HMO GROUP COVERAGE PREMIUM CHANGE NOTICE; PROVIDE FOR SUCCESSOR HEALTH PLAN COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE; TO EXPAND MEDICARE SUPPLEMENT GUARANTEED ISSUANCE FOR DISABLED PERSONS; TO ALLOW THE INSURANCE COMMISSIONER TO ADOPT TEMPORARY RULES FOR MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE TO IMPLEMENT FEDERAL REQUIREMENTS; AND TO MAKE TECHNICAL CORRECTIONS TO REFLECT REPEALS OF LAWS.

The General Assembly of North Carolina enacts:

PART I. NONBINDING ARBITRATION IN HEALTH INSURANCE POLICIES

SECTION 1. G.S. 58-3-35 reads as rewritten:

"**§ 58-3-35. Stipulations as to jurisdiction and limitation of actions.**

(a) ~~No company or order, domestic or foreign, authorized to do business in this State under Articles 1 through 64 of~~ No insurer, self-insurer, service corporation, HMO, or MEWA licensed under this ~~Chapter, may~~ Chapter shall make any condition or stipulation in its insurance contracts or policies concerning the court or jurisdiction ~~wherein~~ in which any suit or action ~~thereon~~ on the contract may be brought.

(b) ~~may be brought, nor may it~~ No insurer, self-insurer, service corporation, HMO, or MEWA licensed under this Chapter shall limit the time within which ~~such~~ any suit or action referred to in subsection (a) of this section may be commenced to less than one year after the cause of action accrues or to less than six months from any time at which a plaintiff takes a nonsuit to an action begun within the legal time. ~~All conditions and stipulations forbidden by this section are void.~~

(c) No health or life insurance policy or annuity contract shall contain any condition, provision, stipulation, or agreement that directly or indirectly deprives an insured or beneficiary of the right to a trial by jury or any question of fact arising under the policy or contract. An insurance policy or contract may contain an arbitration clause. The arbitration procedure and rights of the parties to the arbitration shall be substantially similar to those contained in Rules of the Supreme Court adopted under G.S. 7A-37.1 which give either party the option and right to proceed in the courts after an arbitration award.

(d) All conditions and stipulations forbidden by this section are void."

PART II. PREFERRED PROVIDER PLAN CLARIFICATION

SECTION 2. G.S. 58-50-56(a)(3) reads as rewritten:

"(3) "Preferred provider benefit plan" means a ~~health~~benefit plan offered by an insurer in which health care services are furnished by preferred health care providers under a contract in accordance with this section and in which either or both of the following features are present:

a. Utilization review or quality management programs are used to manage the provision of covered health care ~~services; and~~services.

b. Enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those furnished by participating providers.~~providers, and health care services are provided by preferred providers under a contract pursuant to this section.~~"

PART III. SMALL EMPLOYER RATE GUARANTEES

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

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

a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period, and
b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer, and
c. Any adjustment because of change in coverage or change in case characteristics of the small employer group."

PART IV. PROMOTION OF ALCOHOL AND NARCOTIC SCREENING AND INTERVENTION

SECTION 4.1. G.S. 58-51-15(b)(11) is repealed.

SECTION 4.2. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-16. Promotion of alcohol and narcotic screening and intervention.**

No insurer licensed under this Chapter shall make any condition or stipulation in its accident or health insurance contracts that would defeat or avoid coverage as a result of loss sustained or contracted in consequence of the insured's being under the influence of alcohol or a narcotic."

PART V. NEWBORN AND FOSTER CHILD COVERAGE

SECTION 5. G.S. 58-31-30(b) reads as rewritten:

"(b) Every health benefit plan, as defined in G.S. 58-51-115(a)(1), 58-3-167, that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home."

PART VI. SUCCESSOR PLAN COVERAGE FOR CONFINEMENT OR PREGNANCY

SECTION 6. G.S. 58-51-110(b) reads as rewritten:

"(b) Whenever a contract described in subsection (a) of this section is replaced by another group contract within 15 days of termination of coverage of the previous group

contract, the liability of the succeeding insurer for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding insurer's plan of ~~benefits with respect to classes eligible and activity at work and nonconfinement rules must~~ benefits, regardless of any other provisions of the new group contract relating to active employment or hospital confinement or pregnancy, shall be covered by the succeeding insurer's plan of benefits; and

(2) Each person not covered under the succeeding insurer's plan of benefits in accordance with subdivision (b)(1) of this section must nevertheless be covered by the succeeding insurer if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding insurer's plan."

PART VII. CONTINUATION ELECTION PERIOD

SECTION 7.1. G.S. 58-53-10 reads as rewritten:

"**§ 58-53-10. Eligibility.**

Continuation shall only be available to an employee or member who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately ~~prior to~~ before the date of termination. The employee or member may elect continuation for a period of not fewer than 60 days after the date of termination or loss of eligibility. The employee or member shall make the first contribution upon the election to continue coverage; and the coverage shall be retroactive to the date of termination or loss of eligibility."

SECTION 7.2. G.S. 58-53-30 reads as rewritten:

"**§ 58-53-30. Payment of premiums.**

An employee or member electing continuation must pay to the group policyholder or his employer, in advance, the amount of contribution required by the policyholder or employer, but not more than one hundred two percent (102%) of the full group rate for the insurance applicable under the group policy on the due date of each payment. The employee or member may not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member must make a written election of continuation, on a form furnished by the group ~~policyholder, and pay the first contribution, in advance, to the policyholder or employer on or before the date on which employee's or member's insurance would otherwise terminate.~~policyholder or by the insurer."

PART VIII. HMO GROUP COVERAGE PREMIUM CHANGE NOTICE

SECTION 8. G.S. 58-67-50(b) reads as rewritten:

"(b) (1) Premium Approval.-- No schedule of premiums for ~~enrollee~~ coverage for health care services, or any amendment ~~thereto, may~~ to the schedule, shall be used in conjunction with any health care plan until a copy of ~~such schedule, or amendment thereto,~~ the schedule or amendment has been filed with and approved by the Commissioner.

(2) Individual coverage.—Premiums shall ~~Such premiums may~~ be established in accordance with actuarial principles for various categories of ~~enrollees, provided that premiums~~ enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of ~~his~~ the enrollee's health. ~~However, the premiums~~ Premiums shall not be excessive, inadequate, or unfairly discriminatory; and ~~must~~ shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. ~~Such~~ The premiums or any revisions ~~thereto~~ to the premiums with respect to nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 ~~months; or as an~~ months. As an alternative to giving ~~such~~ this guarantee ~~with respect only to~~ for nongroup enrollee coverage, ~~such~~ the premium or premium revisions may be made applicable to all similar category of enrollee coverage at one time if the health maintenance organization chooses to apply for ~~such~~ the premium revision with respect to such categories of coverages no more frequently than once in any 12-month period. ~~Such~~ The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the ~~corporation~~ HMO has given written notice of the premium revision to the enrollee 45 days ~~prior to~~ before the effective date of ~~such~~ the revision. The enrollee thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may ~~promulgate~~ adopt reasonable rules, after notice and hearing, to require the ~~submission~~ submittal of supporting data and such information ~~as is deemed~~ as the Commissioner considers necessary to determine whether ~~such~~ the rate revisions meet ~~these standards.~~the standards in this subdivision.

(3) Group Coverage. – Employer group premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate, or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any revisions to the premiums for employer group coverage shall be guaranteed for a period of not less than 12 months. No premium

revision shall become effective for any category of group coverage unless the HMO has given written notice of the premium revision to the master group contract holder 45 days before the effective date of the revision. The master group contract holder thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision."

PART IX. HIPAA COVERAGE FOR CONDITIONS FIRST DIAGNOSED UNDER PREVIOUS COVERAGE

SECTION 9. G.S. 58-38-30(d) reads as rewritten:

"(d) Exceptions. –

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. – A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5) Condition first diagnosed under previous coverage. – A group health insurer shall not impose any preexisting condition exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and the condition was covered under the qualifying previous coverage or prior creditable coverage; provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than 63 days before the enrollment date for the new coverage."

PART X. MEDICARE SUPPLEMENT GUARANTEED ISSUANCE

SECTION 10. G.S. 58-54-45 reads as rewritten:

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

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

(b) Persons eligible for Medicare by reason of disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment, have the guaranteed right to purchase Medicare Supplement Plans A and C from any insurer within 63 days after the date of termination or disenrollment.

(c) An insurer may develop premium rates specific to the disabled population. No insurer shall discriminate in the pricing of the Medicare supplement plans referred to in this section because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the plan is submitted during an open enrollment or is submitted within 63 days after the managed care plan is terminated. The rates and any applicable rating factors for the Medicare supplement plans referred to in this section shall be filed with and approved by the Commissioner."

PART XI. MEDICARE SUPPLEMENT AND LONG-TERM CARE RULES

SECTION 11.1. G.S. 58-54-50 reads as rewritten:

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

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

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

(2) Establishing a uniform methodology for calculating and reporting loss ratios.

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.

(4) Establishing standards for Medicare Select policies and certificates.

(5) Any other changes required by Congress or the U.S. Department of Health and Human Services, or any successor agency."

SECTION 11.2. Article 55 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-55-50. Rules for compliance with federal law and regulations.**

The Commissioner may adopt temporary rules necessary to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies."

PART XII. SHPPA REPEAL TECHNICAL CORRECTIONS

SECTION 12.1. G.S. 58-50-110(1) is repealed.

SECTION 12.2. G.S. 58-50-110(14) reads as rewritten:

"(14) 'Late enrollee' has the same meaning as defined in G.S. 58-68-30(b)(2); provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. In addition to the special enrollment provisions in G.S. 58-68-30(f), an eligible employee or dependent shall not be considered a late enrollee under a small employer health benefit plan if:

a. Repealed by Session Laws 1998-211, s. 9.

1, 2. Repealed by Session Laws 1998-211, s. 9.

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

b. The individual elects a different health benefit plan offered ~~through the Alliance or~~ by the small employer during an open enrollment period;

c. Repealed by Session Laws 1998-211, s. 9.

d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment for a spouse is made within 30 days after issuance of the court order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or

e. Repealed by Session Laws 1998-211, s. 9."

SECTION 12.3. G.S. 58-50-130(a)(4a) reads as rewritten:

"(4a) 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 and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan. ~~An accountable health carrier shall not enforce participation or contribution requirements on member~~

~~small employers, as defined in G.S. 143-622(18), unless those requirements meet with the standards adopted by the State Health Plan Purchasing Alliance Board.~~"

PART XIII. THIRD PARTY ADMINISTRATOR

SECTION 13.(a) G.S. 58-56-51(b) reads as rewritten:

"(b) Each application for the issuance or renewal of a license shall be made upon a form prescribed by the Commissioner and shall be accompanied by a nonrefundable filing fee of one hundred dollars ($100.00) and evidence of maintenance of a fidelity bond, errors and omissions liability insurance, or other security, of a type and in an amount to be determined by rules of the Commissioner. Applications for issuance of licenses shall include or be accompanied by the following information and documents:

(1) All organizational documents of the TPA, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, or trust agreement, any other applicable documents, and all amendments to these documents.

(2) The bylaws, rules, regulations, or similar documents regulating the internal affairs of the TPA.

(3) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of affairs of the TPA, including all (i) members of the board of directors, board of trustees, executive committee, or other governing board or committee, (ii) the principal officers in the case of a corporation or the partners or members in the case of a partnership or association, (iii) all shareholders holding directly or indirectly ten percent (10%) or more of the voting securities of the TPA, and (iv) any other person who exercises control or influence over the affairs of the TPA.

(4) Annual financial statements or reports for the two most recent years that prove that the applicant is solvent and any other information the Commissioner may require in order to review the current financial condition of the applicant.

(5) A general description of the business operations, including information on staffing levels and activities proposed in this State and nationwide. The description must provide details setting forth the TPA's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping, and underwriting.

(6) If the applicant will be managing the solicitation of new or renewal business, evidence that it employs or has contracted with an agent licensed by this State for soliciting and taking applications. Any applicant that intends to directly solicit insurance contracts or to otherwise act as an insurance agent must provide proof of having a license as an insurance agent in this State.

(7) Any other pertinent information required by rules of the Commissioner.

The information required by subdivisions (1) through (7) of this subsection, including any ~~trade secrets, shall be kept confidential; provided that the Commissioner may use that information in any judicial or administrative proceeding instituted against the TPA. Applications for renewals of licenses shall include or be accompanied by any changes in the information required by subdivisions (1) through (7) of this subsection.~~documents, materials, or other information in the possession or control of the Department that are furnished by a third-party administrator, insurer, producer, or any employee or agent acting on behalf of the third-party administrator, insurer or producer, or obtained by the Commissioner, shall be kept confidential. However, the Commissioner may use those documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties."

SECTION 13.(b) Article 56 of Chapter 58 of the General Statutes is amended by adding the following new subdivisions to read:

"(b1) In order to assist in the performance of the Commissioner's duties, the Commissioner may:

(1) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (b) of this section, with other state, federal, and international regulatory agencies, with the NAIC and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information.

(2) Receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(3) Enter into agreements governing sharing and use of information consistent with this section.

(b2) No waiver of an existing privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (g) of this section.

(b3) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this State.

(b4) In this section, 'department', 'insurance regulator', 'law enforcement official or authority', 'NAIC', and 'regulatory official or agency' include employees, agents, consultants, and contractors of those entities.

(b5) Applications for renewals of licenses shall include or be accompanied by any changes in the information required by subdivisions (1) through (7) of subsection (b) of this section."

SECTION 14. This act becomes effective October 1, 2001.